








2014 Forging New Frontiers: “Preparing for the Challenge of Childhood Injury Prevention”

The 19th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with
Cincinnati Children’s Hospital Medical Center
December 5-7, 2014

The 2014 Injury Free Coalition for Kids® Conference in Fort Lauderdale, FL, 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 2014 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

CHES
Sponsored by Cincinnati Children’s, a designated provider of continuing education contact hours (CECH) in 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 13.5 total Category 1 contact education contact hours. Maximum advanced-level continuing education contact hours available are 0.

CME
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 providership of Cincinnati Children’s Hospital Medical Center and the Injury Free Coalition for Kids through the Center for Injury Epidemiology & Prevention, Mailman School of Public Health, Columbia University. 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 13.25 *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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Welcome to South Florida!

We are so pleased to have you here for a fantastic conference – the 19th Annual Injury Free Coalition for Kids National Conference – with great speakers, new science, effective programs and a reunion of Injury Free colleagues. This year we welcome back two Injury Free alumnae among our keynote speakers, Beth Edgerton and Joseph Wright. Dr. Edgerton will speak with us about successful prevention strategies and Dr. Wright about advancing advocacy.

We are honored to have among us Susan Baker, public health heroine and universal role model, as our keynote speaker Saturday. Dr. Baker is highly accomplished and has helped define the field, so she is in a unique position to give us a perspective on where we need to go, how we ought to prioritize into the future to best protect our children.

Florida Senator Chris Smith will be our keynote speaker Sunday. Senator Smith has been an outspoken critic of Florida's Stand Your Ground Law. He will be addressing us from his home district, which includes Ft. Lauderdale.

It has been a year of injury challenge, from children left in hot cars, to the rapid introduction of electric cigarettes, to reversal of the injunction against enforcement of the physician gag law. Injury Free folk have “been there” to meet all these challenges and more – building parks, testifying before legislators, evaluating products and programs, forming new partnerships and growing their coalitions. Just prior to the conference, Injury Free-Miami, helped by Injury Free board members and their sites will work to reduce child firearm injury, providing gunlocks in downtown Miami. Local law enforcement, Holtz Children's Hospital, Miami Dade County Public Schools and other partners will join in the effort.

In addition to our presenters, our sponsors make this conference special – and possible – we appreciate their support. Enjoy the conference, the camaraderie and the Florida sunshine,

A handwritten signature in cursive script that reads "Judy Schaechter".

Judy Schaechter, MD, MBA
Injury Free Coalition for Kids Board President
Interim Chair, Department of Pediatrics
Associate Professor of Pediatrics, Division of Adolescent Medicine
University of Miami Miller School of Medicine
Chief of Service, Holtz Children's Hospital



Welcome to the 19th Annual Injury Free Coalition for Kids Conference,

The National Program Staff and the Injury Free Board look forward to hearing your presentations and learning about the important research and program work that you are doing. We have outstanding keynote speakers starting with Dr. Beth Edgerton from HRSA and Dr. Joseph Wright from Howard University, on Friday, and Dr. Susan Baker from Hopkins on Saturday. On Sunday Senator Christopher Smith from Florida will bring us up to date on Stand Your Ground.

This year we are adding a Friday networking session for the Principal Investigators and also one for the Program Coordinators. Injury Free sites have much to contribute to each other in program development, problem solving and preparation for Trauma Center verification.

The Program Committee again invited all eleven CDC Injury Control Research Centers to submit abstracts for presentation. The Scientific Committee chose three of these abstracts for presentation. Dr. Karin Mack, PhD, Associate Director for Science for the Division of Analysis, Research, and Practice Integration at the National Center for Injury Prevention and Control will comment after their presentations.

So network, network, network while seeking solutions to all your Injury Prevention struggles.

A handwritten signature in cursive script that reads "Barbara Barlow".

Barbara Barlow MD, MA
Professor of Surgery in Epidemiology Emerita
Associate Director Center for Injury Epidemiology and Prevention
Columbia University, Mailman School of Public Health
Executive Director and Founder
Injury Free Coalition for Kids



Elizabeth Edgerton, MD, MPH
HRSA Branch Chief for EMSC and Injury Prevention
Rockville, MD

Elizabeth Edgerton, MD, MPH, is the Director of the Division of Child, Adolescent and Family Health at the Maternal and Child Health Bureau (MCHB). Her Division is home to Emergency Medical Services for Children, Injury and Violence Prevention, Bright Futures, Adolescent Health and Oral Health initiatives. As an academician and program administrator, Dr. Edgerton has worked in the fields of EMSC and injury prevention throughout her career.

Dr. Edgerton is a graduate of the Robert Wood Johnson Clinical Scholars Program at UCLA/RAND and was the co-director of the Harbor-UCLA Injury Free Coalition for Kids site and helped to establish the Children's National Medical Center Injury Free site in Washington, DC. She is a previous EMSC Targeted Issues grantee and a recipient of the 2004 National Heroes Award for Outstanding EMSC Research Project. She has served on numerous national advisory panels, including MCHB's Advisory Committee on Heritable Disorders in Newborns and Children and the CDC's National Center for Injury Prevention and Control SAFE USA Partnership Council.

Dr. Edgerton is a past Director of Clinical Prevention for the U.S. Preventive Services Task Force at the Agency for Healthcare Research and Quality, and most recently served as an attending physician in the Emergency Medicine and Trauma Center at Children's National Medical Center in Washington, DC.



Joseph L. Wright, MD, MPH

Professor and Chairman
Department of Pediatrics and Child Health
Howard University College of Medicine
Washington, DC

Joseph L. Wright, MD, MPH is the newly appointed Professor and Chairman of Pediatrics at the Howard University College of Medicine in Washington, DC. He most recently served as Senior Vice President for Community Affairs at Children's National Medical Center the nation's third-oldest children's hospital where he provided strategic leadership for the organization's advocacy mission, public policy positions and community partnership initiatives. He maintains adjunct appointment as professor of emergency medicine and health policy at the George Washington University Schools of Medicine and Public Health. Dr. Wright is among the original cohort of board-certified pediatric emergency physicians in the United States with scholarly interests that include prehospital pediatrics, injury prevention and the needs of underserved communities.

Academically, he has contributed to over 80 publications in the scientific literature and has been admitted as an elected member of Delta Omega, the nation's public health honor society. Dr. Wright's advocacy and public policy leadership has been recognized throughout his career including by the American Academy of Pediatrics as recipient of the Fellow Achievement Award for exceptional contributions in injury prevention, and the Distinguished Service Award for career achievement in pediatric emergency medicine.

He has been appointed to several Institute of Medicine study committees including Pediatric End-of-Life Care, the Future of Emergency Care and Youth Sports Concussions, as well as, provides leadership through service on several national advisory bodies including the American Hospital Association's Maternal and Child Health Council, the March of Dimes' Public Policy Advisory Council, and recently as an Obama administration appointee to the Food and Drug Administration's Pediatric Advisory Committee. Dr. Wright regularly delivers invited expert testimony before Congress and state and municipal legislative bodies, has made numerous media appearances, and lectures widely to both professional and lay audiences.

Dr. Wright earned a B.A. from Wesleyan University in Middletown, CT, his M.D. from Rutgers New Jersey Medical School, and a Masters of Public Health in Administrative Medicine and Management from the George Washington University.



Susan Baker, MPH, ScD (Hon.)

Johns Hopkins School of Public Health

Susan P. Baker, MPH, ScD (Hon.) is a professor of Health Policy and Management at the Johns Hopkins School of Public Health, with joint appointments in the School of Medicine Departments of Pediatrics and Emergency Medicine. She was the founding director of the Johns Hopkins Center for Injury Research and Policy. She is an epidemiologist specializing in injury prevention; her research interests over the past 45 years have included road safety, aviation safety, and occupational safety, as well as poisoning, burns, drowning, and other unintentional and intentional injuries.

She has been especially interested in prevention of injury to young children. Her 13 years in the Office of the Chief Medical Examiner of Maryland trained her to look for the specific details of what happened as well as the factors that determined survival, leading her to read the case histories themselves rather than relying upon coded data. This has contributed to her interest in training doctoral candidates to go beyond analyzing the coded data that is easily found on computer tapes to learning about underlying circumstances – which are typically the key to prevention.

Students also benefit from her emphasis on the administrative, regulatory, and cultural environments that often determine the occurrence and outcome of injury-producing events. She is well known for research showing the need for child restraints in cars, and for developing the widely used Injury Severity Score and authoring *The Injury Fact Book*.

She takes great pleasure in her students, who have founded other centers for injury prevention and are conducting research and injury prevention programs all over the world while they train the leaders of the future.



Senator Christopher Smith

Florida State Senate District 31

Senator Christopher Smith began his public service by serving on local boards within the City of Fort Lauderdale. In 1995 he was appointed to the City's Planning and Zoning Board. At a time of tremendous development within the City of Fort Lauderdale, Senator Smith fought seeking a balance between the need for economic development and the rights of existing property or homeowners.

In 1998 Senator Smith was elected to the Florida House of Representatives serving the City of Fort Lauderdale and six surrounding municipalities. An early and strong advocate for Smart Justice, while in the House of Representatives Senator Smith led the charge against the tough on crime policies of the then Governor, Jeb Bush administration. After the election fiasco of 2000 in which Florida votes were ultimately decided by the Supreme Court, Senator Smith co-authored Florida's election reform package of 2000 which became a model for the rest of the nation. In his final term in the Florida House of Representatives Senator Smith was elected by his peers as the youngest ever Democratic Leader in Florida Legislature.

After being term limited out of the House of Representatives, Senator Smith was elected to the Florida Senate in 2008 representing Broward and Palm Beach County. Due to redistricting Senator Smith now represents 14 municipalities in Central Broward County. In only the third year of his first term, Senator Smith was once again elected Democratic Leader of the senate. As Democratic Leader he is once again setting Democratic policy on statewide issues.

After the tragic death of Trayvon Martin in Sanford, Florida, Senator Smith called upon the Governor and Legislature for action. Due to inaction Senator Smith formed his own Task Force to discuss the controversial Stand Your Ground law in the State of Florida. After fighting against Stand Your Ground when it was first introduced 2005 he has now authored bills on revising Stand Your Ground. Senator Smith has been used as an expert nationwide on the effects of Stand Your Ground legislation. He has discussed the ramifications of that law on CNN, MSNBC, FOX News, NPR and numerous other media outlets. He is currently the author of Senate Bill 122 which is a revision of Stand Your Ground scheduled to be heard this fall in the Florida Senate.

Senator Smith is a graduate of Johnson C Smith University, in Charlotte North Carolina and a law graduate of Florida State University College of Law. He is a partner with the firm of Johnson, Anselmo et al. He has been married for 13 years to Desiree Giles Smith, current Assistant City Manager for the City of Lauderhill. He is the proud father of two, Christopher age 12 and Christian age 7.



Congratulations to the 2014 Abstract of the Year Award Nominees

The people and abstracts below were selected and nominated to receive an award for abstract of the year. Each abstract was judged on the degree to which the research topic identified a new area of study and/or addressed the topic in a novel and unique manner, the degree to which the methodology of the research was scientifically valid, the degree to which the research topic was relevant to injury control or violence prevention, the degree to which the presenter articulated the research and responded to questions and critiques and the degree to which the author communicated the hypothesis, methodology, research, results, and conclusion of the research through written word.

Scoring and ranking will take place during the conference and the award will be presented Sunday afternoon at the conclusion of the conference. There will be two awards: one for best original research abstract and one for best program description or evaluation abstract.

Program Evaluation

Jamie R. Macklin: When Sleeping Isn't Safe: Improving Safe Sleep Practices in Ohio with the EASE Project

Marie Crew: Teen Driving Toolkit for Pediatricians

Aaron Heffernan, MA, LCSW: Hip Hop Summer Camp: A Description of a Therapeutic Arts Program for Preventing Injury
in Child Survivors of Violence in Urban Milwaukee

Original Research

Tanya Charyk Stewart: From Focus Groups to Distracted Driving Video: Using Teen Input to Drive Injury Prevention Programming

Mike Gittelman: A Multi-Center Study of Preventable Contact Burns from Glass Fronted Gas Fireplaces

Eunice Blackmon: Hospital Infant Safe Sleep (HISS) Fails to Model AAP Guidelines

Michael A. Gittelman: A Quality Improvement Program Implemented into Primary Pediatrician Offices Can Encourage Families to Practice Safer Behaviors

Wendy J Pomerantz: Impact of Education on Knowledge and Attitudes of High School Athletes about Concussions

Thank You for Your Service: 2014 PC of the Year Nominees



Dawne Gardner, MBA
Cincinnati, OH



Esther Borer
Worcester, MA



Donna Childress, MPA
Atlanta, GA



Purnima Unni, MPH, CHES
Nashville, TN



Pina Violano, MSPH, RN-BC, CCRN, PhD (c)
New Haven, CT



The National Program Coordinator of the year award recognizes an individual who has developed and implemented local or statewide Injury Free program and/or policy initiatives that have resulted in improved outcomes.

The award began at the 2013 annual conference when Beverly Miller, MEd, of Little Rock, received the first award.

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Schedule at a Glance

Wednesday, December 3, 2014		Room
3:00 am - 5:00 pm	Registration	Lobby
Thursday, December 4, 2014		
7:00 am - 8:30 am	Breakfast	Atrium
8:00 am - 9:00 am	Registration	Lobby
10:30 am	Press Conference: (transportation leaves the hotel at 8:30 am) Alamo Courtyard, Jackson Memorial Hospital • 1611 NW 12th Avenue, Miami, FL	Miami, FL
11:00 am - 1:00 pm	Gun lock Giveaway: (transportation leaves the hotel at 8:30 am) Alamo Courtyard, Jackson Memorial Hospital • 1611 NW 12th Avenue, Miami, FL	Miami, FL
3:00 pm - 6:00 pm	Registration	Lobby
Friday, December 5, 2014		
7:00 am - 8:30 am	Breakfast	Atrium
8:00 am - 9:00 am	Registration	Lobby
9:00 am - 9:10 am	Welcome Judy Schaechter, MD, MBA, Board President	Causeway I-III
8:40 am - 8:50 am	Introduction of Keynote Speaker: Michael Hirsh, MD	Causeway I-III
8:50 am - 9:50 am	Keynote Speaker Joseph Wright, MD, MPH	Causeway I-III
9:50 am - 10:00 am	Break	
10:00 am - 12:00 am	PI Meeting	Salon D-E
10:00 am - 12:00 am	PC Meeting	Causeway I-III
12:00 pm - 1:30 pm	Lunch	Atrium
1:30 pm - 1:40 pm	Introduction of Keynote: Barbara Gaines, MD	Causeway I-III
1:40 pm - 2:40 pm	Keynote Speaker: Beth Edgerton, MD, MPH	Causeway I-III
2:40 pm - 4:00 pm	Panel Discussion: MOC, QI and Tablets; New Frontiers in Anticipatory Guidance for Injury Prevention	Causeway I-III
4:00 pm - 4:15 pm	Break	
4:15 pm - 5:30 pm	“Banging Heads and Water Safety” Brief Interventions for Concussion Education and Understanding Water and Boating Safety	Causeway I-III Causeway I-III
6:00 pm - 7:30 pm	Reception Dinner on your own	Aqua/Terra Ballroom
7:30 pm	Board Meeting	Gulfstream B
Saturday, December 6, 2014		
7:00 am - 8:00 am	Breakfast	Atrium
8:00 am - 8:05 am	Opening Remarks, Judy Schaechter, MD, MBA	Causeway I-III
8:05 am - 8:15 am	Introduction of Keynote Speaker: Barbara Barlow, MD, MA	Causeway I-III
8:15 am - 9:00 am	Keynote Speaker: Susan Baker, MPH, ScD (Hon.)	Causeway I-III
9:00 am - 9:15 am	Break	
9:15 am - 10:35 am	Panel Discussion: Everything Old is New Again: Finding New Approaches to the Prevention of Known and Emerging Injury Risks	Causeway I-III
10:35 am - 10:50 am	Break	
10:50 am - 12:10 am	Panel: Innovation and Research at CDC Injury Control Research Centers Moderator: Steven Rogers, MD	Causeway I-III
12:10 pm - 12:20 pm	CDC Responsive Comments: Karin Mack, PhD	Causeway I-III
12:20 am - 1:45 pm	Lunch	Atrium
1:45 pm - 3:05 pm	Panel Discussion: New Inroads in Safe Teen Driving	Causeway I-III
3:05 pm - 3:20 pm	Break	
3:20 pm - 4:40 pm	Panel Discussion: Hospital Based Child Passenger Safety Programs: Addressing Child Safety Seat Needs and Parental Education	Causeway I-III
6:00 pm - 7:00 pm	Reception	Aqua
7:00 pm	Dinner	Terra Ballroom

Sunday, December 7, 2014

		Room
7:00 am	Breakfast	Atrium
7:30 am - 8:45 am	Business Meeting	Causeway I-III
8:45 am - 9:00 am	Break	
9:00 am - 9:10 am	Introducion of Keynote Speaker: Judy Schaechter, MD, MBA	Causeway I-III
9:10 am - 10:00 am	Keynote Speaker: Senator Christopher Smith	Causeway I-III
10:00 am - 11:20 am	Panel Discussion: Youth Violence: Are There Evidence Based Prevention Strategies?	Causeway I-III
11:20 am -11:35 am	Break	
11:35 am - 1:00 pm	Panel Discussion: Keeping Children Safe in the Car and on the Road	Causeway I-III
1:00 pm	Lunch - Presentation of Awards for Research Papers	Terra Ballroom

Agenda

Friday December 5, 2014

Time & Room

7:00 - 8:30
Atrium

Breakfast

8:00 - 8:30
Lobby

Registration

8:30 - 8:40
Causeway I-III

Welcome Judy Schaechter, MD, MBA, Board President

8:40 - 8:50
Causeway I-III

Introduction of Keynote Speaker: Michael Hirsh, MD

8:50 - 9:50
Causeway I-III

Keynote Speaker Joseph Wright, MD, MPH

The Patient Protection and Affordable Care Act (PPACA) has placed heightened emphasis on the responsibility of tax-exempt, non-governmental hospitals to provide community benefit to the localities that they serve. Here-to-fore, community benefit was primarily a hospital corporate compliance function. However, the advent of greater specificity and more uniformity around the definition and delivery of community benefit is providing new advocacy and scholarship opportunities for university faculty and prevention scientists. Academic medical centers will also be compelled to proactively address local population health challenges, such as childhood injury, as a direct mandate of community benefit compliance. This didactic presentation focuses on the alignment of institutional community benefit compliance with a population health improvement agenda.

This session will enable participants to:

1. Discuss a model approach employed in the District of Columbia (DC), i.e. the DC Healthy Communities Collaborative, that involves partnership of academic medical center and community-based health leadership.
2. Describe the live, interactive navigation of a web-based data portal serving as an active repository of local population health-related metrics.
3. List ways collaboration among hospitals and community-based partners can produce a cost-efficient response to local health needs at the population-level and provide scholarly opportunities for academic medical center faculty.
4. Describe how fundamental tenets of the Health Care Reform legislation can be leveraged to promote commitment to community health improvement by hospitals.
5. Recognize how leadership advocacy exercised by clinicians and prevention scientists can productively engage hospital administrators to meet both corporate compliance requirements and confer meaningful public health benefit on communities served.

9:50 - 10:00

Break

10:00 - 12:00
Causeway I-III
Salons D-E

PI Meeting

PC Meeting

12:00 - 1:30
Atrium

Lunch

1:30 - 1:40
Causeway I-III

Introduction of Keynote Speaker: Barbara Gaines, MD

1:40 - 2:40
Causeway I-III

Keynote Speaker Beth Edgerton, MD, MPH

2:40 - 4:00
Causeway I-III

Panel Discussion: MOC, QI and Tablets; New Frontiers in Anticipatory Guidance for Injury Prevention

Quality improvement (QI) and Maintenance of Certification (MOC) can be utilized as tools to help support injury prevention within both institutions and primary care practices. This abstract session will have three agendas: highlighting efforts to create efficient, informative injury prevention counseling that results in behavior change in the primary care office setting through MOC projects; use of a tablet based educational system for widespread dispersion

Agenda, cont.

of consistent, up to date injury prevention advice, and evaluating the consistency with which children’s hospitals model safe sleep behavior beyond the newborn nurseries.

This session will enable participants to:

1. Recognize that many children’s hospitals have sleep environments that do not look like what we are recommending for our patients, and assess what safe sleep advice is being followed and what is not in the in-patient (non-nursery) setting.
2. Describe how QI and safety committees can be powerful tools for helping hospitals to increase their compliance with recommended injury prevention strategies.
3. Describe how a tablet based injury prevention teaching system can be developed, deployed, and kept updated.
4. Discuss the power of MOC as a mechanism for enlisting injury prevention education and program support in busy primary care settings.
5. Recognize new perspectives on methods for evaluation of compliance with injury prevention guidelines by individuals and institutions.

