Forging New Frontiers:
Pediatric Injury Prevention – Process, Programs and Progress

23rd Annual Injury Free Coalition for Kids® National Conference
November 29 - December 2, 2018

The 2018 Injury Free Coalition for Kids® Conference in Fort Lauderdale, FL, is a dynamic meeting for injury prevention specialists from all disciplines. We bring together medical experts, injury prevention advocates, and community leaders from North America with the goal of preventing injuries and reducing violence to children. Through scientific abstracts, lectures, panel discussions, and workshops presented by leading experts in the field of injury prevention and epidemiology, we disseminate knowledge about lessons learned and best practices in injury prevention.

Attendees of Forging New Frontiers include principal investigators (physicians), program coordinators (nurses, health educators, social workers, community leaders), and researchers. In addition to renewing their convictions to work towards decreasing injuries in children, the conference provides an opportunity for these injury prevention advocates to network with representatives from around North America.

The objectives of the 2018 Annual Conference are to provide participants with an opportunity to:

- Expand knowledge in the field of injury prevention.
- Encourage and disseminate injury prevention research.
- 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

Continuing Medical Education
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Cincinnati Children's and the Injury Free Coalition for Kids at the Center for Injury Epidemiology and Prevention, Mailman School of Public Health, Columbia University. Cincinnati Children's is accredited by the ACCME to provide continuing medical education for physicians. Cincinnati Children's designates this live activity for a maximum of 13 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure
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.

Table of Contents

Table of Contents, Cont.

Table of Contents, Cont.

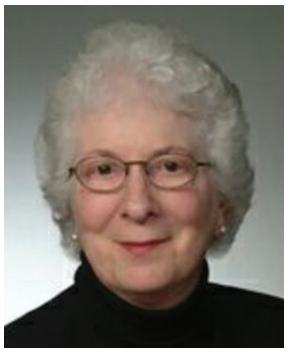
It is my pleasure to welcome you to the 23nd Annual Injury Free Coalition for Kids National Conference. This past year has been a great one for the Injury Free Coalition for Kids. We added several new sites and new PIs and PCs. In addition, we are in solid financial shape leading into the next few years, and we have a great relationship with a new journal, Injury Epidemiology, which will publish papers from our meeting.

Dr. Lois Lee, chair of the Program Committee and incoming Injury Free Coalition for Kids Board Chairperson, has put together a fantastic agenda for this year's conference. We have two outstanding keynote speakers: Dr. Sam Hanke, who brings to us a wealth of knowledge and personal experience on the importance of safe sleep, and Dr. Charles Branas who brings his extensive background in injury prevention and trauma care both nationally and internationally. We will be presenting the Pioneer award to Dr. Phyllis Agran, a national leader in injury prevention programs and policies locally, statewide and internationally whose work is truly inspiring.

This year we had a record number of abstracts submitted and will have 5 abstract sessions. The Abstract Committee worked hard and chose the best abstracts to include in the conference. As a new feature this year, one of our abstract sessions will focus on Safe Sleep to complement the work of our Keynote Speaker Dr. Hanke. We will also have a panel discussion and poster session on this very important topic. The program should stimulate some interesting discussions, teach us new up-to-date injury prevention information, and permit us to engage in networking to allow cross-site pollination of ideas.

I would like to thank the program committee for putting together an outstanding agenda for the next 2 ½ days. I would like to thank all of you for coming to what promises to be another inspiring Injury Free Coalition for Kids conference. Finally, I would like to thank Lenita for all of her hard work and behind-the-scenes effort in ensuring that this conference occurs and run smoothly. Please reach out to me if you need anything. Hopefully, we will all go home with some new information and new friendships. Enjoy the conference!

Wendy J. Pomerantz, MD, MS, FAAP
Injury Free Coalition for Kids Board President
PI Injury Free Coaition for Kids of Cincinnati
Professor of Pediatrics
Cincinnati Children's Hospital
University of Cincinnati



The National Program Staff is so excited about how this conference continues to grow. Everyone is looking forward to hearing all of the presentations to be made this year. Your abstracts brought before the attendees of Forging New Frontiers are always enlightening as is the information shared by our keynote speakers. It is really exciting to have the specialized area of safe sleep examined this year. We are certain that this will be of benefit to many of our attendees and the field itself.

