2013 Forging New Frontiers:

"Meeting the New Challenges in Childhood Injury Prevention"

The 18th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with
Cincinnati Children's Hospital Medical Center
November 8 - 10, 2013

The 2013 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 2013 Annual Conference are to provide participants with an opportunity to:

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

Accreditation Statement

Sponsored by Cincinnati Children's, a designated provider of continuing education contact hours (CECH) 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 I contact education contact hours. Maximum advanced-level continuing education contact hours available are 0.

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Cincinnati Children's Hospital Medical Center and Injury Free Coalition. Cincinnati Children's is accredited by the ACCME to provide continuing medical education for physicians. Cincinnati Children's designates this live activity for a maximum of 13.5 *AMA PRA Category 1 Credit(s)*™ . Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure Statement

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

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

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Dear Injury Free Colleagues and Conference Participants:

Welcome to sunny South Florida and the 17th Annual Conference of the Injury Free Coalition for Kids! On behalf of the board, let me tell you how pleased we are to have you here for learning, networking and planning exciting ways to enrich and cross-pollinate our programs with new injury prevention ideas. This year's conference expands our borders – literally and metaphorically. First, Injury Free is now international! With the addition of our newest IFCK members from Ontario, Canada, we've expanded our map. Welcome Canucks! The conference also includes a global focus with a panel of speakers from around the world.

Over the past several years Injury Free has stretched beyond what comes to mind when some practitioners first think of childhood injury. Perhaps out of necessity, Injury Free has increasingly attended to intentional injury, including a keynote last year on bullying prevention by Joe Wright. The problem of violence in our world, and its impact on children has continued, or even expanded, entering our elementary schools such as Sandy Hook, sporting events, such as the Boston Marathon and neighborhoods such as Sanford, Florida. Of course, we know that the effects of violence occur daily, even when and where there are no headlines. The conference is fortunate to have with us Dr. Daniel Webster, Professor of Health Policy and Management at Johns Hopkins and co-author of Gun Violence in America, to help us focus on firearm prevention. We also have Dr. David Schonfeld, from the National Center of School Crisis and Bereavement, who assisted families after the Newtown, CT shootings.

Other border crossings are more easily tracked. Worcester's Teen DRIVE, a 34 foot distracted driving simulator has logged some 1500 miles and passed through about 15 states to make it to Ft. Lauderdale for all of us to see it. Thank you, Esther and Mike! Finally, we have a brand new award for the most outstanding program coordinator or the year! We know every site has an outstanding coordinator, but we think it is important to recognize innovation and effort that goes above and beyond even the best of the bunch!

A big thank you to our sponsors, without whom this conference would not be possible: Little Tikes, SofSurfaces, and the Allstate Foundation. Also, much appreciation to some very hard working folk. Every conference happens because of the incredible coordination efforts of Lenita Johnson – thank you! Our Program Committee has done a spectacular job under the leadership of Kyran Quinlan and Barbara Barlow. Michael Mello leads the scientific committee, which is a Herculean task. JJ Tepas shepherds our publications in the Journal of Trauma every year. Many thanks to the folks at Cincinnati Children's Hospital for providing the continuing education credits.

Thank you all for being here and for doing what you do every day – protecting our children and preventing injury. Please enjoy the conference, and hopefully, some sun and beach time!

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 18th Annual Conference of the Injury Free Coalition for Kids:

The National Program Staff looks forward to hearing your presentations and those of our two outstanding keynote speakers, Dr. Daniel Webster and Dr. David Schonfeld. We are excited to reconnect with all of you, compatriots in the war against injury, and to greet Injury Free members from two new Injury Free sites: London Health Sciences Centre in London Ontario and Monroe Carell, Jr. Children's Hospital in Nashville, TN.

This conference is designed to provide you with program ideas, new information and Injury Free partners to help you in your daily mission to keep children and their families safe in their communities.

Injury Free continues to partner with Allstate Foundation, helping children recovering from disaster, through community playground projects, which encourage a community commitment to keeping children safe and helping the affected children rediscover joy. This year's new playground project, following hurricane Sandy, is in Freeport, Long Island.

Bloomberg Philanthropies and the Janis Family supported the Allstate Foundation Katrina Recovery Project in New Orleans, a playground build at Harris which was dedicated in January 2013. Partners are essential to all that we do.

Toys R Us continues to support our Home Safety projects, providing a donation for nine different site projects this year.

Little Tykes and SofSurfaces, our playground partners, have continued to support both the playground projects and the conference.

Renew your spirits and celebrate the progress we have all made this year.

Warm Regards,

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

Daniel Webster, ScD, MPH

Johns Hopkins Center for Gun Policy and Research Director
Deputy Director for Research
Johns Hopkins Youth Violence Prevention Center
Professor of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health

Daniel W. Webster, ScD, MPH is Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health where he serves as Director of the Center for Gun Policy and Research and as Deputy Director for the Center for the Prevention of Youth Violence, one of six such centers funded by the Centers for Disease Control and Prevention. He is also affiliated with the Center for Injury Research and Policy and the Division of Public Safety Leadership at Johns Hopkins.

Dr. Webster is the lead editor and a contributor for a recently published book entitled Reducing Gun Violence in America: Informing Policy with Evidence and Analysis. He has published 78 articles in scientific journals, most of which focused on the prevention of gun violence, youth violence, or intimate partner violence. Dr. Webster has led numerous evaluations of a broad range of interventions' effects on violence including firearm and alcohol policies, a replication of Chicago's CeaseFire public health program to reduce violence, policing and criminal justice initiatives designed to reduce gun violence, school-based interventions, and risk assessment and counseling interventions for victims of intimate partner violence.

Dr. Webster developed one of the first courses on violence prevention in a school of public health that he has taught for the past 21 years. He directs the PhD Program in Health and Public Policy at the Johns Hopkins and serves on the Steering Committee for Johns Hopkins' Interdisciplinary Violence Research Fellowship Program.

David Schonfeld, MD

Pediatrician in Chief, Chair, Director
St. Christopher's Hospital for Children
Drexel College of Med, and NCSCB

David J Schonfeld, MD, FAAP – Dr. Schonfeld is a developmental-behavioral pediatrician and the Pediatrician-in-Chief and Director of the National Center for School Crisis and Bereavement at St. Christopher's Hospital for Children and Chair of the Department of Pediatrics at Drexel University College of Medicine. He is a member the American Academy of Pediatrics Disaster Preparedness Advisory Council and the Sandy Hook Commission in CT, and served as a Commissioner for the National Commission on Children and Disasters. Dr. Schonfeld is also Professor Adjunct of Pediatrics at Yale University School of Medicine, Visiting/Honorary Faculty at the Università del Piemonte Orientale (Novara, Italy) and Vrije Universiteit Brussel (Brussels, Belgium) and Guest Professor of Chongqing Medical University (Chongqing, China) and coordinates the mental health component of the European Masters in Disaster Medicine course in Italy.

Dr. Schonfeld established the School Crisis Response Program in 1991, which provided training to tens of thousands of school-related personnel in school systems throughout the country and abroad and provided technical assistance in hundreds of school crisis events. He consulted to the NYC Department of Education to help optimize the infrastructure within the system for crisis preparedness and response and to provide training to and technical assistance in the aftermath of the events of September 11, 2001, which included the training of approximately 1,000 district and school-level crisis teams. In 2005, Dr. Schonfeld was awarded funding by the September 11th Children's Fund and the National Philanthropic Trust to establish a National Center for School Crisis and Bereavement; additional funding from the New York Life Foundation provides partial support for ongoing services. The goal of the NCSCB is to promote an appreciation of the role schools can serve to support students, staff, and families at times of crisis and loss; to collaborate with organizations and agencies to further this goal; and to serve as a resource for information, training materials, consultation, and technical assistance. Dr. Schonfeld has provided consultation and training on school crisis and pediatric bereavement in the aftermath of a number of school crisis events and disasters within the United States and abroad, including school and community shootings in Newtown, CT, Aurora, CO and Chardon, OH; flooding from Hurricanes Sandy in NYC and NJ, Katrina in New Orleans and Ike in Galveston; tornadoes in Joplin, MO and Alabama; and the 2008 earthquake in Sichuan, China.

Dr. Schonfeld has authored articles, book chapters, and a handbook on school crisis preparedness and a book for teachers on supporting the grieving student (The Grieving Student: A Teacher's Guide; published by Brookes Publishing; released September 1, 2010) and has provided presentations and consultations throughout the United States and abroad on the topic of pediatric bereavement and the mental health needs of children in crisis situations. In addition, Dr. Schonfeld is actively engaged in school-based research (funded by NICHD, NIMH, NIDA, the Maternal and Child Health Bureau, William T Grant Foundation, and other foundations) involving children's understanding of and adjustment to serious illness and death and school-based interventions to promote adjustment and risk prevention. He was President of the Society for Developmental and Behavioral Pediatrics from September 2006-07.

Injury Free Arkansas Team Nominee

Beverly Miller, MEd

2013
Program Coordinator of the Year Award

The National Program Coordinator of the Year Award was established to recognize an individual who has developed and implemented local or statewide Injury Free programs and/or policy initiatives that have resulted in improved outcomes. In this, its inaugural year, the Injury Free Board selected Beverly Miller, MEd, Associate Director of Arkansas Children's Hospital Injury Prevention Center (IPC) as the recipient. In the words of Injury Free Arkansas Principal Investigator, Mary Aiken, MD, and her team, Beverly embodies the Coalition's mission of preventing injuries to children by helping people to make their communities safer while remaining respectful of various cultures, beliefs, and lifestyles. It is clear that she has been instrumental in the development of multiple programs that have had a positive impact on the rate of unintentional injury related deaths. In the ten years she has worked within Injury Free, Arkansas has shown a 57% decrease in those deaths.

Among the programs she implemented is a CDC funded program titled Strike Out Child Passenger Safety. It was a multi-state project, which utilized the Injury Free Network and engaged community based T-ball programs to promote booster seat use. The program resulted in a 56% increase in correct booster seat use for the target age group. She also developed a NHTSA-funded program titled Improving Teen Driving through Parental Responsibility. That program sought to increase the use of written teen driving contracts between parents and teens. In addition, Beverly's efforts helped support passage of the more comprehensive Graduated Drivers Licensing legislation in Arkansas. The state experienced a 50% reduction in teen driving deaths one year after its passage. Beverly was also project director for an EMSC-funded program titled Development and Evaluation of Targeted ATV Safety Educational Strategies for Rural Children which resulted in a well-evaluated and accepted ATV Safety Toolkit that has been distributed to 36 states and 3 countries. The Center's ATV Safety Program has expanded nationwide due to Beverly's maintenance of partnerships with the Arkansas Game and Fish Commission, the University of Arkansas, Arkansas Farm Bureau, and the 4H Safety Riding Courses.

In addition to building programs, Beverly has been instrumental in building relationships both within the Center and across the state. Among them are partnerships she has built with Arkansas Children's Hospital and the University of Arkansas Medical School. By working with them, other institutions of higher learning, supporting donors, and key individuals, Beverly has helped spread the Center's message of "It only takes a moment" across the state to organizations that help champion the Center's cause. Her team members say that through her relationships the IPC has gained funding, and increased credibility and support of its mission.

Beverly has also served as a key advocate for injury prevention by working with the Arkansas Highway Safety Office to support both CPS and Teen Driving efforts. She has nurtured the relationship between the Arkansas Department of Health and the IPC to increase the capacity of the Statewide Injury Prevention Program.

Her institutional history that she readily shares with the Center's staff and her vision for the future, serve as a driving force for the advancement of IPC activities. Under her leadership, The Injury Prevention Center staff has grown from three to 20, with a statewide focus on teen driving, child passenger safety, home safety, infant mortality, and intentional injury prevention. Her team calls Beverly a teacher and trainer at heart.

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Schedule at a Glance

Friday, November 8, 2013		Room
10:00 am - 12:30 am	Registration	Lobby
1:00 pm	Welcome: Judy Schaechter, MD, MBA	Gulfstream
1:10 pm	Keynote Speaker Introduction: Judy Schaechter, MD, MBA	
1:20 pm – 2:00 pm	Keynote: Daniel Webster, ScD, MPH	
2:00 pm – 3:30 pm	Panel Discussion: Can't We All Get Along- What's New in Analysis and Prevention of Youth Violence Moderator: Michael P. Hirsh, MD	
3:30 pm – 3:40 pm	Break	
3:40 pm – 5:00 pm	Panel: Intentional Injuries: What is the impact? and How can we Prevent them? Moderator: Kathy Monroe, MD	
5:15 pm	Driving Simulator (additional scheduling posted)	South Side Parking Lot
6:00 pm	Reception	Terra Ballroom
	Dinner on your own	
7:30 pm	Board Meeting	Conference Suite 209

Saturday, November 9, 2013		
7:00 am - 8:00 am	Breakfast	Atrium
7:10 am - 7:50 am	Program Coordinator Meeting	Causeway
8:00 am - 8:15 am	Welcome, Keynote Introduction: Barbara Gaines, MD	Causeway
8:15 am - 9:00 am	Keynote: David J. Schonfeld, MD	
9:00 am – 9:15 am	Break	
9:15 am - 10:45 am	Panel: Understanding and Advancing Teen Driver Safety Moderator: Garry Lapidus PA-C, MPH	
10:45 am - 11:00 am	Break	
11:00 am - 12:30 pm	Panel: Controlling Motor Vehicle Crash Injuries in Children and Teens Moderator: Michael Mello, MD, MPH	
12:30 pm - 2:00 pm	Lunch	Atrium
2:00 pm - 3:30 pm	Panel Discussion: Keeping Kids Safe at Home and in the Community Moderator: Karen Sheehan, MD, MPH	Causeway
3:30 pm - 3:45 pm	Break	
3:45 pm - 5:15 pm	Panel Discussion: Sports and Recreational Injuries Moderator: Wendy Pomerantz, MD, MS	
6:00 pm - 7:00 pm	Reception	Aqua
7:00 pm	Dinner / Program Coordinator of the Year Presentation	Terra Ballroom

Sunday, November 10, 2013		
7:00 am - 8:00 am	Breakfast	Atrium
8:00 am - 9:30 am	Business Meeting	Causeway
9:30 am -9:45 am	Break	
9:45 am - 11:15 am	Panel Discussion: CDC-Funded Injury Research Centers: A High Yield Investment Moderator: Kyran Quinlan, MD, MPH	
11:15 am -11:30 am	Break	
11:30 am -1:15 pm	Panel Discussion: International Child Injury Prevention: Real Life Examples of Successes and Areas for Concentration Moderator: Mike Gittelman, MD	
1:30 pm	Lunch	Atrium

Agenda

Time & Room

Friday November 8, 2013

10:00 am -12:30 pm
Lobby
Registration

1:00 pm
Gulfstream
Welcome: Judy Schaechter, MD, MBA
Injury Free Coalition for Kids, Board President

1:10 pm
Keynote Speaker Introduction: Judy Schaechter, MD, MBA
Injury Free Coalition for Kids, Board President

1:20 pm – 2:00 pm
Keynote: Daniel Webster, ScD, MPH
Director of the Center for Gun Policy and Research at
Johns Hopkins Bloomberg School of Public Health

Reducing Gun Violence in America - Strategies for Protecting Youth and Their Communities

For many, the recent tragedy at Sandy Hook Elementary School involving the murder of 20 young children and six adults underscored the problem of gun violence in America. In his presentation, Dr. Webster will present data on the relationship between firearm availability and mortality risks to children and adolescents. Physicians, public health and safety officials, community-based organizations, and lawmakers have tried a range of strategies to prevent firearm injuries to youth with mixed results. Dr. Webster will identify the weaknesses of current policies and prevention strategies, and offer evidence and insights into how to significantly reduce gun violence in America, especially gun violence involving youth.

This session will enable participants to:
1) Describe how unsupervised access to firearms affects injury and mortality risks to children and adolescents;
2) Discuss effective strategies to reduce unsupervised access to firearms in protecting children and adolescents from firearm injuries;
3) Recognize how current federal and state gun policies contribute to extraordinary high rates of firearm mortality among children and adolescents in the U.S.
4) Identify which state policies are most effective in keeping guns from criminals;
5) Identify opportunities to advance more effective policies and practices to protect youth from gun violence.

2:00 pm – 3:30 pm

Panel Discussion: Can't We All Get Along- What's New in Analysis and Prevention of Youth Violence

Firearm mortality rates are 10-17 times higher among children and youth in the United States than in other high income countries. Firearm homicide is also the second-leading cause of death for young people ages 1-19 in the United States.

This panel discussion will illustrate and discuss a range of approaches to community violence and provide attendees some hope that the inertia seen nationally can be overcome locally.

This session will enable participants to:
1) Discuss the true statistical background of pediatric firearm injuries;
2) Develop strategies of removing the circulating volume of firearms within endangered communities;
3) Develop understanding of how to protect youths living among violent conditions from injury;

Time & Room

Agenda, cont.

4) Describe how to affect the understanding of Medical Trainees regarding Youth Violence;
5) Establish points of collaboration/study/programming between INJURY FREE sites re: Violence Prevention.

Moderator: Michael P. Hirsh, MD
Surgeon-in-Chief, UMASS Memorial Children's Medical Center
Professor of Surgery and Pediatrics UMASS Medical School
Chief, Division of Pediatric Surgery and Trauma
UMASS Memorial Health Care System
Acting Commissioner of the Worcester Department of Public Health
President, Worcester District Medical Society
Injury Free Coalition for Kids of Worcester, Co-Principal Investigator
Past-President, Injury Free Coalition for Kids

Presenters:

Phyllis Hendry, MD: Six-year retrospective review of pediatric firearm injuries

Pina Violano, MSPH, RN-BC, CCRN, CPS-T: Removing Unwanted Guns from the Community

Marlene Melzer-Lange, MD: Camp Ujima: Providing Injury Prevention to Youth Affected by Violent Injuries

Alison Riese MD: A Survey of Resident Attitudes and Behaviors Regarding Youth Violence Prevention in the Acute Setting

3:30 pm – 3:40 pm — Break

3:40 pm – 5:00 pm — **Panel Discussion: Intentional Injuries: What is the impact? and How can we prevent them?**

CDC research shows intentional injury rates are a cause for concern. Intentional injuries are the third leading cause of death in children 1-4 years of age; bullying is becoming increasingly prevalent in high schools; and suicide is the third leading cause of death among 10-19 year olds.

This panel will discuss overall intentional injury rates and specifically address Shaken Baby Syndrome, bullying in high schools and suicidal behaviors. Data will be presented on the urban versus rural rates of intentional injuries, and the epidemiology of the three specific intentional injuries. In addition, the relationship between bullying and other high risk behaviors will be addressed. Two interventional programs will be discussed (a program which educates parents on normal crying patterns in an attempt to decrease shaken baby syndrome and a program to improve lethal means restriction counseling for suicide prevention).

This session will enable participants to:
1) Discuss demographic and injury characteristics of young children with severe intentional injuries;
2) Describe epidemiology of Shaken Baby Syndrome;
3) Discuss a program to educate parents about normal crying patterns;
4) Describe association between bullying (victims and perpetrators) and other high risk behaviors;
5) Describe prevalence of suicidal behaviors in the US and importance of lethal means restriction counseling.

Moderator: Kathy Monroe, MD
Professor of Pediatrics
Children's Hospital of Alabama
Injury Free Coalition for Kids of Birmingham, Principal Investigator

Agenda, cont.

Time & Room	
	Presenters: Brit L Anderson, MD: Intentional Injuries in Young Ohio Children: Is there Urban/Rural Variation? Tanya Charyk Stewart, MsC: Shaken Baby Syndrome and a Triple-Dose Strategy for Its Prevention Heather Mitchell, MD, PEM Fellow: Bullying: Prevalence and Association with High Risk Behaviors Among High School Students Steven Rogers, MD Restricting Youth Suicide: A Pilot Descriptive Study of Behavioral Health Patients in the Pediatric Emergency Department
6:00 pm Terra Ballroom	Reception
7:30 pm Conference Suite 209	Board Meeting
	Dinner on your own

Saturday November 9, 2013

7:00 am - 8:00 am Atrium	Breakfast
7:10 am - 7:50 am Causeway	Program Coordinator Meeting
8:00 am - 8:05 am Causeway	Welcome: Barbara Gaines, MD Injury Free Coalition for Kids, Past President
8:05 am - 8:15 am	Keynote speaker Introduction: Barbara Gaines, MD Injury Free Coalition for Kids, Past President
8:15 am - 9:00 am	Keynote: Whether in response to a community event or a personal/family crisis, healthcare providers have an opportunity to provide important support to children and families to promote their coping and adjustment. The presentation will provide practical suggestions of how to provide such assistance, with an emphasis on psychological first aid and basic supportive services, and outline the common reactions seen to assist with identifying those children who would benefit from additional assistance. The timeline for adjustment and the importance of professional self-care for those providing such support will also be addressed. The presenter will draw on 25 years of experience responding to school and community crisis events and supporting children who are grieving. This session will enable participants to: 1) Describe common symptoms of adjustment reactions after a crisis; 2) Discuss the elements of psychological first aid and importance of basic supportive services; 3) Provide advice to parents on how to support their children after a crisis; 4) Discuss a typical timeline for adjustment; 5) Appreciate the importance of professional self-care.
9:00 am – 9:15 am	Break
9:15 am -10:45 am	**Panel Discussion: Understanding and Advancing Teen Driver Safety** Motor vehicle crashes are the leading cause of death for U.S. teens. The "Understanding and advancing teen driver safety" panel will include four presentations. The first presentation will describe trends in fatal motor vehicle crashes in Alabama, a state with historically elevated crash rates. The second presentation shares the results from a survey of Alabama teens asking about high risk driving behaviors and use of parent/teen driving contracts. The third presentation describes the efficacy of driving simulator training for novice teen drivers. The final

Time & Room

Agenda, cont.

presentation describes a unique community event designed to promote awareness of parent and teen driving safety.