Panel Discussion Moderator: Susan H. Pollack MD,
 Director, Pediatric and Adolescent Injury Prevention Program
 KY Injury Prevention and Research Center
 Coordinator, Kentucky State Safe Kids Coalition
 Assistant Professor, University of Kentucky
 Department of Pediatrics, College of Medicine
 Department of Preventive Medicine, College of Public Health
 PI, Injury Free Coalition for Kids of Lexington at KCH

Presenters:

- Michael Gittleman, MD: A Quality Improvement Program Implemented into Primary Pediatrician Offices Can Encourage Families To Practice Safer Behaviors
 Steve Rogers, MD: The Pediatric E-Network: A Pilot Program for Providing Injury Prevention
 Jamie R. Macklin, MD: Education When Sleeping Isn’t Safe: Improving Safe Sleep Practices in Ohio with the EASE Project

4:00 - 4:15

Break

4:15 - 5:30

Causeway I-III

Panel Discussion. “Banging Heads and Water Safety” Brief Interventions for Concussion Education & Understanding Water and Boating Safety.

Two critical pediatric injury problems will be addressed in this session: the first two panel presentations are about concussions. There are between an estimated 1.6 and 3.8 million sports-related concussions in the United States every year. Concussions account for 13.2% of injuries and concussion reporting rates have doubled in the past decade. It is estimated that high school athletes sustain an estimated 136,000[3] to 300,000 concussions per year. The first abstract will present the results of a randomized controlled brief education intervention with high school athletes.

The second presentation addresses the sustainability of concussion prevention through implementation of an injury surveillance system. The second half of this session focuses on water safety, specifically drowning and boating safety. Every day, about ten people die from unintentional drowning. Of these, two are children aged 14 or younger. Drowning ranks fifth among the leading causes of unintentional injury death in the United States. In 2012, the Coast Guard counted 4515 accidents that involved 651 deaths, 3000 injuries as a result of recreational boating accidents. The fatality rate was 5.4 deaths per 100,000 registered recreational vessels. The first presentation is an epidemiological study on pediatric drowning and near drowning and the second examines boating safety.

This session will enable participants to:

1. Discuss the strength and limitations of a brief concussion education intervention with urban high school athletes.
2. Describe how to implement a standardized concussion management program for high school sport.
3. Discuss how to implement a concussion injury surveillance system.

Agenda, cont.

4. Recognize variability in drowning and near-drowning by age.
5. List key risk factors for boat-related injury and death.

Panel Discussion Moderator: Peter Ehrlich, MD
 Associate Professor, Surgery & Pediatric Surgery
 University of Michigan Medical School;
 Medical Director, Pediatric Trauma
 CS Mott Children's Hospital
 PI, Injury Free Coalition for Kids of Ann Arbor, MI

Presenters

Wendy Pomerantz, MD, MS: Impact of Education on Knowledge and Attitudes of High School Athletes about Concussions

Gillian Holtz, PhD: Sustaining a Countywide Concussion Care Program™

Purnima Unni, MPH: Variability in circumstances of pediatric drowning and near-drowning: Implications for injury prevention

Sarah Stempski MPH, MCHES: New science on boating behavior and risk,

6:30 - 7:30

Aqua/Terra Ballroom

Welcome Reception

7:30

Gulfstream B

Board Meeting

Saturday December 6, 2014

7:00 - 8:00

Atrium

Breakfast

8:00 - 8:05

Causeway I-III

Good Morning Judy Schaechter, MD, MBA

8:05 - 8:15

Causeway I-III

Introduction of Keynote Speaker: Barbara Barlow, MD, MA

8:15 - 9:00

Causeway I-III

Keynote Speaker Sue Baker, MPH, ScD (Hon.): Unfinished Business -- Protecting Our Children from Injury

9:00 - 9:15

Break

9:15 - 10:35

Causeway I-III

Panel Discussion: Everything Old is New Again: Finding New Approaches to the Prevention of Known and Emerging Injury Risks

Injury remains the #1 killer of children and teens in the US with more than 9000 youth deaths from unintentional injuries each year and millions more requiring treatment in the emergency department. When coupled with youth violence and suicide, there continues to be a significant public health problem with lasting physical and emotional harmful effects to individuals, families and communities and with a substantial financial burden in both healthcare costs and future productivity. While injury deaths have decreased by 29% in the last decade, fire and burn injuries remain a leading cause of death, and overdose deaths from opioid pain relievers have tripled. This panel will provide insight into mitigation of well-known injury risks such as violence and suicide, but will also explore emerging injury risks.

This session will enable participants to:

- 1) Describe risk factors, medical interventions and clinical outcomes of unintentional opioid exposures in young children.
- 2) Discuss factors associated with the increasing prevalence of deaths involving opioid poisoning.
- 3) Describe the types of burns associated with glass fronted gas fireplaces.
- 4) Describe how state surveillance systems for suicide cases can be utilized to develop suicide prevention programs.
- 5) Identify opportunities to design innovative violence prevention programs that incorporate evidence-based interventions.

Agenda, cont.

Panel Discussion Moderator: Terri McFadden, MD
Associate Professor
Dept of Pediatrics, Emory University School of Medicine
Primary Care Medical Director
Hughes Spalding Campus of Children's Healthcare
PI, Injury Free Coalition for Kids of Atlanta, GA

Presenters:

Aaron Heffernan, MA, LCSW: Hip Hop Summer Camp: A Description of a Therapeutic Arts Program for Preventing Injury in Child Survivors of Violence in Urban Milwaukee

Anagha Loharikar, MD: Suicide in Illinois, 2005-2010: A Reflection of Patterns, Risks and Opportunities for Prevention

Pallavi Ghuge, MD: Unintentional Opioid Ingestions Presenting to a Pediatric Emergency Department

Lucy Wibbenmeyer, MD, FACS: A Multi-Center Study of Preventable Contact Burns from Glass Fronted Gas Fireplaces

10:35 - 10:50

Break

10:50 - 12:10

Causeway I-III

Panel Discussion: Innovation and Research at CDC Injury Control Research Centers

In 1987 the CDC began funding Injury Control Research Centers (ICRCs) throughout the United States to study ways to prevent injuries and disabilities. Injury Control Research Centers conduct research in all three core phases of injury control (prevention, acute care, and rehabilitation) and serve as training centers as well as information centers for the public. Research design in these centers is interdisciplinary and incorporates the fields of medicine, engineering, epidemiology, law, and criminal justice, behavioral and social sciences, biostatistics, public health, and biomechanics. During this session we will hear from leaders in our field working at Center for Disease Control (CDC) funded Injury Control and Research Centers (ICRC's) from across the country. We will learn about the feasibility of developing multi-center databases to help guide injury prevention measures at hospital based Safety Centers. We will also learn about a novel approach to reduce bullying through the integration of art and academics. Finally, the power of legal penalties to reduce injury rates will be demonstrated during a presentation about the affects Leandra's Law.

This session will enable participants to:

1. Recognize the complexities of developing a multi-center data base and strategies for conducting quality improvement initiatives in Injury Prevention.
2. Discuss the importance of using a public health approach to prevent bullying and how a novel arts-based program can address the problem of bullying.
3. Describe the positive impact that enacting legal penalties can have on preventing injuries through an analysis and interpretation of data from a New York law.
4. Describe the role of a CDC funded Injury Control and Research Center.
5. Recognize opportunities for future Injury Prevention research projects.

Panel Discussion Moderator: Steven C. Rogers, MD
Pediatric Emergency Medicine Specialist
Associate Research Director
Div. of Emergency Medicine
Coordinator of Emergency Psychiatric & Behavioral Health Services
Connecticut Children's Medical Center Research Scientist
Connecticut Children's Injury Prevention Center
Assistant Professor- University of Connecticut School of Medicine
PI, Injury Free Coalition for Kids of Hartford, CT

Presenters:

Eileen McDonald, MS: The Development of a National Database to Assess Children's Hospital Safety Centers

Corinne Peek-Asa, PhD: Using Art to Reduce Cyberbullying in School,

Guohua Li, MD, DrPH: Impact of Leandra's Law on Child Passenger Safety in New York

Time & Room

Agenda, cont.

12:10 - 12:20

Causeway I-III

Comments Karin Mack, PhD
Associate Director for Science
Division of Analysis, Research, and Practice Integration
National Center for Injury Prevention and Control Centers for Disease Control & Prevention

12:20 - 1:45

Atrium

Lunch

1:45 - 3:05

Causeway I-III

Panel Discussion: New Inroads in Safe Teen Driving

Although there has been progress in the number of teen driving fatalities over the past 10 years, motor vehicle crashes remain the leading cause of death for teens in the US. Teens have an especially high rate of crashes in the first few years of driving, often due to inexperience and distraction. In this session, we will hear about new and ongoing programs developed to promote safe teen driving. The presenters will explain the rationale for the programs, describe fresh ideas about developing and instituting the programs, and present methods of measuring the impact of the programs. The use of novel and advancing technologies will be included.

This session will enable participants to:

1. Differentiate between approaches to promote safe driving for new teen drivers.
2. Discuss the use of advancing technologies in teen safe driving programs.
3. Describe methods of analyzing the impact of teen driving programs.
4. Discuss the importance of graduated driver licensing on reducing teen driver crashes.
5. Describe the use of focus groups to guide teen driving program development.

Moderator: Anne Brayer, MD

Professor, Emergency Medicine, and Pediatrics
University of Rochester Medical Center
PI, Injury Free Coalition for Kids of Rochester, NY

Presenters:

Lisa Wolfs, BScN: Informing Teens, Preventing Injuries: 25 Years of Impact

Marie Crew, RN: Teen Driving Toolkit for Pediatricians

Garry Lapidus, PA-C, MPH: Permission to Park: A Statewide Study of High School Parking

Permits to Determine Compliance with Graduated Driver Licensing Law

Tanya Charyk Stewart, MSc: From Focus Groups to Distracted Driving Video: Using Teen Input to Drive Injury Prevention Programming,

3:05 - 3:20

Break

3:20 - 4:40

Causeway I-III

Panel Discussion: Hospital Based Child Passenger Safety Programs: Addressing Child Safety Seat Needs and Parental Education

Motor vehicle crashes continue to be a leading cause of death and injury in children. The proper use of child safety seats can decrease the risk of fatal injury by 70% in the event of a crash. Unfortunately, many children continue to ride unrestrained or improperly restrained in child safety seats. Hospital based child passenger safety programs are important methods to provide child safety seats and child passenger safety education to patients and families. This panel will address several models for child passenger safety education programs for parents in both the inpatient and outpatient setting. The education of staff who can provide car seat consults will also be discussed.

This session will enable attendees to:

- 1) Describe different inpatient and outpatient models for child passenger safety programs.
- 2) List several different methods for educating parents about child passenger safety.
- 3) Describe various models of assessing the child passenger safety knowledge of parents.
- 4) Discuss a car seat educator model to train staff who are not certified as Child Passenger Safety Technicians to participate in a child passenger safety program.
- 5) Recognize the importance of hospital-based child passenger safety programs in increasing the knowledge and use of child passenger safety for patients and families.

Agenda, cont.

Panel Discussion Moderator: Lois Lee, MD, MPH
 Pediatric Emergency Medicine Physician
 Boston Children's Hospital
 Assistant Professor of Pediatrics, Harvard Medical School
 PI, Injury Free Coalition for Kids of Boston, MA

Presenters:

Dina Morrissey, MD, MPH, CPSTI: Does an Inpatient Child Passenger Safety (CPS) Screening Program Improve CPS knowledge, Attitude and Practice among Families
 Katie Horrigan, MPH: Components of a Comprehensive Hospital Based Car Seat Program
 Catherine Rains, MPH: Are Parents Getting the Message? Evaluating Child Safety Seat Consultations at a Hospital Safety Resource Center
 Erin Kuroiwa, MHI: Car Seat Education: What Works Best?

6:00 - 7:00 Reception
 Aqua
 7:00 Dinner
 Terra Ballroom

Sunday December 7, 2014

7:00 Breakfast
 Atrium

7:30 - 8:45 Business Meeting
 Causeway I-III

8:45 - 9:00 Break

9:00 - 9:10 Introduction of Keynote Speaker: Judy Schaechter, MD, MBA
 Causeway I-III

9:10 - 10:00 Keynote Speaker Senator Christopher Smith
 Causeway I-III

10:00 - 11:20 Panel Discussion: Youth Violence: Are There Evidence Based Prevention Strategies?
 Causeway I-III

Pediatric healthcare professionals have long recognized the increase in youth violence. In 2013, pediatric trauma centers in the United States (U.S.) reported 14,123 assault injuries to the National Trauma Data Bank, accounting for 9.2% of all injuries reported and 882 deaths. Assault injury has a high case fatality rate 6.25% only second to self-inflicted injuries. This discussion will review current research in juvenile violence. Topics to include screening for risky behaviors, dating violence, prosecution for unsecured firearms as a preventative measure for unintentional firearm injuries and review of patterns and risk for firearm death. At the end of this in-depth discussion participants will be able to incorporate strategic measures to decrease juvenile violence.

This session will enable participants to:

1. State two risk factors for dating violence.
2. Discuss preventative measures in education to decrease dating violence.
3. Identify weakness and strengths of screening adolescents in primary care setting.
4. Identify disparities in laws for unintentional firearm occurrences.
5. Identify injury prevention strategies to decrease suicide and homicide rates among adolescents.

Panel Discussion Moderator: Matthew L. Moront, MD
 Chief of Pediatric Surgery &
 Trauma Medical Director
 St. Christopher's Hospital for Children's
 PI, Injury Free Coalition for Kids of Philadelphia, PA

Presenters:

Alison Riese, MD MPH: The use of adolescent health risk behavior questionnaires, discussions of youth violence, and its relationship with other risk behavior discussions in primary care
Judy Schaechter, MD, MBA: Pediatric Unintentional Firearm Injury and Gun Ownership/Storage Prosecution
Anagha Loharikar, MD: Deaths from Firearms among Young Victims in Illinois, 2005-2010: a reflection of patterns, risks and opportunities for prevention

11:20 - 11:35

Break

11:35 - 1:00

Causeway I-III

Panel Discussion: Child Passenger, Pedestrian and Bicyclist Safety

Motor vehicle crashes are a leading cause of morbidity and mortality in children in the United States. Many of the deaths from motor vehicle crashes can be prevented by the use of age-appropriate restraints and reductions in impaired and distracted driving. Motor vehicle occupants are not the only ones at risk. According to the Centers for Disease Control, pedestrians are 1.5 times more likely than passenger vehicle occupants to be killed in a car crash on each trip. Other users of the road include bicyclists who are also at significant risk for injury. Data from the CDC reveals that while only 1% of all trips taken in the U.S. are by bicycle, bicyclists face a higher risk of crash-related injury and deaths than occupants of motor vehicles.

During this session, the panelists will discuss a model for evaluating the training of child passenger safety technicians, a program to improve child passenger safety for those at highest risk, factors associated with the use of proper restraints, racial disparities in the use of proper child restraints and pedestrian and bicycle safety programs.

This session will enable participants to:

1. Recognize how a logic model can be used to evaluate a child passenger safety program.
2. Identify how to use data from their own child passenger safety checklists to describe their efforts and identify potential gaps in service to in order to better align precious resources to the neediest groups.
3. Describe demographic factors associated with restraint use in motor vehicle crashes in children 0-9 years old and recognize that children riding in motor vehicles are still riding unrestrained, despite legislation and best practice recommendations regarding motor vehicle child passenger safety.
4. Recognize existing pediatric pedestrian and bicycle injury prevention programs and how to disseminate injury prevention programs using a train-the-trainer methodology.
5. Describe existing pediatric pedestrian and bicycle injury prevention programs and how to disseminate injury prevention programs using a train-the-trainer methodology.

Panel Discussion Moderator: Andrew W. Kiragu, MD

PI, Injury Free Coalition for Kids of Minneapolis, MN

Presenters:

Hope Mullins, MPH: Evaluation of a Child Passenger Safety Program
Amber Kroeker, MPH CPST: The Forgotten Child: Using Data to Drive Practice in Child Passenger Safety- Are we Missing the Mark?
Lois Lee, MD, MPH: Restraint Use in Motor Vehicle Crash Fatalities in Children 0-9 Years
Valerie Neilson MSP: Evidence Based Pediatric Injury Prevention Programs

1:00

Terra Ballroom

Lunch - Presentation of Awards for Research Papers

Accreditation Statement

CHES

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CME

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 providership of Cincinnati Children's Hospital Medical Center and the Injury Free Coalition for Kids through the Center for Injury Epidemiology & Prevention, Mailman School of Public Health, Columbia University. 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 13.25 *AMA PRA Category 1 Credit(s)*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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

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2014 Forging New Frontiers: “Preparing for the Challenge of Childhood Injury Prevention”

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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.

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

**2014 Forging New Frontiers:
“Preparing for the Challenges of
Childhood Injury Prevention”**



ABSTRACTS

Prevention Advocacy: Activating Your Institutional Voice in the Health Care Reform Era

Joseph Wright, MD, MPH

Background:

The Patient Protection and Affordable Care Act (PPACA) has placed heightened emphasis on the responsibility of tax-exempt, non-governmental hospitals to provide community benefit to the localities that they serve. Here-to-fore, community benefit was primarily a hospital corporate compliance function. However, the advent of greater specificity and more uniformity around the definition and delivery of community benefit is providing new advocacy and scholarship opportunities for university faculty and prevention scientists. Academic medical centers will also be compelled to proactively address local population health challenges, such as childhood injury, as a direct mandate of community benefit compliance.

Methods:

This didactic presentation focuses on the alignment of institutional community benefit compliance with a population health improvement agenda. Participants will be introduced to a model approach employed in the District of Columbia (DC), i.e. the DC Healthy Communities Collaborative, that involves partnership of academic medical center and community-based health leadership.

Live, interactive navigation of a web-based data portal serving as an active repository of local population health-related metrics will complement the didactic presentation content.

Results:

Collaboration vs. Competition: Working as collaborators, rather than competitors, health care entities in the District of Columbia learned to approach prevention opportunities in the community health environment from a place of cooperative synergy. Cost of Collaboration: Hospitals and community health centers contributed both financially and personnel resources to meet the collective goals of the DC Healthy Communities Collaborative. Hospital administrators representing participating medical centers were convinced of the cost efficiency of this approach in meeting institutional corporate reporting requirements. [1] Note: IRS issued guidance supporting collaborative community health needs assessments after the establishment of the DCHCC.

Conclusions:

Fundamental tenets of the Health Care Reform legislation can be leveraged to promote commitment to community health improvement by hospitals.

Leadership advocacy exercised by clinicians and prevention scientists can productively engage hospital administrators to meet both corporate compliance requirements and confer meaningful public health benefit on communities served. Collaboration among hospitals and with community-based partners can produce a cost-efficient response to local health needs at the population-level and provide scholarly opportunities for academic medical center faculty.

Objectives:

Attendees will learn:

- 1) About provisions of the Patient Protection and Affordable Care Act that address community benefit.
- 2) About strategies for conduction of a community health needs assessment and the development of a community health improvement plan.
- 3) How to develop the levers for the engagement of hospital administration in committing to a population health agenda.

Innovative Prevention Strategies from Safe Sleep to Bullying Prevention

Elizabeth Edgerton, MD, MPH

Background:

Injury and violence continues to be the leading cause of morbidity and mortality among infants, children and adolescents and takes the lives of a disproportionately high number of youth from at-risk communities. Over 4,000 infants die of sudden unexpected death annually, many that are associated with unsafe sleep environments. More than a third of middle school and high school students are affected by bullying which impacts on their health and well-being. The promotion of safe sleep and bullying prevention initiatives require complex behavior and environmental changes.

The Health Resources and Services Administration's Maternal Child Health Bureau optimized the strategies of collaborative innovation and improvement networks (CollIN) and social media to improve pediatric outcomes in these injury and violence prevention areas.

Methods:

Collaborative Innovation and Improvement Networks incorporates collaborative learning, common and coordinated strategies, measureable outcomes and continuous rapid cycles of change to drive change at a systems level. Focusing on safe sleep practices, the CollIN methodology was applied to states with high levels of infant mortality. Social media was used to deliver bullying prevention messages to adolescents and parents. Metrics were developed and analyzed to show

the spread of national prevention messaging and the impact on the content of social media conversations.

Results:

CollIN can be an effective tool to bring together diverse sectors to address a common problem over a short period of time using available best practices for rapid measurement of change. Social media is an effective tool to message hard to reach populations, and developed metrics can be identified to assess the impact on the dissemination and impact of prevention messaging.