In addition to growing and learning professionally, it is always wonderful to reconnect with all of you and develop support for each other as we work to make a difference in the fight against childhood injury. Please take time to greet the other Injury Free attendees and to welcome our new Injury Free sites and members.

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

Warmest wishes,

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

We enthusiastically welcome you to the 23rd Forging New Frontiers: The Annual Conference of the Injury Free Coalition for Kids. This year we have two new features: a morning session focused on Infant Safe Sleep and Lunch Round Table Discussions. I would like to thank the Program Committee for organizing this exciting conference and the presenters for bringing their knowledge and passion. As always, we want your feedback as we strive to make this conference a leading injury prevention meeting.

Every year we look forward to publication of selected abstracts in our Annual Conference Supplement. I am excited to again be serving as the guest editor for the Annual Conference Supplement in Injury Epidemiology. You will want to read the inaugural publication in Injury Epidemiology from last year's conference. It is inspiring to see the great work of our injury prevention colleagues.

I will be succeeding Wendy Pomerantz as Board President of the Injury Free Coalition for Kids. Our organization's membership and connections are continuing to grow. Building on the work of the past and present leadership, I am excited to continue to advance the organization forward.

Thank you for attending the conference. I hope you leave even more inspired to keep working to make this world a safer place for children.

Sincerely,

Lois Lee, MD, MPH, FAAP
Injury Free Coalition for Kids, President-elect
Program Chair, Forging New Frontiers: The Annual Conference of the Injury Free Coalition for Kids.
PI, Injury Free Coalition for Kids-Boston
Associate Professor of Pediatrics and Emergency Medicine
Harvard Medical School
Boston Children's Hospital

Samuel Hanke, MD, MS, Cincinnati, OH

Chief Patient Experience Officer
Assistant Professor- Pediatric Cardiology
The Heart Institute
Cincinnati Children's Hospital, Cincinnati, OH

Dr. Samuel Hanke is a pediatric cardiologist and an assistant professor in clinical pediatrics in the Heart Institute at Cincinnati Children's Medical Center. He received his medical degree from the University of Louisville and completed his pediatric residency, chief residency and cardiology fellowship at Cincinnati Children's. He currently provides medical care to fragile infants and children with congenital and acquired heart disease in both inpatient and outpatient environments. He also completed additional training in quality improvement science and currently holds a faculty appointment in the Anderson Center for Health System's Excellence at Cincinnati Children's.

When not providing pediatric cardiac care, Dr. Hanke serves as president of Charlie's Kids foundation, an organization he and his wife founded after the untimely loss of their first son Charlie in 2010 to Sudden Infant Death Syndrome (SIDS) and an unsafe sleep environment. His organization has been committed to educating families about SIDS and Safe Sleep to help prevent other parents from suffering the sudden and unthinkable loss of an infant.

Charles Branas, PhD, New York, NY

Gelman Professor and Chair
Department of Epidemiology
Director, CU Center for Injury Epidemiology & Prevention
Columbia University, Mailman School of Public Health

Dr. Branas is Anna Cheskis Gelman and Murray Charles Gelman Professor of Epidemiology, Chair of the Department of Epidemiology at the Columbia University Mailman School of Public Health, and Co-Director of the Center for Injury Epidemiology and Prevention at Columbia University.

Dr. Branas has conducted research that extends from urban and rural areas in the US to communities across the globe, incorporating place-based interventions and human geography. He has led win-win science that generates new knowledge while simultaneously creating positive, real-world changes and providing health-enhancing resources for local communities. His pioneering work on geographic access to medical care has changed the healthcare landscape, leading to the designation of new hospitals and a series of national scientific replications in the US and other countries for many conditions: trauma, cancer, stroke, etc. His research on the geography and factors underpinning gun violence has been cited by landmark Supreme Court decisions, Congress, and the NIH Director.

Dr. Branas has also led large-scale scientific work to transform thousands of vacant lots, abandoned buildings and other blighted spaces in improving the health and safety of entire communities. These are the first citywide randomized controlled trials of urban blight remediation and have shown this intervention to be a highly cost-effective solution to persistent urban health problems like gun violence. He has worked internationally on four continents and led multi-national efforts, producing extensive cohorts of developing nation scientists, national health metrics, and worldwide press coverage.