This session will enable participants to:
1) Describe a methodology to access statewide trends fatal motor vehicle crashes among teens;
2) Describe statewide factors impacting fatal motor vehicle crashes among teens;
3) Describe factors related to high-risk driving among teens and the use of a parent/teen contract to reduce risk;
4) Describe the challenges of conducting a study to measure a complex intervention (driving simulator training);
5) Describe an event designed to engage parent and teens in safe driving.

Moderator: Garry Lapidus PA-C, MPH
Connecticut Children's Medical Center & Hartford Hospital
Injury Prevention Center Director
University of Connecticut School of Medicine
Associate Professor of Pediatrics and Public Health
Injury Free Coaliton for Kids of Hartford, Principal Investigator
Injury Free Coaliton for Kids Board Member

Presenters:
Marie Crew, RNC-NIC: Trends in Alabama Teen Driving Death and Injury
Elizabeth Iron, MD: Risky Teen Driving Behaviors and Driving Contracts
Steven Rogers, MD: Efficacy of Driving Simulator Training for Novice Teen Drivers
Susan Cohen, BS: Unexpected Funding Provides for Teen Driving ROADeo Event

10:45 am - 11:00 am — Break

11:00 am - 12:30 pm — **Panel Discussion: Controlling Motor Vehicle Crash Injuries in Children and Teens**

Motor vehicle crashes are one of the leading causes of death for children and adolescents. A variety of countermeasures have been successful in decreasing the risk of injury and death in a crash. Uptake of these protective measures has not been universal. This panel will discuss the impact of enforcement strategies on use of seat belts, and specifically on its relationship to teen drivers and rear-seat teen passengers. The panel will also explore the attitudes and behaviors of teens regarding the high risk behavior of texting while driving and examine for differences between suburban and rural teens. A novel model for universal screening of families with hospitalized children for child passenger safety best practices will also be presented.

Objectives:
1) Describe the risk of rear-seated teens in motor vehicle crashes;
2) Discuss the relationship of state seat belt legislation and teen rear seat belt use;
3) Differentiate between primary and secondary enforcement of seat belt use and
4) Describe a mechanism for universal screening of families within the hospital for appropriate child passenger seat use;
5) Describe attitudes and behaviors related to texting and driving among suburban and rural teen drivers.

Moderator: Michael Mello, MD, MPH
Injury Prevention Center Director at Rhode Island Hospital
Associate Professor of Emergency Medicine
Associate Professor of Health Services, Policy and Practice
Alpert Medical School of Brown University

Time & Room

Agenda, cont.

Injury Free Coalition for Kids of Providence, Principal Investigator
Injury Free Coalition for Kids Board of Directors

Presenters:
Joyce Pressley, Phd, MPH: Seat Belt Use in Teen Passengers Seated in the Rear Seat of Passenger Vehicles Involved in Fatal Collisions On a U.S. Roadway;
Lois Lee, MD, MPH: Comparison of Motor Vehicle Crash Occupant Fatalities in States with Primary Versus Secondary Seat Belt Laws;
Dina Morrissey, MD, MPH: Hasbro Children's Hospital Inpatient Child Passenger Safety (CPS) Program;
Purnima Unni, MPH, CHES: Suburban and Rural Teen Driver Attitudes Towards Texting While Driving.

12:30 pm - 2:00 pm
Atrium

Lunch

2:00 pm - 3:30 pm
Causeway

Panel Discussion: Keeping Kids Safe at Home and in the Community

CDC research shows most injuries to children under the age of five occur in the home, and as they grow and their environments expand the injuries move into the community. This panel is will examine programs designed to make a difference in within the home as well as environmental safety hazards and children's efforts to navigate within the community. Presenters will share their successes as well as their challenges.

This session will enable participants to:
1) Develop home safety messaging through partnerships with community agencies;
2) Describe how the political and cultural climate may impact the implementation of home visiting for injury prevention;
3) Discuss how children can become more active in their communities and have lower rates of pedestrian injury;
4) Discuss how to engage community members in addressing complex health issues;
5) Describe how to apply various methods such as focus groups, walkability audits, geocoding, and written surveys to understand the safety issues so one can develop strategies to address them.

Moderator: Karen Sheehan, MD, MPH
Interim Co-Director, Mary Ann and J. Milburn Smith Child Health Research Program
Ann & Robert H. Lurie Children's Hospital of Chicago Research Center
Attending, Ann & Robert H. Lurie Children's Hospital of Chicago
Professor of Pediatrics & Preventive Medicine,
Northwestern University's Feinberg School of Medicine
Injury Free Coalition for Kids Chicago, Principal Investigator
Injury Free Coalition for Kids Board Member

Presenters:
Pamela W. Goslar, PhD: Multidisciplinary Approach to healthier communities – The Reinvent Phoenix Project
Charles DiMaggio, PhD, MPH: Effectiveness of a Safe Routes to School Program in Preventing School-Aged Pedestrian Injury
Judy Schaechter, MD, MBA: Home Visitor Home Safety Checklist: Program Response to a Community Pilot
Katie Amsden, CHES: Home Safety Kits: Directing Next Steps in Primary Prevention of Home Injuries

3:30 pm - 3:45 pm

Break

Agenda, cont.

Time & Room	
3:45 pm - 5:15 pm	**Panel Discussion: Sports and Recreational Injuries**

CDC research shows that approximately 30 million children participate in youth sports activities annually in the United States. This number has been increasing. Although sport and recreational activities have important health benefits, they are an important cause of injuries in youth. There are an estimated 3-5 million sports and recreation related injuries annually in the United States in children with an estimated direct cost of over $280 million each year. Many sports and recreation related injuries are preventable. Understanding these injuries and how to prevent them will reduce morbidity and mortality in children.

This session will enable participants to:

1) Evaluate how the number and severity of hospital admissions for traumatic brain injuries (TBIs) have changed as emergency department visits for these injuries have increased;
2) Determine which sports are responsible for the majority of TBIs resulting in hospital admission;
3) Discuss and determine compliance with the Rhode Island Youth Programs Concussion Act;
4) Describe policy strategies and the importance of partnerships in preventing open water drowning and how these processes can be used for other child and teen injury topics;
5) Discuss how to create partnerships in a community and engage local lawmakers and media to increase injury prevention awareness.

Moderator: Wendy Pomerantz, MD, MS
Professor of Pediatrics
University of Cincinnati
Cincinnati Children's Hospital
Division of Emergency Medicine
Injury Free Coalition for Kids of Cincinnati, Principal Investigator

Presenters:

Holly R. Hanson, MD: Sports-Related Traumatic Brain Injury: Increased ED Utilization but Not Severity

Dina Morrissey, MD, MPH: Statewide Assessment of the Rhode Island Concussion Law

Celeste Chung, MSW, MPH: A Policy Strategy Plan to Prevent Open Water Drowning among Children and Teens in Washington State

Sarah A. Denny, MD: An Effective Statewide Public Awareness Campaign to Encourage Legislators, Media, and Community Organizations to Support Bicycle Helmets

6:00 pm - 7:00 pm Aqua	Reception
7:00 pm Terra Ballroom	Dinner / Program Coordinator of the Year Presentation

Sunday November 10, 2013

7:00 am - 8:00 am Atrium	Breakfast
8:00 am - 9:30 am Causeway	Business Meeting
9:30 am -9:45 am	Break

Agenda, cont.

Room

9:45 am - 11:15 am

Panel Discussion: CDC-Funded Injury Research Centers: A High Yield Investment

In 1987 the CDC began funding Injury Control Research Centers (ICRCs) throughout the United States to 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. CDC Representative Karin A. Mack, PhD will discuss ways that everyone can connect with the ICRCs as well as the recent move of the ICRC administration within National Center for Injury Prevention & Control.

In this session, attendees will hear presentations from several of the 11 CDC-funded Injury Control Research Centers (ICRCs). Housed at major research institutions, these CDC-funded centers represent a significant federal investment in the injury prevention public health infrastructure in the country. Presentations will cover administration, education, outreach and research at the sites. Areas of particular research focus will be emphasized. Exposure to the work being done at the ICRCs may allow attendees to discover areas of mutual interest and potential collaboration.

This session will enable participants to:
1) Describe of the system of CDC-funded Injury Control Research Centers in the United States;
2) Recognize that each ICRC has areas of focus of research activities;
3) Recognize the funding issues associated with ICRCs;
4) Discuss how an ICRC is administered and how the activities of the ICRCs are integrated into both the university and the community.

Moderator: Kyran Quinlan, MD, MPH
Associate Professor of Clinical Pediatrics
Northwestern University's Feinberg School of Medicine
Erie Family Health Center Pediatrician, Chicago, IL
Injury Free Coalition for Kids Board of Directors

Speaker: Karin A. Mack, PhD: Emory University
Presenters:
1) Joyce Pressley, PhD, MPH: Columbia ICRC
2) Andrea Gielen, ScD, ScM: Hopkins ICRC
3) Tina Creguer, BA: University of Michigan ICRC
4) Jeffrey Coben, MD: West Virginia ICRC
5) Lisa Roth, Blank Children's Hospital/University of Iowa ICRC
6) Meghan Shanahan, PhD: The University of North Carolina at Chapel Hill ICRC

11:15 am -11:30 am

Break

11:30 am -1:15 pm

Panel Discussion: International Child Injury Prevention: Real Life Examples of Successes and Areas for Concentration

Every day around the world the lives of more than 2000 families are torn apart by the loss of a child to an unintentional injury. Unintentional injuries are a significant area of concern from the age of one year, and progressively contribute more to overall rates of death until children reach adulthood. Much work done by the Injury Free Coalition for Kids (IFCK) has concentrated on community prevention within the US. Since the production of the "World Report on Child Injury Prevention" by the WHO, IFCK has searched for ways to extend its injury prevention model to be incorporated in other countries.

The purpose of this International Child Injury Panel is to understand the global burden of child injury in our changing world. Our four esteemed speakers have much experience in working with World Organizations and other countries to prevent injuries internationally.

This session will enable participants to:
1) Recognize the injury problem globally;
2) Discuss interventions that are being implemented internationally and how they have been successful;
3) Describe obstacles and priorities within global child injury prevention;
4) Recognize examples of effective prevention interventions and the need for increased global child injury prevention capacity building.

Moderator: Mike Gittelman, MD
Professor, Clinical Pediatrics
Division of Emergency Medicine
Comprehensive Children's Injury Center
Cincinnati Children's Hospital
Injury Free Coalition for Kids of Cincinnati, Principal Investigator

Presenters:
Cinnamon A Dixon, DO, MPH: Global Child Injury Prevention
Kelly Larson, MPH: The Bloomberg Global Road Safety Program: Reducing Road Traffic Fatalities and Injuries Through the Implementation of Evidence-Based Interventions
Tracy Fountain: Middle East Child Injury Prevention Community Programme
Jane Harrington,MSc, Canada: There's No Place Like Home: Implementation of a Home Safety Device Program

1:30 pm Lunch
Atrium

Accreditation Statement

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 I contact education contact hours. Maximum advanced-level continuing education contact hours available are 0.

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Cincinnati Children's Hospital Medical Center and Injury Free Coalition. Cincinnati Children's is accredited by the ACCME to provide continuing medical education for physicians. Cincinnati Children's designates this live activity for a maximum of 13.5 *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.

2013 Forging New Frontiers:

"Meeting the New Challenges in Childhood Injury Prevention"

The 18th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with
Cincinnati Children's Hospital Medical Center
November 8 - 10, 2013

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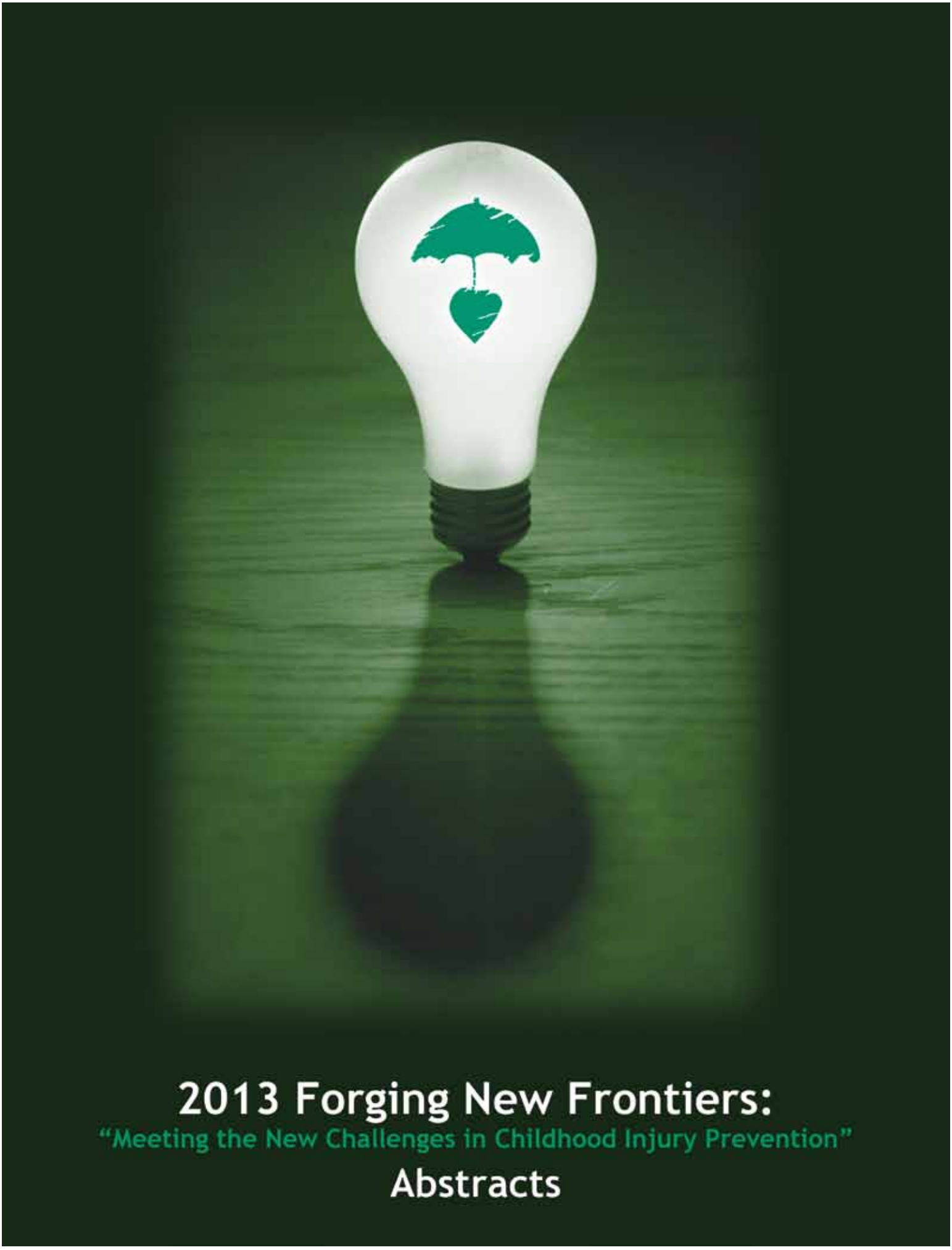
None of the speakers intend to discuss unlabeled uses of a commercial product or an investigational use of a product not yet approved for this purpose.

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



2013 Forging New Frontiers:

"Meeting the New Challenges in Childhood Injury Prevention"

Abstracts

Reducing Gun Violence in America - Strategies for Protecting Youth and their Communities

Daniel Webster, ScD, MPH

Background:
Firearm mortality rates are 10 to 17 times higher among children and youth in the United States than in other high-income countries. These disparities are due to greater access to firearms, facilitated by cultural beliefs and public policies that often place gun owners and seller's interests over public safety.

Methods:
Studies of prevention strategies ranging from physician counseling, community education campaigns, and gun legislation were reviewed. Key public policies were reviewed and public opinion data were analyzed.

Results:
Findings are mixed, but recent studies have shown that physician counseling and community education which supplies gun owners with trigger locks or gun storage lockers can promote safer gun storage. Child access prevention laws reduce teen suicides and deaths from unintentional shootings. Laws prohibiting high-risk groups from possessing guns can reduce violence, but can be more effective with better regulation of gun sales to reduce diversion to criminals and underage youth.

Conclusions:
American youth and their communities pay a heavy price for lax gun policies. Laws protecting youth can be effective, but not in place in most states. Support for strengthening policies to keep guns out of "the wrong hands" is widespread and bipartisan.

Objectives:
Attendees will learn:
1. What strategies to reduce unsupervised access to firearms are effective in protecting children and adolescents from firearm injuries;
2. How current federal and state gun policies contribute to extraordinary high rates of firearm mortality among children and adolescents in the U.S.;
3. Which state policies are most effective in keeping guns from criminals.

Six-Year Retrospective Review of Pediatric Firearm Injuries

Andrea Suen, MD; Phyllis Hendry, MD; Colleen Kalynych, PhD; Julia Paul, MSN, RN

Background:
Pediatric firearm injuries are an increasing source of morbidity and mortality. Epidemiologic trends assist in determining effective prevention strategies and address disparities. Study site is an urban Level I trauma center (TC) and Pediatric Emergency Department (ED). Firearm injuries in adolescents are common; however, not well studied in younger children. Study purpose was to determine trends in firearm injuries to develop prevention strategies and prospective study models. Aims were to describe epidemiology of firearm injuries in patients 0-18 years old presenting to a TC and ED with a case study of patients 0-14 years old for determining shooting characteristics.

Methods:
Part I obtained data from the trauma registry. Inclusion criteria were patients 0-18 y/o presenting 2005 to 2010 with firearm injury and registry inclusion. Demographic and injury data was extracted. Part II included retrospective review of patients 0-14 years old including hospital records, rescue and crime scene reports. Data from 0-14 y/o group included shooting details and treatment information. Data was entered in RedCap™ with further analysis pending review of crime records. Categorical variables were described using counts and percentages. Differences between groups were assessed using odds ratios, along with 95% confidence intervals, extracted from logistic regression models.

Results:
Database query resulted in 456 patients (0-18 y/o) including 78 0-14 years old. Records were reviewed for 70 of 78 patients leaving 448 for analysis. In 15-18 years old group 89% were male versus 71% in 0-14 years old. Eighty-three percent; 64% in 0-14 years old group. Death occurred in 3% (15-18 years old) and 1% (0-14 years old). Patients in 15-18 years old group were twice more likely (23 vs. 11%) to arrive via car or walk-in compared to 0-14 years old group (OR=2.32; 95%CI 1.07, 5.03). Patients in 0-14 years old group were almost four times more likely to be shot at home compared to 15-18 years old (OR=3.76 ; 95% 2.29, 6.19). Forty-eight percent in 0-14 years old group had evening presentation (1801-2400). Twenty-three percent had critical procedures with 33 % in 0-4 years old, 26 % in 10-14 years old, and 7% in 5-9 years old group.

Shooter relationship was known person (30%) and unknown person (69%). Mental or medical conditions included: ADHD (7%), bipolar (3%); multiple conditions (3%). Common injury sites were extremities (53%), trunk (39%), and head (14%). Patients in 5-9 years old group were 6 times more likely to have multiple injury sites compared to 10-14 years old group (OR=6.26, 95% CI 1.26, 31.09). Types of firearms included 17% airgun, 16% pistol, and 66% unknown. Only 13% had documented child protective services notification.

Conclusions:
In light of recent national tragedies, there is renewed interest in firearm safety. Preliminary results from this study suggest firearm injuries differ in younger victims compared to adolescents. The younger subset was more likely to be shot at home versus public settings. Hospital and rescue records lacked important shooting details often found in crime scene reports that are necessary for development of effective crime and prevention strategies.