Conclusions:

Impacting change at the individual or systems level can be challenging. Understanding how to engage system sectors or reach individual audience can be critical to affect change. Collaborative Innovation and Improvement Networks (CollIN) and social media can be effective strategies to address these challenges.

Objectives:

Attendees will learn:

- 1) To understand the impact of sudden unexpected infant death and bullying on the morbidity and mortality of the pediatric population
- 2) To describe two innovative strategies to address safe sleep and bullying prevention
- 3) To describe the benefits of Collaborative Innovation and Improvement Networks (CollIN) and social media as strategies for prevention

A Quality Improvement Program Implemented Into Primary Pediatrician Offices Can Encourage Families to Practice Safer Behaviors

Michael Gittelman, MD, Sarah Denny, MD, Samantha Anzeljc, PhD, Melissa Arnold, BSJ

Background:

Pediatricians often feel uncomfortable providing families with injury anticipatory guidance (AG) due to little training or time during an office visit. Utilizing a standardized screening tool with specific injury prevention (IP) instructions has been shown to screen families for more injury risks and allow pediatricians to address more inappropriate behaviors. This study's objective was to determine the self-reported behavior changes made by families screened for injury risk in a pediatric office setting and provided with recommendations for change.

Methods:

Pediatric practices, recruited from the Ohio Chapter, AAPs database, self-selected to participate in a quality

improvement learning collaborative (QILC). Practice teams, comprised of a lead physician and project manager, learned quality improvement (QI) basics and IP strategies at a one-day learning session. Two screening tools with corresponding talking points were developed by an expert panel to address injuries among youth at the birth-4 month and 6-12 month well child care (WCC) visits. Teams worked to implement the tools into every WCC visit for each participating practice.

Aims for the 7-month QILC were: 1) use the age-appropriate screening tool at all WCC visits and 2) address all recognized age-appropriate injury risks with families. Providers submitted all survey responses and IP AG discussed into the Ohio Chapter, AAP's QI database. Frequencies for screening tool use and appropriate IP AG discussions were calculated. Patients who completed a screening tool multiple times were matched to determine change in behavior. Providers received MOC IV credit for participation.

Results:

Seven practices (38 providers) participated in the QILC. After 7 months, there was an increase, from baseline, in screening for all recommended IP topics: birth-4 months (13.2% to 84.3%), 6 -12 months (9.8% to 82.5%). Only 48% and 45% of families attending birth-4 month WCC visits (n=1174) correctly answered all of the IP AG questions on car seat safety and safe sleep, respectively. Providers increased discussions about car seat safety from 0% to 90% and safe sleep from 18.6% to 89.9%. Less than 50% of families attending 6-12 month WCC visits (n=981) correctly answered all IP AG questions on car seat safety (46%), choking hazards (42%), and home safety (52%); provider discussions increased by at least 80% for each topic.

Of those families with multiple visits and with whom a practitioner addressed the inappropriate behavior, 62.7% (n=171) of birth-4 month and 66.3% (n=89) of 6-12 month families made a change in at least one of their risky IP behaviors on subsequent screens. Furthermore, 27.5% of all inappropriately answered topics were improved among birth-4 month families and 15.1% of 6-12 month families, after a practitioner addressed the topic area.

Conclusions:

Participation in a MOC Part IV QI program within pediatric offices can increase screening and discussion of injury prevention practices. As a result of these injury prevention discussions, more families reported to practice safer behaviors at later visits.

Objectives:

Attendees will learn:

- 1) How to perform a QI injury program within a primary care setting
- 2) How to Utilize an injury screening tool within primary care to assess risky behaviors
- 3) How counseling about injuries in a primary care practice can instigate changes in behavior.

The Pediatric E-Network: A Pilot Program for Providing Injury Prevention Education

Steven Rogers, MD, Garry Lapidus, PA-C, MPH, Kevin Borrup, JD, MPH

Background:

Injuries are the leading cause of childhood mortality and morbidity in the United States. Pediatricians are encouraged to provide anticipatory guidance to all patients and families which includes injury prevention education. Pediatric office visits are often time limited which may adversely affect the pediatrician's ability to provide all the recommended anticipatory guidance. Studies have shown that children whose parents received less anticipatory guidance around injury prevention were more likely to have a subsequent injury than their peers. The Pediatric E-Network is designed to fill a critical need in modern clinical practice by delivering anticipatory guidance, with a focus on safety information, to patients and their families via a convenient touch-screen tablet system.

Methods:

We developed the Pediatric E-Network through a framework for Android based systems. This innovation provides the ability to remotely control content and updates to equipped Android tablet devices through our proprietary E-Network. Currently, we have developed four (4) educational modules on safe teen driving, choking prevention, child passenger safety, and bicycle/pedestrian safety. Pediatric practices were randomly recruited to implement the Pediatric E-Network anticipatory guidance systems at no financial cost.

Results:

All four educational modules were successfully developed using novel formats to deliver safety message content. Twenty (20) pediatric practices were recruited and successfully implemented the Pediatric E-Network anticipatory guidance system. Fifty (50) Android tablet computers were deployed in these practices. To date, more than 5,000 patients at these pediatric offices have viewed the educational modules.

Conclusions:

It is feasible to deploy a tablet-based anticipatory guidance system that focuses on injury prevention education in community based pediatric practices. This system can also be controlled remotely including monitoring usage and providing updates.

Objectives:

Attendees will learn:

- 1) To recognize the importance of anticipatory guidance and the burden this imposes upon primary care providers
- 2) To understand the complexities of developing a tablet based educational system to assist in providing anticipatory guidance with a focus on injury prevention
- 3) How to demonstrate that deployment of a tablet based education network is feasible

When Sleeping Isn't Safe: Improving Safe Sleep Practices in Ohio with the EASE Project

Jamie Macklin MD, Sarah Denny MD, and Michael Gittelman MD

Background:

Ohio currently has the 4th highest infant mortality rate in the United States and the 2nd highest African-American infant mortality rate. Sleep-related deaths account for the highest percentage of these deaths behind prematurity. It has become imperative that healthcare providers educate parents/caregivers about the importance of following safe sleep practices at home, as well as mimicking them in the hospital setting. Unfortunately, studies have shown that over half of children's hospitals are not adhering to published infant Safe Sleep guidelines.

The Ohio AAP chapter has recently initiated the EASE (Education and Sleep Environment) Project, a quality improvement project in six children's hospitals in Ohio created to improve the sleep environments of hospitalized infants. The EASE Project's objectives are two-fold and seek to increase the quantities of safe sleep behaviors being practiced in Ohio's children's hospitals, as well as to provide safe sleep education to parents/caregivers of hospitalized infants at discharge.

Methods:

Pediatric hospitalists from each of the six children's hospitals were invited to participate in this project in January 2014. The hospitalists were asked to form "safe sleep teams", comprised of physicians and nursing staff, within their institutions. The hospitalists and their committees are responsible for conducting at least ten weekly audits on the

sleep environments of their hospitalized infants and submitting them to an online project database for data analysis. Three PDSA cycles of the safe sleep teams' choosing are also required over the 12-month study period and can include policy creation/amendments, health care provider education measures, parent/caregiver education modalities, and/or environmental management strategies. Monthly Action Period Calls are being conducted to address any concerns, to assess progress, and to provide additional education and resources for project participants.

Results:

Since data collection began in February 2014, we have shown an improvement in hospitalized infants being placed in a safe sleep environment. A large majority (85%) are now being placed on their backs in their cribs when sleeping. We continue to face problems with the crib environments themselves, with loose blankets and toys still present in 38% of cribs, though this has improved from 50%. We are successfully educating the families of hospitalized infants about safe sleep practices 76% of the time, improved from 49%.

Conclusions:

Preliminary results indicate that a hospitalist-led quality improvement project has improved safe sleep practices in six children's hospitals in Ohio in the first months of its timeline. We expect the quantities of these practices to increase over the next several months as further PDSA cycles are completed. We anticipate that demonstrating these behaviors in the hospital setting may lead to more appropriate safe sleep practices at home, potentially resulting in fewer sleep-related deaths in Ohio.

Objectives:

Attendees will learn:

- 1) About the 2011 AAP Safe Sleep guidelines
- 2) How to use initiatives to implement these guidelines in the hospital setting
- 3) To recognize and discuss challenges and barriers to maintaining these practices.

Impact of Education on Knowledge and Attitudes of High School Athletes About Concussions

Wendy Pomerantz, MD, MS, Brad Kurowski, MD, MS, Courtney Schaiper, MS, Mona Ho, MS and Mike Gittelman, MD

Background:

High school athletes often under-report concussions, thus putting themselves at risk for prolonged recovery and more severe injuries. The objective of this

study was to assess whether a pre-season concussion education program compared to an observation control would improve knowledge of adolescents on how to recognize concussions and their attitudes toward reporting concussions.

Methods:

The design was a prospective observational cohort study comparing an intervention group that received preseason concussion education to a control group that did not receive the education. Participants included male and female athletes aged 13-18 years from two large, urban high schools in the same school district, recruited from selected sports considered higher risk for concussion (football, soccer, wrestling, basketball). During preseason, each participant was given a survey asking about previous education, current knowledge, and self-reported attitudes about reporting concussions.

The intervention school received a 20-30 minute educational session on concussions. A post season survey was given to all participants to again determine knowledge, and self-reported attitudes about reporting concussions. Multivariate linear regression were used to evaluate the association of study arm, age, gender, sport, and prior concussion and prior concussion education with knowledge about concussions and self-reported attitudes about reporting concussions at the end of the season.

Results:

234 students were in the intervention school and 262 in the control school. There were more males (82.9% vs 72.5%, $p=0.006$) in the intervention school, and more in the control school had received previous concussion education (78.2% vs 35.9%, $p<0.001$). 167 (71.4%) in the intervention group and 221 (84.4%) in the control group completed the post-season survey. In the multivariate models the concussion education intervention was the only variable found to be significantly associated with improved knowledge ($p=0.01$) and self-reported attitudes toward reporting concussions ($p<0.001$) at the end of the season.

Conclusions:

Brief concussion education improves knowledge and attitudes about reporting concussions in high school athletes. Future studies will be important in determining whether education results in improved behaviors about reporting concussions.

Objectives:

Attendees will learn:

- 1) How brief concussion education improves knowledge and attitudes about reporting concussions in high school athletes.

- 2) How Initial gain in concussion knowledge and attitudes declined over time, but attitudes remained improved at the end of the season.
- 3) About optimal type, timing, and long-term benefits of concussion education on actual reporting of concussions needs to be determined.

Sustaining a Countywide Concussion Care Program™

Gillian Hotz, PhD, Ray Crittenden, MSc, Lauren Baker, BSc

Background:

A Countywide Concussion Care Program™ (CCCP) was developed in 2011 in Miami-Dade County (M-DC) in order to standardize concussion management for all M-DC High Schools and to reduce concussions in athletes participating in contact sports. The program includes concussion education and training for coaches, athletic trainers, and athletes; baseline ImpACT™ testing, effective medical treatment with monitored return to play and return to learn, and implementation of a concussion injury surveillance system.

Methods:

The CCCP was initiated by a high school soccer player who sustained multiple concussions and his private school. This resulted in the creation of a task force consisting of physicians, community leaders, school officials, athletes and concerned parents. The combination of these stakeholder's diverse backgrounds and single mission created a team with resources to develop a program utilizing a public health approach toward preventing concussions. The CCCP protocol was developed for all 36 M-DC public high schools in 2011.

This protocol includes training and education of certified athletic trainers (ATC) and coaches, sideline evaluation with SCAT3 and King Devick, baseline ImpACT testing, clinic follow up with a gradual return to play and learn protocol, and use of a concussion injury surveillance system. Utilizing a brief web-based injury surveillance system has allowed us to track the number of concussions from all 36 M-DC public high schools from sports related injuries. This information is critical toward preventing and evaluating demographic information, frequency of repeated concussions, equipment and field conditions, exposure rates, number of seasons played, specific sport, and recovery-time for return to play.

Results:

Since August, 2011, there have been 13,397 athletes from the 36 public high schools that play contact sports

that have completed ImpACT baseline testing. About 400 post injury tests (3%) have been administered, with mean age of 15.5 years. Since August, 2012, there have been 234 concussion Injury surveillance forms completed for the following sports: basketball (14), football (179), lacrosse (5), soccer (29), and wrestling (7). Of these, 29 athletes were female and 205 were male with a mean age of 16.2 years and 46 were freshmen, 45 sophomores, 61 juniors, and 82 seniors. This group reported an average of 20 days before cleared to return to play.

Conclusions:

The CCCP is continuously being evaluated as new research provide more insight into the treatment, management, and recovery from concussive injury in youth sports. The concussion injury surveillance system is able to track concussion injuries throughout the county. This information allows the research team to analyze the number and severity of concussions in high school athletes and develop specific programs in order to address any significant trends. Since the passing of the Florida Youth Concussion Legislation in July 2012, reporting of concussions has increased. Continued training and education workshops for the athletic trainers and athletes that play football have increased reporting of suspected concussions. The program continues to be funded by the original private high school on a yearly basis.

Objectives:

Attendees will learn:

- 1) How to implement a standardized concussion management program for high school sports,
- 2) To recognize the importance of a team approach to manage concussions effectively,
- 3) How to develop and utilize a concussion injury surveillance system.

Variability in Circumstances of Pediatric Drowning and Near-Drowning: Implications for Injury Prevention

Julie Phillips, MD, Purnima Unni, MPH, CHES, Cristina Estrada, MD, and Dai Chung, MD

Background:

Drowning ranks fifth among the leading causes of unintentional injury death in the United States. About one in five people who die from drowning are children 14 and younger. In Tennessee, twenty-two children died as a result of drowning in 2012. Drowning and near drowning cases occur in a variety of situations and locations and vary across regions. Therefore, detailed examination of circumstances surrounding these cases is needed to guide injury prevention initiatives.

Methods:

A retrospective analysis of data (January 1, 2005 - October 31, 2010) from the trauma registry of a level one pediatric trauma center in Middle Tennessee was conducted. Furthermore, chart review of drowning and near-drowning patients from the trauma registry and those presenting to the Emergency Department of a level 1 trauma center was carried out. A total of 153 patients below 15 years were identified based on ICD-9 codes. In-depth analysis through chart reviews was also carried out to understand and categorize circumstances and details leading to drowning and near-drowning. Extent of supervision was categorized as continuous, intermittent, or absent.

Results:

The mean age of patients was 3.5 years (SD = 2.9). Males comprised 62% of the cases. The average length of stay in the hospital was 1.4 days (SD = 2.7). About 41% were released the same day. There were 18 (12%) drowning deaths. The leading site for drowning or near-drowning was private pools (38%), followed by public pools (32%), bathtubs (15%), and open bodies of water (10%). Most cases were associated with no supervision (47%) or intermittent supervision (46%). Lack of supervision was significantly associated with fatalities ($p < .05$).

The majority of cases (75%) presented between May and August. Of the 13 infants (< 1 year), 12 cases involved bathtubs. There were no fatalities among infants. There were 105 patients (69%) between 1 and 4 years. Private and public pools accounted for 77% of all cases in this group. This age group accounted for 83% of all the fatalities. There were 24 patients (16%) between 5 to 9 years. The injury site patterns were similar to the 1 to 4 years group.

Conclusions:

Like many injuries, drowning-related injuries are predictable and preventable. In most cases, continuous and vigilant supervision was lacking. Injury prevention initiatives should continue to emphasize continuous supervision by parents and caregivers. Priority should be given to interventions targeting parents of 1-4 year old children. Private pools are a major risk factor. Renewed focus on pool fencing and emphasis on active supervision is needed. Benefits of formal swimming lessons for this age group should also be communicated.

Objectives:

- 1) To understand variability in drowning and near-drowning by age.
- 2) To describe the nature and circumstances of pediatric drowning and near drowning cases by age.
- 3) To identify relevant injury prevention implications.

New science on boating behavior and risk

Elizabeth Bennett, MPH, MCHES, Celeste Chung, MPH, Beth Ebel, MD, MSc, MPH, Beth Mueller, DPH, MPH, Linda Quan, MD, Alex Quistberg, PhD, MPH, Melissa Schiff, MD, MPH, Sarah Stempski MPH, MCHES

Background:

Recreational boating presents a unique injury setting where, in addition to common injuries such as falls, burns and cuts, boaters are also at risk from asphyxia, submersion, and hypothermia. In 2012, the United States Coast Guard reported 4,515 recreational boating incidents involving 651 deaths, 3,000 injuries and \$38 million dollars of property damage. We present recent findings on boating risks and safety to address this public health problem.

Methods:

Four studies were conducted to assess boating safety in Washington State. Study A: Case-control study using the Washington Boat Accident Investigation Report Database to evaluate risk factors for boater death. Study B: Qualitative study among boaters that explored life jacket use by adults and children. Study C: Cross-sectional survey examining barriers to life jacket use among adult recreational boaters. Study D: Statewide observational survey of boaters. Studies A, C and D used robust Poisson regression to estimate risk or prevalence ratios and 95% confidence intervals. Study B used grounded theory methods to develop themes.

Results:

A) Boating fatalities were more likely if boaters did not use life jackets, if alcohol was present and in non-motorized boats. B-D) Children were more likely to wear life jackets if adults wore them. C) Low adult life jacket use was associated with any alcohol use, perceived swimming ability, and the perception that life jackets were uncomfortable.

Conclusions:

Proper adult role modeling, the design of more comfortable life jackets and boater education classes are effective strategies for increasing life jacket use among adults and children. As has been done with seat belts and bicycle helmets, the passage and enforcement of life jacket legislation for teens and adults on high risk waterways is likely the most promising approach for prompting this behavior change. The collective impact of these related studies in an understudied area of injury research informs next steps for boating injury prevention.

Objectives:

Attendees will learn:

- 1) To identify key risk factors for boat-related injury

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and death,

2) To recognize risk perception and behavior of life jacket wear,

3) About policy, program, education and media implications of key findings.

Unfinished Business -- Protecting Our Children from Injury

Susan Baker, MPH, ScD (Hon.)

Background:

In recent decades, enormous progress has been made in protecting children from injury. However, it is time to emphasize some of the injury problems that still await solutions. Examples of these problems include gun safety to protect our youngsters and the drowning of children and teenagers. A child who pulls the trigger of a gun, not understanding that it is a real gun with deadly ammunition, and kills a playmate or family member may never recover from the trauma of having taken another life - nor will those who mourn for a loved one recover from the loss.

Lives lost to drowning are similarly devastating and occur in far greater numbers. In the case of most drownings, either there is a witness, or a potential rescuer is on the scene soon enough to have resuscitated the victim. In each case, training in rescue and resuscitation could change the outcome.

Methodology:

A number of childproof designs for guns, called personalized weapons, exist. Changes in regulations can ensure that a gun can be fired only by an authorized person - typically the person who bought the gun or someone specifically designated. Requiring such technology has the potential to make a difference. Also, training the population in the area of water safety can save thousands of lives. We need to make sure that anyone who completes high school is required to learn the elements of resuscitation and to require all parents whose children have access to home swimming pools to know how to resuscitate a near-drowning victim. These steps would create a well-trained population with the ability to rescue children who fall into pools and swimmers faced with challenges they cannot meet.

Results:

It is possible to make a difference in these tragedies. It is estimated that personalized guns would prevent 37% of all unintentional gun deaths. In addition, such a requirement would prevent many of the ~800 annual teenage suicides by firearm. Personalized weapons do not challenge the second amendment, yet the resistance of the powerful 'gun lobby' makes requiring this technology a difficult endeavor.

Likewise, there are many lives that can be saved with changes in regulations related to water safety. More than a thousand children and teenagers drown each year. In the under-five age group drowning is the leading cause of injury death, claiming more than three

times the number of children who die as motor vehicle occupants. Yet too few people are trained to know exactly what to do.

Conclusions:

Addressing these and other problems that will be discussed are ambitious goals, and it is easy to become discouraged when working -- without apparent results -- for an injury prevention goal. It may help to think about the history of milk pasteurization and realize that many decades elapsed between recognition of the fact that thousands of deaths and illnesses could be prevented through pasteurization, and the time when milk was routinely pasteurized. Patience, persistence, and knowledge of the facts will win if we give priority to some of the unfinished business that awaits us.

Objectives:

Attendees will learn:

- 1) To describe several injury problems that remain to be addressed.
- 2) To understand why it is important to address injury prevention areas currently not addressed.
- 3) To identify and discuss barriers to implementation of remedies.