Phyllis Agran, MD, MPH, FAAP, Orange, CA

Professor UCI School of Medicine
Department of Pediatrics
Pediatric Gastroenterology & Nutrition

Dr. Agran is American Board of Pediatrics certified in General Pediatrics and Pediatric Gastroenterology. She is Professor Emeritus, UC Irvine School of Medicine and a practicing physician. She founded the Child Injury Prevention Research Group at UCI focused on translating research into policy. She is a past president of California Chapter 4, American Academy of Pediatrics. She serves on the National American Academy of Pediatrics, Executive Committee of the Council on Injury and Violence Prevention. Her current work, a Healthy Tomorrows Partnership for Children project, Clinic in the Park - Connect - Screen - Educate, is a one-stop health collaborative model designed to promote health and prevent disease, targeting vulnerable children. She has been an advocate for public health policies aimed at reducing trauma and injury to children. She received her BA degree from UC Berkeley, a Masters Degree in Biology from Boston University, an MPH from Harvard University, and her medical degree from UC Irvine.

Congratulations 2018 Abstract of the Year Award Nominees

The abstracts below were selected for presentation at the conference and nominated to receive recognition as the 2018 abstract of the year. Each abstract was judged on the degree to which: the research topic identified a new area of study and/or addressed the topic in a novel and unique manner, the methodology of the research was scientifically valid, the research topic was relevant to injury control or violence prevention, the way the presenter articulated the research and responded to questions and critiques and the degree to which the author communicated the hypothesis, methodology, research, results, and conclusion of the research through written word. Scoring and ranking will take place during the conference and the award will be presented Saturday evening dinner. There will be two awards: one for best original research abstract and one for best program evaluation.

Original Research

Modifiable Risk Factors in Non-Natural Infant Death, Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago, Il

Racial and Ethnic Disparities in Sudden Unexpected Infant Deaths. Wide Variations in Large US Cities, Rush University Medical Center, Chicago, Il

Pilot of Primary Care Physician Discussion and Resource Allocation After Screening for Unintentional Injuries and Social Determinants of Health, Cincinnati Children's Hospital, Cincinnati, OH

An Educational Intervention for Medical Students to Improve Firearm Injury Prevention Counseling, Children's Hospital of Wisconsin, Milwaukee, WI

Social Workers' Determination of When Children's Access or Potential Access to Firearms Constitutes Child Neglect, University of Iowa Stead Family Children's Hospital, Iowa City, IA

Trends and Characteristics of Playground-Related Extremity Fractures in Children, Children's Hospital of New York-Presbyterian, Columbia University Medical Center, New York, NY

The All-Terrain Vehicle Exposure and Crash Experiences of Iowa FFA Members Iowa, University of Iowa Stead Family Children's Hospital, Iowa City, IA

Gaps in ATV Injury Reporting in Alabama: A Case for Statewide Trauma Databases, Univerisity of Alabama at Birmingham, Birmingham, AL

Perception of Injury Risk Among Parents of Youth Bicyclists, Children's Hospital of Pittsburgh, Pittsburgh, PA

Program Evaluation

As Easy as ABC: Do Crib Cards and Tracking Boards Improve Safe Sleep in a Free-Standing Pediatric Hospital? Children's Healthcare of Atlanta, Atlanta, GA

Sleep Baby Safe: Moving Safe Sleep from Campaign to Conversation, Children's Health Alliance of Wisconsin, Milwaukee, WI

Pioneer Award Winner

Phyllis Agran, MD, MPH, FAAP

Dr. Phyllis Agran is the 2018 Injury Free Coalition for Kids® Pioneer Award recipient. The award is presented annually to an individual who has demonstrated substantial dedication to the mission of preventing injuries to children and their families. It is designed to honor a person who has been a forerunner in the field of injury prevention, one who is an innovator and a calculated risk taker, blazing trails where there have been none, and one who does not remain silent when needs are not met

As a recognized expert in pediatric gastroenterology, Dr. Phyllis Agran has practiced in the Orange County community for more than 30 years. She is board certified in both general pediatrics and pediatric gastroenterology and nutrition (American Board of Pediatrics). Dr. Agran is a member of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition, (NASPGHN). She is professor emeritus at the UC Irvine School of Medicine, department of pediatrics.