Objectives:
Attendees will learn:
1. How to understand epidemiology of pediatric firearm injuries;
2. How to review differences in firearm injuries; between adolescents and younger children;
3. How to determine and discuss obstacles to determining shooter and gun characteristics in firearm research.

Removing Unwanted Guns from the Community

Pina Violano, MSPH, RN-BC, CCRN, CPS-T; Cassandra Driscoll, MPH, CPS-T; Kevin Schuster, MD; Esther Borer; Michael Hirsch, MD

Background:
In 2010 there were 31,672 fatalities and 73,505 nonfatal injuries attributable to firearms, amounting to a total of 105,177 victims of firearms in a single year, of these firearm victims, 15,281 were unintentional incidences. The most recent cost injury reports, indicate that firearms were responsible for almost 40.8 billion dollars in medical and work loss costs in 2005 (CDC, 2012).

Across the United States, 68% of homicides were committed with guns which is the second leading cause of death for young people ages 1-19 (Centers for Disease Control and Prevention, 2012). Firearms also play a large role in suicides, with more than 90% of suicide attempts with a firearm resulting in a fatality (Miller, Hemenway, & Azrael, 2004). These higher rates of deaths, homicides, suicides, and unintentional death due to firearms are often precipitated by easy gun access in the home environment. In order to prevent both intentional and unintentional injuries due to firearms it is vital to provide individuals with the opportunity to dispose of their unwanted firearms. The goals of this study are to: remove unwanted and potentially dangerous firearms, as well as to educate gun owners on proper storage of firearms.

Methods:
The gun buyback program was implemented in three participating locations in Phoenix, AZ, Worcester, MA, and New Haven, CT. Each participating location designated a location and time in collaboration with the local police department. Participants were defined as those who relinquished a firearm during the gun buyback program. A total of 301 self-report surveys were collected from willing participants. They were entered into a composite data base and analyzed using SAS.

Results:
Eighty percent of the participants were white, 74.1% were males and 83% were over 45 years of age. Approximately half of all guns relinquished were acquired by inheritance and almost 70% of participants reported turning in the firearm due to safety reasons. Sixty-eight percent of the participants had other firearms that remained in the house locked and 32% wanted and received gunlocks.

Conclusions:
Research shows that guns kept in homes are more likely to be involved in a fatal or nonfatal accidental shooting, criminal assault, or suicide attempt than to be used to injure or kill in self-defense (Kellermann, Somes, Rivara, Lee, & Banton, 1998). In 2010 there were a total of 27,422 suicides among white males, which comprises 71.5% of all suicides in the United States (CDC, 2012). This gun buyback program has successfully reduced access to firearms among the highest risk group for suicide. It has also created an avenue for safety education and the resources like gun locks to decrease easy access to guns in the home, which acts to decrease the rate of unintentional injury due to firearms.

Objectives:
Attendees will learn:
1. How gun buybacks are effective at removing unwanted and potentially dangerous firearms from the general population;
2. How gun buybacks are one prong of a multipronged public health approach that includes, but is not limited to, educational and law enforcement efforts;
3. How gun buybacks are an avenue that could further

safety education and facilitate conversation that can act as a catalyst in increasing gun safety awareness.

Camp Ujima: Providing Injury Prevention to Youth Affected by Violent Injuries

Toni Rivera-Joachin, MSBM; Marlene Melzer-Lange, MD; Brooke Mortag; Michael Levas, MD; Rebekah Angove

Background:
Youth injured through interpersonal violence are at risk for repeat injury, acute stress syndrome and post-traumatic stress. Project Ujima, a violence prevention and intervention program, serves over 300 youth annually who present to the Emergency Department at a pediatric hospital. In working with these youth, it is clear that youth struggle in the summer with trauma and needs for youth development activities.

Methods:
We developed Camp Ujima, a summer day camp, to provide injury prevention, health education, trauma-informed care, and family support. Youth leaders, selected from Project Ujima participants, provided input into the camp activities. Collaborations with the Mayor's office for summer employment, a meal program, and a myriad of non-profit arts and youth serving agencies were developed.

Results:
We have held Camp Ujima for the past eleven summers, with an average of 50 campers each summer. The camp is held in a local school. We found that transportation to the school is needed to promote security for our campers. Activities include visits from injury prevention specialists from our hospital, rap music therapy provided by a psychologist, AODA prevention counselors, cultural arts and recreation. A camper talent and art show is presented to families at the end of camp. Surveys of campers showed strong relationship building with staff and each other as well as a positive summer experience.

Conclusions:
A summer day camp, provided to youth injured through interpersonal violence, provides a platform for successfully providing injury prevention to a group of at-risk youth.

Objectives:
Attendees will learn:
1. How to understand needs of violently injured youth;
2. How to develop community collaborations to provide injury prevention;
3. How to promote injury prevention to youth at risk.

A Survey of Resident Attitudes and Behaviors Regarding Youth Violence Prevention in the Acute Setting

Alison Riese, MD; Frances Turcotte-Benedict MD

Background:
Youth violence (YV) is a major public health problem in the United States. Emergency Medicine (EM), surgery, and pediatric physicians play an integral role in screening and treating violently injured patients. In addition, residency training is a critical time for shaping physician knowledge base and establishing standard practice guidelines. Studies examining youth violence prevention (YVP) practices and interventions to change physician behavior have mainly focused on the outpatient setting, while emergency room and inpatient interventions have been solely patient-centered. There is a paucity of research assessing physician behaviors while caring for acutely injured youth. We aimed to 1) to assess EM, surgical, and pediatric resident behaviors and practices while caring for YV patients, and 2) to determine resident attitudes toward YVP and perceived barriers to conducting violence risk assessments and referrals.

Methods:
This was a cross-sectional survey of EM, surgery, and pediatric residents at one large medical institution, using a self-administered paper questionnaire. Question items were derived using the Theory of Planned Behavior (TBP) and published guidelines of youth violence competencies for physicians, as well as consultation with an expert in survey methodology. Participants were recruited and completed questionnaires at their respective didactic conferences. Data was analyzed using descriptive statistics and chi-square test to examine differences between resident specialties.

Results:
Fifty-five out of 73 residents completed the questionnaire, comprised of 42% EM, 33% pediatrics, and 25% surgery residents, with a response rate of 75%. Fifteen percent of respondents reported receiving YVP training during residency. Overall, a large majority of respondents reported consistently (>50% of the time) collecting a history of events leading to violent injury (91%.) A smaller percentage of residents reported consistently assessing factors affecting future risk of YV (20%) or injury sequelea such as mental health (65%) or substance abuse (69%,) or referring to support services (69%.)

Surgery residents were statistically more likely to refer to social work ($p= 0.001$) and screen for substance abuse ($p= 0.008$) than EM residents. While the majority

of residents agreed that YV is a preventable major public health problem, can be reduced by hospital-based interventions, and that physicians should play a role in YVP, there was less agreement that YVP should be a resident task or priority. Residents sited lack of time and lack of training as the top two barriers for both conducting risk assessments and referring to support services.

Conclusions:
Based on the TPB, physicians' attitudes, subjective norms, and perceived behavioral control are key in behavior decision-making. Our single academic site study suggests that, while EM, surgery, and pediatric residents agree that YVP is essential and should involve physicians, most do not perceive this as part of their tasks, nor do they feel competent in this role. If replicated in other residency environments, findings can be used to develop additional residency education and training resources on youth violence.

Objectives:
Attendees will learn:
1. How they can benefit from current literature on healthcare providers' youth violence prevention knowledge, attitudes, and practices;
2. How to recognize resident strengths and deficits pertaining to youth violence prevention during the acute treatment of violently injured youth at one Level 1 Trauma Center;
3. How to understand directions for future research in resident Youth Violence Prevention practices.

Intentional Injuries in Young Ohio Children: Is there Urban/Rural Variation?

Brit L Anderson, MD; Wendy J Pomerantz, MD, MS; Michael A Gittelman, MD

Background:
Intentional injuries are the third leading cause of death in children 1-4 years of age. Although adolescent violence has been well-described as being more common in urban areas, there is little data from the US describing intentional injuries in young children on an urban-rural spectrum. The purposes of this study are: 1) To determine rate of severe intentional injuries in children aged <5 years in urban versus rural Ohio counties 2) To describe severe intentional injuries in young Ohio children.

Methods:
Data was extracted retrospectively from the Ohio Trauma Registry which includes all trauma patients hospitalized for > 48 hours, who died in an Ohio hospital, or who were transported from hospital to hospital. We collected data on children <5 years of age who suffered intentional injuries, based on Ecode, from 1/1/2003-12/31/2011. Injury rates were calculated using county where the injury occurred and US census data. Each county was assigned an urbanization level A, B, C, or D based on population density ("A" = the highest density/ most urban; "D" = lowest density/ most rural). Demographic and injury information was collected. Mean income and % of families with children < 5 years who lived below the poverty level in each Ohio county were obtained from the US census and divided into quartiles to determine if injury rates varied by quartile. All rates are per 100,000 children <5 per year.

Results:
984 patients were included; the overall injury rate was 143.2. The average age was 0.66 (SD 1.02) years. 583 (59.2%) were male. 225 (22.9%) were Black, 25 (2.5%) Hispanic, and 655(66.6%) White. The mean injury severity score (ISS) was 13.2 (SD=9.9), Glasgow coma scale (GCS) on presentation was 12.1 (SD=4.7), hospital length of stay (LOS) was 7.2 days (SD= 11.4), and intensive care unit LOS was 1.8 days (SD= 5.6). 855 (86.9%) were discharged alive, 129 (13.1%) died. Injuries rates by urbanization level: A: 150.1, B: 93.3, C: 156.2, and D:135.3.

There was no statistically significant association between urbanization level and injury mechanism (p=0.081).There was a significant association between county injury rate and county mean income; the lowest income quartile to highest had a mean injury rate of 162.1, 166.1, 160.1, 84.7(p=0.05). There was also a significant association between % of families with children <5 years living below poverty. When the percentage of families with children under 5 years living below the poverty line were divided into quartiles from counties with the injury rates for highest percentage to lowest percentage below poverty were: 190.0, 164.0, 116.7, and 102.3 (p=0.04).

Conclusions:
No association was found between intentional injury rate and urbanization level in young Ohio children; there was an association between mean income and percentage of families below poverty level and injury rate.

Objectives:
Attendees will learn:
1. How to discuss the overall rate of severe intentional injuries in young Ohio children as well as the rate of injury by county;
2. How to discuss demographic and injury characteristics of young children with severe

intentional injuries;
3. How to examine associations between injury rates and county urbanization level, injury characteristics, and demographic variables.

Shaken Baby Syndrome and a Triple-Dose Strategy for Its Prevention

Tanya Charyk Stewart, MSE; Denise Polgar, EMCA; Jason Gilliland, PhD; David Tanner, MSc; Murray Girotti; Neil Parry; Douglas Fraser, MD, PhD

Background:
Inflicted traumatic brain injury associated with Shaken Baby Syndrome (SBS) is a leading cause of injury mortality and morbidity in infants. A triple-dose SBS prevention program was implemented with the aim to reduce the incidence of SBS. The objectives of this study were to describe the epidemiology of SBS, the triple-dose prevention program and its evaluation.

Methods:
Descriptive and spatial epidemiologic profiles of SBS cases treated at Children's Hospital, London Health Sciences Centre from 1991-2013 were created. Dose 1 (in-hospital education): Pre-post impact evaluation of RN training, with a questionnaire developed to assess parents' satisfaction with the program. Dose 2 (public health home visits): Process evaluation of additional education given to new parents. Dose 3 (media campaign): A questionnaire developed to rate the importance of factors on a 7-point Likert scale. These factors were used to create weights for statistical modeling and mapping within a GIS to target prevention ads.

Results:
Forty-four percent of severe infant injuries were intentional. A total of 56 SBS cases were identified. The median age was 3.0 months, with 63% male. The median ISS was 26.0 with an 18% mortality rate. RNs learned new information on crying patterns and SBS, with a 47% increase in knowledge post training ($p<0.001$). Over 25,000 parents were educated in-hospital; a 93% education compliance rate. Nearly all parents (93%) rated the program as useful, citing "what to do when the crying becomes frustrating" as the most important message. Only 6% of families needed to be educated during home visits. Locations of families with a new baby, high population density and percentage of lone parents were found to be the most important factors for selecting media sites. The spatial analysis revealed six areas needed to be targeted for ad locations.

Conclusions:
SBS is a devastating intentional injury that often results in poor outcomes for the child. Implementing a triple-dose prevention program that provides education on crying patterns, coping strategies and the dangers of shaking is key to SBS prevention. The program increased knowledge. Parents rated the program as useful. The media campaign allowed us to extend the primary prevention beyond new parents to help create a cultural change in the way crying, the primary trigger for SBS, is viewed. Targeting our intervention increased the likelihood that our message was reaching the population in greatest need.

Objectives:
Attendees will learn:
1. How to describe the epidemiology of Shaken Baby Syndrome (SBS);
2. How to describe "The Period of PURPLE Crying"® SBS-prevention program and it's delivery via a "triple dose" approach (in-hospital, public health home visits and media campaign);
3. How to recognize PURPLE® as an effective program to educate parents about normal infant crying patterns and to help create a cultural change in the way inconsolable crying is viewed.

Bullying: Prevalence and Association with High Risk Behaviors Among High School Students

Heather Mitchell, MD; Laurie Marzullo, MD; Kathy Monroe, MD; William King; RPh, MPH, DrPH

Background:
Bullying is an important public and child health issue in the United States. It is gaining recognition as a serious and potentially life threatening event which is increasing in frequency and in more insidious ways among school aged children. The high prevalence of bullying experiences at school suggests that improved awareness and successful interventions could impact the quality of life and prevent injury and death among a significant number of school aged children. The primary objective of this survey is to estimate the prevalence of local area high school bullying experiences and the association of these experiences with multiple high risk behaviors.

Methods:
A twenty nine question survey, adapted from the National Youth Risk Behavior survey was administered to high school students. Three local high schools were selected for participation. The 10th grade students (n=516), ages 15-18 at each high school were asked to complete the survey. Data analysis was performed using Epi Info V.7.0.9.7, CDC, 2/29/12.

Results:
Bullying behaviors (perpetrated, victimized and witnessed by students) were commonly reported: 150 (30.8%) students had physically bullied and 284 (55.0%) had verbally bullied another student at least once over the past year. Also, 152 (29.5%) had been physically bullied and 264 (51.2%) had been verbally bullied at least once over the past year. Finally, 340 (66%) students had witnessed someone being physically bullied and 419 (81.2%) had witnessed someone being verbally bullied at least once over the past year. Students involved in bullying as either the victim or perpetrator had significantly higher odds than those who were not involved in bullying to have feelings of depression("been physically bullied" OR = 3.2, 95%CI (2.1, 4.8)) and suicide ideation (OR = 3.4, 95%CI (2.0, 5.6)), to carry weapons to school ("gun to school" OR = 2.3, 95%CI (1.2, 4.3)) and to use both alcohol and other substances.

Conclusions:
Results of this study show that bullying is prevalent in high schools and that being involved in bullying as a victim or perpetrator significantly increases the odds of high risk behaviors when compared to those students who are not involved in bullying. Recognizing that an association does exist between bullying and high risk behaviors is the first step for schools, communities and governments to developing interventions that reduce bullying behaviors.

Objectives:
Attendees will learn:
1. How to recognize prevalence of bullying in high schools;
2. How to determine the association between being involved in bullying as either the victim or perpetrator and high risk behaviors;
3. How to describe the impact of results on schools, communities, governments.

Restricting Youth Suicide: A Pilot Descriptive Study of Behavioral Health Patients in the Pediatric Emergency Department

Steven C. Rogers, MD; Ashika Brinkley, MPH; Lynn Mangini, MD; Yifrah Kaminer, MD, MBA; Hassan Saleheen, MBBS, MPH; Kevin Borrup, JD, MPA; Garry Lapidus, PA-C, MPH

Background:
Suicide is the third leading cause of death among persons 10-19 years of age in the U.S., accounting for approximately 1,800 deaths annually. An estimated eight to 25 suicide attempts occur for every suicide death. Adolescents with suicidal behaviors are often evaluated in Emergency Departments (ED). Among all adolescents, drug overdoses account for the majority of suicide attempts and firearms are used in the majority of fatalities. Patients with a history of a suicide attempt are at an increased risk of subsequent suicide especially in the year after an attempt. People at risk of suicide should have limited or no access to potentially fatal items such as drugs, alcohol and firearms.

This can be conveyed in the ED setting through an established form of education described as Lethal Means Restriction (LMR) counseling which may be an effective strategy for preventing self harm in this high risk population. Our pediatric emergency department (PED) does not have a standard procedure to provide means restriction counseling to patient families or caretakers at the time of disposition. The purpose of this pilot study is to determine the baseline rate of LMR counseling in our PED.

Methods:
We identified all psychiatric and behavioral health patients presenting to our PED from January 1 through May 31, 2012 (n=1,117) and then abstracted descriptive data on a random sample (n= 168) of this cohort. Data included demographics (age, sex, race/ethnicity), chief complaint, current and past psychiatric history, discharge diagnosis, disposition, discharge instructions and documentation of any LMR counseling provided in the ED.

Results:
Of the 168 patients, 49.4% were male, 49.7% white and 87.5% were in the custody of their parents. 55.1% of patients had a previous inpatient psychiatric admission. The most common diagnoses include mood disorder (30.4%), depression (27.4%) and ADHD (17.3%). Suicidal ideation was noted for 35.7% of patients but only 5.1% received any LMR counseling. Regarding access to lethal means, 8.4% of patients reported unrestricted access and 9.6% reported restricted access. Of those reporting unrestricted access only 14.3% of these patients have documentation of any LMR counseling occurring during the ED visit.

Conclusions:
Providing a safe environment for adolescents at risk for suicidal behaviors should be a priority for all families/caretakers and encouraged by healthcare providers. These pilot study results suggest a need for a standard procedure to improve the frequency of documented LMR counseling for all at risk youth. We plan to implement an intervention study protocol in our PED and aim to demonstrate improved rate of documented counseling as well as a high rate of adherence to lethal

means restriction by families/caretakers of these high risk youth.

Objectives:
Attendees will learn:
1. How to describe the prevalence of suicidal behaviors in the U.S.;
2. How to recognize the importance of consistently providing effective lethal means restriction counseling for all high risk patients in the ED setting;
3. How to evaluate the results of our pending intervention that aims to improve the frequency of documented LMR counseling in a pediatric ED setting.

Supporting Children in the Aftermath of a Crisis

David Schonfeld, MD

Background:
Whether in response to a community event or a personal/family crisis, pediatric healthcare providers have an opportunity to provide important support to children and families to promote their coping and adjustment.

Methods:
The presenter has provided consultation and training on school crisis and pediatric bereavement in the aftermath of a number of school crisis events and disasters within the United States and abroad, including school and community shootings in Newtown, CT, Aurora, CO and Chardon, OH; flooding from Hurricanes Sandy in NYC and NJ, Katrina in New Orleans and Ike in Galveston; tornadoes in Joplin, MO and Alabama; and the 2008 earthquake in Sichuan, China. He will draw on 25 years of experience responding to school and community crisis events and supporting children who are grieving.

Results:
The presentation will provide practical suggestions of how to provide support to children and families in the aftermath of a personal, family, or community crisis, with an emphasis on psychological first aid and basic supportive services, and outline the common reactions seen to assist with identifying those children who would benefit from additional assistance. The timeline for adjustment and the importance of professional self-care for those providing such support will also be addressed.

Conclusions:
Pediatric healthcare providers serve a critical role in providing support to children and families in the aftermath of a crisis and can utilize these skills in the aftermath of a major event or in the everyday practice of pediatric healthcare.

Objectives:
Participants will learn:
1. The common symptoms of adjustment reactions after a crisis and a typical timeline for adjustment;
2. The elements of psychological first aid and the importance of basic supportive services, as well as professional self-care;
3. How to provide advice to parents on how to support their children after a crisis.

Trends in Alabama Teen Driving Death and Injury

Marie Crew RNC-NIC, BS; Elizabeth Irons MD; William King RPH, MPH, DrPH; Jesse Norris; Michele Nichols MD; Kathy Monroe MD

Background:
Motor vehicle crashes (MVC) are a leading cause of morbidity and mortality in teens. Alabama has been in the top five states for MVC fatality rate among teens in the U.S. for several years. Interventions such as a Graduated Driver's License law and media campaigns to increase public awareness have been employed to decrease MVC death and injury. Recently, we evaluated twelve years of teen MVC deaths and injuries to discern if changes in trend have occurred subsequent to legislative and educational interventions.