Hip Hop Summer Camp: A Description of a Therapeutic Arts Program for Preventing Injury in Child Survivors of Violence in Urban Milwaukee

Aaron Heffernan, MA, LCSW, Marlene D. Melzer-Lange, MD, Toni Rivera-Joachin BS, MSBM

Background:

Program Description: The Hip Hop Therapy Program sponsored by Project UJIMA of Children's Hospital of Wisconsin is a six-week expressive arts program for reducing recidivism in injured urban youth. Aims include: 1. providing a safe haven for traumatized children during the most violent months in the city; 2. treating PTSD symptomatology leading to re-traumatization and re-injury; and 3. bridging service gaps for families that don't typically seek therapeutic support post-injury. Background: Since 1995, Project UJIMA, a nationally recognized violence prevention program, has provided critical support to victims of community violence in Milwaukee. Participants reside in neighborhoods of high unemployment and high crime, and are referred to UJIMA through the hospital ED. In 2002, responding to growing numbers of child victims of gun violence in the city, UJIMA developed a summer camp program providing 50 children between the ages 7-17 with the opportunity to participate in

safe activities in a trauma-informed setting. In 2010, UJIMA identified the need to address chronic re-traumatization and recidivism in camp participants, and invested in the development of a culturally relevant therapeutic intervention known as Hip Hop Therapy to address their PTSD symptoms. Since 2011, the Hip Hop Therapy Program has directly served 40-50 children each summer, while bridging gaps in ongoing therapeutic support for families.

Methods:

Method: Regardless of talent, children meet for therapeutic “studio time” with a licensed trauma therapist with experience in the expressive arts, addressing themes of injury and resilience through multiple artistic forms: composition/recording original songs/raps using digital beat-making and recording software choreography of original dance routines synthesis of all three modes (original writing, recording, and dance) Studio work is presented at the final day of camp in a talent showcase for friends and family.

Results:

Results: Since 2011, 60-80% of children enrolled in camp have contributed to the talent show. There is high investment in the final production, resulting in an extremely low drop-out rate for participants since 2011. Additionally, the talent show brings an estimated 160 parents, family members, and community leaders to the show each summer, resulting in increased engagement with UJIMA programming year-round. In 2012, there was a fivefold increase in referrals for outpatient psychotherapy for UJIMA participants from 2011 -- a rate which was maintained through 2013.

Conclusions:

Conclusions: Evidence of increased engagement of injured youth and families following the implementation of the Hip Hop Therapy Program suggests that it is an effective intervention worth replicating. These results are relevant to both injury and violence prevention in a population that suffers from high rates of recidivism and re-traumatization post-injury.

Objectives:

Attendees will learn:

- 1) How to raise awareness about the relationship between violence reduction and injury prevention in traumatized urban youth
- 2) To recognize Hip Hop Therapy as an effective, culturally relevant modality for reducing recidivism
- 3) How to use Hip Hop as an intervention in a six-week summer camp setting

Suicide in Illinois, 2005-2010: A Reflection of Patterns, Risks and Opportunities for Prevention

Anagha Loharikar, MD, Suzanne McLone, MPH, Maryann Mason, PhD, Jennifer Cartland, PhD, Karen Sheehan, MD, MPH.

Background:

There were over 59,531 deaths due to violence in the United States in 2010; over 38,000 of these were suicides. In Illinois in 2010, suicide was among the five leading causes of death for people between the ages of 15 and 64 years. We sought to understand the epidemiology of suicide cases in Illinois to identify opportunities for prevention.

Methods:

The Illinois Violent Death Reporting System (IVDRS) conducts routine surveillance of violent deaths, including suicides, homicides, deaths from legal intervention, deaths from undetermined intent, and unintentional firearm deaths, in five counties in Illinois, which comprises approximately 45% of all violent deaths in IL. Data are reported from death certificates, coroner or medical examiner reports and law enforcement documents. We used IVDRS data to examine the demographics and circumstances surrounding suicides between 2005 and 2010.

Results:

Between 2005 and 2010, 3092 suicides were reported; 711 (23%) were female. The median age was 45 years (range 10 to 98 years); age groups included ages 10-24 (14%), ages 25-34 (15%), ages 35-64 (57%) and ages 65 and over (14%). Most (76%) victims were white; 340 (11%) were black, 253 (8%) were Hispanic and 107 (4%) were Asian. Proportion of non-white victims within an age group was higher among younger age groups compared with older age groups (37% of victims between ages 10-34 years vs. 18% of victims ages 35 years and older.) Most common methods of suicide include hanging/strangulation (33%), firearm (32%) and poisoning (21%). Use of hanging/strangulation was more common among young victims, ages 10-24 years (47%), while use of a firearm was more common among older victims, age 65 years and over (51%).

Of all victims, 632 (20%) had history of prior suicide attempt, almost half (49%) had reported mental health problems, most (65%) left a suicide note and most (74%) had disclosed to another person their intention to commit suicide; rates were consistent among age groups. Some (34%) victims had positive blood alcohol tests and some (10%) had a reported substance abuse problem. Of victims age 10-24 years, 145 (34%) reported current depressed mood. Individual factors reported as contributing to suicide included presence

of crisis within two weeks prior (22%), problems with an intimate partner (25%), physical health problems (19%), financial problems (14%), job difficulty (15%), criminal legal problems (7%). These factors were less present among young victims age 10-24 years. Of all suicide cases reported, 68 (2%) were documented to be perpetrators of homicide prior to suicide.

Conclusions:

Routine surveillance of suicide cases offers insight into opportunities for prevention; understanding risks and circumstances affecting different ages can help target prevention programs. This review suggests an increased need for mental health services and aggressive intervention after disclosing suicide plans or attempted suicide, as well as quicker access to mental health services for those persons experiencing crisis and at-risk for suicide attempt.

Objectives:

Attendees will learn:

- 1) To characterize the epidemiology of suicide in Illinois, assessing for differences by age and/or gender.
- 2) To understand the contributing circumstances to suicide.
- 3) To explore several opportunities for intervention to prevent suicide.

Unintentional Opioid Ingestions Presenting to a Pediatric Emergency Department

Pallavi Ghuge, MD, MPH, Christopher Pruitt, MD, Abhay Kulkarnib, Michele Nichols, MD

Background:

Poisoning is the second leading cause of unintentional injury-related death for all ages. The incidence of poisoning deaths in the United States is on the rise. In 2010, opioid medications were involved in 43% of drug poisoning deaths in the United States. The purpose of this study is to describe unintentional opioid exposures in young children, including demographics, medical interventions and clinical outcomes.

Methods:

This was a retrospective, cross-sectional study of children 0-6 years of age with possible opioid exposure over a three-year period (July 2010 - June 2013). Charts were screened from referrals through the local Regional Poison Control Center (PCC), as well as patients presenting to our urban, tertiary children's hospital emergency department (ED). Hospital charts were identified by relevant International Classification of Diseases, Ninth Revision (ICD-9) codes. Inpatient

charts were reviewed for admitted patients. Data collected included gender, age, specific drug, whether or not they were referred to the ED by the PCC, presence of symptoms, therapeutic interventions, ED disposition, and outcomes for admitted patients.

Results:

The PCC received calls for 431 children with possible opioid exposure during the study period. 57% of patients were male, and median age was 2 years. The most common drug to which children were exposed was buprenorphine/naloxone. Caretakers reported initial symptoms for 140 (32%) of these children; all of these were referred to our ED, though only 113 (80%) presented. An additional 122 patients presented to the ED without PCC referral. Of the total 235 patients, 83 (34 %) needed a therapeutic intervention, the most common of which was activated charcoal (41 children). Naloxone was administered to 30 patients. Three children underwent endotracheal intubation (2 methadone exposures, 1 buprenorphine/naloxone). Sixty-five patients were hospitalized, with a median length of stay of one day. While there were no fatalities, one child suffered severe morbidity (anoxic brain injury).

Conclusions:

While opioid exposures in young children is a common and potentially life-threatening problem, most children remain asymptomatic. The majority of patients are able to be discharged from the ED after observation, and of those who are admitted, most have favorable outcomes and brief hospital stays. A small number of these patients require considerable medical interventions.

Objectives:

Attendees will learn:

- 1) About the increasing prevalence of and deaths related to opioid poisonings in the United States.
- 2) To identify the epidemiologic characteristics of young children who are exposed to opioid medications.
- 3) To understand the clinical course and outcomes for children with symptomatic opioid ingestions.

A Multi-Center Study of Preventable Contact Burns from Glass Fronted Gas Fireplaces

Lucy Wibbenmeyer, MD FACS, Michael Gittelman, MD, Karen Kluesner, RN, Daniel Dillard, BA

Background:

Glass fronted gas fireplaces (GFGF) have exterior

surfaces that can reach extremely high temperatures. Burn injuries from contact with the glass front can be severe, often with long-term sequela. These injuries are potentially preventable. The purpose of this multi-institutional study was to determine the magnitude and severity of GFGF injuries treated at North American burn centers.

Methods:

Fourteen burn centers (28.6% of all burn centers) participated in the study. Cases were identified through their hospital-based trauma registries using ICD-9 discharge codes with E codes for contact burn (E924.8 or E924.9) from January 1, 2006 to December 31, 2010. Manual review of these records for mention of injury caused by skin contact with the glass front of a gas fireplace that were < 10 years of age identified the study group. De-identified demographic, burn injury, financial (hospital charges) and follow-up data were extracted by each site and entered into a centralized RedCap database collection tool.

Burn injury data included place of burn occurrence, anatomic location of burn and depth of burn (either directly from the chart or inferred from the percentage that required grafting). Hospital data included length of stay (LOS), surgical data, therapy data and complications. Complications included infections, graft loss, re-operations and contractures. Follow up was defined as the second clinic visit for those treated as out patients and the first clinic visit for those treated as in patients. IRB approval was obtained at each site prior to data collection.

Results:

During the five year study period, 402/8348 (4.8%) of the contact burns evaluated were the result of contact with a GFGF. The mean age of the study group was 16.8 ± 13.3 months. The annual average number of GFGF burn injuries was 80.4 ± 18.1 increasing annually by 10 injuries per year. The majority suffered burns to their hands (396, 98.5%), with burns to the face being the second most common site (14, 3.5%). The majority of children presented with partial thickness wounds (363, 90.0%), while eight (2.0%) presented with full thickness wounds and 31 (7.7%) with a mixture of both. Thirty-one (7.71%) children were admitted for their injuries with a mean LOS of 5.10 ± 8.7 days. Surgical intervention was performed in 27 (6.71%). Two hundred and sixty-nine required rehabilitation therapy (66.9%).

Conclusions:

The number of GFGF injuries reported was far greater than the approximately 30 injuries over a 10 year period estimated by the Consumer Products Safety Commission (CPSC). For the affected children, these injuries can lead to long term sequela and cause significant societal

costs. Safety guidelines for these products should be revised in order to prevent further injuries.

Objectives:

Attendees will learn:

- 1) About gas-fronted glass fireplace injuries
- 2) To understand the type of injuries sustained and who is at risk
- 3) To recognize advocacy efforts to prevent future injuries

The Development of a National Database to Assess Children's Hospital Safety Centers

Eileen McDonald, MS, Michael Gittelman, MD, Ben Hoffman, MD, Catherine Rains, MPH, Mark Zonfrillo, MD, MSCE

Background:

Safety Centers (SCs) are children's hospital-based outlets that provide families with safety products and education about preventing injuries. Currently, there are approximately 40 centers located in children's hospitals nationally. No single model for staffing, supplying or sustaining SCs has emerged. In order to compare these different centers and determine best practices, uniform data must be captured and analyzed. The purpose of this program was to bring together SC experts, determine data points to be captured, develop a database for data entry, and determine the feasibility of a centralized database for SC evaluation.

Methods:

With funding from the Centers for Disease Control and Prevention (CDC), the Children's Hospital Association and two SC principal investigators convened an Expert Advisory Committee of a select group of center directors and staff to reach consensus on data elements that could be or were already collected. One off-site meeting was held to finalize data issues; monthly conference calls were conducted to ensure fidelity to the protocol and address data quality issues. Study visits were limited to adult visitors who received either a child safety seat or safety helmet. Research Electronic Data Capture (REDCap) software was used to develop the data entry form and centralized database. Data collected included the site name, date of visit, number of bike helmets and car seats distributed, the cost of each product, and type of education provided. Data collection began at each participating site when they received approval from their Institutional Review Board. Redcap data were downloaded into Stata to conduct standard descriptive summaries.

Results:

Nine centers located at seven children's hospitals collected data between 8/1/13-12/31/13. Seven (77.8%) submitted data throughout the collaborative. A total of 658 products were distributed during the study period; 55% car seats and 45% helmets. Most products were provided to families at cost (71%). Education was provided for 95% of all safety products distributed: 96% received information about the product purchased, 82% received printed materials, and 73% had hands-on training. Visitors to the SCs were usually referred by a hospital provider (34%), followed by word of mouth (24%) and walk-in (22%). Other data will be explored in the presentation including Expert Advisor committee members' opinions about the importance of this work.

Conclusions:

Children's hospital SCs can serve as a resource for families in the hospital by providing safety education and products. This work demonstrates that a centralized database is feasible and information to compare centers can be obtained. For more meaningful comparisons to emerge, support is needed to grow and sustain a database that represents the broader diversity of topics and services offered.

Objectives:

Attendees will learn:

- 1) How SC support the mission of children's hospitals
- 2) To describe the process of bringing together a group of experts to determine data elements and processes
- 3) To discuss other strategies for conducting quality improvement initiatives to capture data from sites

Using Art to Reduce Cyberbullying in School

Corinne Peek-Asa, PhD, Jennifer Fawcett, MFA, Sean Lewis, MFA, Marizen Ramirez, PhD

Background:

Bullying is the most common form of school violence, and cyberbullying is an increasingly common form of bullying. School-based programs focused on bullying prevention have shown varying success, with few evaluations including long-term outcome and impact measures. A stronger evidence base is needed to help inform decisions about school-based programming, and new, innovative approaches are needed. Arts-based programming, which appeals to the active emotional brains of adolescents, offers a promising approach for behavior change.

Methods:

This program is a collaboration between injury prevention researchers, a University performing arts program, and a theater group. The project centers around "Out of Bounds," a play about cyberbullying. "Out of Bounds" was developed by The Working Group Theater and Hancher Performing Arts at the University of Iowa, and its goal is to create conversation about bullying. The development of the play was informed by research findings from ongoing qualitative and policy research with school principals. "Out of Bounds" has been performed in several Iowa middle and high schools, and is an excellent foundation on which to build arts-based activities focused on bullying prevention. The arts activities are being developed for multiple age groups and multiple settings, including classrooms, after school programs, and at home. The activities have been developed so that they map onto standard core curriculum requirements.

Results:

Our program is unique because we integrate arts and academics for a maximum impact on bullying, and we address bullying as a community-wide, rather than an individual phenomenon. In this presentation, we will discuss the development of "Out of Bounds", show clips from the play as it was performed in a middle school, and demonstrate the arts-based curriculum. The arts-based curriculum includes approaches that integrate photovoice, reflective writing/drawing, developing scenes for the play, and appreciative inquiry. The presentation will also discuss our plans to evaluate the program, and plans to disseminate the program based on evaluation findings.

Conclusions:

The arts provide an innovative approach to address increased awareness of cyberbullying and motivating change to reduce its prevalence. Few arts-based programs have been integrated into behavioral change approaches, although schools are increasingly searching for ways to integrate arts into core education.

Objectives:

Attendees will learn:

- 1) To understand the prevalence of bullying and how it fits into the public health model.
- 2) To describe conceptual approaches to preventing bullying behavior.
- 3) To recognize an arts-based program for schools to address bullying in their school environment and community.

Impact of Leandra's Law on Child Passenger Safety in New York

Guohua Li, MD, DrPH, Joanne Brady, PhD

Background:

New York State's Child Passenger Protection Act - commonly referred to as Leandra's Law - was enacted in December 2009 following the death of Leandra Rosado. Leandra's Law was designed to protect child passengers from alcohol- or drug-impaired driving. Under this law penalties for driving under the influence of alcohol or drugs when a passenger under 16 years of age is aboard are increased from a misdemeanor or traffic violation to a felony. This study is aimed to assess the effectiveness of Leandra's Law in improving child passenger safety.

Methods:

Using a natural experiment design, we analyzed fatal traffic crash population data for New York between 2007 and 2012. Annual rates of fatal crash involvement, fatal crash involvement with alcohol-impaired drivers, and crash fatalities were calculated for child passengers (under 16 years) and adolescent passengers (16-19 years). Poisson regression modeling and the difference-in-differences technique were used to assess the net effect of Leandra's Law on child passenger safety.

Results:

Between the pre-law (2007-9) and the post-law (2010-12) periods, the rates of fatal crash involvement, fatal crash involvement with alcohol-impaired drivers, and crash fatalities for child passengers decreased 27.2%, 55.6%, and 20.3%, respectively. There were six child passenger fatalities involving alcohol-impaired drivers during the 3-year pre-law period compared to none during the 3-year post-law period. Multivariable Poisson modeling revealed that implementation of Leandra's law was associated with a 15% reduction in the risk of being involved in fatal crashes for child passengers (adjusted risk ratio 0.85, 95% confidence interval 0.75-0.98).

Conclusions:

Implementation of Leandra's Law has contributed significantly to improving child passenger safety in New York.

Objectives:

Attendees will learn:

- 1) To understand what is the New York State's Child Passenger Protection Law about?
- 2) About any measurable changes in child passenger safety records between before and after the law
- 3) How to analyze and interpret the data from New

Informing Teens, Preventing Injuries: 25 years of Impact

Lisa Wolfs, BScN, Tanya Charyk Stewart, MSc, Brandon Batey, MSc, Jane Harrington, MSc

Background:

Twenty-five years ago a group of professionals at London Health Sciences Centre (LHSC) developed IMPACT™ (Impaired Minds Produced by Alcohol Cause Trauma); a collaborative, multidisciplinary program that educates high school students about the dangers of drinking and driving, the link of alcohol to poor decision-making and the resulting consequences of high-risk behaviour. The objective of this study is to expose the changes the IMPACT program has required to undergo in response to the evolving needs of teens over the past twenty-five years.

Methods:

In the beginning, IMPACT's focus was the prevention of alcohol related injury in teens. Students ages 15-19 were invited to take the "journey of the trauma patient" which included a demonstration of a mock resuscitation, and a tour of the LHSC's emergency department, critical care facility, and ambulance bay. In 2006, IMPACT became a joint-hospital initiative between LHSC and a neighboring rehabilitation hospital to provide students with a glimpse of life after injury. Further in 2006, IMPACT revised its acronym to "Impaired Minds Produce Actions Causing Trauma" to encompass other forms of impairment such as illicit drug use.

In 2007, IMPACT's hospital based program expanded its reach by providing in-school presentations to students on injury and strategies to reduce risk. Most recently IMPACT has undergone a complete, comprehensive redesign in response to rapidly evolving needs of teens; taking into account a broad array of topics that include binge drinking, drug use, distracted driving, self-harm, bullying, and other teen-identified issues. In 2013, IMPACT was re-branded and subsequently dropped its acronym. It obtained a new logo and tag line: Impact: Informing Teens, Preventing Injuries. New clicker technology has been incorporated into in-school presentations as of 2014, to facilitate class discussion and optimize student participation.

Results:

Since its inception, IMPACT at LHSC has reached over 10,000 students in-hospital, over 22,000 students in-schools, and continues to reach approximately 3000 students annually in the hospital-based and school-based program. The in-hospital program contains a mock resuscitation in the emergency department, as well as 4 rotating acute care sessions (nursing,

respiratory therapy, paramedic, intensive care unit). There is also a rehabilitation component with simulations and a survivor presentation. The 2013 redesign of the Impact program was piloted in separate London high-schools in June 2014. Evaluation of the redesigned Impact is ongoing and initial positive feedback from students demonstrates that the adaptation of its content and messaging is a beneficial approach to preventing teen injury related to high-risk behaviour.

Conclusions:

The Impact program's sustainability depends on its ability to respond to rapidly evolving issues identified by teens. Over the past 25 years Impact has successfully adapted both its content and the delivery of its messages through teen input and the identification of trauma risk-factors in the youth population.

Objectives:

Attendees will learn:

- 1) How to sustain injury prevention programming targeted at teens.
- 2) To adapt programming in response to changing demographics, advancing technologies and target relevance.
- 3) To utilize technology to guide presentations and target messages.

Teen Driving Toolkit for Pediatricians

Marie Crew, RN, Taylor Woodin, MSIII, Elizabeth Irons, MD, Kathy Monroe, MD, Bill King, RPh MPH, DrPH

Background:

Motor vehicle crashes are the number one cause of teen deaths in the U.S. Graduated Drivers License (GDL's) have been shown to decrease teen deaths. After informal discussions with parents/ caregivers and teen drivers, it was apparent that most were unaware of the GDL. Discussion by several teen driving advocates wondered if pediatricians could be a conduit for educational opportunities for their patients and parents. Determination was needed concerning what pediatricians knew about the GDL and what educational opportunities the pediatricians would utilize.