Dr. Agran has drawn upon her experience to become a leading advocate for policies and programs to prevent pediatric injuries and promote better health and safety outcomes for children locally, statewide and nationally. Dr. Agran and her husband Larry Agran were instrumental in establishing the first mandatory child passenger safety law in California.

On the forefront of research, Dr. Agran began her pediatric gastroenterology practice and conducted research in the field of injury epidemiology and prevention at UC Irvine, School of Medicine. She has received many research grants from the National Center for Injury Prevention, Centers for Disease Control; the National Institute of Medicine, Child Health and Human Development; the US Department of Transportation, National Highway Traffic Safety Administration; and, the State of California, Office of Traffic Safety. Her research studies have been published in the Journal of the American Medical Association, Pediatrics and Accident Analysis and Prevention. Dr. Agran has long been personally and professionally committed to translating research findings into evidence-based guidelines and interventions for preventing injuries.

As a respected leader in the field of pediatric gastroenterology, Dr. Agran has served as Medical Director of the Injury and Violence Prevention Program of the Orange County Chapter of the AAP. Representing the National American Academy of Pediatrics, Dr. Agran served on the Federal Safe Routes to School Task Force and the National Academy of Sciences Transportation Research Board Committee on School Transportation. She is the State AAP representative on the California School Pupil Transportation Advisory Committee.

Dr. Agran is a fellow of the American Academy of Pediatrics (FAAP) and a member of the National American Academy of Pediatrics (AAP). She served as the President of the local Orange County Chapter of the American Academy of Pediatrics, CA4, AAP (2009-2011). She has been an advocate for public health policies aimed at reducing trauma and injury to children. She served on the national American Academy of Pediatrics Committee on Injury, Violence and Poison Prevention, participating in the development and writing of policies. She was chair of the educational arm, the Section on Injury, Violence and Poison Prevention, and now serves on the Violence Prevention Subcommittee with a long-standing interest in bullying.

PI of the Year Award

Wendy Pomerantz, MD, MS, FAAP

Wendy J. Pomerantz, MD, 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 Cincinnati Children's Hospital Medical Center and a Master of Science in epidemiology at the University of Cincinnati.

Currently, she has a faculty appointment as a professor of clinical pediatrics at the University of Cincinnati School of Medicine and Cincinnati Children's Hospital Medical Center in Cincinnati, Ohio. Her interests include injury and poison prevention, emergency medical services, ATV and motor bike injuries, education, and geographic information systems.

From the beginning of her career, Dr. Wendy Pomerantz displayed great leadership by graduating Summa Cum Laude with a B.A. in Biochemistry followed by a medical degree and M.S in Epidemiology. Wendy took her education and began applying her knowledge immediately into the field of injury prevention where she quickly became a recognized leader. She continues today to forge her leadership as the co-director of Injury Free Coalition for Kids in Greater Cincinnati and current president of the National Injury Free Coalition for Kids Board. It is in this position with Injury Free that Wendy tackles issues and challenges to help grow and improve the coalition brand. Wendy also holds a leadership position as the co-director of Cincinnati Children's Hospital Comprehensive Children's Injury Center (CCIC), where every day she practices the CCIC's mission to provide the best available care in her position as a pediatric emergency medicine attending physician. Wendy consistently studies the best practices of injury care to share and train other health care professionals, contributes to the development of effective community injury prevention programs, provides insights to advance local pop health initiatives and strives to improve the individual experience of care.

Wendy's leadership extends into the national, hospital and community curriculums she helped developed to promote injury prevention across all platforms. AS a mentor, Dr. Pomerantz has helped to develop an advocacy training environment at CCHMC, which places special emphasis on injury prevention practices. It aims to enhance residents' outreach experience and knowledge in academic areas as well as clinical and community settings.

Dr. Pomerantz research spans across multiple mechanisms of injury prevention. She is a passionate expert in her field who freely shares her expertise with others. She is widely published and her work supports improvement in strategies and practices to achieve desirable outcomes for the reduction of unintentional injury among the pediatric population. Always encouraging and mentoring others in the field of research, Wendy generously fosters students' intellectual and professional development and shares the research spotlight with those who share her passion. Wendy dedicates her time, energy and expertise to translational research efforts and effective community endeavors while demonstrating a willingness to collaborate with peers to share knowledge and innovative ideas.