Methods:
A retrospective analysis of Alabama teen MVC deaths and injury for the years 2000-2011 was conducted. The Spearman rank correlation was used to test for correlation of deaths and injury over time. MVC data were obtained from a FARS dataset managed by the Center for Advanced Public Safety at the University of Alabama. A Lowess regression - scattergram analysis was used to identify period specific changes in deaths and injury over time. The Mann Whitney U test was used to evaluate median differences in deaths and injury comparing pre 2007 and post 2007 data. Statistical analysis was conducted using True Epistat 5.0 software.

Results:
Alabama teen MVC deaths and injury demonstrated a significant negative correlation over the twelve year time period (R sub s for deaths and injury = -0.87, $p<0.001$ and -0.92, $p<0.001$, respectively). Lowess regression identified a notable decline in deaths and injury after the year 2006. Median deaths and injury for the pre-2007 time period were significantly higher than the post 2007 time period, ($U=35.0$, $p=0.003$).

Conclusions:
Alabama teen driver deaths and injury have decreased over the study 12 year period, most notably after 2006. There are many factors that may have contributed to this trend. These factors may include stricter laws for teen drivers (enacted in 2002 and updated in 2010), less teen driving due to a nationwide economic downturn, delayed licensing in teens, steady improvements in overall seat belt use, and heightened public awareness of risky behaviors in teen driving.

Objectives:
Attendees will learn:
1. How to recognize factors that may have contributed to a decrease in teen driving deaths;
2. How to determine means of raising public awareness utilizing media;
3. How to build state coalitions for both data sharing and public awareness campaigns .

Risky Teen Driving Behaviors and Driving Contracts

Elizabeth Irons, MD; Michele Nichols, MD; William King, RPh, MPH, DrPH; Kathy Monroe MD

Background:
Motor vehicle crashes (MVCs) are the number one cause of death for teens in the U.S. Our state has a particularly high rate of teen driving fatalities. Graduated Driver's License laws, driving instructional classes, parent teen driving contracts and pediatrician counseling have shown some positive, albeit inconsistent, influence on decreasing teen driving fatalities. We surveyed area teens to determine the prevalence of high risk driving behaviors including non-use of seat belts, texting, drinking and drug use while driving and to determine their exposure to driving contracts.

Methods:
This descriptive study utilized a teen driver questionnaire(adapted from the CDCs National Youth Risk Behavioral Survey) to provide estimates and baseline information on teen driving behaviors in our state. Questions that dealt with behavior as drivers and passengers in the car were included. Institutional Review Board approval was obtained. Participation in a driver's contract was determined and comparisons made between paricipants with and without a drivers contract in place.

Results:
A total of 1399 surveys were collected (52% of respondents were male, 64% were Caucasian, 29% African American,3% were Hispanic). When asked about seat belt use while driving, 42% of respondents answered "always", with 27% reporting "most of the time", and 12% reporting "rarely" or "never". 60% of respondents reported that they routinely drive 5-10 mph over the speed limit. 13% of respondents stated that they have driven after using marijuana or other drugs in the past. When asked about behaviors while driving in the last 30 days, 41% reported texting while driving and 11% reported driving after drinking. 67% of teens reported being a passenger in a car with driver texting and 27% reported being passenger in car after driver had been drinking.

80% of those surveyed reported having discussed safe driving with a parent. Only 16% had discussed safe driving with their doctor. 26% had signed a driving contract and 63% had taken a driving class. The percent of respondents who had signed a driving contract and reported texting while driving in the last thirty days was significantly less than those who had not signed a driving contract ($x2=71.0$, $p<0.001$). There was also a significant association between those who had signed a driving contract and who reported routinely driving more than 5 mph over the speed limit ($x2=32.9$, $p<0.001$). All other risky behavior differences between the groups were non significant.

Conclusions:
The results of our study reveal an alarming number of risky behaviors in teen drivers in our state. When compared to the data from the 2011 National Youth Risk Behavior Study, we see that our numbers are higher in every category compared. The effect of a driving contract was helpful in specific behaviors only.

Objectives:
Participants will learn:
1.How to recognize states that have higher rates of risky teen driving behaviors than the national youth risk survey results;
2. How to determine the rate in which driving contracts are used;
3. How to determine why driving contracts are helpful in reducing some but not all risky driving behaviors.

Efficacy Of Driving Simulator Training For Novice Teen Drivers

Brendan Campbell, MD, MPH; Kevin Borrup, JD, MPPA; Hassan Saleheen, MBBS, MPH; Steven Rogers, MD; Garry Lapidus, PA-C, MPH

Background:
Motor vehicle crashes (MVC) continue to be the leading

cause of death and injury for American teenagers. The objective of this study was to determine if driving simulator training lowers motor vehicle crash rates and driving infractions for novice teen drivers.

Methods:
We recruited 15 and 16 years olds at a public high school who did not yet have a driver's license. After obtaining informed consent, participants completed a survey on safety knowledge and attitudes, and were randomized into either a control or intervention group. The intervention group had the opportunity to complete a standardized, 12-lesson driving simulator training module. Subjects were offered a $100 incentive upon completion of all 12 modules. Six desktop driving simulators were set up in the high school library and made available for use during and after school. We tracked each subject's completion of the 12 simulator modules, and their performance was automatically graded. Twelve months after the intervention all subjects were asked to complete a survey asking about MVC history and driving infractions.

Results:
We enrolled 219 students, and randomly assigned 130 to the intervention group, and 89 to the control group. Nearly two-thirds (n=137, 63%) of subjects completed the pre-simulator survey, follow-up survey, and obtained a license. Nearly half of the intervention group (n=42, 48%) completed some of the 12 simulator training modules: 2-5 modules (n=8, 19%), 6-11 modules (n=7, 17%), and all 12 modules (n=27, 64%). Post-simulator training involvement in a MVC (intervention=14.9% vs control=12.0%, $p>.05$) and driving infractions (intervention=11.5% vs control=18.0%, $p>.05$) did not differ significantly between groups.

Conclusions:
Simulator training did not produce a measurable reduction in self-reported driving infractions and MVC's. Low completion rates for simulator training limited our assessment of efficacy. Future evaluation of driving simulator training should include approaches that ensure higher completion rates.

Objectives:
Participants will learn:
1. How to understand simulator intervention technologies;
2. How to describe high school student recruitment;
3. How to explain challenges faced in implementing complex interventions.

Unexpected Funding Provides for Teen Driving ROADeo Event

Susan Cohen, BS

Background:
Arkansas teens die in car crashes at a rate two times that of the United States. The mission of the Arkansas Children's Hospital Injury Prevention Center (IPC) includes the reduction of injury, death and disabilities. Motor vehicle crashes are one of our key focus areas. The center operates using innovative research projects, education & training, along with advocacy and empowering community coalitions. Our teen driving staff assisted by our Motor Vehicle Analyst travel the state, training volunteers to implement evidence based programming in their defined communities.

Since the Arkansas Graduated Driver License Law passed in 2009 it has added restrictions on the number of passengers, nighttime driving and cell phone usage. Parents must not only, familiarize themselves with the new restrictions, they have to be prepared to enforce them, just as the members of Law Enforcement and the Justice System have the same obligation.

The Allstate Foundation is a great friend to the IPC and has provided funds to support our teen driving program development and outreach. Their support has developed into more than just funding a proposal, we are partners in our work.

Methods:
When approached by Allstate Foundation about the possibility of receiving additional funds the questions were; can you use the money, do you have a project in mind and how soon can we get a proposal?

We presented a new event that would promote safer teen driving, skills and tips for the road, and have parents and teens learning together, a Teen Driving ROADeo.

The ROADeo included learning stations that teens and parents would rotate through, upon completing the ten stations t-shirts and vehicle emergency kits were given to participants. Set up on the stadium parking lot teens 14 -17 and their parents visited stations including: GDL information, traffic stop behavior, how to change a tire, check your vehicle fluids, and the proper use of jumper cables, blind spot awareness, texting and driving, impaired driving, railroad crossing safety and vehicle insurance 101. Both parents and teens participated in pre/post test on the event.

Results:
72 families participated in the event, with 68 of them completing the series of stations and both pre/post test. 94% "learned something new", 80% of the parents were surprised by something their children knew about driving laws, 50% of the students were surprised at how the impaired driving goggles changed their ability to drive, 55% would like more time at the texting and driving simulator, 92% would recommend this event to a friend.

Conclusions:
This was a media friendly event, great coverage before, during and after. We have our second ROADeo scheduled for August 13, 2013 in the neigboring community of Conway. Being offered additional money by your funder is a dream come true for centers working in injury prevention, you have cleared a major hurdle of educating your funding source on not only how important your work is, but that as an agency you are fiscally responsible.

Objectives:
Participants will learn:
1. How to recognize how important it is to keep a wish list of projects or programs that you would like to do if you had the resources;
2. How to have an event that will engage participants of varying demographics;
3. How to best use your media before, during and after an event.

Seat Belt Use in Teen Passengers Seated in the Rear Seat of Passenger Vehicles Involved in Fatal Collisions on a US Roadway

Joyce Pressley, PhD, MPH; Hajere Gatollari

Background:
Early laws mandating that car manufacturers include seatbelts in passenger cars did not require belts for backseat passengers. In many states today, teen passengers can ride legally unbelted in the rear seat of passenger cars. This study examined factors associated with teen use of rear seatbelts and with injury outcomes of belted and unbelted rear-seated teen passengers.

Methods:
The Fatal Analysis Reporting System (FARS) for 2010-2011 was used to examine factors associated with teen motor vehicle (MV) backseat occupant (n=3,463) seatbelt use. Inclusion criteria included a moving passenger vehicle traveling on a U.S. roadway involved in a fatal collision in which at least one teen was riding in the rear seat. Exclusions included buses, bicycles, ATVs, three-wheeled vehicles, nonpassenger trucks, vehicles not in transit and cases that met vehicle inclusion criteria but were missing belt status (9.7%). SAS was used to process the large data sets and to conduct statistical analyses using Chi Square, ANOVA and multilevel logistic regression. Multi-level models controlled for non-independence of cases at the vehicle level (clustering with multiple backseat passengers per vehicle) using SAS Glimmix, binomial logit with a random intercept, Newton- Raphson optimization technique and Gauss-Hermite Quadrature likelihood approximation. Relative risk is reported with 95% CI. Significance was at the 0.05 level.

Results:
Of the rear-seated teen passengers, only 47.8% were restrained. Restraint use declined linearly with increasing age from that observed in younger teens aged 13-14 (64.7%), compared to older teens of 15-17 (48.0%) and 18-19 (41.6%) years of age ($X2=100.6$, $p<0.0001$).
Of the 50 states (and DC) examined, only 13 had backseat seatbelt laws that covered all ages, 16 only covered children, and 22 states had age gaps. In 10 states, 8-15 year olds were uncovered. Presence of a law requiring backseat seatbelt use was associated with an increase in restraint use (51.8% vs. 37.8%, ChiSq=80.4, $p<0.0001$). Enforcement was primary in only 34 states. One state had no law coverage.

Nearly one-fifth (19.6%) of rear-seated teens were ejected with 95.8% of ejections in unrestrained teens. Partial ejections were more fatal than complete ejections with two-thirds (66.7%) of partially ejected teens dying. Overall, 77% of mortality occurred in unbelted rear-seated teens. Backseat passengers of belted drivers were more likely to be belted (62.0% vs. 19.8%, ChiSq =503.2, $p<0.0001$). Vehicle rollovers occurred in 41.0% of vehicles which had higher mortality than nonrollover crashes (27.3% vs. 19.5%, ChiSq=29.0, $p<0.0001$). Restrained rear-seated passengers in rollovers were less likely to die (12.5% vs. 35.7%, $p<0.001$). In multilevel models that controlled for clustering, passenger age and gender, driver age and gender, restraint status, impairment and crash time of day, coverage by a backseat seatbelt law was associated with an increased odds of being buckled for primary (2.29, 1.48-3.54) but not secondary law coverage (1.59, 0.85-2.86).

Conclusions:
There exist large age gaps in rear-seat seatbelt laws. Unrestrained rear-seated teens had increased mortality. Presence of a primary enforced seat belt law was associated with higher belt use.

Objectives:
Attendees will learn:
1. How to discuss the importance of rear-seated teen seat belt use;
2. How to identify gaps in rear-seat seat belt laws;
3. How to describe the relationship between belt status and mortality in rear-seated teens involved fatal collisions.

Comparison of Motor Vehicle Crash Occupant Fatalities in States with Primary Versus Secondary Enforcement Seat Belt Laws

Lois Lee, MD, MPH; Lindsey Burghardt, MD; Eric Fleegler MD, MPH; Lise Nigrovic, MD, MPH; William Meehan, MD; Sara Schutzman, MD; Rebekah Mannix, MD, MPH

Background:
Motor vehicle crashes are the leading cause of death in persons 5-34 years old in the United States. Using a seat belt decreases the risk of death and serious injuries. Primary enforcement seat belt laws allow police to ticket a motorist solely for not using a seat belt. Secondary enforcement laws allow police to ticket a motorist for not using a seat belt only after being stopped for another violation. Seat belt use is higher in states with primary compared to secondary enforcement laws. The study objective was to compare motor vehicle crash occupant fatality rates in states with primary vs. secondary enforcement seat belt laws.

Methods:
We performed a retrospective, cross-sectional analysis of all motor vehicle occupant crashes identified in the Fatality Analysis Reporting System from 2001-2010 in the United States. The primary outcome measure was motor vehicle occupant fatality rates. We used the t test to compare motor vehicle fatality rates in primary vs. secondary enforcement/no law states. For states with primary enforcement laws we compared rates for coverage of only the front seat compared to all seats in the vehicle. For comparison of fatality rates before and after the adoption of primary enforcement laws, we used linear regression, controlling for year of legislation. To account for other legislative and economic factors associated with motor vehicle fatalities, we created a clustered multivariate Poisson regression model to adjust for state highway speed limit, maximum legal blood alcohol limit, median household income, and study year.

Results:
From 2001-2010, we identified 347,547 motor vehicle occupant fatalities, for an overall rate during this period of 11.7 per 100,000 persons in the United States. In 2001 only 15 states had primary enforcement laws, 34 had secondary laws, and one state had no seat belt law; the national fatality rate was 12.8/100,000 persons. In 2010 primary enforcement laws were present in 30 states, secondary laws in 19 states, and no law in one state; the national fatality rate was 9.0/100,000 persons. Crash fatality rates were lower in states with primary compared to secondary enforcement laws (12.3/100,000 vs. 14.9/100,000; $p < 0.001$). States with primary enforcement laws covering all seats had lower fatality rates compared to laws only covering the front seat (13.3/100,000 vs. 11.7/100,000; $p = 0.02$).

The mean crash fatality rate before adoption of primary enforcement laws was 16.2/100,000 compared to 13.2/100,000 after the law ($p<0.0.3$). The multivariate regression analysis demonstrated states with primary enforcement laws had lower fatality rates than states with secondary laws (adjusted incidence rate ratio 0.72; 95% confidence interval 0.66-0.77).
Conclusions:
States with primary enforcement seat belt laws have lower motor vehicle occupant fatality rates than states with secondary enforcement laws. Legislative efforts should continue to encourage adoption of primary enforcement laws in all states.

Objectives:
Attendees will learn:
1. How to recognize the distinctions between primary and secondary enforcement seat belt laws;
2. How to describe the changes of motor vehicle occupant crash legislation and fatalities over time in the United States;
3. How to describe the differences in motor vehicle occupant crash fatality rates in states with primary compared to secondary enforcement seat belt laws.

Hasbro Children's Hospital Inpatient Child Passenger Safety (CPS) Program

Dina Morrissey, MD, MPH; Christina McRoberts, RN; Elvera Sofos, MD; Bryn Gonzales-Ellis, MD; Michael Mello, MD, MPH

Background:
Motor vehicle crashes are the leading cause of death for children between the ages of 1 and 14. It is well established that correct use of a child safety seat (CSS) can reduce the risk of fatal injury by up to 71%. 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. There is a great need to raise awareness about CPS and

to provide caregivers with resources to obtain a CSS as well as CPS education.

Methods:
We formulated a series of six questions focused on child passenger safety that were incorporated into the Hasbro Children's Hospital (HCH) nursing admission assessment. The questions must be answered for all children under the age of 13 years that are admitted to HCH. If a patient screens "positive" an electronic referral is automatically sent to the car seat program at the Injury Prevention Center (IPC). Referrals are reviewed and categorized by the level of urgency. Urgent referrals are attended to prior to discharge whenever possible. All caregivers are offered CPS educational materials as well as contact information for the IPC car seat program prior to discharge.

Results:
The program was launched on February 15, 2013. During this time period a total of 349 referrals were generated and sent to the car seat program at the IPC. Twenty of these referrals were categorized as urgent and 12 caregivers were scheduled for appointments. We were unable to reach 5 of the 20 urgent referrals and 3 caregivers declined assistance. Of the 12 appointments scheduled, 3 did not show up for their appointment, 5 received car seats and 3 appointments are pending at this time. Issues with duplicate referrals as well as missing or inaccurate information are currently being addressed.

Conclusions:
Since implementation of this program we have been able to screen all caregivers of children under the age of 13 years admitted to Hasbro Children's Hospital for appropriate CSS use. We have been able to identify urgent needs and attend to them prior to discharge in many cases, however many challenges still exist. Issues with duplicate referrals as well as inaccurate or missing information on referrals are being addressed. Screening caregivers of patients under the age of 13 years upon hospital admission may be an important way to identify urgent CPS needs and also to raise awareness and provide education and resources for caregivers who desire further assistance.

Objectives:
Attendees will learn:
1. How to develop an inpatient child passenger safety screening program;
2. How to describe the challenges that exist in the development implementation of a Child Passenger Safety program directed at inpatients;
3. How to recognize the challenges that arise when implementing a CPS program directed at inpatients.

Suburban and Rural Teen Driver Attitudes Towards Texting While Driving

Purnima Unni, MPH, CHES; Dai Chung, MD; Barbara Shultz, RN,BSN,MSN

Background:
Texting while driving is one of the most risky distractions for teenage drivers. Distractions are a major cause of motor vehicle crashes. Efforts to understand and combat this issue are therefore a matter of high priority. This study examines attitudes and intentions of rural and suburban teenage drivers towards texting while driving. It also examines the association, if any between awareness of GDL laws and safe driving practices. Study results will be relevant to injury prevention professionals interested in curbing texting while driving among teenagers. It reveals similarities and differences in attitudes and behavior among rural and suburban teenage drivers.

Methods:
A structured survey was administered to a convenience sample of students (n = 1174) in a rural high school and a suburban high school. These two schools had agreed to participate in a teen safe driving initiative. The survey and protocol used to collect the data were approved by the Institutional Review Board of Vanderbilt University. Only data from teen drivers (n = 589) was analyzed using SPSS v 19.0.

Results:
More than half the teenagers reported sending or receiving more than 100 text messages a day in both schools. About 77% of drivers indicated that texting was the most dangerous task while driving. Just under half of the drivers indicated awareness of GDL. Interestingly, an overwhelming 84% reported that texting while driving was not legal. Significantly more suburban teenage drivers had taken driver's education classes than rural teenage drivers. However, suburban teenage drivers reported sending or receiving more texts while driving. They were significantly more confident in their driving ability than their rural counterparts.

On matters of driving, teenage drivers (73%) value their parents' opinion most. More than 50% of parents of drivers in both schools frequently or always reminded them not to text and drive. However, teenagers reported parents texted while driving. Only 30% reported no texting by parents while driving. Rural parents texted less than suburban parents. Rural teenage drivers were significantly more favorable to support laws that restrict phone use while driving. Likelihood of shutting off phone while driving was very

low for both groups. Designating a friend to text on their behalf was more likely.

Conclusions:
Findings of our study, though not generalizable, affirm the challenge of persuading teenage drivers to not text while driving. Teenage drivers know that texting while driving is dangerous and illegal. However, this behavior is prevalent and teenagers are reluctant to switch off their cellphones while driving.

Teenage drivers indicated that they cared most about their parents' opinions on matters relating to driving. Many parents also remind them not to text while driving. However, parents' urgings seem to be ineffective. We speculate that this may be a result of observed parental texting behavior by teenagers.

There were some differences between rural and suburban teenage drivers. However, these differences do not seem to warrant a completely different approach for each group.

Objectives:
Attendees will learn:
1. How to explain driving attitudes and behaviors among rural and suburban teen drivers;
2. How to determine differences in intentions to follow recommendations to curb texting while driving among teen drivers;
3. How to examine the role of GDL and parental influence on safe teen driving.