Methods:

Funded by the Allstate Foundation, the Alabama AAP created a coalition of interested stakeholders, the Alabama Safe Teen Driving coalition. A series of Grand Rounds were conducted across the state. A pre

and post test were performed for the attendees at these conferences. A toolkit to assist pediatricians in talking with adolescents and parents was created and disseminated. A follow up survey was sent out to pediatricians that attended the conferences in order to assess the usefulness of the toolkit. Log likelihood ratios used to assess use of toolkit.

Results:

A total of 147 pediatricians attended the sessions with only 61% being aware that our state had a graduated drivers' license. Although, 35% of pediatricians surveyed see more than 70 adolescents in their practice each year, nearly half, 49.3% reported that they never have discussions with teen patients about safe driving. 42% were not familiar with driving contracts and of those who were familiar, only 15% had ever recommended one to a patient.

The pre test indicated that only 21.0% of participants knew GDL components before the educational intervention compared to 98.6% of post test participants could correctly identify the GDL components ($z=13.4$, $p<0.001$). In follow up survey ($n=45$), toolkit use was most common in the primary care setting(93% usage rate($G2 =7.4$, $p=0.007$). The toolkit was also used more in practices that see 20 or more teens per week(84.6%) ($G2 = 10.1$, $p=0.002$).

Conclusions:

Many state pediatricians were unaware of our state law regarding GDL. Despite seeing a number of adolescents in their practices, many pediatricians were not familiar with driving contracts nor did they discuss safe driving with their patients. A brief educational intervention greatly improved knowledge among participants. The toolkit to assist pediatricians has been especially useful in primary care settings and in practices that see a high number of teens per week.

Objectives:

Attendees will learn:

1. How the determination was made to create a Tool Kit for Pediatricians and provide educational Grand Round sessions.
2. To identify components included in a Tool Kit for Pediatricians.
3. How a tool kit can impact educational opportunities for the pediatrician and their patients/parents.

Permission to park: A statewide study of high school parking permits to determine compliance with graduated driver licensing law

Garry D. Lapidus, PA-C, MPH, Meghan A. Wilson, MPH, Audrey Apanovitch, Victoria Champany

Background:

Motor vehicle crashes are the leading cause of fatality and acquired disability in adolescents in the United States. Motor vehicle crashes continue to be the leading cause of death for Connecticut teenagers. In response, the state of Connecticut enacted graduated driver licensing (GDL) laws in 2008, which has resulted in a 20-40% reduction in teen motor vehicle crashes. Newly licensed 16 and 17-year-old drivers are required to complete a student parking pass application, also referred to as a driving agreement, in order to drive and park their vehicles at a high school. To date, no study has reported on the components of these driving agreements. The objective of this study is to describe the content of a high school driving agreement, with a special focus on its compliance with the Connecticut Graduated Driver Licensing (GDL) Laws.

Methods:

We requested via email for all 237 Connecticut high schools to send a copy of their parking pass application by fax, mail, or email. After one week, follow-up request e-mails were sent to schools that did not respond to the first inquiry; a third and final e-mail request was sent to non-responding schools three weeks following the initial request. A 25 variable coding sheet was constructed that represented elements could possibly be included on high school parking forms.

These variables included: need permit to park, prohibited to drive off campus, parent permission to drive to and from school, parent permission to ride to off-campus event with other students as drivers, parent permission to drive other students to off-campus events, parent permission to drive siblings to school, references to GDL laws, revocation with infractions, consequences of dangerous driving in parking lot, allowed to share permit to others, etc. Each parking form was coded and checked for inter-rated reliability. Data was entered into excel and analyzed using SPSS.

Results:

Out of the 237 high schools that were contacted, 103 schools responded, yielding a 43% response rate. Twenty-one percent of responding schools are located in urban areas, 71% are located in suburban areas, and 8% are located in rural areas. Ninety-two percent of responding schools required a permit to park and 38% prohibited students to drive off campus during school

hours. While 76% of schools required parent permission from a student to drive to and from school, only 7% required parent permission for a student to ride to an off campus event with other students as drivers. Only 12% of high schools referenced the Connecticut GDL laws on their parking pass applications.

Conclusions:

Only a minority of Connecticut high schools reference the GDL laws on their high school parking forms. Connecticut high schools should adopt a uniform high school parking form agreement that references the GDL laws and includes provisions that support these laws in an effort to promote teen driving safety.

Objectives:

Attendees will learn:

- 1) About the importance of graduated driver licensing laws and how they promote teen driving safety.
- 2) To Explain how high school parking agreements can serve as a means to educate teenagers and their parents about driving laws and the components of a model high school parking agreement.
- 3) To describe how schools can create a culture of safe driving by creating parking agreements that require young drivers to follow current driving laws on schools grounds as well as for school events and functions.

From Focus Groups to Distracted Driving Video: Using Teen Input to Drive Injury Prevention Programming

Tanya Charyk-Stewart, MSc Jane Harrington, MSc, Lisa Wolfs, BScN, Brandon Batey, MSc, Neil Merritt, MD, Neil Parry, MSc

Background:

The Impact Program is an adolescent, injury prevention program with both school and hospital-based components aimed at preventing injury and decreasing high-risk behaviours. The objective of this study was to obtain student input on the various aspects of the school-based component of the Impact program, as part of the program evaluation and re-design process.

Methods:

During 2013, a series of 9 secondary schools were selected in various geographic regions of our city and county to get a mix of students varying in primary language, religion and socioeconomic status. A mixed-methods questionnaire was developed and pre-tested on program content, format, relevance, quality and effectiveness. For the quantitative component, an

interactive classroom communication “clicker” system was utilized to engage students and allow them to contribute their opinion anonymously. Attitude and opinion questions were ranked on a 7-point Likert scale. Open-ended, qualitative questions were included in the focus groups, with responses recorded and themed.

Results:

There were a total of 167 respondents at the focus groups with a mean age of 16 years. Approximately half (52%) were male and 69% were in grade 11. Ninety-three percent of respondents rated the content of the Impact presentation as comprehensive (median 6 out of 7, with 7 being very comprehensive). The general consensus from respondents (89%) was that the Impact presentation was relevant and addressed issues for teens at their school and their group of friends (median 6 out of 7, with 7 being very relevant). Suggestions of emerging issues or issues to emphasize in the Impact program included texting, consequences of drugs, partying, self-harm and abusive relationships.

The most prevalent motor vehicle collision (MVC)-related issue for teens was texting and driving (78% rated as “common”), followed by drugs and driving (54% rated as common) and drinking and driving (29% rated as common) ($p < 0.001$). Texting and driving was perceived significantly more common an issue for adolescents than other types of driving risk factors, with one student commenting, “if you don’t (text and drive) you either don’t have a phone or don’t have a driver’s license.” Twenty-nine percent of respondents rated the format of Impact a 5 on the 7-point Likert scale. When asked how to improve the program, students wanted “more photos and videos” and to hear “the stories...the accounts”.

Conclusions:

Injury prevention programs must continually be evaluated to ensure they are relevant, addressing issues important for youth in your region, and presented in a format that resonates with the audience. The results of our student focus groups identified MVCs and texting as important issues, as well as a desire for the teens to hear the personal stories along with a visual element. This provided our team with the information needed to develop the next logical direction for our program; the production of a distracted driving video (“Distracted Driving: Josh’s Story” <http://youtu.be/BFPke9gBybc>) to be incorporated into the school presentations.

Objectives:

Attendees will learn:

1) To describe the need for continual evaluation of injury prevention programs to ensure they are

relevant, addressing issues important for youth in your region.

2) To demonstrate how focus groups can be utilized to drive program change.

3) To illustrate the importance of presenting a vicarious experience for youth in a visual format, to ensure information is presented in a way that resonates with the audience.

Does an Inpatient Child Passenger Safety (CPS) Screening Program Improve CPS knowledge, Attitude and Practice among Families

Dina Morrissey, MD, MPH, Jose Lora, BS, Michael Mello, MD, MPH

Background:

It is well established that correct use of a child safety seat (CSS) can reduce the risk of fatal injury by up to 71% in the event of a motor vehicle crash. Misuse rates for CSS have been shown to be as high as 70% and CSS use drops in older age groups and is estimated to be only 47% for children between the ages of 4 - 7 years. There is a need to raise awareness about CPS and to provide caregivers (parents/legal guardians) with resources to obtain a CSS and CPS education. In February 2013, a CPS screening/educational program for families of all patients under the age of 13 years admitted to Hasbro Children’s Hospital was implemented.

Methods:

We assessed change in CPS knowledge, practice, and attitude of caregivers of admitted children using pre and post surveys. Two cohorts of 100 English-speaking participants were recruited; a baseline cohort (August - November 2012) and post-program implementation cohort (February - April 2014). Participants completed an initial survey during their hospital stay and a second survey three weeks after discharge. A Fisher exact test was performed to determine sample size needed to detect a 20% change with program implementation.

Results:

A pre-program sample of 103 caregivers completed the in-hospital survey, with a total of 84 completing the follow up. A post-program implementation sample of 105 caregivers completed the in-hospital survey, 92 of which completed the follow up. Univariate analysis demonstrated no difference between the two groups when comparing caregiver age, gender, relationship to child, race or ethnicity. The two groups were also similar for hospitalized child’s age, weight and height.

CPS knowledge, attitude or self-reported practice was not different when comparing the pre-program and post-program groups. Of interest, 170/206 (82%) of caregivers that completed the in-hospital survey agreed that a child is less likely to be injured or killed in a car crash if kept in a rear-facing car seat until the age of two, while only 55% (114/206) disagreed with the statement that regardless of height and weight children over the age of 8 are equally safe with a seatbelt alone versus a booster seat and seatbelt. Twenty percent of participants stated their pediatrician never discussed car seat use during well child visits.

Conclusions:

Appropriate use of a CSS has been proven to save lives, however misuse and nonuse of CSS is high. This evaluation did not demonstrate efficacy of this program in terms of change in CPS knowledge, attitude or practice among the participants. Potential reasons include the study was not powered to detect differences smaller than 20%. As hospitals consider inpatient CPS programs, other screening/educational strategies need to be considered and possibly direct observation of car seat use maybe be needed to detect families with incorrect CPS behaviors. More outreach to primary care pediatricians may also be needed.

Objectives:

Attendees will learn:

- 1) How to screen inpatients for appropriate car/ booster seat use.
- 2) To identify pros/cons of evaluations.
- 3) To identify child passenger safety areas that need to be addressed.

Components of a Comprehensive Hospital Based Car Seat

Bridget Clementi, MBA, Katie Horrigan, MPH, Marlene Melzer-Lange, MD

Background:

Upon admission all patients less than 4' 9" seen in the Emergency Room, Clinic offices, Child Protection Center, Day Surgery and Inpatient units are screened for car seat needs. Trained car seat educators complete car seat consults with caregivers to distribute seats, teach them to fit their child into the seat and complete necessary documentation.

Methods:

The car seat educator model was created as a step down model of the Child Passenger Safety Technician (CPST) to distribute hospital issued seats. In 2004 there

were 30 trained car seat educators. Today we have over 180 Car Partners, RNs and Respiratory Therapists that are trained as car seat educators at multiple CHW sites to distribute regular car seats, adjust infant seat harness straps to fit patients for car seat trials, loan hip spica seats and vests and distribute car beds. Initial educator trainings are offered monthly and consist of an online course and a 60-90 minute hands-on training. Ongoing trainings for staff, readily available car seat consult resources, the electronic health record, staff newsletters, a system wide car seat committee and staff members across multiple departments (both hospital and community based) help us manage daily program activities. A hospital budget for car seats, Foundation support, a grant through the Wisconsin Department of Transportation and recipient donations cover the cost of seats.

Results:

In 2013 approximately 400 infant, convertible, forward-facing harness seats, booster seats and car beds were distributed and about 100 seats for patients with hip spica casts and braces were loaned. Units and departments are self sufficient in meeting the car seat needs of their patients. The car seat consult process allows us to avoid delayed discharges. The program is more sustainable with many trained staff members. Staffing CPST to meet the car seat needs in an organization that is open 24/7 can be both tricky and costly. The car seat educator model is a more affordable model that allows us to train many staff members to meet the car seat needs of our families.

Conclusions:

Motor vehicle crashes are the number one cause of death for children. Our multi-faceted car seat program allows us to better identify families in need of car seats and provide car seat education.

Objectives:

Attendees will learn:

- 1) To understand the car seat educator model.
- 2) To identify staff trainings and resources used to support the program.
- 3) To recognize key components in growing a child passenger safety program.

Are Parents Getting the Message? Evaluating Child Safety Seat Consultations at a Hospital Safety Resource Center

Anyah Land, MPH, Catherine Rains, MPH, Carolyn Schinker, MBA, Kelly Klasek, MBA, Nicole Kozma, MPH, Greta Todd, MA

Background:

Injury is the leading cause of death for children and adults under 45 years old. Motor vehicle collisions are a common mechanism of injury. Injury and death can be reduced when children are properly secured in child safety seats. An urban level one trauma center seeks to prevent injury and death by sponsoring a Safety Resource Center (SRC). The SRC offers free education by Certified Child Passenger Safety Technicians about child passenger safety and how to properly restrain their child in a child safety seat. Discounted safety products are also sold. Benefits of SRCs on increased safety product use are well supported in the literature.

However, improper use of child safety seats is a common problem. 68% of the SRC's guests in 2012 arrived with an incorrectly installed child safety seat in their vehicle. How can we know that SRC guests are using the products properly? Are parents and caregivers gaining knowledge from these sessions? How do we show the merits of the SRC to hospital leaders?

Methods:

Hospital outreach evaluators created an evaluation tool to measure child safety seat knowledge among SRC participants. After reviewing the literature, evaluators created a pre and post knowledge assessment showing pictures of children properly and improperly installed in child safety seats. Participants are asked to identify incorrect and correct technique from the photos. Participants are also asked true and false questions about key points of child seat safety best practices such as when a child should change from a rear-facing to a forward-facing seat. Participants are sent a post-test two to four-weeks after their appointment via email.

Results:

1,432 received car seat instruction from the SRC from September 1, 2012 - August 31, 2013. During this time, 366 parents and caregivers took a pre-test and 234 parents and caregivers took a post-test about their knowledge of child passenger safety specific to their child's safety seat. Results of pre- and post-tests were tabulated and analyzed using SPSS 19.0. Mean scores were compared using an independent samples t-test. The average total score on pre-test was 72% and the average total score on post-test was 77%, a mean change in knowledge of 5% (95% CI: 1.2% - 8.5%, $p < .01$).

Conclusions:

Results demonstrate that the SRC is effective in improving knowledge of child passenger safety. This evaluation process has been able to show the value of this program to hospital leadership and surrounding community. This presentation will discuss key

components of evaluating the effectiveness of child safety seat consultations and how to assess knowledge of child passenger safety for parents. The presentation will also discuss lessons learned in implementation of an evaluation tool and challenges presented in assessing child safety seat knowledge.

Objectives:

Attendees will learn:

- 1) To recognize key components in evaluating child safety seat knowledge from established literature and best practices
- 2) How to create a child safety seat knowledge evaluation tool
- 3) To identify lessons learned in implementing a safety center evaluation tool

Car Seat Education: What Works Best?

Erin Kuroiwa, MHI; Rebecca Ragar, MPH; Angelica Baker, BA; Sally Moffat, RN, MSN; Pamela Garcia-Filion, PhD; David Notrica, MD;

Background:

As many as 25-46% of children continue to ride unrestrained and up to 82% ride in improperly installed car seats. Research is needed to identify best teaching strategies to improve proper car seat installation. Study aims were to compare participant child passenger safety proficiency between the traditional didactic and social learning/DVD assisted teaching methods. The primary goal of this study was to demonstrate the effectiveness of the social learning teaching method.

Methods:

A randomized controlled trial of 212 parents seeking car seat education. Parents were assigned to didactic (n=102) or DVD-social learning (vSL) (n=110). The didactic class involved live lecture; vSL included a brief lecture and a video utilizing social learning principles Simple Steps to Child Passenger Safety. Proficiency in child passenger safety was evaluated pre- and post- class via: (1) 5-part car seat installation demonstration; (2) 15-question objective test; and (3) 5-question confidence assessment. Data were summarized and compared between groups using nonparametric tests.

Results:

A total of 212 participants were enrolled; 102 in the didactic and 110 in the social learning. Most participants (95%) were female, 76% were Hispanic, 60% Spanish speaking, and 56% had 12 years of

education. Previous car seat use was reported by 92% of participants and 86% had 2 kids in the home.

Before and after the class, each participant was asked to demonstrate proper car seat installation. Only one-fifth of the participants installed the car seat correctly. At the post-class assessment, percentage of correct car seat installation rose to 53%. Overall, there was not a statistically significant difference in post-class car seat installation ability between the two education methods. However, compared to the didactic class, the social learning class better demonstrated tether use (30% didactic; 48% social learning) and anchor hook installation (79% didactic; 86% social learning).

Only 6% of participants in the didactic class and 4% in the social learning class were able to answer 10 or more questions correctly on the objective pre-class test. Post-class test scores increased in both groups ($p > 0.05$) rising to 76% of participants in the didactic class able to answer 10 or more questions correctly and 67% in the social learning class. Responses to a booster seat head support question produced discordant results (didactic: 57% post vs 32% pre, $p < 0.001$; social learning: 37% post vs 45% pre, $p > 0.05$). Confidence scores increased 2 to 4 units between the pre- and post-assessment. At post assessment, the majority of class participants (86-95% didactic; 84-93% social learning) selected a 9 or 10 indicating confidence in ability to correctly install a car seat.

Conclusions:

Both teaching methods improved parent proficiency in child passenger restraint. A DVD-based social learning teaching method, which requires less time and resources, can be used in child passenger safety community outreach programs. Methods should be evaluated to find ways to increase the percentage of participants demonstrating post-class car seat installation proficiency.

Objectives:

Attendees will learn:

- 1) To identify effective interventions to improve proper car seat use.
- 2) To compare teaching methods for child passenger safety outreach education.
- 3) To explore opportunities for further research to improve car seat installation proficiency.

The use of adolescent health risk behavior questionnaires, discussions of youth violence, and its relationship with other risk behavior discussions in primary care

Alison Riese, MD MPH, Megan Ranney, MD MPH, Janette Baird, PhD, Michael Mello, MD MPH

Background:

Although pediatricians are encouraged to screen for a variety of health risk behaviors, few universally do so. Pre-visit questionnaires may prompt these discussions. Youth violence is often left out of adolescent questionnaires, and it is unknown if adding this topic would compete with discussion of other important topics.

Methods:

The study was implemented at the primary care clinics within a large urban teaching hospital in the Northeast. A consecutive sample of adolescents aged 13-21 presenting for annual visits were recruited during a baseline phase, followed by an intervention phase. During the baseline, participants were asked whether their doctor discussed a number of risk behaviors [fighting/violence, sexual activity, tobacco smoking, alcohol use, drug use, emotions, school performance, and seatbelt/helmet use]. Intervention phase participants completed one of two versions of a pre-visit electronic risk behavior questionnaire, a standard questionnaire or the standard questionnaire + youth violence items.

The responses were then printed and delivered to the provider for review prior to the patient encounter. Immediately following the visit, the adolescent completed a post-visit survey that inquired about topics discussed during the visit. Baseline and intervention discussion frequencies were compared using Chi Square test. Mean number of health risk topics addressed was compared using two-sided t-tests.

Results:

During the baseline phase 50 adolescents (78% of eligible) completed post-visit surveys; during the intervention phase, 183 adolescents (91% of eligible) completed pre- and post-visit surveys (93 adolescents with standard questionnaire + youth violence items, and 90 adolescents with standard questionnaire alone). At baseline, fighting/violence was the risk topic least discussed (n=18/50, 36%), next to seatbelts/helmets (n=29, 58%), drug use (n=31, 62%), and tobacco use (n=32/50, 64%). With the use of the pre-visit questionnaire during the intervention phase, the discussion frequency of youth violence (n=60/93, 65%; p=0.001) and drug use (n=140/183, 77%; p=0.03) rose significantly from baseline. No significant change in

discussion frequency occurred for the remaining health risk behavior topics. Including violence questions did not impact the mean number of health risk behavior topics addressed as there was no significant difference between the group who received the pre-visit questionnaire with youth violence items (6.0, 95% CI 5.6-6.5) and the standard questionnaire (5.7, 95% CI 5.3-6.2). Adolescents in either group who reported having a discussion about youth violence with their doctor did report significantly greater number of total health risk topics discussed (mean=7.0 95% CI 6.8-7.3) compared to those who did not have youth violence discussions (mean=4.6, 95% CI 4.2-5.0).