Wendy's innovative efforts benefit the pediatric population and also improved care within "quality" domains (safety, effectiveness, patient-centeredness, timeliness, efficiency, collaboration, comprehensive care and equality). She further demonstrates her pursuit of finding "what works" through her active participation in events, internal, external and national committees and local programs, using clinical and community insight to support a culture of innovation.

Wendy's passion for educational creativity and the welfare of students, community and faculty along with her energy, and accomplishments have convinced others how important their leadership is in all areas and all levels of prevention. In many ways Wendy exceeds the challenging requirements and expectations for this PI award. Her commitment, advocacy, research, mentoring and leadership in the field of injury prevention exceeds 20+ years and her efforts to reduce the rate of unintentional injury within the hospital walls, in the local communities, and on a national platform are never ending. She is a leader every minute of every day amongst residents, hospital staff and the patients and families she provides care for.

PC Lifetime Achievement Award

Beverly Miller, MEd

Beverly Miller, Associate Director of Arkansas Children's Injury Prevention Center (IPC), is a recipient of the Injury Free Coalition for Kids PC Lifetime Achievement Award. She is only the second person to receive this award and the first program coordinator to be recognized in this manner. Her embodiment of the coalition's mission to prevent injuries to children by helping people to make their communities safer while remaining respectful of various cultures, beliefs, and lifestyles locally across the state of Arkansas and across the nation positioned her for this honor. Her enthusiasm about the work and the relentless effort to make a difference made her contributing board member of the Injury Free Coalition for Kids and the first PC to receive the PC of the Year Award.

Ms. Miller has been instrumental in the development of multiple programs at the Arkansas Children's Injury Prevention Center (IPC) that have had a sustained and positive impact on the rate of unintentional injury related deaths in the state. During the first ten years after founding of the IPC, there was a 57% decrease in these deaths in the state of Arkansas.

In addition to her work in prevention programs, Beverly's conceptual development of community-sited research led to the CDC-funded program titled Strike Out Child Passenger Safety, a multi-state project utilizing the Injury Free Network. Using community-based T-ball programs to promote booster seat use resulted in a 56% increase in correct child passenger restraint. She also developed a NHTSA funded program titled Improving Teen Driving Through Parental Responsibility which sought to increase the use of written teen driving contracts between parents and teens that formed the basis of a statewide teen driving program in Arkansas that has been very successful in engaging youth leaders in schools across the state. These programmatic efforts complemented IPC-led advocacy to establish the Arkansas Graduated Driver License policy in 2009.

Under Ms. Miller's leadership, Injury Free Arkansas developed an EMSC funded program titled Development and Evaluation of Targeted ATV Safety Educational Strategies for Rural Children which sought to develop education activities around ATV safety. The result was a well evaluated and widely accepted ATV Safety Toolkit that has been distributed to 36 states and three countries. Her conceptual development of strategies to study infant safe sleep built on the IPC's Safety Baby Showers program and the theoretical foundation for the Generations in Families Talking Safe Sleep (GIFTSS) project, funded by NICHD (Aitken, PI) that is evaluating the impact of a tailored intervention for safe sleep for teenaged mothers and their families.

In addition to the development of programs, Beverly is respected within the IPC as a developer of people. A great deal of her time is spent mentoring and encouraging young professionals entering the field of Injury Prevention. Under her guidance, the Injury Prevention Center staff has grown from three to 20 health educators, research assistants, and outreach staff. The IPC statewide efforts focus on Teen Driving, Child Passenger Safety, Home Safety and Infant Mortality. More recently, the IPC has undertaken intentional injury, including suicide prevention and safe storage of firearms, in coordination with partners across the state. With her great institutional history that she readily shares with our staff, Beverly's vision for the future serves as a driving force for the advancement IPC activities.

Beverly has served as a key advocate for injury prevention by working with the Arkansas Highway Safety Office to support both Child Passenger Safety and Teen Driving efforts. Our ATV Safety Program has expanded nationwide due to her maintaining partnerships with the Arkansas Game and Fish Commission, the University of Arkansas, Arkansas Farm Bureau, and the 4H Safety Riding Courses.