Multidisciplinary Approach to healthier communities – The Reinvent Phoenix Project

Pamela Goslar, PhD; Debarati "Mimi" Majumdar Narayan, PhD; C.J. Hager, MRCP: Mariana del Hierro, MA; Dean Brennan; Ernesto Fonseca, PhD; Curt Upton

Background:
Reinvent Phoenix, funded through HUD, a collaborative effort between the city, ASU, St. Luke's Health Initiative. A major objective is to improve the health of residents who live along the light rail through reducing injuries associated with walking and biking while increasing active living. St. Luke's, lead agency for the health component, is a public foundation for health policy, community development and capacity building. St. Joseph's Hospital is subcontracted to focus on the injury prevention aspects of the project, using epidemiological techniques to describe the characteristics of the population and identify injury "hot spots"; conduct field observations; and, provide input relative to interventions.

Methods:
Quantitative and qualitative data were used to identify areas most at risk for injury events. Qualitative data were obtained through community workshop mapping exercises. Residents were encouraged to express concerns for safety. Selected walking audits were completed. Data from Trauma Registry (ASTR) and the City collision data included location of event, demographic and injury related elements. The data sets were matched, geo-coded, mapped, and analyzed using IBM SPSS. Field observations were conducted. Following a series of meetings and reviews of maps, evidence based recommendations were provided.

Results:
Gateway has 14,000 residents (over 70% Hispanic) and includes major industrial areas and residential housing. Slightly over 50 residents attended the workshop with the majority parents of school aged children. The workshop was conducted in Spanish. GIS maps summarized the results of the workshop. 115 injuries were analyzed. Only 15% were children. Analysis and mapping identified high risk locations including one intersection responsible for almost 15% of pedestrian injuries. Field observations identified major deficiencies in bicycle routes, sidewalks, crosswalks, poor lighting, and land use issues. Behavioral factors were also noted.

Conclusions:
This project is an example of involvement in (re-) development at the planning stage. Challenges exist. Community residents were hesitant to participate due to fears related to immigration issues and a lack of belief that something besides "research" was being done. Using trusted leaders increased participation and Injury Free members from the streets department made immediate visual improvements. A common vocabulary is a challenge with a multidisciplinary team, complicated by mixing practitioners and academicians.

On-going communication, lots of questions and clarifications helps. Including health as an issue to be addressed in planning and (re-)development; lack of law enforcement involvement and the exclusion of behavioral recommendations created more challenges. The use of GIS mapped injury data with destination points is invaluable. Coupled with pictures the visual imagery allows a deeper understanding of existing conditions. A major success of this project has been the involvement of community members as partners engaged throughout the implementation process.

Objectives:
Attendees will learn:
1. How to describe an epidemiological approach

that includes the use of health related data and field observations to inform collaborators regarding potential changes to increase active living (walking, biking, use of public transportation) while reducing related injuries;
2. How to summarize the value and challenges of integrating injury prevention with urban planning and design methodologies with governmental organizational requirements when engaged in chronic disease prevention and management;
3. How to demonstrate a collaborative approach that actively involves community members as partners with a variety of organizations and disciplines in addressing improving the health of the community through changes in policy and environment.

Effectiveness of a Safe Routes to School Program in Preventing School-Aged Pedestrian Injury

Charles DiMaggio, PhD, MPH; Guohua Li, MD, DHPH

Background:
In 2005, the US Congress allocated $612 million for a national Safe Routes to School (SRTS) program to encourage walking and bicycling to schools. We analyzed motor vehicle crash data to asssess the effectiveness of SRTS interventions in reducing school-aged pedestrian injury in New York City.

Methods:
Using geocoded motor vehicle crash data for 168806 pedestrian injuries in New York City between 2001 and 2010, annual pedestrian injury rates per 10 000 population were calculated for different age groups and for census tracts with and without SRTS interventions during school-travel hours (defined as 7 AM to 9 AM and 2 PM to 4 PM, Monday through Friday during September through June).

Results:
During the study period, the annual rate of pedestrian injury decreased 33% (95% confidence interval [CI]: 30 to 36) among school- aged children (5- to 19-year-olds) and 14% (95% CI: 12 to 16) in other age groups. The annual rate of school-aged pedestrian injury during school-travel hours decreased 44% (95% CI: 17 to 65) from 8.0 injuries per 10 000 population in the pre-intervention period (2001–2008) to 4.4 injuries per 10 000 population in the pos-tintervention period (2009– 2010) in census tracts with SRTS interventions. The rate remained virtually unchanged in census tracts without SRTS interventions (0% [95% CI: –8 to 8]).

Conclusions:
Implementation of the SRTS program in New York City has contributed to a marked reduction in pedestrian injury in school- aged children. Pediatrics 2013;131:290–296

Objectives:
Attendees will learn:
1. How to describe a number of studies that have demonstrated community acceptance of Safe Routes to School interventions as well as their success in addressing perceptions about safety;
2. How to recognize the effectiveness of efforts in reducing pedestrian injury risk in school-aged children;
3. How to describe how implementation of a Safe Routes to School program in New York City may have contributed to a substantial reduction in school-aged pedestrian injury rates, with the effects largely limited to school-travel hours in census tracts with these interventions.

Home Visitor Home Safety Checklist: Program Response to a Community Pilot

Judy Schaechter, MD, MBA; Lyse Deus, MA; Maria-Paula Garcia, MA

Background:
Unintentional injury in the home is a leading cause of death and emergency room visits for young children. Education and safety product availability can help reduce identified risks in the home. Visitors in the home who inspect whether home safety equipment is being used are considered to be more reliable than parental report alone. Home visitors may also be a valuable outreach source of injury prevention counseling.

Methods:
A local taxing district historically funding early childhood home visitors for purposes other than injury prevention (pregnancy prevention, child abuse prevention, literacy support, etc.) added a periodic home safety/injury prevention assessment and counseling tool to their contract requirements. The 28-item tool was developed based on local surveillance data and coalition priorities. Providers were trained in uniform fashion.

Results:
Five out of eight home visitation providers implemented the assessments as planned. The remaining three provider groups expressed concern about the checklist. In one case, a central issue was contractual (time and money). For all three there were

concerns about asking families about injury risks in the home. Concerns fell into three categories: 1) Were parents sufficiently empowered to make the changes suggested? This was especially true when parents were teens, foster children, poor, lived with other families or rented. 2) Would resources necessary be provided? 3) Would questions about firearms put the parent, the home visitor and the provider agency at risk? In addition, regarding firearms, the county attorney opined that state statute might prohibit home visitors from asking parents if there was a gun in the home or vehicle.

We collected home safety assessment data on 368 home visits from five different provider groups visiting families with very young children. Among the data collected: Just 17/368 answered in the affirmative that they ever travel with a child without a car seat or booster seat. Regarding fencing or other appropriate barrier around a pool, 15 answered yes, 19 no and the remainder responded that the question was not applicable as the family did not live where there was a pool. 88/358 completing the question of when was the last time you changed the batteries of the fire alarm(s) reported "more than a year ago" or they "can't remember."

Conclusions:
IFCK-Miami has made strong coalition partnerships, committing to address injury countywide across its programming and funding priorities. The assessment pilot is confirming IFCK-Miami work in the area of child passenger safety, identifying new priority areas, tailored to the community through local assessment, and areas which may be better fits for assessment in certain sub- communities. Additionally, within Florida's political and cultural climate, questions about firearms may require cautious approach and review. Further, large scale home safety assessment and counseling will require careful training; home visitors providing services other than injury prevention may not readily understand how to help parents make their own homes safer for young children, especially when they must advocate in their own homes.

Objectives:
Attendees will learn:
1. How to recognize the cross-over potential of early learning home-visitors for injury prevention;
2. How to appreciate both the sensitivity of the firearm issue and the need to include it in injury prevention;
3. Provide an example of home visitation assessment as a localized issue benefiting from local data and evaluation.

Home Safety Kits: Directing Next Steps in Primary Prevention of Home Injuries

Katie Amsden, CHES; Amy Hill, MS; Jessica Choi; Rebecca Levin, MPH; Karen Sheehan, MD, MPH

Background:
Injuries are the leading cause of death for people 1-44 years in the U.S. Over 50% of emergency room visits for unintentional injuries among children are from occurrences in the home and are preventable.
The primary aim of this study was to gather qualitative data on the perceptions of parents and providers regarding the utility of home safety kits in preventing household injuries among children.

Methods:
In an effort to prevent household injuries, Ann & Robert H. Lurie Children's Hospital of Chicago created and disseminated home safety kits. The kits provide families with educational materials and tools that require simple steps in preventing household injuries. The kits were distributed through community agency partners to parents in Chicago.
Focus groups were conducted with parents and providers in Chicago. Sixty-two (6M/56F) people participated in six groups ranging from 4-18 people. Sessions were audiotaped, transcribed and interpreted for themes.

Results:
The most beneficial items reported by the groups included four tangible items, smoke detectors, cabinet latches, bathtub thermometers and window guards. When asked about the least beneficial items in the kits, participants mention that included items should be easy to use or install. When asked about potential improvements to the kits, the educational material was mentioned the most. Participants suggested the need for additional educational material on certain topics while also reducing the amount of reading required.

Conclusions:
Data identified family home safety needs and led to changes in the kits to meet these needs. An educational booklet written below a 5th grade reading level, including facts and serving as a checklist was created to replace numerous pamphlets. Cabinet latches were replaced with new latches not requiring tools for installation. The smoke detector and window stoppers were removed and will be distributed during fire prevention week and a window fall campaign, when more public emphasis is put on each issue. Similar programs should include resources which are tangible, thus providing a visual object to aid in learning and remembering about a specific topic. Resources should be easy to use or install. Educational

reading resources should include few words but several pictures. Next steps include gathering feedback on the newly revised home safety kits.

Objectives:
Participants will learn to:
1. How to provide recommendations for designing home injury prevention resources for parents;
2. How to describe parental perceptions of home injury prevention tools;
3 How to understand provider perceptions of home injury prevention tools.

Sports-Related Traumatic Brain Injury: Increased ED Utilization but Not Severity

Holly Hanson, MD; Wendy Pomerantz, MD; Mike Gittelman, MD

Background:
Emergency Department (ED) visits for traumatic brain injury (TBI) are on the rise; in particular, sports-related TBI visits have increased 62% since 2001. No studies have looked at how admissions or severity of TBIs have changed as a result of this increase in ED visits for sports-related TBI. Our objectives were to evaluate how the number and severity of admissions had changed as ED visits for sports-related TBI have increased and to determine which sports were responsible for the majority of TBI admissions.

Methods:
A retrospective study of children aged 0-19 years was performed at a Level 1 Trauma Center. Patients from 2002-2011, with a primary or secondary diagnosis of TBI by ICD-9 code, were identified from the hospital's trauma registry. Data extracted included: demographics, type and mechanism of injury, sport (based on CDC definition), injury severity score (ISS), length of inpatient stay (LOS), and disposition. Frequencies were used to characterize the population, Chi-square analysis was performed to determine differences between groups, and one way analysis of variance was completed to look at relationship between year and ISS or LOS.

Results:
25,410 patients presented to the ED for TBI during the study period. Sport was responsible for injury in 3,878 (15.4%) cases. 3,506 (90.4%) were discharged home, 372 (9.6%) were admitted. 73% were males and 78% Caucasian, the mean age was 13 ± 3.5 years, and 84.4% had private insurance. There was no difference in age or sex between patients admitted and those discharged home. There were more Caucasians and patients with Medicaid/Medicare admitted. In the ED, football (29.1%), soccer (16.5%), and basketball (15.4%) were the most common sports responsible for TBI; however, skateboarding/rollerblading (27%), sledding (21.4%), and skiing (20.7%) were the sports admitted most frequently. Despite an increase in both ED visits for sport-related TBI and admissions, there was no significant change ($p=0.48$) in the percentage of kids admitted across all 10 years. Additionally, mean ISS for those children admitted decreased from 7.8 to 3.8 ($p=0.003$) across the 10 years, while the mean LOS remained unchanged at 1.6 days ($p=0.62$).

Conclusions:
The number of pediatric sport-related TBI both presenting to the ED and being admitted has increased over the last 10 years; however, the percentage of children being admitted from the ED has not changed. The severity of admitted sports-related TBI is decreasing. Injury prevention should focus on preventing TBI mechanisms with high morbidity like sledding, skiing, and rollerblading/skateboarding.

Objectives:
Attendees will learn:
1. How the percentage of ED visits for pediatric sports-related traumatic brain injury requiring admission annually has remained unchanged over the past 10 years;
2. How to describe how severity of admissions, measured by ISS, has decreased; while the length of stay has remained stable;
3. Why Injury prevention should focus on preventing severe TBI mechanisms like sledding, skiing, and rollerblading/skateboarding.

Statewide Assessment of the Rhode Island Concussion Law

Dina Morrissey, MD, MPH; Thomas Scupp, MD; Neha Raukar, MD; Jennifer Andrade-Koziol, MPH; Michael Mello, MD, MPH

Background:
Sport-related concussion among youth athletes has become an area of increasing concern. An estimated 7.7 million youth participate in organized sports each year and the CDC estimates that they sustain between 1.6 and 3.8 million sports related concussions annually. In response to this the state of Rhode Island passed the School and Youth Programs Concussion Act (SYPCA) in July 2010 and amended this law in February 2011. The law outlines both mandatory and recommended provisions in regards to managing student athletes with a suspected concussion. The purpose of this study was

to assess compliance with this law among Rhode Island high schools and community league organizations.

Methods:
We designed a 29 question survey in order to assess the level of compliance with both the mandatory and recommended elements outlined in the SYPCA. The survey was sent by email to athletic directors of all Rhode Island Interscholastic League (RIIL) member high schools, non-member high schools and selected community league sports organizations. Contact information was obtained from the RIIL and from publicly accessible websites.

Results:
Surveys were sent by email to 66 athletic directors. Seven (7) were returned as undeliverable. Of the 59 individuals that received surveys, 42 (71%) responded and a total of 38 submitted a completed survey. Compliance with mandated elements was almost universal. Among RIIL-member schools that completed the survey, 100% stated they require concussion information sheets to be signed by both student-athletes and parents prior to start of the sports season. All reported that student-athletes with a suspected concussion are immediately removed from play and 93% (29/31) stated that student-athletes must receive written clearance from a licensed physician prior to being able to return to play. All schools require annual concussion training for coaches and 29 (93%) require annual concussion training for volunteers involved in school sports.

Among RIIL member schools, only 6 schools require all of their student athletes to complete pre-season neurocognitive testing and nearly 20% (6/31) do not offer pre-season neurocognitive testing to their student athletes. Approximately half of RIIL member respondents (17/31) stated that their school has a written return to play protocol for student-athletes that have sustained a concussion and only 8 (26%) respondents indicated that nurses are required to complete any concussion training. Compliance with both mandated and recommended elements of the law was lower among non-RIIL schools and community league organizations. Only 3 out of 7 stated that they complied with all mandated elements in the law. Only one respondent was in compliance with all the recommended elements of the law.

Conclusions:
Compliance with mandated elements of the RI School and Youth Programs concussion act is close to universal; however compliance with recommended elements is limited. To best protect youth athletes, all recommendations outlined in the law should be mandatory. Additionally, non-RIIL schools and community sports organizations should be required to comply with the law.

Objectives:
Attendees will learn:
1. How to describe provisions outlined in the Rhode Island Youth Programs Concussion Act;
2. How to describe Statewide compliance with both mandated and suggested provisions outlined in the Rhode Island Youth Programs Concussion Act;
3. How to use recommendations to increase compliance with the law.

A Policy Strategy Plan to Prevent Open Water Drowning among Children and Teens in Washington State

Celeste Chung, MSW, MPH; Elizabeth 'Tizzy' Bennett, MPH, MCHES; Kathy Williams, MS; Linda Quan, MD

Background:
Drowning is one of the leading causes of unintentional injury death among children and teens in Washington State. Most of these drownings occur in open water, such as lakes, rivers, and the ocean. Yet there are few policies and systems to prevent open water drownings. As a result, Seattle Children's Hospital and the Washington State Department of Health developed the Washington State Open Water Drowning Prevention: Policy Strategies for Children and Youth, 2011-2016.

Methods:
With funding from the Centers for Disease Control and Prevention (CDC), Seattle Children's Hospital and the Washington State Department of Health convened a multidisciplinary task force to identify, develop, and implement policy and systems changes to improve water safety for children and youth in Washington State. Task force members included injury prevention and water safety experts and representatives from local and state public health agencies, law enforcement agencies, parks and recreation agencies, and other community organizations.

Over a one year period, the task force reviewed existing policies and recommended best practices from around the world. Using the Haddon Matrix; data; policy criteria, and feedback from multiple stakeholders, the Task Force developed seven priority areas for policy change: (1) safer water recreation sites, (2) personal flotation devices, (3) boating under the influence and open water enforcement, (4) surveillance, (5) swimming skills and water safety education, (6) physical open water barriers, and (7)

partnerships. Each priority area has short- and long-term policy and systems change strategies.

Results:
Since the development of the policy strategy guide, Seattle Children's Hospital, the Washington State Department of Health, and their partners have worked together to implement policy strategies for each priority area. Implementation of the policy strategies resulted in the development of the Washington State Designated Swim Area Guidelines, a revised law that adds implied consent for boat operators, a media tour to promote the new law and other water safety messages, the development of a Drowning Investigation Tool, and a change in policy to allow women's only swim programs at a parks and recreation department. With funding through 2016, the lead agencies and their partners will continue to develop, promote, and implement policy changes to prevent child and youth drownings.

Conclusions:
Policies outlined in the Washington State Open Water Drowning Prevention: Policy Strategies for Children and Youth, 2011-2016 have been successfully implemented. Implementation has resulted in a change to the boating under the influence law, the development of designated swim area guidelines, a drowning investigation tool, women's only swim programming, among other accomplishments. This policy strategy process and plan is a model that can be replicated to prevent drowning and other child and teen injuries in other states.

Objectives:
Attendees will learn
1. How to describe policy strategies to prevent open water drownings;
2. How to develop partnerships in preventing open water drowning;
3. How this policy process can be used for other child and teen injury topics.

An Effective Statewide Public Awareness Campaign to Encourage Legislators, Media, and Community Organizations to Support Bicycle Helmets

Sarah Denny, MD; Mike Gittelman, MD; Melissa Wervey Arnold, BSJ; Hayley Southworth, MS

Background:
Bicycle helmets can reduce the risk of brain injury by up to 88%, but studies estimate that only 15-20% of children in the state of Ohio wear them. The Ohio Chapter of the American Academy of Pediatrics (OAAP) Bike Helmet Week campaign, "Put a Lid on It", was developed to build a coalition, educate the public on the importance of wearing bike helmets, distribute bike helmets to those children in need, and increase awareness of helmet safety among legislators.

Methods:
The OAAP spearheaded a coalition of statewide groups to participate in a week long bicycle helmet campaign. Key stakeholders were identified and invited to participate, including law enforcement, parks and recreation, biking groups, state and local health departments, health educators and pediatricians. The OAAP provided partners with various resources including helmets, measuring tapes, helmet stickers, toolkits with statistics and brochures and assistance with media and legislative involvement. In return, partners were asked to hold a bicycle safety event during our state's designated bicycle helmet week. Grants were obtained to purchase helmets for distribution and hire a marketing professional.

Marketing funds were used to develop toolkits, a Facebook page, and Facebook advertisements targeting parents of children < 15 years. Messaging was sent out through the coalition networks, state legislators, and radio, print and TV media were notified about local events. Legislators were contacted and given additional information in an effort to gain legislative support for future bike helmet legislation.

Results:
The 2013 "Put a Lid on it" included 100 coalition partners across Ohio and over 100 events during or around Bike Helmet Awareness Week. A total of $20,500 was received in grant money to provide over 4,000 bike helmets, distributed by the coalition in over 40 Ohio counties. In 2013 it is estimated that over 12 million people were reached with the message between print, TV, radio and social media by this campaign. At least 5 legislators either participated in an event or put out a release about the importance of helmets. Helmet legislation was introduced in the Ohio Senate with OAAP recommendations.

Conclusions:
The "Put a Lid on It" campaign effectively developed partnerships throughout the state to promote statewide bicycle helmet use by children < 15 years of age. Funds obtained by grants helped to support helmet distribution, media campaign and legislator packets/participation. This successful template could be used by other states for other injury prevention efforts to increase attention and drive legislative efforts on many different injury prevention issues.

Objectives:
Attendees will learn:
1. How to develop partnerships in the community to increase injury prevention awareness;
2.How to develop a successful media campaign;
3.How to use strategies to engage local lawmakers in the mission to prevent injuries in children.