Conclusions:

The introduction of a pre-visit questionnaire increased discussions of youth violence and drug use with adolescents during annual visits, but did not significantly affect discussion frequency of other health risk topic investigated. Discussion of youth violence did not preclude discussion of other health risk topics.

Objectives:

Attendees will learn:

- 1) About the baseline rates of health risk behavior screening/discussion in this sample of urban adolescents
- 2) How to utilize electronic pre-visit questionnaires for risk behavior screening
- 3) To understand how youth violence discussions do not impede discussions of other topics

Pediatric Unintentional Firearm Injury and Gun Ownership/Storage Prosecution

Grey Faulkenberry, MD, Gerry Greenberg, DD, Judy Schaechter, MD, MBA

Background:

Firearm injury is a leading cause of death in among US children and young adults. Compared to firearm suicides and homicides, the burden of unintentional firearm injury is relatively small. Yet, it has been suggested that unintentional firearm death may disproportionately affect children. At the same time, it is increasingly recognized that accurate classification of manner of death may under or over count unintentional death, instead misclassifying these deaths as homicides and suicides and visa-versa. Child Access Prevention (CAP) laws were passed as deterrents to unsafe storage of firearms, as a means to prevent child and adolescent access to guns and thus unintentional firearm injury.

Prosecution under CAP laws may be rare. Most child deaths take place in the home. The shooter is most often a child, usually a sibling. The gun owner is most often a family member. While a parent -gun owner who permitted access to a weapon may be guilty under the law, jurors may be reluctant to convict. Prosecutors may be reluctant to indict.

Methods:

We conducted an Internet search of pediatric (<19 year old) firearm deaths. Deaths of children occurring within US states were included. Manner of death was considered unintentional if reported as such by law enforcement, media sources and/or family in the media, or if the circumstance reported was consistent with an NVDRS definition of unintentional manner of death. Cases were combed and coded for reporting of gun owner relationship and storage. Pediatric firearm victim names were followed for reports of legal charges against alleged shooters and/or firearm owners. Cases were coded for incident region, urban/rural area, relationship between victim and shooter, relationship between victim and gun owner, gun owner's race and record of past crime.

Results:

The majority of cases fitting the definition of unintentional firearm death occurred within a residence with a gun owned by a family member. For more than half of these cases there was no evidence of charges being brought against the gun owner. This was particularly true if the gun owner was a parent of the deceased, had no mention of a criminal record and lived in a rural area.

Conclusions:

Charges to gun owners was rare overall. However, prosecution was more likely for non-relative shooter or gun-owner to victim relationships and when the gun possessor had a criminal record. Additional cases were noted in which adolescent shooters were charged, even while the adult gun owners were not held responsible. Limitations: An Internet search will likely be incomplete and miss several cases reported in vital statistics. Classification of unintentional death is preliminary and may not hold under further scrutiny.

Objectives:

Attendees will learn:

- 1) To recognize the relative disproportionate burden of unintentional firearm deaths among children and youth.
- 2) To understand the NVDRS classification of unintentional firearm death and why vital statistics data may misclassify these deaths.
- 3) How to advocate for appropriate child access prevention laws and enforcement.

Deaths from Firearms among Young Victims in Illinois, 2005-2010: a reflection of patterns, risks and opportunities for prevention

Anagha Loharikar, MD, Suzanne McLone, MPH, Maryann Mason, PhD, Jennifer Cartland, PhD, Karen Sheehan, MD, MPH.

Background:

Homicide and suicide are leading causes of death among young people in the United States; of the 4,741 violent pediatric deaths (aged 0-19 years) in the United States in 2010, over half (54%) were due to firearms. In Illinois in 2010, 57% of violent pediatric deaths were due to firearms. We sought to understand the epidemiology of firearm deaths among young persons, age 0-19 years, in Illinois between 2005 and 2010.

Methods:

The Illinois Violent Death Reporting System (IVDRS) conducts routine surveillance of violent deaths, which include suicides, homicides, deaths from legal intervention, deaths from undetermined intent, and unintentional firearm deaths, in five counties in Illinois, which comprise 75% of all pediatric firearm deaths in the state. Data are reported from death certificates, coroner or medical examiner reports and law enforcement documents. We used IVDRS data to examine pediatric deaths (age 0-19 years) from firearms reported to IVDRS between 2005 and 2010. This report describes deaths by demographics, manner of death, type of weapon used and circumstances surrounding each death.

Results:

Between 2005 and 2010, 688 firearm deaths were reported. Most (92%) victims were male, and the median age was 17 years (range <1-19 years); cases by age group were: 0-4 years (2%), 5-9 years (2%), 10-14 years (6%), 15-17 years (41%) and 18-19 years (49%). Most (65%) victims were black, 29% were Hispanic, 6% were white, and <1% were Asian. Of all pediatric deaths from firearms, most (90%) were homicide, some (7%) were suicide, 2% were reported as deaths during legal intervention, and 2% were reported as unintentional deaths. Most (80%) deaths occurred in the city of Chicago. Of all deaths, 363 (53%) occurred in the street or sidewalk, 181 (26%) occurred in a house, apartment or yard, and 89 (13%) occurred in a motor vehicle.

Of all pediatric firearm death victims, relationship of victim to suspect was known in 177 (26%) cases; reported relationship of victims included rival gang member (12%), stranger (2%), friend (2%), acquaintance (2%), injured by law enforcement officer (2%), sibling (1%), child (1%), and other family member (1%). Most (75%) victims had negative blood alcohol tests.

Type of firearm was known in over half (58%) of cases; of these, most (97%) deaths were caused by injury from a handgun, although handgun ownership and suspect information was largely unavailable. Mean number of bullets used was 2 bullets (median=1 bullet, range 1-16 bullets.)

Conclusions:

Routine surveillance of deaths from firearms offers insight into opportunities for prevention. Homicide by firearms remains highest among young black men in the city of Chicago. To decrease firearm deaths, a multi-level strategy will be required including providing youth alternatives to choosing violence and limiting easy access to firearms.

Objectives:

Attendees will learn:

- 1) To understand the epidemiology of firearm deaths among young persons in Illinois.
- 2) To discuss opportunities for interventions to prevent firearm violence in the clinical setting, community, and state and federal legislation.
- 3) How firearm violence disproportionately affects young people; pediatricians can play a key role in discussing firearm safety with patients and families.

Evaluation of a Child Passenger Safety Program

Samantha Mullins, MPH, Beverly Miller, MEd, Holly Terry, BS, Maury Long, AAS, Mary Aitken, MD

Background:

Motor vehicle crashes are the leading cause of death for children. Over the last ten years nearly 5,000 children under the age of 19 have been killed in motor vehicle crashes each year. Arkansas ranks 4th in the nation for children killed in motor vehicle crashes with a rate of 12.5, which is almost double the national rate of 6.8. The American Academy of Pediatrics estimates that car seats can reduce the risk of injury by up to 82%, but 60-85% of car seats are installed incorrectly.

To improve correct selection and installation of child safety seats, Safe Kids and the National Highway Transportation Safety Administration developed a Child Passenger Safety Technician (CPS-T) training program in 1997. Technicians must recertify every two years, but current national and Arkansas recertification rates are only 50% and 45%, respectively. Our study seeks to evaluate the current CPS recertification training program as implemented and identify factors that might improve recertification rates.

Methods:

A logic model based on the Health Belief Model was developed to guide the evaluation processes. We are evaluating motor vehicle safety knowledge, skills, beliefs and intentions (KABI) of CPS-T participants prior to and after training. We will assess participant characteristics including education and field of work to identify factors associated with higher levels of knowledge prior to CPS-T training and long term training outcomes. To achieve this, short term and long term follow-up surveys will assess KABI, barriers to use of training, and plans for recertification. The overall evaluation goal is to provide information that will inform identification and retention of the most appropriate population for certification and support needed for recertification.

Results:

This project is in process. To date, 125 students have completed the pre/post -test knowledge assessment and participated in the required seat check event. Preliminary review of in-class assessment data indicate that improvement is needed in use of check-up forms, along with additional training in key points of parent education. On follow up surveys, 69% of class participants have completed a 7-day post class follow-up, 57 % a 3 month follow-up, and 44% a 6 month follow-up. The 7 day to 6 month follow-up measures how students plan to use the training and assesses barriers to the use of the CPS training. The surveys indicate that new technicians need more practice checking seats, support securing seats for check-up activities, and mentoring to improve presentation skills.

Conclusions:

Evaluation of state-wide child passenger safety technician training can: 1) help programs build community capacity for identification of new technicians, 2) identify weakness in current training and mentoring activities, and 3) identify and reduce barriers to technician's use of new acquired skills and lack of recertification.

Objectives:

Attendees will learn:

- 1) How to use the logic model to evaluate child a passenger safety program.
- 2) To understand barriers to CPS-T recertification.
- 3) How to discuss the necessity of for CPS program evaluations.

THE FORGOTTEN CHILD: Using Data to Drive Practice in Child Passenger Safety- Are we Missing the Mark?

Amber Kroeker, MPH CPST, Amy Teddy, BS CPST, Michelle Macy, MD, MS

Background:

Motor vehicle crashes (MVCs) are a leading cause of death and disability among children ages 4-8 in the U.S., and the second leading cause of injury-related admission at C.S. Mott Children's Hospital. National estimates on booster seat use in 4-7 year olds varies between 41% and 47%. Improper restraint use in booster aged children results in significant risk of injury. Despite the high risk of injury from MVCs in this age group, public policy, parental awareness, and child passenger safety programs may lack focus on this 'Forgotten Child' age group. The objective of this study was to evaluate our own child passenger safety program, apply current injury data and evidence-based programming to align our efforts according to highest risk age group. Pickrell, T. M., & Ye, T. J. (2013, April). The 2011 National Survey of the Use of Booster Seats

Methods:

Analysis of trauma registry for inpatient admissions was used to identify children ages 0-17 admitted to Mott Children's Hospital with motor vehicle crash injuries from 2009-2013. A total of 274 cases were identified, 112 (41%) for children age 0-12 (ages most likely to use a child restraint). Analysis of seat check forms used by certified child passenger safety technicians in Washtenaw and Livingston Counties to identify types of seats checked (rear-facing (RF), forward-facing (FF), booster (B) at community fitting stations. A total of 1649 forms from January 2012 to May 2013 were evaluated and 1053 met inclusion criteria (RF car seat, FF car seat, booster seat type listed).

Results:

Resource allocation was greatest for an age-group at lowest risk of MVC-related hospitalization (0-3 years) versus highest risk age-group (4-8 and 9-12 years). MVC admissions from 2009-2013 (n=112) were as follows: 0-3= 26% 4-8= 37% 9-12= 37% Carseat check forms for 2012-2013 (n= 1053) were as follows: Rear-facing= 60% Forward Facing = 26% Booster= 14%

A targeted booster seat campaign was initiated including: increased collaboration with preschools, pediatricians, Safe Kids coalitions, daycare centers and Head Start programs to increase booster seat awareness and usage. A booster seat use ("A Guide To Booster Fit") infographic was developed identifying

key concepts for parents AND children to remember. Outcome Measures: Infographic distributed to pediatric clinics (n=12), child care centers (n=32), Head Start centers (n=4). Targeted booster seat presentations directly to parents (n=142) Evaluation of 320 seat check forms from January to March 2014 did not yet reveal a significant increase in booster seat inspections.

Conclusions:

Evaluation of our child passenger safety program revealed significant gaps in service to high-risk groups (booster age children). Targeted interventions with Head Start programs and child care centers may significantly increase awareness of the "Forgotten Child" translating into increased and prolonged use of booster seats.

Objectives:

Attendees will learn:

- 1) How to use data from their own child passenger safety checklists to describe their efforts.
- 2) To identify potential gaps in service to order or better align precious resources to the neediest groups.
- 3) How to develop a targeted campaign and re-allocate effort to gain the greatest reduction in injuries.

Restraint Use in Motor Vehicle Crash Fatalities in Children 0-9 Years Old

Lois Lee, MD, MPH, Caitlin Farrell, MD, Rebekah Mannix, MD, MPH

Background:

Motor vehicle crashes (MVC) continue to be a leading cause of death in children less than 10 years old in the United States. Although all states have child passenger safety laws, these laws vary by ages covered and types of child passenger safety seats required. As a result, proper restraint use for child passengers in motor vehicles is variable. The objective of this study is to describe factors associated with restraint use, no restraint use, or improper restraint use in (MVC) fatalities in children 0-9 years old.

Methods:

The Fatality Analysis Reporting System (FARS) was used to obtain data on MVC fatalities from 2001-2010 in children 0-9 years old. This is a database maintained by the National Highway Transportation Safety Administration (NHTSA) on all fatal motor vehicle crashes in the United States. Demographic information, including age, gender, and race, and restraint use in these crashes were obtained. Frequencies for type of restraint use were calculated. Race, type of car (sedan

or van vs. utility vehicle or truck), and seat in the car (front vs. rear) were analyzed for proper restraint use compared to no restraint/improper restraint use with the Chi-square statistic.

Results:

There were 7891 MVC fatalities in children 0-9 years old from 2001-2010. Among these fatalities, 3254 (41%) had proper restraint use, 2929 (37%) used no restraint, and 925 (12) had improper restraint use. Front seat passengers accounted for 20% (1595/7891) fatalities; of these 1595 children 643 (40%) had proper restraint use, 756 (47%) used no restraint, and 109 (7%) had improper restraint use. There was no difference in restraint use by gender among 3905 males and 3717 females: proper restraint use (males 42%, females 43%), no restraint use (males 39%, females 38%), and improper restraint use (males 9%, females 9%).

There was a statistically significant difference in proper vs. no/improper restraint use by race among 4922 white children and 1311 black children ($p=0.0001$): proper restraint use (whites 46%, blacks 32%), no restraint use (whites 35%, blacks 50%), and improper restraint use (whites 9%, blacks 8%). Children riding in a utility vehicle/truck compared to sedan/van, and those riding in the front seat of the vehicle compared to rear seats, were significantly more likely to have no restraint/improper restraint use ($p=0.0001$).

Conclusions:

Overall, more than one third of all motor vehicle fatalities in children 0-9 years old had no restraint use. Black children, those in a utility vehicle or truck, and those riding in the front seat of the vehicle were more likely to have no restraint/improper restraint use. Continued efforts must be made to enforce legislation and educate the public about best practices regarding child passenger safety to improve proper restraint use and to decrease motor vehicle crash fatalities in children.

Objectives:

Attendees will learn:

- 1) To recognize demographic factors associated with restraint use in motor vehicle crashes in children 0- 9 years old.
- 2) To identify motor vehicle related factors, including type of vehicle and seat position, associated with restraint use in motor vehicle crashes in children.
- 3) To understand children riding in motor vehicles are still riding unrestrained, despite legislation and best practice recommendations regarding motor vehicle child passenger safety.

Evidence Based Pediatric Injury Prevention Programs

Valerie Neilson, MSP, Nicole Vayssier, MPH, Jonathan Hooshmand, MPH, Rachele Solomon, MPH, Josette Severyn, MURP, Carolina Gutierrez, PhD, and Gillian Hotz, PhD

Background:

Pedestrian and bicycle injuries are among the leading causes of pediatric injuries in Miami-Dade County (M-DC) and nationally. The University of Miami's WalkSafe® (2001) and BikeSafe® (2009) Programs were primarily developed to decrease the number of pediatric pedestrian and bicycle related injuries, improving pedestrian and bicycle safety, increasing physical activity levels in children, and encouraging the use of walkable and bikeable environments in and around schools. Both programs use a 5-E Model of Education, Engineering, Enforcement, Evaluation and Encouragement.

The cornerstone of these programs is their educational curricula implemented yearly for elementary and middle school age children demonstrating a significant increase in the children's knowledge as related to pedestrian and bicycle safety and significant decrease in the number of pedestrian injuries.

Methods:

Both programs were initially developed by organizing task force meetings to gather relevant community partners and stakeholders to help guide the development of the educational curricula. Over the years data has been gathered and evaluated from pre and post testing of the educational curricula and findings published. Grant funding from multiple agencies along with M-DC School Board support has enabled the continued implementation and sustainability of these injury prevention programs in our public schools. Both WalkSafe and BikeSafe programs follow a train-the-trainer model that facilitates reach in schools tracked through the use of teacher curriculum completion forms. Student modes of transportation to school are also collected through student travel tally sheets. Additionally, trauma centers data and crash data is collected monthly to identify trends in pediatric pedestrian and bicycle related injuries in our county.

Results:

To date the WalkSafe program elementary school educational 3-day curriculum has educated over 815,000 children in over 200 M-DC public schools. Since its inception in 2002, pedestrian injury rates in M-DC children of 5-14 years have decreased by over 72%. In recent years, expansion of the WalkSafe program throughout the State of Florida has reached

an additional 110,058 children at 199 schools. Also, since the 2011 the inception of the BikeSafe program, a middle school educational 4 day curriculum, has educated 7,947 children across 34 M-DC public schools.

Conclusions:

The WalkSafe & BikeSafe programs continue to expand in reach through grant-funding and following a train-the-trainer model. The ultimate goal of these evidenced based programs is to expand reach to prevent pediatric pedestrian and bicycle injuries and promote children to walk and bike safely nationwide. Trauma center data will continue to be monitored to track pediatric pedestrian and bicycle related injury rates. In addition, school active transportation rates will be monitored to track increases in children walking and biking to and from school.

Objectives:

Attendees will learn:

- 1) About existing pediatric pedestrian and bicycle injury prevention programs;
- 2) How to disseminate injury prevention programs using a train-the-trainer;
- 3) How to track pediatric pedestrian and bicycle injury rates.

**2014 Forging New Frontiers:
“Preparing for the Challenges of
Childhood Injury Prevention”**



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BIOS

Susan Baker, MPH, ScD (Hon.)

Johns Hopkins School of Public Health Baltimore, MD

Susan P. Baker, MPH, ScD (Hon.) is a professor of Health Policy and Management at the Johns Hopkins School of Public Health, with joint appointments in the School of Medicine Departments of Pediatrics and Emergency Medicine. She was the founding director of the Johns Hopkins Center for Injury Research and Policy. She is an epidemiologist specializing in injury prevention; her research interests over the past 45 years have included road safety, aviation safety, and occupational safety, as well as poisoning, burns, drowning, and other unintentional and intentional injuries. She has been especially interested in prevention of injury to young children. Her 13 years in the Office of the Chief Medical Examiner of Maryland trained her to look for the specific details of what happened as well as the factors that determined survival, leading her to read the case histories themselves rather than relying upon coded data. This has contributed to her interest in training doctoral candidates to go beyond analyzing the coded data that is easily found on computer tapes to learning about underlying circumstances – which are typically the key to prevention. Students also benefit from her emphasis on the administrative, regulatory, and cultural environments that often determine the occurrence and outcome of injury-producing events. She is well known for research showing the need for child restraints in cars, and for developing the widely used Injury Severity Score and authoring The Injury Fact Book.

She takes great pleasure in her students, who have founded other centers for injury prevention and are conducting research and injury prevention programs all over the world while they train the leaders of the future.

Barbara Ann Barlow, MD, MA

Executive Director, Injury Free Coalition for Kids National Office

Special Lecturer in Epidemiology

Dr. Barbara Barlow is Professor Emeritus of Surgery in Epidemiology, Special Lecturer in Epidemiology at Columbia University, Mailman School of Public Health in New York and Associate Director of the CDC funded Center for Injury Epidemiology and Prevention at Columbia. She is also the Founder and Executive Director of the Injury Free Coalition for Kids, a National Program developed with funding from the Robert Wood Johnson Foundation of Princeton, New Jersey. Injury Free is a coalition of Injury Prevention Programs in Pediatric Trauma Centers located in major cities in the United States. The Injury Free Program reduces injury through education, construction of safe play areas, and the development and support of safe supervised activities with strong adult mentors.

Major injury admissions of community children in Harlem decreased by more than 60% since the program was initiated at Harlem Hospital in 1988. The Program and Dr. Barlow have received awards from the American Hospital Association, the American Academy of Pediatrics, the U.S. Department of Transportation, the National Highway Traffic Safety Association, the National Safety Council, the American Trauma Society, the National Association of Public Hospitals, Society of Public Health Educators of the American Public Health Association, Johnson and Johnson Foundation, Allstate Foundation, the Hospital Association of New York, the American Association of Medical Colleges' David E. Rogers Award, the Renaissance Woman Award from the Foundation for Women in Medicine, the Distinguished Career Award from the American Public Health Association Section on Injury Control and Emergency Health Services, and the Sloan Public Service Award from the Fund for the City of New York.