Beverly is a teacher and trainer at heart and is often called upon to present at many meetings and conferences on the topic of injury prevention. In the past two years, Beverly served as a consultant and then as a key part of the development of the American Trauma Society's core injury prevention curriculum and is now part of the instructor pool for the ATS Injury Prevention Coordinator's Course, a 2-day program designed to provide a comprehensive overview of topics and concepts needed to establish an evidence-based injury prevention course in a trauma center.

23rd Annual Injury Free Coalition for Kids® National Conference

Forging New Frontiers: Pediatric Injury Prevention – Process, Programs and Progress

2018 Schedule at a Glance

		ROOM
Thurday, November 29, 2018		
10:00-12:00	Conference Setup	Salon E
1:00-5:00	Registration	Salon E
Friday, November 30, 2018		
6:00-8:30	Breakfast	Atrium
7:30-8:30	Registration	Salon E
8:30-8:35	Logistics: E. Lenita Johnson, MA	Salons A-D
	Welcome: Wendy Pomerantz, MD, MS, FAAP	
8:35-8:45	Introduction of Keynote Speaker: Wendy Pomerantz, MD, MS, FAAP	Salons A-D
8:45-9:30	Keynote Speaker: Sam Hanke, MD	Salons A-D
	Remembering Charlie- How to Engage Families to Prevent Sleep-Related Deaths	
9:30-10:15	Panel Discussion: Crib Notes: Innovations to Promote Safe Infant Sleep	Salons A-D
10:15-10:25	Break	
10:25-10:50	Lightening Round Safe Sleep Posters: Know Better, Do Better: Exploring Educational Approaches to Improving Knowledge, Practice and Policies of Infant Safe Sleep	Salons A-D
10:50-11:30	Panel Discussion: Safe Sleep	Salons A-D
11:30-12:00	Posters: Safe Sleep with Author Attendance	Salon E
12:00-1:00	Lunch	Atrium
1:00-2:00	Platform Presentations: General Injury/Firearm Injury Prevention	Salons A-D
2:00-3:00	Panel Discussion Littlest Kids...Biggest Injuries	Salons A-D
3:00-3:15	Break	
3:15-5:00	PI Meeting	Salons A & B
3:15-5:00	PC meeting	Salons C&D
6:00-7:00	Reception/Research Posters	Aqua/Terra
7:00-9:00	Board of Director's Meeting	Gulfstream
Saturday December 1, 2018		
7:00-8:00	Breakfast	Atrium
7:00-8:00	Registration	Salon E
8:00-8:10	Introduction of Keynote Speaker: Barbara Barlow, MD, MA, New York, NY	Salons A-D
8:10-9:00	Keynote Speaker, Charles Branas, PhD, New York, NY	
	"Gun violence as disease"	
9:00-10:30	Panel Discussion - Riding, Sliding and Biking: A look at Recreational Injuries	Salons A-D
10:30-10:45	Break	
10:45-11:45	Panel Discussion -Motor Vehicle Injuries are the Most Significant Cause of Mortality in Children from 1 to 19 Years.	Salons A-D
12:00-1:30	Lunch Round Table Discussions	Causeway I-III
1:30-1:35	Introduction of Keynote Speaker & Pioneer Award Winner	Salons A-D
1:35-2:00	Keynote Speaker Pioneer Award Winner, Phyllis Agran, MD, MPH, FAAP	Salons A-D
	Pediatric Injury Prevention Policy Successes, Gaps and Opportunities:	
2:00-2:15	Break	
2:15-3:15	Workshop - Race, Bias, and Injury	Salons A&B
2:15-3:15	Workshop - How to Get Your Work on Paper and Then to Presentation: How to Write a Scientific Abstract	Salons C&D
3:15-3:30	Break	
3:30-4:30	Workshop - Race and Injury: Introducing a New Framework for Thinking about Racial Disparities	Salons A&B
3:30-4:30	Workshop - Integrating Patient Reported Outcomes and Interactive Dashboard Technology into Program Evaluation	Salons C&D
4:30-5:30	Group Meeting:Young Faculty, Maneesha Agarwal, MD, Atlanta, GA	Room 209
5:30-6:30	Reception	Salon E
6:30	Dinner, Awards Presentations, and Drum Karaoke	Causeway I-III