CDC-Funded Injury Research Centers: A High Yield Investment

Kyran Quinlan, MD, MPH; Joyce Pressley, PhD, MPH; Andrea Gielen, ScD, ScM; Tina Creguer, BA; Jeffrey Coben,MD; Lisa Roth; Meghan Shanahan, PhD

Background:
Injury is the leading cause of death of children in the United States. The Centers for Disease Control and Prevention, the lead federal public health agency, has made significant investment in advancing an understanding of the epidemiology and prevention of child injury. The CDC currently funds 11 Injury Control Research Centers across the country. The experiences and challenges demonstrated through research, education and programming at many of those centers offer a bases from which childhood injury prevention efforts can grow.

Methods:
Six of the 11 Centers will share information about their experiences and methods of operation. Together their efforts will provide insight into major areas of focus, the range of outreach and educational activities as well as significant current research projects. The injury center at Johns Hopkins University will provide an overview of their center and efforts to "Close the gap between research and practice." The center at W. Virginia will discuss a focus on injury issues related to underserved in Appalachia.

The newly funded center at Columbia will describe efforts in creating infrastructure for activities around research, training and education, and outreach. The Michigan center will provide details regarding their core areas of outreach, education, statistics and research. The Iowa center will discuss the fruitful partnership between the CDC-funded center and the IFCK site. The North Carolina ICRC will present on how, after 26 years since its creation, it continues to strive to affect change at the state, national, and international level.

Results:
The ICRC presentations will open the door for conversation and partnership possibilities between Injury Prevention Specialists.

Conclusions:
Partnerships and Coalition building through the ABCs and Injury Prevention Model developed by Dr. Barbara Barlow have demonstrated the ability to make a difference at the local level, and nationally among Injury Free Coalition for Kids members. This panel can provide a foundation for partnerships between ICRC centers and Injury Free sites.

Objectives:
Attendees will learn:
1. About the system of CDC-funded Injury Control Research Centers in the United States and the focus areas of each of the attending Centers;
2. How an ICRC is administered and how the activities of the ICRCs are integrated into both the university and the community;
3. To Identify opportunities for collaboration with ICRCs on injury prevention activities.

Global Child Injury Prevention

Cinnamon A Dixon, DO, MPH

Background:
We have long known that injury is a leading cause of death in children in high-income countries (HIC). However, with increased globalization, advancements in other areas of child health and improvements in data collection, it is increasingly clear that injury is a leading cause of child death and ill-health in low-income and middle-income countries (LMIC). The purpose of this presentation is to provide US-based injury experts with the basic understanding of the burden of global child injury and to create a framework by which global child injury prevention is considered.

Methods:
The presentation will discuss the scope of child injury in the global context; identifying epidemiologic trends based on age, gender and social/regional determinants. Key obstacles and priorities within child global injury prevention will be explored. Examples of effective in-country injury interventions and high-level international child injury capacity building references will be shared.

Results:
At the conclusion of the presentation, participants will understand the association between globalization and

child injury, recognize some of the main challenges and opportunities within global injury prevention, and have increased insight as to effective global child injury prevention strategies and capacity building initiatives.

Conclusions:
Ideally, participants will be empowered to support and/or become more involved child injury prevention in the global setting.

Objectives:
Attendees will learn:
1. How to understand the global burden of child injury in our changing world;
2. How to describe obstacles and priorities within global child injury prevention;
3. How to recognize examples of effective prevention interventions and the need for increased global child injury prevention capacity building.

The Bloomberg Global Road Safety Program: Reducing Road Traffic Fatalities and Injuries Through The Implementation of Evidence-Based Interventions

Kelly Larson, MPH

Background:
Each year, 1.24 million people are killed on the world's roads and an additional 20-50 million sustain non-fatal injuries. Almost half of all road traffic fatalities are among vulnerable road users - pedestrians, motorcyclists and bicyclists. Road traffic injuries are currently the 8th leading cause of death worldwide, and unless action is taken, the World Health Organization anticipates road traffic injuries will rise to the 5th leading cause of death by 2030. According to to the Global Burden of Disease 2004, road traffic injuries are 14th leading cause of death for children 0-4 years, 2nd for 5-14 year olds and the leading cause of death for 15-29 year olds.

Methods:
In order to reduce road traffic fatalities and injuries, Bloomberg Philanthropies has invested in a 5-year, $125 million global road safety program. The program targets 10 low- and middle-income countries that make up almost half of all road traffic fatalities annually. Supporting six international partners, Bloomberg Philanthropies and its partners are working with non-governmental and governmental organizations to implement proven, evidence-based interventions that will save lives. They include: increased seat-belt and helmet use, decreased speed and drinking and driving, sustainable urban transport and improvement of high risk roads.

Results:
Since the program's inception 1.6 billion people are covered by strengthened road safety laws; over 13,300 professional have been trained on road safety interventions, including police and public health officials; over 5,500 miles of high-risks roads have been assessed and improvements recommended. In Lipetsk, Russia following strong social marketing campaigns and increased police enforcement, seat-belt use has risen from 48% in 2010 to 75% in 2010. In Brazil, a national law in 2011 allowed for speed camera installation without public announcing the exact location, enhancing police efforts to control speed. In Phnom Penh, Cambodia, drinking and driving rates dropped from nearly 10% in 2010 to 0% in 2012 following strong police enforcement. In Vietnam, helmet use has nearly doubled to 90% since their successful 2007 national helmet law.

Conclusions:
Road traffic fatalities are preventable. By implementing evidence-based, proven interventions, such as increased helmet and seat-belt use, decreased speed and drinking and driving, improving high risk roads and moving people out of cars and into sustainable urban transportation, road traffic crashes and therefore deaths and injuries can be reduced. Through strong road safety legislation, enhanced professional training, particularly of police on enforcement, improved infrastructure, hard hitting mass media campaigns, support of advocacy for effective implementation of road safety laws and monitoring and evaluation of activities, we can and have saved thousands of lives.

Objectives:
Attendees will learn:
1. How to understand the global burden of road traffic injuries;
2. How to identify proven, evidence based road safety interventions that will save lives;
3. How key interventions being implemented in 10 low- and middle income countries and their impact on road traffic fatalities and injuries.

Middle East Child Injury Prevention Community Programme

Tracy Fountain

Background:
Back to Basics UAE is a social venture which was initiated in 2008 to generate awareness across the United Arab Emirates towards Child Injury Prevention. A small amount of funding was provided by the government to kick start the programme and the rest was personally funded by founder Tracy Fountain a UK citizen, residing in the United Arab Emirates for 15 years. The motivation to launch the programme was due to the high volume of severe injuries across the region and a lack of community awareness towards child safety. Lack of available data has restricted the programme and to this day we still do not know the prevalence of child injury in the UAE. The extent of child injuries can be put down to a number of factors: a rapid growth of infrastructure, lack of safety legislation, no community outreach or education plus a huge reliance on unskilled domestic staff from low income countries.

Methods:
Back to Basics set out to target parents and domestic staff with educational workshops on child injury prevention and paediatric first aid. The workshops were developed in Arabic, English, Tagalog and Sinhalese. Attention was paid towards cultural barriers, linguistic and literacy factors, to ensure the key messages of the campaigns and workshops were met. 4,500 parents and caregivers were trained separately and surveys were conducted on both sample groups to gauge the level of knowledge prior to the training. The majority of domestic staff did not know the number to call for an ambulance, a high percentage of parents were also unaware. More than 85% of the domestic staff could not swim yet a high proportion supervised young children around swimming pools.

Results:
Since the pilot phase of the workshops, Abu Dhabi Health Authority has adopted the programme and by the end of 2013 one hundred Doctors and Pediatric nurses will be trained as ambassadors in Abu Dhabi to launch injury prevention programmes through their hospitals. In addition the recently passed Wahdeema's law has led to a UAE wide Child Protection programme under the Ministry of Interior. Through this department we will appoint 50 more ambassadors under the patronage of HH Sheikh Saif bin Zayed Al Nahyan, Deputy Prime Minister and Minister of Interior. Across the seven Emirates these ambassadors will be responsible for community initiatives within their Emirate and campaigns / workshops will be required to be delivered, with details of the initiatives fed through a portal to monitor their performance. Within this portal they will also have access to materials and documents to expand their own knowledge.

Conclusions:
Since the training we now intend to gather data from the candidates to find out if they have used their skills and what changes they have made to their home environments. We will also use these candidates to generate awareness through their community.

Objectives:
1. Recognize the problem of child injury exists in the UAE;
2. Learn preventative measures (behavioral & practical);
3. Learn how to respond with best practice when an injury occurs.

There's No Place Like Home: Implementation of a Home Safety Device Program

Jane Harrington,MSc; Tanya Charyk Stewart, MSc; Lisa Wolfs, BScN

Background:
Injuries are the number one health concern for children. Each year nearly 3,000 children come to the Children's Hospital, London Health Sciences Centre for treatment of an injury that occurred in the home. This is the most common reason children visit our Emergency Department. Children are injured in falls by slipping, tripping, falls down stairs and off furniture. Although many parents feel home is the safest place for their children, they are at a significant risk for injury. Children's Hospital, Trauma Program recognized the need for home safety education as well as products to safely equip the home.The aim was to provide a primary prevention program to new families aimed at reducing the incidence of home injuries in London and surrounding area. This is the first hospital-based home injury prevention program of its kind in Ontario.

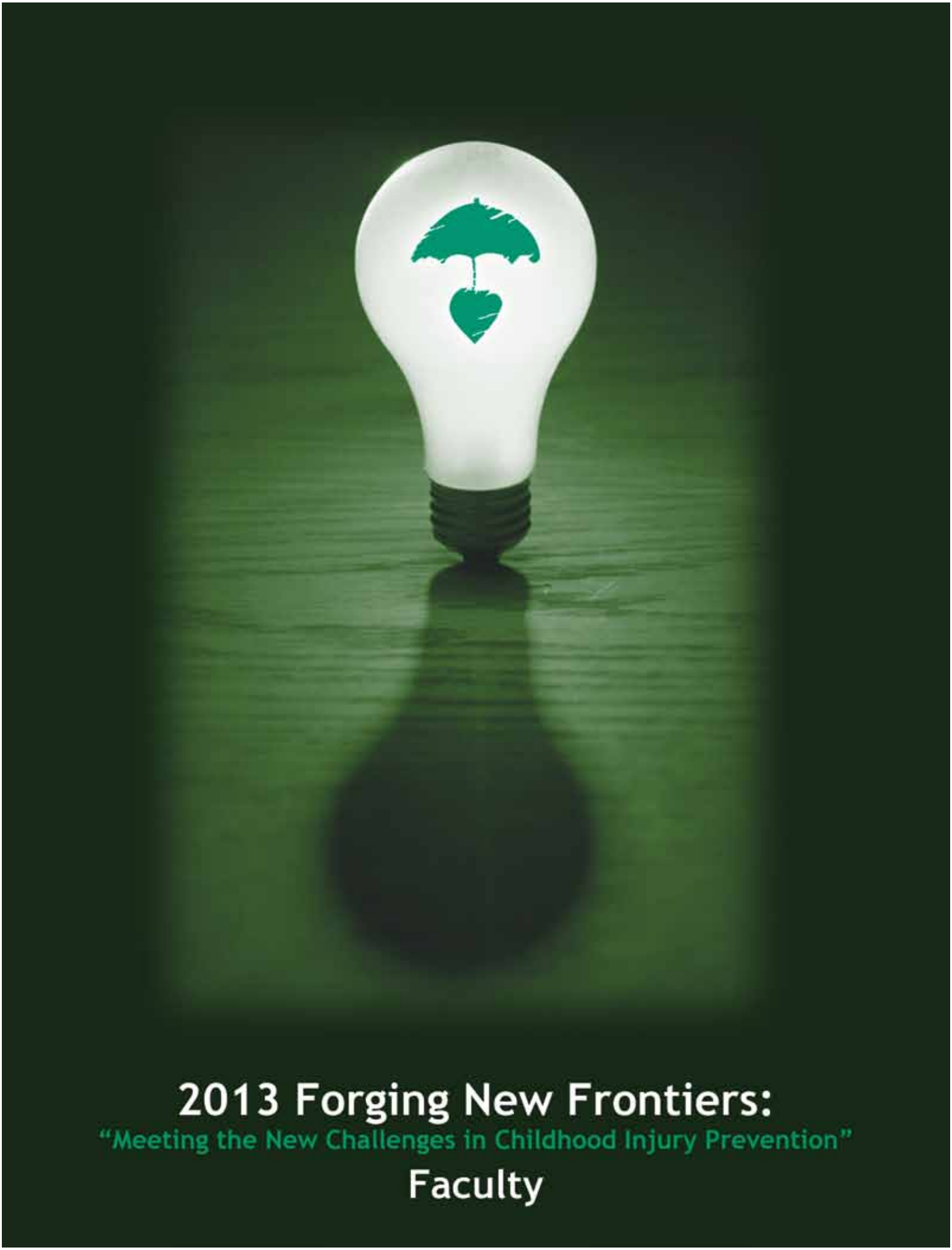
Methods:
Solidified funding through the Children's Health Foundation Grant for Injury Prevention. Setting - Regional Birthing Centre and Level I Paediatric Trauma Centre Inclusion criteria - first time families or infants under 18 months of age who visit the Emergency Department for a home related injury. The program provides education and home safety devices at the mothers' pre admit appointment as well as reach families in other children's care areas; including Mother

Baby Care Unit, Neonatal Intensive Care Unit and the Paediatric Emergency Department. Midwives, Children's Aid Services, and public health are also involved. There is a follow up with families via telephone or email survey 6 months post delivery.

Results:
Implementation of the home safety device program in multiple areas of a birthing centre/trauma centre in April 2013. The majority of the kits were distributed in the obstetrical pre admit clinic. In the first month of the program, 230 home safety device kits were given away to first time families. Based on previous data we should reach approximately 1500 new families per year and 200 infants in the Emergency Department. Anecdotal response from families has been encouraging. Media uptake of the program was also positive and has led to parents and patients asking more questions and receiving the education.

Conclusions:
Evaluation is ongoing, and initial positive response from families demonstrates that the implementation of an innovative home safety device program is a beneficial and positive approach to helping prepare first time families for the arrival of their baby.
Our goal is to ultimately reduce the incidence of home related injuries to infants. Working within an extremely busy hospital setting against competing priorities can have its challenges. Working with nurses and other healthcare professionals to create a reasonable approach for education allows for a more comprehensive and effective program.

Objectives:
Attendees will learn:
1. How to identify a need for injury prevention; programming utilizing quantitative and qualitative data
2. How to design a injury prevention program to address the leading type of injury for children under the age of 5 within the community using existing infrastructure of a birthing centre/trauma centre;
3. How to use a multidisciplinary approach to provide home safety devices and education to new families.



2013 Forging New Frontiers:

"Meeting the New Challenges in Childhood Injury Prevention"

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Injury Free Coalition for Kids of Chicago, Principal Investigator
Injury Free Coalition for Kids, Board of Directors

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

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

Daniel W. Webster, ScD, MPH
Johns Hopkins Center for Gun Policy and Research Director
Johns Hopkins Center for the Prevention of Youth Violence
Deputy Director for Research
Professor of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health, Baltimore, MD

Program Committee

Barbara Barlow MD
Committee Chair
Mailman School of Public Health, Columbia University
Injury Free Coalition for Kids, National Program Office
Injury Free Coalition for Kids Executive Director and Founder

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Program Manager
Injury Prevention and Trauma Services
Riley Hospital for Children at Indiana University Health
Injury Free Coalition for Kids of Indianapolis, Program Coordinator

Mike Gittelman, MD
Professor, Clinical Pediatrics
Division of Emergency Medicine
Comprehensive Children's Injury Center
Cincinnati Children's Hospital
Injury Free Coalition for Kids of Cincinnati Principal Investigator

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

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Director of Ambulatory Pediatrics
Hughes Spalding Children's Hospital
Assistant Professor Emory University School of Medicine.
Injury Free Coalition for Kids of Atlanta Principal Investigator

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Committee Co-Chair
Associate Professor of Clinical Pediatrics
Northwestern University's Feinberg School of Medicine
Erie Family Health Center Pediatrician, Chicago, IL
Injury Free Coalition for Kids of Chicago
Injury Free Coalition for Kids, Board of Directors

Science and Publication Committee

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Committee Chair
Injury Prevention Center Director at Rhode Island Hospital
Associate Professor of Emergency Medicine
Associate Professor of Health Services, Policy and Practice
Alpert Medical School of Brown University
Providence, Rhode Island
Injury Free Coalition for Kids of Providence, Principal Investigator
Injury Free Coalition for Kids, Board of Dirrectors

Lois Lee, MD, MPH
Attending Physician , Division of Emergency Medicine Boston Children's Hospital
Assistant Professor Harvard Medical School
Medical Director Pediatric Injury Prevention Program
Injury Free Coalition for Kids of Boston, Principal Investigator
Injury Free Coalition for Kids, Board of Directors

Kathy Monroe, MD
Professor of Pediatrics
Medical Director ED
Childrens Hospital of Alabama
Injury Free Coalition for Kids of Birmingham Principal Investigator

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

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Columbia University Mailman School of Public Health
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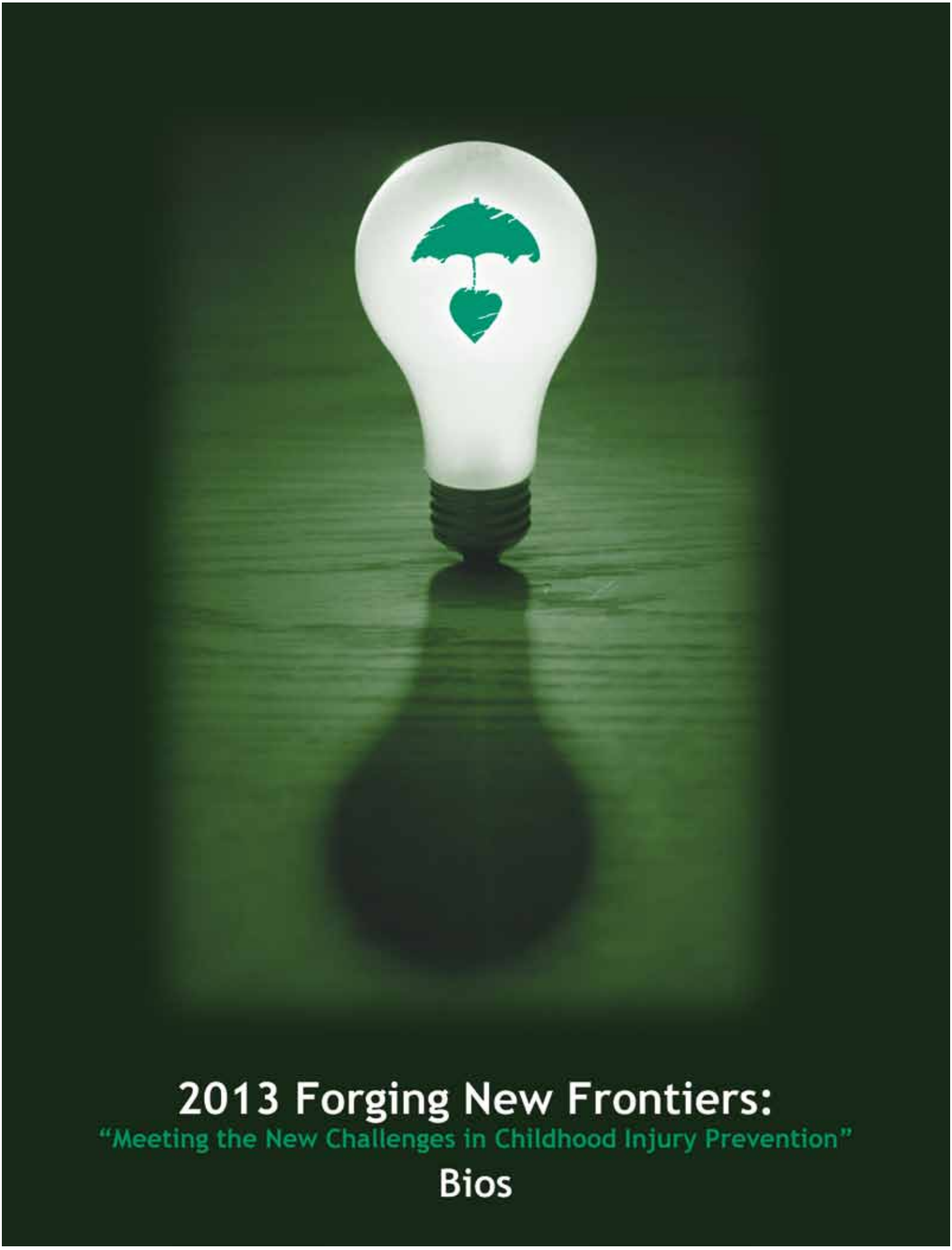


2013 Forging New Frontiers:

"Meeting the New Challenges in Childhood Injury Prevention"

Bios

Katie Amsden, MPH, CHES

Ann & Robert H. Lurie Children's Hospital, Illinois

Katie Amsden, MPH, CHES is a Research and Education Coordinator at Ann & Robert H. Lurie Children's Hospital of Chicago. Ms. Amsden manages several research studies and grants, analyzes data and prepares scientific publications. In addition to her work at Lurie Children's, Ms. Amsden's experience covers a wide range of various public health settings from serving as a health educator to adults in a cardiac rehab program, planning and implementing health fairs, serving as a health coach to individuals with chronic conditions, and caring for elderly dementia-suffering individuals.