Dr. Barlow's research focused on traumatic injury to children and on injury prevention for the past thirty-five years. She is a former member of the American College of Surgeons Committee on Trauma and the American Academy of Pediatrics Committee on Pediatric Emergency Medicine. Dr. Barlow received a B.A. from Vassar College, an M.A. in Psychology from Columbia University and an M.D. from Albert Einstein College of Medicine where she was elected to Alpha Omega Alpha. Her general surgical training was completed at Bronx Municipal Hospital followed by a Fellowship in Pediatric Surgery at Babies Hospital, Columbia Presbyterian Medical Center. Dr. Barlow was Chief of Pediatric Surgery at Harlem Hospital from 1975 to 1999, where she started the Injury Prevention Program, and Director of Surgery at Harlem Hospital from 1999 until 2009. In 2011 she was awarded the CDC Foundation Hero Award for her work in Injury Prevention.

Anne Brayer, MD

Associate Professor Emergency Medicine and Pediatrics, Injury Free Coalition for Kids of Rochester

Anne Brayer, MD, FAAP, is a Pediatric Emergency Medicine physician at the Ronald McDonald Pediatric Emergency Department, who has been on the faculty of the University of Rochester since 1992. She has worked in the pediatric emergency department for over 20 years, and is the Pediatric Emergency Medicine fellowship director. She has been the director of the Injury Free Coalition of Rochester since its inception in 2004. She runs a teen driving program in Rochester, funded by the Allstate Foundation, since 2008. Dr. Brayer received her training at the University of Rochester and the Children's Hospital of Pittsburgh. She has published research in a variety of areas, including accidental toxic ingestions, head injury in children, home care of acutely ill infants, and the use of telemedicine in acute care pediatrics. She has an active interest in injury prevention. She oversaw the construction of two Injury Free/Allstate playgrounds in Rochester.

Tanya Charyk Stewart, MSc

Injury Epidemiologist, Injury Free Coalition for Kids of London, Ontario

Tanya is the Injury Epidemiologist for the Trauma Program at LHSC & Children's Hospital and Primary Investigator for Injury Free Coalition for Kids of London. She has an appointment with the Department of Surgery at the Schulich School of Medicine & Dentistry at Western as an Adjunct Research Professor. Her research interests include quality improvement, injury prevention evaluations and injury research, specializing in traumatic brain injuries and their prevention in the pediatric population. Tanya won the Johnson & Johnson Injury Prevention Award for Best Injury Prevention Research, presented at the international Trauma 2009 conference in Auckland, NZ and in 2007 & 2012 she won national Research Awards at the Trauma Association of Canada's Annual Scientific Meetings. The SBS prevention work of the Trauma Program she co-led won the Southwest LHIN Quality Award for Population-based Integrated Health Services in 2012.

Marie Crew, RNC-NIC, CPSTI

**Children's Hospital of Birmingham, Child Passenger Safety Resource Center, Alabama
Injury Free Coalition for Kids of Birmingham**

Marie has been active in injury prevention in children for the last 14 years. However, she has worked with neonates and pediatric populations since graduating from Nursing School 36 years ago. Children and improving their lives are her passion. She has 4 grown children and 9 wonderful grandchildren from 9 months to 15 years. Marie was drawn to working with teen driving issues when 10 teens were killed in less than 1 month in Central Alabama. She has worked with programs for teens, caregivers, parents and legislators for the last 4 years.

Elizabeth Edgerton, MD, MPH

HRSA Branch Chief for EMSC and Injury Prevention, Rockville, MD

Elizabeth Edgerton, MD, MPH, is the Director of the Division of Child, Adolescent and Family Health at the Maternal and Child Health Bureau (MCHB). Her Division is home to Emergency Medical Services for Children, Injury and Violence Prevention, Bright Futures, Adolescent Health and Oral Health initiatives. As an academician and program administrator, Dr. Edgerton has worked in the fields of EMSC and injury prevention throughout her career.

Dr. Edgerton is a graduate of the Robert Wood Johnson Clinical Scholars Program at UCLA/RAND and was the co-director of the Harbor-UCLA Injury Free Coalition for Kids site and helped established the Children's National Medical Center Injury Free site in Washington, DC. She is a previous EMSC Targeted Issues grantee and a recipient of the 2004 National Heroes Award for Outstanding EMSC Research Project. She has served on numerous national advisory panels, including MCHB's Advisory Committee on Heritable Disorders in Newborns and Children and the CDC's National Center for Injury Prevention and Control SAFE USA Partnership Council. Dr. Edgerton is a past Director of Clinical Prevention for the U.S. Preventive Services Task Force at the Agency for Healthcare Research and Quality, and most recently served as an attending physician in the Emergency Medicine and Trauma Center at Children's National Medical Center in Washington, DC.

Peter Ehrlich, MD

**Associate Professor, Surgery, Pediatric Surgery, University of Michigan Medical School; Medical Director, Pediatric Trauma, CS Mott Children's Hospital
Injury Free Coalition for Kids of Ann Arbor**

Dr. Ehrlich's research focuses on pediatric and adolescent injury. His current projects include the biomechanics of falls related to playground design. He is also particularly interested in the relationship between substance abuse injury and risk taking in adolescents. He has conducted intervention trials to explore risk taking and longitudinal models of change. He is interested in the relationship of parents as role models for injury behavior. Dr. Ehrlich leads the University of Michigan Injury Center's Outreach activities.

Barbara Gaines, MD

Assistant Professor of Surgery; Director of Trauma and Injury Prevention, Injury Free Coalition for Kids of Pittsburgh (Children's)

Dr. Gaines has been with Children's Hospital of Pittsburgh since 2000. She is Director of the Benedum Pediatric Trauma and Injury Prevention Programs; she serves as a pediatric surgeon with Children's Hospital of Pittsburgh of UPMC, (which is a Level I Trauma Center). Dr. Gaines is Principal Investigator of the Injury Prevention Program. She is an Associate Professor of Pediatric Surgery and Clinical Director of Pediatric General

and Thoracic Surgery with the University of Pittsburgh School of Medicine. She is triple board certified in pediatric surgery, general surgery and surgical critical care. In addition to her trauma responsibilities, she is also the Program Director for the Pediatric Surgery Training Program, an advanced training program for surgical trainees, and she is actively involved in teaching medical students, surgery residents, and pediatric surgery fellows. Dr. Gaines academic and community outreach interests include outcomes and quality of life after pediatric injury and prevention of childhood injury.

Dr. Gaines is actively involved in state and national trauma-related organizations, below are a few examples.

President, Pediatric Trauma Society

Past-President, Injury-Free Coalition for Kids

Chair, Ad Hoc Pediatric Committee, AAST

Member, American College of Surgeons Committee on Trauma

Pallavi Ghuge, MD, MPH

Children's Hospital of Birmingham, AL

Injury Free Coalition for Kids of Birmingham

Pallavi Ghuge, MD, MPH is a third year fellow in Pediatric Emergency Medicine at Childrens hospital of Alabama.

She received her MPH in Epidemiology from University of Alabama at Birmingham in 2009. She finished her pediatric residency at Morehouse School of Medicine, Atlanta in 2012. During fellowship her research interest was to look at unintentional Opioid poisoning presenting in the emergency department.

Mike Gittelman, MD

Professor of Clinical Pediatrics

Co-Director, Injury Free Coalition for Kids of Cincinnati

Mike Gittelman, MD, FAAP, is a pediatric emergency room physician at Cincinnati Children's Hospital, Medical Center in Cincinnati, Ohio and he is a Professor of Clinical Pediatrics at the University Of Cincinnati School Of Medicine. He completed his undergraduate work at Swarthmore College and his medical school training at the Medical College of Pennsylvania, both of which are located in Philadelphia, PA. He completed his residency in Pediatrics at St. Christopher's Hospital for Children in Philadelphia, PA, and a fellowship in Pediatric Emergency Medicine at Cincinnati Children's Hospital.

His area of expertise is within the field of injury control. Prior to their formation of a Council, he served as the Chairperson for the American Academy of Pediatrics' Section on Injury and Poison Prevention. He is a Board Member of the AAP's Ohio Chapter, and he is a Co-Director of the Comprehensive Children's Injury Center at Cincinnati Children's Hospital. He is involved in resident education on injury prevention and he works with high-risk communities in an effort to reduce pediatric injuries. One of his research interests has been to study the impact of an ER encounter on promoting a behavior change to prevent injuries. More recently he has worked with the Ohio Chapter to develop a state-wide bicycle helmet intervention and to develop an injury QI program for pediatricians.

Aaron Heffernan, MA, LCSW

Children's Hospital of Wisconsin, Milwaukee, Wisconsin

Injury Free Coalition for Kids of Milwaukee

Aaron Heffernan, MA, LCSW, is a child and family therapist with over 15 years of experience in the field of mental health. He holds Masters Degrees in Philosophy and Social Work from the University of Wisconsin, Milwaukee, and has worked as an outpatient psychotherapist at Children's Hospital of Wisconsin since 2005. Aaron is a certified practitioner of EMDR, which he blends with expressive arts modalities in his work with children in foster care and adoption systems and with child survivors of inner city violence. He completed certification in Trauma Counseling at the University of Wisconsin-Milwaukee in 2011, and is a close partner with Project UJIMA, a nationally recognized violence prevention program at Children's Hospital of Wisconsin. In 2010, Aaron developed a Hip Hop Music Therapy program which he has implemented at UJIMA's summer camp for child victims of urban violence. He has served on several panels addressing urban youth trauma in Milwaukee, and has developed staff trainings on culturally appropriate trauma treatment for urban youth which he has provided at several social service agencies in the Milwaukee area. He is a husband and father of three children, and a semi-professional musician.

Michael Hirsh, MD

Professor of Surgery & Pediatrics

UMass Memorial Children's Medical Center

Co-Director, Injury Free for Kids, Worcester

Michael Hirsh is Division Chief of Pediatric Surgery and Trauma at UMass Memorial Children's Medical Center and Associate Surgical Director of the Trauma Center and Pediatric Intensive Care Unit. He formerly served as Principal Investigator of Injury Free Pittsburgh from 1993-2000. His experience is in developing and applying innovative interventions to prevent pediatric injury.

As co-director of Injury-Free Pittsburgh, Dr. Hirsh created Health Rangers, a mentoring program which pairs potentially at-risk middle school children with mentors at local hospitals. He is also a co-founder of Goods for Guns, a firearms exchange program. Dr. Hirsh also designed and brought Safety Street to the Pittsburgh Children's Museum, a life-size, outdoor exhibit designed to teach children the fundamentals of street safety.

Publications include: Hirsh MP: Public Approach to Violence (Physician's News Digest June 1997); and Masiello, M, Friend, J, Hirsh MP, Synder K: Pittsburgh Goods for Guns Antiviolence Coalition: A Successful Four Year Expanded Gun Buy-Back Program (Pediatrics, Abstracts for Section Scientific Presentations at AAP 1998 Annual Meeting). Dr. Hirsh received his MD from Harvard University in 1979, completed surgical residency at Columbia-Presbyterian Medical Center, and Fellowship training in the Department of Pediatric and Transplant Surgery at St. Christopher's Hospital for Children in Philadelphia. Dr. Hirsh has won numerous public service and teaching awards, and is board certified in General Surgery, Pediatric Surgery and Critical Care.

Katie Horrigan, MPH

Director, Community Education & Outreach

Children's Hospital of Wisconsin

Injury Free Coalition for Kids of Milwaukee

Katie Horrigan has more than 14 years experience in the field of public health, both in Massachusetts and Wisconsin. She has a Master Degree in Public Health from Boston University, and a Bachelor's Degree in Community Health Education from the University of Wisconsin, LaCrosse. Her experience includes planning, implementing and evaluating prevention programs tailored to the needs of communities. In her current role, she oversees a variety of health education initiatives and topics, including injury prevention, that reach throughout the State of Wisconsin. She has been a certified child passenger safety technician for more than 6 years. Children's Hospital of Wisconsin is the lead organization for the Injury Free Coalition for Kids - Milwaukee, Safe Kids Wisconsin and Safe Kids Southeast Wisconsin. In addition to these coalitions, Katie's team also leads a variety of unique program offerings around hospital-based child passenger safety, teen driving safety, and bullying prevention, as well as the Kohl's Cares Grow Safe and Healthy program, which includes a game-based injury prevention app which is available through the Apple App Store and Google Play.

Gillian Hotz, PhD

Director KiDZ Neuroscience Center, University of Miami Miller School of Medicine

Injury Free Coalition for Kids of Miami

Gillian Hotz, PhD is the Director of the KiDZ Neuroscience Center and the Concussion, WalkSafe™ & BikeSafe™ & SkateSafe™ Programs, Professor Department of Neurosurgery & The Miami Project to Cure Paralysis, at University of Miami Miller School of Medicine. Dr. Hotz is the Principal Investigator on many funded national, state and local grants and is internationally recognized as a leader for injury prevention research projects and clinical trials for children with traumatic brain injury. The pediatric injury prevention evidence based programs include; The WalkSafe™ program was developed in 2001 at the University of Miami Miller School of Medicine and the Ryder Trauma Center at Jackson Memorial Medical Center. WalkSafe aims to improve pedestrian safety, increase physical activity, and enhance the walkability surrounding elementary schools. Since 2003, the pediatric pedestrian-hit-by-car (PPHBC) rates have declined by more than 60% in Miami-Dade County (M-DC). The BikeSafe Program is now educating middle school age children in parks and classroom settings in middle schools in MDC.

Since 1996, Dr. Hotz has directed a comprehensive Concussion Program and one of the first Credentialed IMPACT Consultants. She also Chaired the State Concussion Task Force which worked on legislation being passed in March 2012 for the management of youth concussions. In 2011, she developed a Countywide Concussion program in M-DC and is one of the team doctors for the University of Miami football team. Dr. Hotz and her team have developed a standard concussion management protocol for all High School and College athletes which includes; training and education about concussion to coaches, athletic trainers, athletes and parents, baseline IMPACT testing, a concussion injury surveillance system and clinical evaluation for return to play and school. www.UConcussion.com

Most recently she guest edited the Brain Injury Professional Magazine “Perspectives in Pediatric Brain Injury” and received the 2012 Clinical Innovation Award from the National Brain Injury Society. She has presented at many conferences on the local, national and international levels as well as published extensively in journals and books. Dr. Hotz is an author of two neurocognitive tests the Brief Test of Head Injury and the Pediatric Test of Brain Injury. She also is a member of a number of Boards and Advisory Groups specifically ACRM Pediatric Adolescent Task Force, Florida Injury Prevention Advisory Council, Florida Committee on Trauma, and the Sarah Jane Brain Project.

Andrew Kiragu, MD

**Assistant Professor of Pediatrics at the University of Minnesota
Hennepin County Medical Center
Co-Director, Injury Free Coalition for Kids of Minnesota**

Dr. Andrew Kiragu is currently the Assistant Chief of the Department of Pediatrics and Medical Director of the Pediatric Intensive Care Unit at Hennepin County Medical Center. He is an Assistant Professor of Pediatrics at the University of Minnesota. He completed his undergraduate studies at Dalhousie University in Nova Scotia, Canada and subsequently graduated from Howard University College of Medicine in Washington, DC. He served his residency in Internal Medicine and Pediatrics at the University of Minnesota, followed by a fellowship in Pediatric Critical Care. He is the PI for IFCK, Minneapolis. He serves on the boards of the MN Chapter of the AAP, Safe Kids MN and the Midwest Injury Prevention Alliance.

Amber Kroeker, MPH, CPST

**University of Michigan - C.S. Mott Children’s Hospital, Ann Arbor, Michigan
Injury Free Coalition for Kids of Ann Arbor**

Amber Kroeker is a health educator in the Injury Prevention Program at the University of Michigan - C.S. Mott Children’s Hospital and coordinator for Safe Kids Huron Valley. In this position Mrs. Kroeker develops and facilitates community and hospital based interventions that prevent injuries to children, manages research projects pertaining to pediatric injury and trauma, and coordinates the Safe Sleep Taskforce at University of Michigan Hospital and Health Systems.

Prior to her current work in injury prevention, Mrs. Kroeker served as a clinical research coordinator in the Department of Pediatrics at University of Michigan, a health educator for the National Psoriasis Foundation, and Clinical Instructor at Cambridge College. Mrs. Kroeker received her B.S. in microbiology and chemistry from Oregon State University and a Masters in Public Health from Oregon Health and Science University. Mrs. Kroeker is a Certified Child Passenger Safety Technician and a Safe to Sleep Champion for the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

Erin Kuroiwa, MHI

Phoenix Children’s Hospital in Arizona, Phoenix, Arizona

Erin Kuroiwa, MHI is the Manager of Injury Prevention at Phoenix Children’s Hospital in Arizona. Erin enjoys working with families, professionals, and communities to create advocacy groups and community campaigns to improve health and safety. Ms. Kuroiwa is a Certified Child Passenger Safety Technician and Instructor. She has also completed the Special Needs enrichment training. She co-created the Car Seat Helper App and believes that innovation is an important element in promoting public health. Ms. Kuroiwa earned her master’s in healthcare innovation from Arizona State University.

Garry Lapidus, PA-C, MPH

Director, Injury Prevention Center, Connecticut Children’s Medical Center/Hartford Hospital, Assoc. Prof. of Pediatrics & Public Health, UConn School of Medicine, Injury Free Coalition for Kids of Hartford

Garry Lapidus has worked for 35 years as a physician assistant and is a member of the pediatric faculty and medical staff at Connecticut Children’s Medical Center. Mr. Lapidus is a national leader in injury prevention research, education and training, community based programs, and public policy. He is a published author in the field with over 50 peer reviewed journal articles and has given numerous presentations to local, national, and international audiences. He is past Chair of the Injury Control and Emergency Health Services section of the American Public Health Association and currently serves on the advisory board for the Injury Free.

Mr. Lapidus serves as a member of the several grant scientific review panels. He is the instructor for the “Injury and Violence Prevention” course currently offered as part of the Master of Public Health Program at the University of Connecticut School of Medicine. He also serves as a preceptor for medical and public health graduate students engaged in injury research and practicum projects.

Lois Lee, MD, MPH

Assistant Professor of Pediatrics

Injury Free Coalition for Kids of Boston

Dr. Lois Lee is an attending pediatric emergency medicine physician at Boston Children’s Hospital and an Assistant Professor of Pediatrics at Harvard Medical School. She received her MD from the University of Pennsylvania School of Medicine, and completed her internship and residency in pediatrics at the Children’s Hospital of Philadelphia. She did her fellowship in pediatric emergency medicine at Children’s Hospital Boston. She received her MPH from the Harvard School of Public Health. Her clinical and research interests are in pediatric trauma care and injury prevention. She also practices injury prevention at home with her 11-year-old son and her 8-year-old daughter.

Gouhua Li, MD, DrPH

Professor of Epidemiology and Anesthesia

Columbia University, New York, NY

Guohua Li, MD, DrPH is the M. Finster Professor of Epidemiology and Anesthesiology and Director of the Center for Injury Epidemiology and Prevention at Columbia University. He received his medical degree from Beijing Medical University and his doctoral and post-doctoral training in injury epidemiology and prevention at Johns Hopkins University. He started his career as an assistant professor of emergency medicine at the Johns Hopkins School of Medicine in 1995. As one of the first epidemiologists working in the fledgling field of academic emergency medicine, Dr. Li used the emergency department as a population research laboratory for studying major public health problems, including injury, violence, alcohol abuse, and drug overdose.

Before moving to Columbia University in 2007, Dr. Li served as professor and director of research at the Department of Emergency Medicine, Johns Hopkins University School of Medicine. Dr. Li has published over 150 manuscripts in peer-reviewed journals. He is a coauthor of the influential text Injury Fact Book, 2nd Ed (Oxford University Press, 1992) and co-editor of the reference book Injury Research: Theories, Methods, and Approaches (Springer, 2012). Dr. Li’s work has been funded primarily through competitive research grants from the National Institutes of Health in the past two decades. His research has contributed to the development, implementation, and evaluation of graduated driver licensing programs to prevent injuries from motor vehicle crashes in novice drivers, and provided the scientific evidence for extending the mandatory retirement age for airline pilots from 60 to 65 by the International Civil Aviation Organization and the Federal Aviation Administration. Dr. Li is credited for developing the decomposition method for quantifying the major contributing factors to injury mortality variations across population groups, geographic regions, and time periods.

He also made seminal contributions to the development of the multiphase approach to age-period-cohort modeling, a semi-parametric technique for studying long-term, complex epidemiological patterns in contingency table data. Dr. Li is a William Haddon, Jr Fellow, a Fellow in Aerospace Medicine, and a Fellow of the American College of Epidemiology. He is a recipient of the Kenneth Rothman Epidemiology Prize (1999), the Guggenheim Fellowship (2005), and the John Paul Stapp Award (2009).

Anagha Loharikar, MD

Assistant Professor of Pediatrics

Injury Free Coalition for Kids of Chicago

Anagha Loharikar is an Assistant Professor with the Division of Academic General Pediatrics and Primary Care at Feinberg School of Medicine at Northwestern University. In addition to her clinical service at a primary care center in an urban, largely immigrant, community, she serves as the Director of the Global Health Education Program for the Pediatric Residency at Ann & Robert H. Lurie Children’s Hospital of Chicago and course instructor in the Program in Public Health at Northwestern University.

While in medical school at the University of Illinois, she received the Fulbright Scholarship to work with a non-governmental organization in rural India, which focused on development through women’s health and empowerment. After medical school, Dr. Loharikar completed residency in Social Pediatrics at the Children’s Hospital at Montefiore in Bronx, New York. Following her year as a chief resident, she completed fellowship in the Epidemic Intelligence Service with the Centers for Disease Control and Prevention.

Karen Mack, PhD

National Center for Injury Prevention and Control, Atlanta, Georgia

Karin A. Mack, PhD is currently the Associate Director for Science for the Division of Analysis, Research, and Practice Integration, National Center for Injury Prevention and Control. She is also an Adjunct Assistant Professor in Emory University's Sociology Department. She has nearly 20 years of Federal Service, has given over 90 scientific presentations, and is the author of many injury research publications, including the July 2013 Vital Signs, Overdoses of Prescription Opioid Pain Relievers and Other Drugs among Women – United States, 1999-2010. She is also a co-editor of the 2012 book, Healthy & Safe Homes: Research Practice Policy. Dr. Mack has received eighteen service awards from CDC and two special achievement awards from NIH. She currently serves as a Governing Council representative for the Injury Control and Emergency Health Services Section of the American Public Health Association.

Jamie Macklin, MD

OSU Wexner Medical Center and Nationwide Children's Hospital, Columbus, Ohio

Jamie Macklin is an adult medicine and pediatric hospitalist, currently practicing at the OSU Wexner Medical Center and Nationwide Children's Hospital. She received her medical degree from Tulane University School of Medicine in New Orleans, LA, and completed an internal medicine/pediatrics residency at the OSU Medical Center/Nationwide Children's Hospital, Columbus, OH. Her clinical interests currently include quality improvement regarding safe sleep and breastfeeding education. When not in the hospital, she enjoys spending time with her husband, Josh, and two young daughters, Lucy and Victoria.

Eileen McDonald, MS

Johns Hopkins University, Baltimore, MD
Injury Free Coalition for Kids of Baltimore

Eileen M. McDonald is an associate scientist in the Department of Health, Behavior and Society at the Johns Hopkins Bloomberg School of Public Health, where she directs the masters program in health education and health communication. She is also core faculty of the Johns Hopkins Center for Injury Research and Policy. Her research focuses on the application of innovative health education methods, health communication technology, and other hospital- and community-based interventions aimed at reducing pediatric injuries. Among her currently active research projects is an m-health application to promote booster seats among parents of young children being seen in the emergency department, a demonstration project testing a partnership between nurse home visitors and fire personnel in Phoenix AZ to improve smoke alarm and fire safety among low-income families, and a randomized controlled trial of a safe sleep intervention in a pediatric well-child clinic.

Ms. McDonald was a co-creator of the Johns Hopkins Children's Safety Center, a first-of-its-kind, hospital-based safety resource center, that provides free injury prevention education and promotes the use of safety products to reduce injuries among children and families. As director, Ms. McDonald now oversees three Johns Hopkins safety centers, including the CARES Safety Center, a mobile safety center implemented in partnership with the Baltimore City Fire Department. Ms. McDonald has authored a nationally distributed guidebook for child safety and numerous research articles on injury prevention and health education topics. Ms. McDonald holds a bachelor's degree in health education and a master's degree in health administration. Ms. McDonald is the director of Injury Free Coalition for Kids–Baltimore.

Terri McFadden-Garden, MD

Associate Professor of Pediatrics
Co-Principal Investigator, Injury Free Coalition for Kids of Atlanta

Dr. McFadden is a General Pediatrician and an Associate Professor in the Department of Pediatrics of the Emory University School of Medicine. She serves as Medical Director of Primary Care at the Hughes Spalding campus of Children's Healthcare of Atlanta where she sees patients and teaches medical students, pediatric residents and allied health students. She is also the Medical Director for primary care with the Emory Department of Pediatrics Urban Health Program. She is board certified by the American Board of Pediatrics and is a Fellow of the American Academy of Pediatrics where she serves on the Executive Committee of the Council on Early Childhood. McFadden is the Co-Medical Director of the Injury Free Coalition for Kids (IFCK)-Atlanta childhood injury prevention program. She also serves as Medical Director of the Georgia Coalition of Reach Out and Read. Her academic and professional interests include comprehensive care for the underserved, childhood injury prevention, preschool literacy promotion, and medical education. She has a Bachelor of Science degree from Spelman College and a medical degree from the Johns Hopkins School of Medicine.

Marlene Melzer-Lange, MD

Professor of Pediatrics

Children's Hospital of Wisconsin Milwaukee, Wisconsin

Injury Free Coalition for Kids of Milwaukee

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

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

Matthew Moront, MD

Professor of Surgery

Chief of Pediatric Surgery and Trauma Medical Director, St. Christopher's Hospital for Children's

Injury Free Coalition for Kids of Philadelphia

Dr. Matthew Moront earned his medical degree from Georgetown University. He completed his General Surgery residency at the University of Massachusetts Medical Center. Dr. Moront also completed his fellowship in Pediatric Surgery at Children's National Medical Center in Washington DC. Upon completion of his fellowship, Dr. Moront spent a few months as an attending surgeon at Specialty Surgeons of Pittsburgh. In 2000, he assumed an attending position at St. Christopher's Hospital for Children and later that year was appointed Director of Trauma Services. Additionally, Dr. Moront functions as an Attending Surgeon at Hahnemann University Hospital, Mercer Hospital, St. Luke's Hospital and Albert Einstein Medical Center. As of July 2014, Dr. Moront has been appointed to Division Chief of Pediatric General, Thoracic & Minimally Invasive Surgery at St. Christopher's Hospital for Children. Dr. Moront has an array of teaching experiences related to pediatric trauma and general surgery, maintains certification as an Advanced Trauma Life Support instructor and is an active member of professional organizations American College of Surgeons, American Medical Association, Disaster Management Action Team, Medical Center, Chief Logistics Officer, American Trauma Society, American Pediatric Surgical Association, American Academy of Pediatrics Surgical Section, and Eastern Association for the Surgery Trauma.

Dina Morrissey, MD, MPH, CPSTI

Program Coordinator, Injury Free Coalition for Kids of Providence

Dina Morrissey, MD, MPH is the program coordinator for community activities at the Injury Prevention Center at Rhode Island Hospital. She coordinates the Injury Free Coalition for Kids in Providence program, the Safe Kids RI program, Kohl's Cares for Kids on the Go program, and the IPC Home Safety programs. Dr. Morrissey earned her MD degree at the University of Massachusetts Medical School and completed a residency in pediatrics at Yale-New Haven Hospital. Dr. Morrissey has practiced as a primary care pediatrician and recently earned an MPH from the University of Massachusetts Medical School.

Hope Mullins, MPH

Research Coordinator, Injury Free Coalition for Kids of Little Rock

Hope Mullins 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 with an emphasis on health education. She is also a certified child passenger safety technician and a certified research specialist.

Valerie Neilson, MSP, AICP

BikeSafe® Program Manager

**KiDZ Neuroscience Center at the Miami Project to Cure Paralysis University of Miami Miller School of Medicine
Injury Free Coalition for Kids of Miami**

Valerie Neilson received her Master of Science in Planning with a concentration on Health & the Built Environment in 2009 from Florida State University. From 2009-2012 she worked as an environmental planner for a private consulting firm and became certified by the American Institute of Certified Planners (AICP) in May 2012.

Since fall of 2012, Valerie has worked for the University of Miami as the BikeSafe® Program Manager, an injury prevention program for children endorsed by Safe Routes to School and Miami-Dade County Public Schools. Valerie serves as Vice Chair for the Health & Built Environment Committee of the Consortium for a Healthier Miami-Dade County as well as a Board Member for the Miami-Dade County Metropolitan Planning Organization's Bicycle and Pedestrian Advisory Committee.

Corinne Peek-Asa, PhD

Professor of Occupational and Environmental Health

University of Iowa, College of Public Health

Corinne Peek-Asa, PhD, is the Associate Dean for Research of the University of Iowa, College of Public Health, a Professor of Occupational and Environmental Health and Director of the CDC-funded Injury Prevention Research Center. Dr. Peek-Asa is an epidemiologist who specializes in the implementation and evaluation of programs and policies to prevent acute traumatic injuries and violence. She has more than 160 scientific publications and current studies in the areas of teen driving safety, bicycle safety, workplace violence, residential fire injuries, domestic violence, sexual violence, and international road traffic safety.

Dr. Peek-Asa currently serves on the Board of Scientific Counselors for the National Institute for Occupational Safety and Health, is the past-President of the Society for the Advancement of Violence and Injury Research and received the SAVIR President's Award in 2011. She was named a 2009 Research America! Public Health Hero.

Susan Pollack MD

Kentucky Children's Hospital, Lexington Kentucky

Injury Free Coalition for Kids of Lexington

Susan H. Pollack MD, FAAP is an Assistant Professor at the University of Kentucky in the Dept. of Pediatrics, College of Medicine, Dept. of Preventive Medicine, College of Public Health and Kentucky Injury Prevention and Research Center (KIPRC). She directs the Pediatric and Adolescent Injury Prevention Program at KIPRC, which, in addition to leading Injury Free, assists the KY Department for Public Health/Maternal and Child Health in providing leadership for the state Child Fatality Review (CFR) and Injury Prevention Program, including the Kentucky State Safe Kids Coalition. Injury Free has built a niche reaching individuals in special needs areas of the community (immigrants, victims of domestic violence, children in foster care and families of children with disabilities), but the larger program magnifies reach by its focus on injury prevention education and support for the agencies and professionals who in turn reach the public.

Dr. Pollack was honored to serve on AAP's COIPP (fire and other issues). Through APHA and the AAP she has had the opportunity to participate in the writing of "Health, Mental Health and Safety Guidelines for Schools" and "Caring for Our Children" (child care standards), to work on CFR issues and safety consultations for Head Start. She served on the IOM committee to look at health effects of child labor and the evaluation teams for the National Institute for Safety and Health's Agriculture, Forestry and Fishing Program. Her advocacy efforts have helped in the passage of EMSC legislation, strengthened Graduated Drivers' Licensing, and required booster seats.

Wendy Pomerantz, MD, MS

Professor of Clinical Pediatrics

Co-Director, Injury Free Coalition for Kids of 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. She has been a pediatric emergency medicine physician for the past 18 years. She has published many peer-reviewed articles in the fields of injury and poison prevention. Her interests include poison prevention, concussions, program evaluation, education, and geographic information systems.

Catherine Rains, MPH

St. Louis Children's Hospital

Injury Free Coalition for Kids of St. Louis

Catherine Rains earned her Master of Public Health degree from St. Louis University in 2010 and has been an evaluator of public health programs in academic, government and non-profit settings.

She has been with St. Louis Children's Hospital for 4 years as a program evaluator for community outreach programs. In her role with the Child Health Advocacy and Outreach department of the hospital, she creates effective evaluation tools to measure the success of community based education and prevention programs addressing many health topics including pedestrian safety and child passenger safety.

Alison Riese, MD, MPH

Hasbro Children's Hospital/Rhode Island Hospital, Rhode Island

Injury Free Coalition for Kids of Providence

Alison Riese is an academic pediatrician at Hasbro Children's Hospital in Providence, RI. She attended medical school at University of Massachusetts Medical School, and completed her pediatrics residency at the Hasbro Children's Hospital/Brown University program. She recently completed a research fellowship in injury prevention and her Masters in Public Health at Brown University. She received an Academic Pediatrics Association Young Investigator's Award in 2013. Her research interests include doctor communication about adolescent health risk behaviors, particularly youth violence involvement, and pediatric resident education in injury prevention and advocacy.

Steven Rogers, MD

Co-PI Injury Free Hartford / Pediatric Emergency Department Attending

Assistant Professor of Pediatrics

Physician, Injury Free Coalition for Kids of Hartford

Steven Rogers, MD is a Pediatric Emergency Medicine physician and Injury Prevention research scientist at Connecticut Children's Medical Center and Injury Prevention Center. These positions allow him to have a unique perspective on preventing as well as treating sick and injured children. His academic and research activities in injury prevention have been focused on the most common causes of death in 1-18 year olds including such areas as motor vehicle/pedestrian safety, drowning, suicide and violence screening/prevention. He is enrolled in a Master's of Science in Clinical and Translational Research program at the University of Connecticut. His current focus is on improving the care of high risk behavioral health and psychiatric patients in the emergency department. He is also developing new technology that will enhance injury prevention education as well as improve clinicians' ability to identify and prevent injury/violence in high risk patient populations.

Judy Schaechter, MD, MBA

Interim Chair, Department of Pediatrics

Associate Professor of Pediatrics, Division of Adolescent Medicine

Injury Free Coalition for Kids of Miami

Dr. Judy Schaechter, is Interim Chair of the Department of Pediatrics at the University of Miami Miller School of Medicine and chief of service at Holtz Children's Hospital at Jackson Memorial Medical Center. She is a general pediatrician with special interests in adolescence, injury and violence prevention, access to health care, education, and community health.

Dr. Schaechter is president of the national Injury Free Coalition for Kids board, keeping children safe where they live and play, and founder/director of Injury Free Coalition for Kids-Miami. Judy is the appointed child health policy expert on the Florida Healthy Kids Corporation Board, bringing health insurance to the state's children 5-18 years of age. Serving on Florida's Children and Youth Cabinet, Judy coordinates with the state's agency directors to improve health, safety and education. She is a senior advisor to the Florida Children's Movement which established a 24/7 parent phone line for developmental screening and services, promotes child literacy and champions parents as advocates. As a founding board member of The Children's Trust, she helped to create health teams in 165 schools and established a home visitation program in Miami-Dade County.

Dr. Schaechter chairs the Miami-Dade County Immunization Coalition and stewards the Pediatric Mobile Clinic, providing health and mental health care to uninsured children and families. She is a plaintiff in the First Amendment “Physician Gag Law” case contesting Florida’s law restricting physician speech to prevent child firearm injury. Dr. Schaechter has been recognized as a Home Town Hero, Woman of Valor, Health Care Hero, Woman Worth Knowing, White House Fellow Finalist, and has been honored with a Hope Award, Family Advocacy Award, and induction into the Iron Arrow Honor Society.

Karen Sheehan, MD, MPH

Professor of Pediatrics and Preventive Medicine

Northwestern University’s Feinberg School of Medicine, Chicago, Illinois

Ann & Robert H. Lurie Children’s Hospital of Chicago’s Injury Prevention and Research Center

Injury Free Coalition for Kids of Chicago

Karen Sheehan, MD, MPH is a Professor of Pediatrics and Preventive Medicine at Northwestern University’s Feinberg School of Medicine. She is the Medical Director of Ann & Robert H. Lurie Children’s Hospital of Chicago’s Injury Prevention and Research Center and the violence prevention collaborative, Strengthening Chicago’s Youth (SCY). Dr. Sheehan serves as the Associate Chair of Advocacy for the Department of Pediatrics and is also the Interim Co-Director of the Mary Ann & J. Milburn Smith Child Health Research Program. She is a founding volunteer of the Chicago Youth Programs, a community-based organization that works to improve the health and life opportunities of at risk youth. She divides her clinical time between directing the Chicago Youth Programs’ Clinic at Lurie Children’s and attending in the Pediatric Emergency Department.

Senator Christopher Smith

Florida State Senate Distrct 31

Senator Christopher Smith was elected to the Florida Senate in 2008 representing Broward and Palm Beach County. Due to redistricting Senator Smith now represents 14 municipalities in Central Broward County. In only the third year of his first term, Senator Smith was elected Democratic Leader of the senate. As Democratic Leader he is setting Democratic policy on statewide issues.

After the tragic death of Trayvon Martin in Sanford, Florida, Senator Smith called upon the Governor and Legislature for action. Due to inaction Senator Smith formed a Task Force to discuss the controversial Stand Your Ground law in the State of Florida. After fighting against the Stand Your Ground when it was first introduced 2005 he has now authored bills on revising Stand Your Ground. Senator Smith has been used as an expert nationwide on the effects of Stand Your Ground legislation.

Senator Smith is a graduate of Johnson C Smith University, in Charlotte North Carolina and a law graduate of Florida State University College of Law. He is a partner with the firm of Johnson, Anselmo et al.

Sarah Stempski, MPH, MCHES

Health Educator in the Family Resource Center at Seattle Children’s Hospital

Sarah Stempski, MPH, MCHES, is a Health Educator in the Family Resource Center at Seattle Children’s Hospital. She graduated from the University of Washington School of Public Health Social and Behavioral Sciences Program, with a focus on injury prevention, social determinants of health and strategies of health promotion. Her recent work includes drowning prevention initiatives focused on policy change, with the collaboration of Dr. Linda Quan and Elizabeth Bennett. She also works on obesity prevention, child passenger safety and other areas of child health and safety.

Purnima Unni, MPH, CHES

Monroe Carell Jr. Children’s Hospital at Vanderbilt, Tennessee

Injury Free Coalition for Kids of Nashville

Purnima Unni 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 .

Lisa Wolfs, BScN

Injury Prevention Specialist, Injury Free Coalition for Kids of London, Ontario

Lisa is an Injury Prevention Specialist for the Trauma Program at LHSC & Children's Hospital. Lisa holds a Bachelor of Health Sciences degree in Nursing from University of Western Ontario. Her professional experience includes both adult and pediatric emergency nursing, as well as community care nursing in rural/remote First Nations communities. Lisa is currently completing a Master of Public Health degree from Lakehead University. She is a coordinator of the IMPACT (Impaired Minds Produce Actions Causing Trauma) program.

Joseph Wright, MD, MPH

Professor of Pediatrics

Howard University College of Medicine, Washington, DC

Joseph L. Wright, MD, MPH is the newly appointed Professor and Chairman of Pediatrics at the Howard University College of Medicine in Washington, DC. He most recently served as Senior Vice President for Community Affairs at Children's National Medical Center the nation's third-oldest children's hospital where he provided strategic leadership for the organization's advocacy mission, public policy positions and community partnership initiatives. He maintains adjunct appointment as professor of emergency medicine and health policy at the George Washington University Schools of Medicine and Public Health. Dr. Wright is among the original cohort of board-certified pediatric emergency physicians in the United States with scholarly interests that include prehospital pediatrics, injury prevention and the needs of underserved communities.

Academically, he has contributed to over 80 publications in the scientific literature and has been admitted as an elected member of Delta Omega, the nation's public health honor society. Dr. Wright's advocacy and public policy leadership has been recognized throughout his career including by the American Academy of Pediatrics as recipient of the Fellow Achievement Award for exceptional contributions in injury prevention, and the Distinguished Service Award for career achievement in pediatric emergency medicine. He has been appointed to several Institute of Medicine study committees including Pediatric End-of-Life Care, the Future of Emergency Care and Youth Sports Concussions, as well as, provides leadership through service on several national advisory bodies including the American Hospital Association's Maternal and Child Health Council, the March of Dimes' Public Policy Advisory Council, and recently as an Obama administration appointee to the Food and Drug Administration's Pediatric Advisory Committee. Dr. Wright regularly delivers invited expert testimony before Congress and state and municipal legislative bodies, has made numerous media appearances, and lectures widely to both professional and lay audiences.

Dr. Wright earned a B.A. from Wesleyan University in Middletown, CT, his M.D. from Rutgers New Jersey Medical School, and a Masters of Public Health in Administrative Medicine and Management from the George Washington University.

**2014 Forging New Frontiers:
“Preparing for the Challenges of
Childhood Injury Prevention”**



**EVALUATION &
CME CERTIFICATION**

ACCREDITATION

Accreditation Statement

CHES
Sponsored by Cincinnati Children's, a designated provider of continuing education contact hours (CECH) in 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 13.5 total Category 1 contact education contact hours. Maximum advanced-level continuing education contact hours available are 0.

CME
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 providership of Cincinnati Children's Hospital Medical Center and the Injury Free Coalition for Kids through the Center for Injury Epidemiology & Prevention, Mailman School of Public Health, Columbia University. 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 13.25 *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.