Ms. Amsden received her Bachelor of Science degree in Community Health Education from the University of Wisconsin-La Crosse and her Masters Degree in Public Health from the University of Illinois at Chicago.

Brit Anderson, MD

Cincinnati Children's Hospital Medical Center

I am a third year pediatric emergency medicine fellow at Cincinnati Children's Hospital Medical Center. I completed medical school at Northwestern Feinberg School of Medicine and pediatrics residency at Children's Memorial Hospital in Chicago, Illinois. My research interests include injury prevention and advocacy largely because of my experiences in the emergency department. During fellowship I have been involved in projects focused on injury: studying concussions in high school football players and unintentional injuries in young children. I look forward to continuing work in injury prevention throughout my career.

Dr. Barbara Barlow, MD

Executive Director, Injury Free Coalition for Kids National Office

Dr. Barbara Barlow is Professor Emerita of Surgery in Epidemiology at Columbia University Mailman School of Public Health in New York. She is also the Founder and Executive Director of the Injury Free Coalition for Kids, a National Program developed with funding from of the Robert Wood Johnson Foundation of Princeton, New Jersey. Injury Free is a coalition of Injury Prevention Programs in Pediatric Trauma Centers located in major cities in the United States. The Injury Free Program reduces injury through education, construction of safe play areas, and the development and support of safe supervised activities with strong adult mentors. Major injury admissions of community children in Harlem have decreased by more than 60% since the program started in 1988.

The Program and Dr. Barlow have received awards from the American Hospital Association, the American Academy of Pediatrics, the U.S. Department of Transportation, the National Highway Traffic Safety Association, the National Safety Council, the American Trauma Society, the National Association of Public Hospitals, Society of Public Health Educators of the American Public Health Association, Johnson and Johnson Foundation, Allstate Foundation, the Hospital Association of New York, the American Association of Medical Colleges' David E. Rogers Award, the Renaissance Woman Award from the Foundation for Women in Medicine, the Distinguished Career Award from the American Public Health Association Section on Injury Control and Emergency Health Services, and the Sloan Public Service Award from the Fund for the City of New York. Dr. Barlow's research has focused on traumatic injury to children and on injury prevention for the past twenty-five years. She is a former member of the American College of Surgeons Committee on Trauma and the American Academy of Pediatrics Committee on Pediatric Emergency Medicine. Dr. Barlow received a B.A. from Vassar College, an M.A. in Psychology from Columbia University and an M.D. from Albert Einstein College of Medicine where she was elected to Alpha Omega Alpha. Her general surgical training was completed at Bronx Municipal Hospital followed by a Fellowship in Pediatric Surgery at Babies Hospital, Columbia Presbyterian Medical Center.

Tanya Charyk Stewart, MsC

Children's Hospital, London, Onterio, Health Sciences Centre

Tanya is the Injury Epidemiologist for the Trauma Program at LHSC & Children's Hospital. 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 Shaken Baby Syndrome prevention work she is presenting at Injury Free won the Southwest Ontario Local Health Integration Network Quality Award for Population-based Integrated Health Services in 2012.

Celeste Chung, MSW, MPH

Seattle Children's Hospital, Washington

Celeste Chung, MSW, MPH, coordinates a CDC-funded drowning prevention policy project at Seattle Children's Hospital. Celeste leads the development of drowning prevention education and policy advocacy materials. Recently, she led a statewide working group in the development of the Washington State Designated Swim Area Guidelines. She provides technical assistance to communities developing life jacket loaner programs and organizations improving access to swimming in low-income and diverse communities. She is on the leadership team for the Washington State Drowning Prevention Network and provides technical assistance to the Network. Celeste also works on health equity, community outreach, and community benefit.

Jeffrey Coben, MD

West Virginia CDC-Injury Control Research Center

Dr. Jeffrey Coben has been named Interim Dean of the WVU School of Public Health, effective February 1, 2013. Dr. Coben graduated with honors from Springfield College in Springfield, Massachusetts. He is an Alpha Omega Alpha graduate of the University of Pittsburgh, School of Medicine. After graduation, he undertook residency training in emergency medicine and internal medicine at Northwestern University Medical Center. Since 1980, he has maintained continuous certification by both the American Board of Emergency Medicine and the American Board of Internal Medicine.

Dr. Coben's public health career has included previous academic appointments at the University of Pittsburgh, where he founded and directed the Center for Injury Research and Control, and as Assistant Dean at the Philadelphia-based institution that developed into the Drexel School of Public Health.

Dr. Coben has achieved international recognition for his accomplishments in the field of injury prevention and control. He has authored over 100 scholarly works, and is the only individual to ever serve as director of a CDC-supported injury control research center at two different academic institutions (WVU and the University of Pittsburgh). He has served on the Board of Directors of the National Commission Against Drunk Driving, the U.S. Office of Women's Health Advisory Committee for Violence Against Women, and as Senior Scholar-in-Residence for Domestic Violence at the Agency for Healthcare Research and Quality. He has held continuous extramural funding for nearly 20 years to support his injury prevention research, including leading collaborative international research efforts with investigators from New Zealand and Canada. Dr. Coben is a tenured Professor in the Department of Health Policy, Management, and Leadership within the WVU School of Public Health, and in the Department of Emergency Medicine within the WVU School of Medicine. Since joining WVU in 2004, he has served as director of the Center for Rural Emergency Medicine, director of the CDC-supported Injury Control Research Center, and Vice Chair for Research within the Department of Emergency Medicine. He is a member of the West Virginia Domestic Violence Fatality Review Team, a member of the West Virginia Council for the Prevention of Suicide, and a founding board member of the West Virginia Health Improvement Institute. - See more at: http://publichealth.hsc.wvu.edu/pages/Personnel/Faculty/Coben#sthash.bDES0WB3.dpuf

Susan Cohen

Arkansas Children's Hospital

Susan Cohen is the Operations Manager for the Injury Prevention Center (IPC) at Arkansas Children's Hospital. New to the Injury Prevention field, Susan brings over 30 years of development and nonprofit management experience to the IPC. Maximizing the use of community resources to expand outreach and education programs is the focus of her work. Susan holds a Bachelor of Science from the University of Central Arkansas and is a certified child passenger safety technician.

Tina Creguer

University of Michigan Injury Center, Michigan

With more than 20 years of corporate management and marketing experience, Tina Creguer brings a unique set of business and outreach skills to managing the University of Michigan Injury Center. She previously served as Vice President of Marketing Communications for a global publishing company and has a reputation for bringing creativity and effective processes to organizations. Tina provides leadership to the Center's outreach programs, educational events, strategic andfinancial planning, communications, and operations. She also participates as part of the center's Internal Advisory Committee.

Marie Crew, RNC-NIC, BS, CPSTI

Children's Hopital of Birmingham, Child Passenger Safety Resource Center, Alabama

Marie has been a Registered Nurse for 35 years with most of that time as a pediatric and neonatal nurse. She obtained her certification as a High Risk Neonatal Nurse in 1986. Marie began working at Children's of Alabama in 2000 as a Child Passenger Safety Technician and became an instructor a year later. She is now the coordinator for their Child Passenger Safety Resource Center. Her duties include teaching certification classes statewide, providing educational program to parents, caregiver, first responders, healthcare professionals, social workers and community individuals, as well as many administrative duties.

Sarah Denny, MD

Nationwide Children's Hospital/Ohio State University College of Medicine, Ohio

Sarah A. Denny, MD, is an attending physician at Nationwide Children's Hospital in the Emergency Department and Assistant Clinical Professor of Pediatrics at The Ohio State University College of Medicine. She completed her residency in general pediatrics at University of Washington, Seattle Children's Hospital. She is on the Executive Committee of the Council on Injury, Violence, and Poison Prevention for the American Academy of Pediatrics and the Co-Chair of the Ohio Chapter of the American Academy of Pediatrics, Committee for Injury, Violence and Poison Prevention.

She has worked with the Ohio AAP to establish a Bike Helmet Awareness Week, which features a multi-faceted awareness campaign, including social media, legislative advocacy, bike rodeos, television and radio features, and community outreach.

Her interests include injury prevention, advocacy and patient education, specifically related to bicycle helmets and safe sleep. Sarah also works with the pediatric residents on advocacy projects, giving lectures on how to be an advocate for children, especially as it pertains to injury prevention and also helping them to develop their own advocacy projects.

Charles DiMaggio, PhD, MPH, PA-C

Columbia University's College of Physicians and Surgeons and the Mailman School of Public Health, New York

Charles DiMaggio, PhD, MPH, PA-C is associate professor in the departments of anesthesiology and epidemiology at Columbia University's College of Physicians and Surgeons and the Mailman School of Public Health. He is an injury epidemiologist whose NIH and CDC-funded work includes describing and analyzing the epidemiology of pediatric pedestrian injuries for the New York City Department of Transportation, establishing a surveillance program to track and explain the behavioral health effects of the terrorist attacks of September 11th, 2001 in New York, and investigating the developmental and behavioral effects of anesthesia on young children. He has an active interest in the application of epidemiological approaches like Bayesian and spatial models to large data sets, and teaches introductory and advanced methods using the SAS and R programming languages. Dr. DiMaggio's previous positions include chief research scientist with the Nassau County, NY, Department of Health where he worked on a variety of projects including bioterrorism preparedness, syndromic surveillance, and health disparities, and as chief physician assistant and director of research for the emergency department at Mt. Sinai School of Medicine at Elmhurst Hospital Center in NY.

Cinnamon Dixon, DO, MPH

Cincinnati Children's Hospital Medical Center, Ohio

Cinnamon Dixon, DO, MPH, is an assistant professor of pediatrics and emergency medicine attending physician researcher at Cincinnati Children's Hospital Medical Center. Appointed in the Divisions of Emergency Medicine and Global Health, her interests include global pediatric injury prevention and trauma care, and the development of novel mobile interventions for child safety. As a former Pediatric Emergency Medicine Global Health Research fellow, a World Health Organization (WHO) intern and a Columbia University Mailman School of Public Health Systems Improvement of Emergency Care in Ghana scholarship awardee, Dr. Dixon has had multiple international clinical and research experiences, most notably in Central and South America and Africa. Dr. Dixon is the lead author for the American Academy of Pediatrics Global Child Health Education Modules Project on Injury/Trauma. She is also an active consultant for the WHO Department of Violence and Injury Prevention where she has co-lead and authored multiple global injury prevention modules and factsheets, and most recently developed the WHO Child Injury Prevention Short Course.

Tracy Fountain

Founder Back to Basics UAE, Dubai

Tracy is a British citizen residing in the UAE for the past 15 years. Her expertise is in Training & Development and she is currently studying for a Masters in Advanced Child Protection. She developed the first community, government endorsed, Child Injury Prevention programme which considered linguistic, cultural and literacy factors associated with the region. In recognition of this Tracy gained support from the Acumen Fund through winning the Acumen Fund Social Entrepreneur Award in Dubai, 2012.

Tracy's programme has now been adopted at State level by the Ministry of Interior Child Protection Centre and funding has been made available to recruit and Train 50 Injury Prevention Ambassadors within each of the seven Emirates of the UAE, who will then provide campaigns and education to parents and caregivers across the region.

Barbara Gaines, MD

Trauma and Injury Prevention, Injury Free Coalition for Kids of Pittsburgh (Children's), Pennsylvania

Principal Investigator, Injury Prevention Program, Children's Hospital of Pittsburgh, Pittsburgh, PA
Barbara A. Gaines, MD is the Principal Investigator for the Children's Hospital of Pittsburgh Injury Prevention Program. She is a pediatric surgeon and assistant professor at University of Pittsburgh School of Medicine. She has a Bachelor of Arts from Brown University and a medical degree from University of Virginia, Charlottesville, VA. Dr. Gaines serves as Assistant Director of the Benedum Trauma Program at Children's Hospital of Pittsburgh. In addition to her administrative responsibilities at Children's Hospital of Pittsburgh, she teaches medical students, pediatric surgery residents and pediatric surgery fellows in the outpatient and inpatient settings. Dr. Gaines academic and community outreach interests include children injury prevention.

Andrea Gielen, ScD, ScM

Johns Hopkins Center for Injury Research and Policy at the Johns Hopkins Bloomberg School of Public Health, Maryland

Andrea Carlson Gielen, ScD, ScM is Professor and Director of the Johns Hopkins Center for Injury Research and Policy at the Johns Hopkins Bloomberg School of Public Health. Her professional career has included work as a research analyst at the National Institutes of Health, a community health educator at the Maryland Department of Health and Mental Hygiene, and as an academic researcher at Johns Hopkins. Her research focuses on developing and testing interventions to prevent child injury and domestic violence, especially as they affect low-income, urban populations. Dr. Gielen's research team created national model health education programs, including a hospital based and mobile children's safety resource center that provides tailored education and low cost safety products to families. Dr. Gielen has published more than 150 journal articles, and she edited the first textbook on the application of behavioral sciences to injury and violence prevention, and a forthcoming book on health behavior change. She has served on technical advisory boards and as a consultant to governmental and private national and international organizations such as the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the World Health Organization. She teaches courses in program planning for health behavior change and injury prevention. Dr. Gielen has received the Distinguished Career Award from the American Public Health Association and the Research Laureate Award from the American Academy of Health Behavior, as well as awards for her work in home safety and urban health.

Mike Gittelman, MD

Cincinnati Children's Hospital Medical Center, Ohio

Mike Gittelman, MD, is a pediatric emergency room physician at Cincinnati Children's Hospital and he is a Professor of Clinical Pediatrics at the University of Cincinnati School of Medicine.

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.

Pamela Goslar, Ph.D.

Prevention and Outcomes Research, St. Joseph's Hospital and Medical Center, Arizona

Pam Goslar reports an "eclectic" past. She earned a bachelor's degree in education from Cameron University (Lawton, OK), a master of accountancy from DePaul University (Chicago, IL) and a Ph.D. in Epidemiology from the J. Norman Arnold School of Public Health, University of South Carolina (Columbia, SC). Currently she is Program Director, Prevention and Outcomes Research at St. Joseph's Hospital and Medical Center an American College of Surgeons verified Level I Trauma Center in Phoenix, Arizona. With 20 years experience in Injury Prevention and Epidemiology she has presented at the national and state levels in these areas and on the use of data to design, implement and evaluate programs. She has been published in the Journal of Trauma, Neurology, Journal of Neurosurgery, American Journal of Surgery, American Surgeon, and Ethnicity & Disease.

Three things you would probably never guess about me – (1) in high school I worked in the pits at the Phoenix International Raceway. (2) I was a champion badminton player in college. (3) I make the worst coffee. In fact, I'm the only female in any of the offices where I have worked (and in my own home) asked NEVER to make coffee!

Holly Hanson, MD

Cincinnati Children's Hospital Medical Center, Ohio

Dr. Hanson received her Bachelor of Science from Mount Vernon Nazarene University in Mount Vernon, Ohio in 2006. She graduated with her Doctor of Medicine degree, in 2010, from Northeastern Ohio Medical University. She then went on to complete pediatric residency at Cincinnati Children's Hospital Medical Center and is now a fellow in Pediatric Emergency Medicine at Cincinnati Children's Hospital Medical Center. She is a member of AOA, the Gold Humanism Honor Society, and the AAP. Her research interests include sports injuries and traumatic brain injury.

Jane Harrington, MsC

Children's Hospital, London Health Sciences Centre, Onterio, Canada

Jane is currently an Injury Prevention Specialist in the Trauma Program at Children's Hospital, London Health Sciences Centre (LHSC) and is the Injury Free Coalition for Kids Program Coordinator for this site. She is a coordinator of the IMPACT (Impaired Minds Produce Actions Causing Trauma) program. She is a graduate of the University of Western Ontario with an Honors Bachelor of Science degree in Microbiology & Immunology and the University of London/London School of Hygiene and Tropical Medicine with a Masters of Science degree in Infectious Diseases. During her schooling, Jane worked at LHSC pediatric and adult emergency Department and learned first hand the devastation of traumatic injury. She is the Chair of the Not By Accident Committee, past chair of the South West Injury Prevention Network and sits on many community and inter-hospital committees dedicated to reducing injury. Jane is a strong advocate for pediatric injury prevention and has worked to implement programming within the hospital, such as The Period of Purple Crying Program for shaken baby awareness, Bicycle Helmet Giveaway Program in the ED and the Home Safety Device Program for first time parents.

Phyllis Hendry, MD

Univiersity of Florida Health Science Center, Florida

Phyllis L. Hendry, MD completed her pediatric residency at Louisiana State University Medical Center in Shreveport. Her pediatric emergency fellowship training was at the University of Florida College of Medicine/Jacksonville. Dr. Hendry is a tenured Associate Professor of Emergency Medicine and Pediatrics at the University of Florida Health Science Center/Jacksonville. She served as Director of Pediatric Emergency Services at Shands Jacksonville from 1993-2005. Dr. Hendry currently serves as Assistant Chair for Research in the Department of Emergency Medicine and works clinical shifts in the Shands Jacksonville Pediatric Emergency Department.

Dr. Hendry's past accomplishments include serving as a medical consultant and medical director for Community PedsCare, a pediatric palliative and hospice program; state Medical Director for the Florida Department of Health's, Emergency Medical Services for Children (EMSC) program from 1999-2005; associate editor of the textbook The Clinical Practice of Emergency Medicine by Lippincott Williams and Wilkins for two editions; and contributor to the Advanced Pediatric Life Support and Pediatric Education for Prehospital Professionals textbooks. She is the principal investigator for the Pediatric Emergency Care Safety Initiative (PECSI) Project and several ongoing clinical trials. Her areas of research interest include EMS data systems, pain management, injury prevention, mental health emergencies, faculty development, bereavement and end-of-life care.

Michael Hirsh, MD

UMASS Memorial Children's Medical Center, Massachusetts

Dr. Michael Hirsh was born in New York City. After attending Bronx High School of Science, he matriculated at Columbia College of Columbia University where he obtained a BA in 1975. He graduated summa cum laude and Phi Beta Kappa. He then went to Harvard Medical School where he graduated in 1979. He then began surgical residency training at Columbia Presbyterian University Medical Center from 1979 to 1984 and completed a pediatric surgical fellowship at St. Christopher's Hospital for Children of Temple University in Philadelphia in 1986. Thereafter, he spent six years at the University of Massachusetts Medical Center and from 1988 to 1992 was co-director of the Trauma Center there. He also was co-director of the Pediatric Critical Care Unit. In 1992, Dr. Hirsh left Worcester, Massachusetts, to take a position first at Allegheny General in Pittsburgh, PA. He worked there from 1992 to 1997. Dr. Hirsh transferred his work to Mercy Hospital of Pittsburgh where he worked until he returned to University of Massachusetts Memorial Medical Center in 2000. He is a Professor of Pediatrics and Surgery at the University of Massachusetts Medical School and Director of the Divisions of Pediatric Surgery and Trauma of the University of Massachusetts Memorial Children's Medical Center. He also became Associate Director of Pediatric Critical Care. Dr. Hirsh has been Co-Director of the Trauma Program as well and served as overall Trauma Director for patients of all ages from 2004-2007. During this time, UMMHC received its accreditation as a Level 1 Adult and Pediatric Trauma Center (2005). Dr. Hirsh currently serves on the Board of the Injury Free Coalition, a consortium of 43 Injury Prevention sites based at Level 1 Pediatric Trauma Centers, as its Past President (2008-2010).

He is the co-founder of the Goods for Guns Coalition of Worcester that has been organizing a yearly Gun Buy-Back since 2002, co-sponsored by the Worcester Police Department, the Department of Public Health, The Worcester District Medical Society and UMass Memorial Health Care's Injury Prevention Program. He also is serving as the President of the Worcester District Medical Society. In 2010, he was appointed Surgeon-In-Chief for the UMassMemorial Children's Medical Center. On April 15, 2012, Dr. Hirsh was appointed by City Manager, Michael O'Brien, as the Acting Commissioner of Public Health for the City of Worcester. He has been happily married for 33 years to wife, Julianne and has 2 children, Scott, 29 and Esty, 24.

Elizabeth Iron, MD

Childrens Hopital of Birmingham, Alabama

Elizabeth Irons recently completed her residency in Pediatrics at the University of Alabama at Birmingham. During residency she was actively involved in teen driving research. Elizabeth was part of a statewide teen driving committee and participated in the yearly Teen Driving Summit in Jefferson County, Alabama. As part of a grant from the state AAP, she traveled to multiple cities in the state to talk with pediatricians about the dangers associated with teen driving. She is currently in private practice in Alabaster, AL.

Garry Lapidus PA-C, MPH

Connecticut Children's Medical Center and Hartford Hospital, Connecticut

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

Kelly Larson, MPH

Bloomberg Global Road Safety Program, New York

Kelly Larson directs the 5-year, $125 million Bloomberg Global Road Safety Program and provides technical assistance and support to implementing partners of the Bloomberg Initiative to Reduce Tobacco Use. Prior to joining Bloomberg Philanthropies in August 2008, Kelly managed local, national, and international public health programs with the New York City Department of Health and Mental Hygiene, National Hemophilia Foundation, the United Nations Development Program and served as a Peace Corps Volunteer on a remote outer island in the Federated States of Micronesia.

Lois Lee, MD, MPH

Children's Hospital Boston, Massachusetts

Lois K. Lee, MD, MPH is a board certified pediatric emergency medicine specialist with a clinical and research focus on pediatric trauma care and injury prevention. She graduated magna cum laude from Emory University, where she majored in chemistry and music, and she received her M.D. from the University of Pennsylvania School of Medicine. She then completed her internship and residency in pediatrics at the Children's Hospital of Philadelphia. It was there that she first developed an interest in pediatric injury prevention after working on a research project about childhood injuries and deaths related to the use of air bags in cars. She came to Boston in 1999 for her subspecialty fellowship training in pediatric emergency medicine at Children's Hospital Boston. During her fellowship she also completed a Masters of Public Health (MPH) at the Harvard School of Public Health. She is a staff physician in the Emergency Department at Children's Hospital Boston, and she has continued to pursue her interest in pediatric trauma care and injury prevention with her teaching, research, and advocacy. In these roles she promotes child passenger safety, home safety, and is advocating for legislation for the primary seat belt bill in Massachusetts.

Karin A. Mack, PhD

Emory University, 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.

Michael Mello, MD, MPH

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

Dr. Mello is Director of the Injury Prevention Center at Rhode Island Hospital/Hasbro Children's Hospital and a practicing board certified emergency medicine physician with 24 years of clinical experience. He is an Associate Professor of Emergency Medicine and Associate Professor of Health Services, Policy and Practice at Brown University. He co-directs the medical school's required clerkship in community health and has additional experience as an educator as Director of the Collis Injury Prevention Research Fellowship for physicians. His research has focused on unintentional injury prevention and behavioral modifications to reduce injury occurrence and has received PI research support from CDC, NIH, and several foundations.

He is an associate editor for Academic Emergency Medicine, past national president of the Society for Advancement of Violence and Injury Research, and current President-elect of Injury Free Coalition for Kids.

Marlene Melzer-Lange, MD

Children's Hospital of Wisconsin, Wisconsin

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.

Heather Mitchell, MD

University of Alabama at Birmingham, Alabama

Heather Mitchell, MD completed her pediatric residency and emergency medicine fellowship at the University of Alabama at Birmingham. She has just started as an Assistant Professor of Pediatrics at the University of Alabama at Birmingham and is a Pediatric Emergency Medicine attending in the Children's Hospital of Alabama Emergency Department.

Kathy Monroe, MD

University of Alabama at Birmingham, Alabama

Kathy Monroe is Professor of Pediatrics at the University of Alabama in Birmingham. She is the Medical Director of the Pediatric Emergency Medicine Department in the Childrens' Hospital of Alabama and is the Co-Director of the Injury Free Coalition for Kids of Birmingham Alabama. She serves as the Alabama AAP chair of the Injury Prevention committee. She is actively involved in the education of pediatric residents specifically in the injury prevention areas and is the Co-Residency Research Support Committee Chair. For the past three years, she has been a member of the Alabama Child Death Review Team. She has been a research mentor for NIH summer medical student research program and is co-sponsor for the medical school pediatric interest group.

Dina Morrissey, MD, MPH, CPSTI

The Injury Prevention Center at Rhode Island Hospital, Rhode Island

Dina Morrissey, MD, MPH is the program coordinator for community activities at the Injury Prevention Center at Rhode Island Hospital and Hasbro Children's Hospital. She coordinates the Injury Free Coalition for Kids in Providence program, the Safe Kids Rhode Island 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. She has practiced as a primary care pediatrician and recently earned an MPH from the University of Massachusetts Medical School. Dr. Morrissey is also a certified child passenger safety technician instructor.

Wendy J. Pomerantz, M.D, MS

Children's Hospital Medical Center in Cincinnati, Ohio

Wendy J. Pomerantz, M.D., M.S., FAAP 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 is a Pediatric Emergency Medicine Physician with a faculty appointment as a Professor of 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. Her interests include injury and poison prevention, ATV and motor bike injuries, education, and geographic information systems. She has published many peer-reviewed articles in the fields of injury and poison prevention. She one of the Co-directors of Injury Free Coalition for Kids in Greater Cincinnati and serves on the Ohio EMS Board. In addition, she serves as the Ohio EMSC Chairperson, as a member of AAP State of Ohio Committee of Injury and Poison Prevention, as a member of the Cincinnati American Red Cross Medical Assistance Team, and as a member of the Greater Cincinnati Safe Kids Coalition. She is also a member of the American Academy of Pediatrics Section of Injury Violence and Poison Prevention Executive Committee.

Joyce Pressley, PhD, MPH

The Mailman School of Public Health, Columbia University, New York

Joyce Pressley, PhD, MPH, is an Associate Professor of Epidemiology and Health Policy and Management at Columbia University Medical Center and Co-director of the Outreach core for the Columbia University CDC Injury Control Research Center. She is a member of the Committee on Occupant Protection of the Transportation Research Board of the National Academies, a Governing Councilor of the American Public Health Association (APHA), and Chair of the 2013 Program Committee for APHA's Injury Control and Emergency Health Services section and Director of the Department of Epidemiology's master's level internship and thesis programs.

Dr. Pressley's experience in research and community-based injury prevention programs crosses the disciplinary boundaries of health policy, epidemiology, emergency medicine, critical care, economics, health planning and management. She has experience in strategic planning at the local city, county and regional levels gained through her role as a former Director of Emergency Medical Services for an 11 county EMS planning and implementation program whose goals included improving access, communication and public education at the community level and identifying deficiencies and planning for the certification of regional critical care units for trauma, burn and poisoning.

Her current research interests include evaluating the impact of legislative regulatory policies and laws on unintentional injury, motor vehicle safety, technological advances for motor vehicle occupant protection, injury-related health disparities and injury in vulnerable populations. She has published in the areas of motor vehicle safety, home safety including window falls, the impact of injury-related laws, injury disparities, and injury in vulnerable populations. She previously served as the principal investigator of an NIH-funded, injury-related health disparities research core, Director of Injury Free Health Policy and Population Studies and chaired the Injury Control and Emergency Health Services Section of the American Public Health Association.

Kyran Quinlan, MD, MPH

Erie Family Health Center/Feinberg School of Medicine at Northwestern University, Illinois

Dr. Kyran Quinlan is a general pediatrician who chairs the executive committee of the American Academy of Pediatrics Council on Injury Violence and Poison Prevention. He trained in child injury epidemiology and prevention at the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control. His published works include a study showing that the majority of child passengers killed by drinking drivers die while riding in the same vehicle with them. He has published numerous studies on child safety and has been successful in helping to protect children through community advocacy efforts.

He received an MD from Loyola University in Chicago, completed his pediatric residency training at the University of Chicago, and received a Masters in Public Health at the University of Illinois at Chicago. He recently completed two years as a Physician Advocacy Fellow of the Center on Medicine as a Profession working on child pedestrian safety in low-income areas on the south side of Chicago. He practices general pediatrics at Erie Family Health Center and is an Associate Professor of Clinical Pediatrics at the Feinberg School of Medicine at Northwestern University.

Alison Riese, MD

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

Alison Riese, MD is currently completing a two year research fellowship with the Injury Prevention Center at Rhode Island Hospital in Providence, RI. She received her medical degree from University of Massachusetts Medical School and completed Pediatrics residency at the Hasbro Children's Hospital/Brown University Program. Her research interests involve youth violence, particularly increasing screening and counseling in primary care as well as strengthening support for victims post-injury. She received an AAP CATCH grant during residency and an Academic Pediatrics Association Young Investigators Award for her current research. She works clinically in the Hasbro Emergency Department and is pursuing her MPH at Brown.

Steven Rogers, MD

Connecticut Children's Medical Center and Injury Prevention Center, Connecticut

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.

Lisa Roth

CDC-Injury Prevention Research Center, Iowa
Blank Children's Hospital, Iowa

Lisa Roth began working as a community outreach educator at Blank Children's Hospital in February 2004. She coordinated the Injury Free Coalition for Kids of Des Moines from 2004-2008 and returned to that position in 2011. During her time away from Blank Children's Hospital she worked as the research coordinator at the University of Iowa Injury Prevention Research Center. She holds her Bachelor of Science degree in Community Health Education from Iowa State University. Lisa is also a certified CPS technician instructor and was instrumental in implementing the statewide CPS training program. Her primary responsibilities include developing, implementing and evaluating injury prevention outreach activities in the Greater Des Moines area and statewide.

Judy Schaechter, MD, MBA

University of Miami Miller School of Medicine, Florida

Judy Schaechter, M.D., M.B.A., is associate professor and interim chair of the Department of Pediatrics at the University Of Miami Miller School Of Medicine. She also serves as chief of service at Holtz Children's Hospital at Jackson Memorial Medical Center. She is a general pediatrician with special interests in adolescence, prevention, education, and community health.

In 2000, she founded the Injury Free Coalition for Kids of Miami, educating more than 20,000 families and child service practitioners annually regarding injury prevention in 3 languages. Injury Free has maintained a publically-accessible injury surveillance system for over a decade and continues to train parents, home visitors, law enforcement, firefighters, and educators in home, water, and traffic safety. Injury Free was part of a pilot which led to the Centers for Disease Control's National Violent Death Reporting System and recognized the significant undercounting of unintentional child firearm deaths. In November 2012, Dr. Schaechter was elected president of the national organization of Injury Free Coalition for Kids, with over 42 sites across the Americas.

Dr. Schaechter is an investigator with the National Children's Study (NCS), concentrating on health disparities and health literacy for Hispanic mothers. She has advanced the Pediatric Mobile Clinic program, which provides comprehensive health, mental health, and case management to uninsured children and families in South Florida. Dr. Schaechter is the appointed child health policy expert on the Florida Healthy Kids Corporation Board, serves as the

Board's Treasurer, is a member of the Executive Committee, and also chairs the Finance and Satisfaction Committees. Judy has been with the Florida Children and Youth Cabinet since its inception and is a Senior Advisor to the Florida Children's Movement. She served on the Florida Governor's Council on Physical Fitness and chaired the Health and Nutrition Committee. As chair of The Children's Trust's Health Committee, she initiated a public-private partnership for health clinics in 165 schools.

Dr. Schaechter has recently presented at national conferences on a range of child health issues including adolescent brain development, bullying, eating disorders, firearms, social media, vaccines through the life span, and violence prevention. She has been recognized for her work in injury prevention and as a family and community advocate. Judy is a plaintiff in the First Amendment lawsuit challenging Florida's law banning physicians from asking about child access to firearms.

David Schonfeld, MD

St. Christopher's Hospital for Children and Drexel University College of Medicine, Pennsylvania

Dr. David Schonfeld is a developmental-behavioral pediatrician and the Pediatrician-in-Chief and Director of the National Center for School Crisis and Bereavement at St. Christopher's Hospital for Children and Chair of the Department of Pediatrics at Drexel University College of Medicine. He is a member the American Academy of Pediatrics Disaster Preparedness Advisory Council and the Sandy Hook Commission in CT, and served as a Commissioner for the National Commission on Children and Disasters.

Dr. Schonfeld established the School Crisis Response Program in 1991, which provided training to tens of thousands of school-related personnel in school systems throughout the country and abroad and provided technical assistance in hundreds of school crisis events. He consulted to the New York City Department of Education to assist with crisis preparedness and response, and provided particular help in the aftermath of the events of September 11, 2001, including training approximately 1,000 district and school-level crisis teams. In 2005, Dr. Schonfeld established the National Center for School Crisis and Bereavement or NCSCB. The goal of the NCSCB is promoting an appreciation of the role schools can fulfill supporting students, staff, and families at times of crisis and loss; collaborating with organizations and agencies to further this goal; and serving as a resource for information, training materials, consultation, and technical assistance.

Dr. Schonfeld has provided consultation and training on school crisis and pediatric bereavement in the aftermath of a number of school crisis events and disasters within the United States and abroad, including school and community shootings in Newtown, CT, Aurora, CO and Chardon, OH; flooding from Hurricanes Sandy in NYC and NJ, Katrina in New Orleans and Ike in Galveston; tornadoes in Joplin, MO and Alabama; and the 2008 earthquake in Sichuan, China.

Dr. Schonfeld has authored articles, book chapters, and a handbook on school crisis preparedness and a book for teachers on supporting the grieving student titled, "The Grieving Student: A Teacher's Guide" and has provided presentations and consultations throughout the United States and abroad on the topic of pediatric bereavement and the mental health needs of children in crisis situations. In addition, Dr. Schonfeld is actively engaged in school-based research involving children's understanding of and adjustment to serious illness and death and school-based interventions to promote adjustment and risk prevention.

Meghan Shanahan, PhD

The University of North Carolina at Chapel Hill
Injury Prevention Research Center of Chapel Hill, North Carolina

Meghan Shanahan PhD, MPH is a Research Scientist at the University of North Carolina at Chapel Hill's Injury Prevention Research Center and a Research Assistant Professor in the Maternal and Child Health Department at the UNC Gillings School of Global Public Health.

Dr. Shanahan's broad focus is to develop and evaluate interventions designed to optimize child health and development. Much of her current work focuses on child maltreatment. For the past six years, she has worked on the process and outcome evaluation of a statewide abusive head trauma prevention program, The Period of PURPLE Crying®: Keeping Babies Safe in North Carolina. Additionally, she has been involved in a variety of other evaluations of child maltreatment prevention programs, including one using technology to provide information and support to adolescent mothers and one to promote positive parenting among mothers with substance abuse problems. She is also developing a child maltreatment surveillance system in Wake County, North Carolina.

Dr. Shanahan earned her PhD and MPH from the Maternal and Child Health Department at the University of North Carolina at Chapel Hill's Gillings Schools of Global Public Health.

Karen Sheehan, MD, MPH

Northwestern University's Feinberg School of Medicine, Illinois

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

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.

Purnima Unni, MPH, CHES

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

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 .

Pina Violano, MSPH, RN-BC, CCRN, CPS-T

Yale-New Haven Hospital, Connecticut

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

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

Daniel W. Webster, ScD, MPH

Johns Hopkins Youth Violence Prevention Center

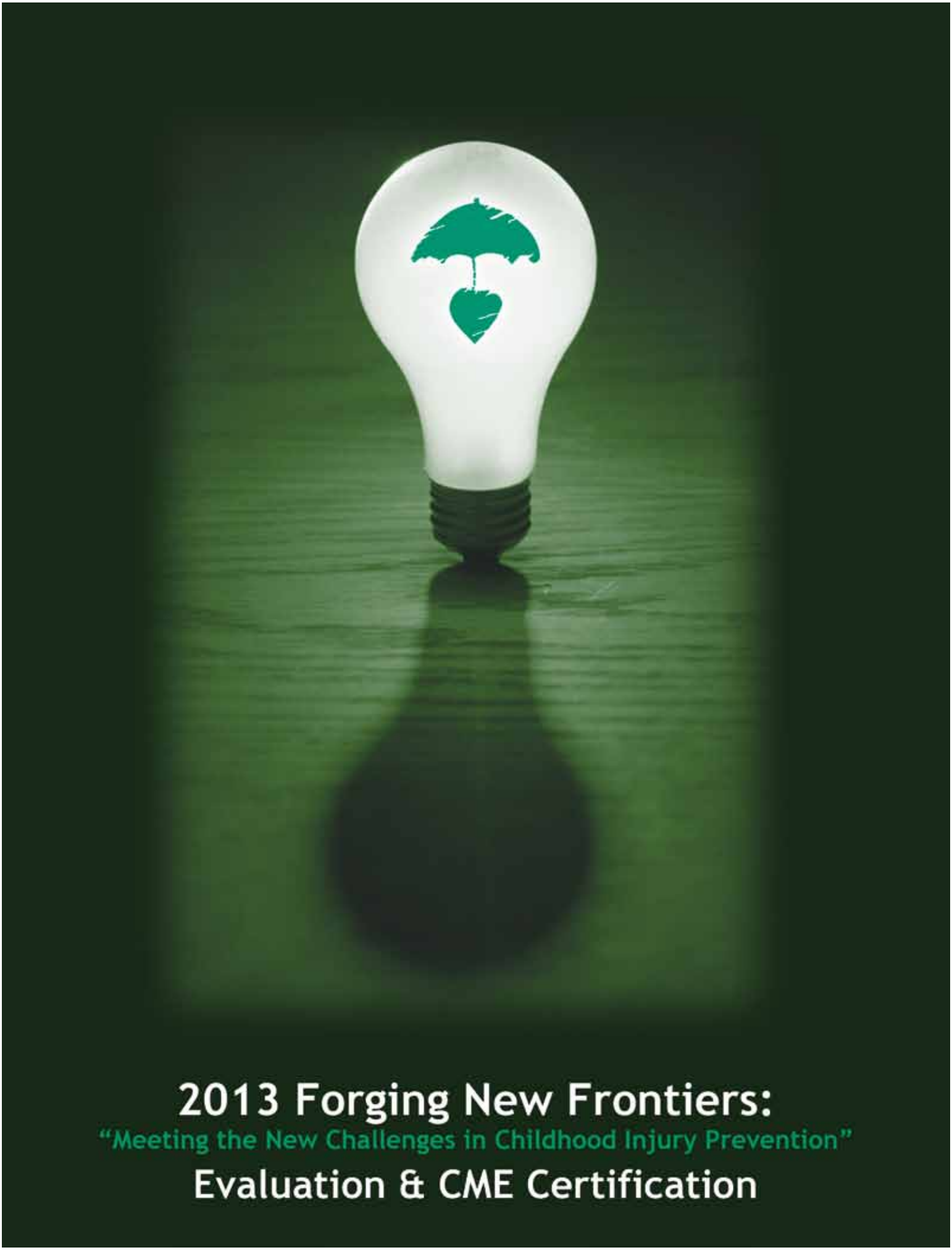
Johns Hopkins Bloomberg School of Public Health, Baltimore

Daniel W. Webster, ScD, MPH is Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health where he serves as Director of the Center for Gun Policy and Research and as Deputy Director for the Center for the Prevention of Youth Violence, one of six such centers funded by the Centers for Disease Control and Prevention. He is also affiliated with the Center for Injury Research and Policy and the Division of Public Safety Leadership at Johns Hopkins.

Dr. Webster is the lead editor and a contributor for a recently published book entitled Reducing Gun Violence in America: Informing Policy with Evidence and Analysis. He has published 78 articles in scientific journals, most of which focused on the prevention of gun violence, youth violence, or intimate partner violence. Dr. Webster has led numerous

evaluations of a broad range of interventions' effects on violence including firearm and alcohol policies, a replication of Chicago's CeaseFire public health program to reduce violence, policing and criminal justice initiatives designed to reduce gun violence, school-based interventions, and risk assessment and counseling interventions for victims of intimate partner violence.

Dr. Webster developed one of the first courses on violence prevention in a school of public health that he has taught for the past 21 years. He directs the PhD Program in Health and Public Policy at the Johns Hopkins and serves on the Steering Committee for Johns Hopkins' Interdisciplinary Violence Research Fellowship Program.



2013 Forging New Frontiers:

"Meeting the New Challenges in Childhood Injury Prevention"

Evaluation & CME Certification

Evaluation

We continually strive to make this conference the best that it can be. Your evaluations help us with that process. This year's evaluations will be done online. Please visit our website, www.injuryfree.org to share your comments.

Accreditation

Attendees of this year's conference are eligible for up to 13.5 *AMA PRA Category 1 CME Credit(s)*™. Upon completion of the evaluation, those needing a CME certificate will be able to access them at the end of the conference when evaluations are completed online. If you have questions, please contact E. Lenita Johnson at 816-651-7777.

Accreditation Statement

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 I contact education contact hours. Maximum advanced-level continuing education contact hours available are 0.

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Cincinnati Children's Hospital Medical Center and Injury Free Coalition. Cincinnati Children's is accredited by the ACCME to provide continuing medical education for physicians. Cincinnati Children's designates this live activity for a maximum of 13.5 *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.