2018 Schedule at a Glance, Cont.

Sunday December 2, 2018		
8:00-9:15	Group Meeting: IAMSBIRT, Michael Mello, MD, MPH, Providence, RI	Gulfstream A
8:00-9:15	Group Meeting: ASK/Gun Buyback, Michael Hirsh, MD, Worcester, MA	Salons A&B
8:00-9:15	Group Meeting: Safe Sleep, Adrienne Gallardo, MA, CPST-I, Portland OR	Salons C&D
9:15-9:30	Break	
9:30-10:00	Business meeting: Wendy Pomerantz, MD, MS, FAAP, Board Chairperson, Cincinnati, OH	Salons A-D
10:00-11:15	Poster Lightening Rounds: Striking New Research Findings in the Injury Prevention World	Salons A-D
11:15-12:00	Manned Poster Session/Lunch Pick up	Salon E

2018 Agenda

Time & Room

Thursday November 29

Salon E

10:00-12:00 Conference Setup
1:00-5:00 Registration

Friday November 30

Atrium

6:00-8:30 Breakfast

Salon E

7:30-8:30 Registration

Salons A-D

8:30-8:35 Welcome and Logistics: E. Lenita Johnson, MA, Kansas City, MO, Wendy Pomerantz, MD, MS, FAAP, Cincinnati, OH
8:35-8:45 Introduction of Keynote Speaker: Wendy Pomerantz, MD, MS, FAAP, Cincinnati, OH
8:45-9:30 Keynote Speaker: Sam Hanke, MD, Cincinnati, OH

Remembering Charlie- How to Engage Families to Prevent Sleep-Related Deaths
Since the significant reduction of the Sudden Unexpected Infant Death rate in the mid-1990s, the rates of SUID in the USA has remained stagnant. The evolution of the safe to sleep recommendations from the American Academy of Pediatrics was in response to this stagnant SUID rate. Despite these new recommendations over 3,500 babies are dying every year largely from preventable unsafe sleep environments. In this presentation, Dr. Samuel Hanke shares his story of the loss of his firstborn son, Charlie, to an unsafe sleep environment, the personal impact of this loss, and his efforts to advocate for the spread of safe sleep education nationwide.

Participants in this session will learn to:
1. Identify the statistics of SUID and sleep-related deaths in the United States.
2. Describe the impact of sleep-related deaths on families.
3. Discuss potential strategies to engage families in safe sleep education.
4. Recognize examples of successful SUID reduction strategies.
5. Discuss strategies to address the barriers to safe sleep practices.

9:30-10:15 **Crib notes: Innovations to Promote Safe Infant Sleep**
Each year approximately 3500 families in the United States lose an infant from sleep-related death. The number of infant deaths per year had decreased in the 1990s but in the last 15 years there has been no significant progress in the number of infants dying suddenly and unexpectedly. We have much work to do to find innovative ways to protect infants from SIDS and suffocation. This session will evaluate the epidemiology of this nationwide problem with a close review of the nation's 4 largest cities and an emphasis on racial disparities, particularly as it pertains to African American and Hispanic populations. We will also examine a successful statewide campaign to train healthcare providers to disseminate knowledge on safe sleep, as has been informed by the American Academy of Pediatrics. Lastly, we will address modeling safe sleep for infants in the hospital-setting and the limitations of specific interventions, such as utilization of visual cue cards as reminders. By focusing the discussion on expanding our knowledge, improving our conversations, and effectively demonstrating safe sleep, we hope to start to impact the rate of sleep-related deaths once again.

Participants in this session will learn to:
1. Describe keys to implementing safe sleep practices for infants <1 year in a hospital-setting.
2. Recognize that African American families are disproportionately affected by sudden infant death syndrome.
3. Discuss the limitations of utilizing a visual cue card to promote safe sleep in a hospital-setting.
4. Establish resources for implementing a campaign to teach healthcare providers about safe sleep recommendations.
5. Identify dramatic variations in racial disparities of sleep-related infant deaths in the largest US cities.

Moderators: Kyran Quinlan, MD, Chicago, IL
Holly Hanson, MD, MS, Nashville, TN

Time & Room

Presenters:
Practicing What We Preach: Modeling a Safe Sleep Environment for Hospitalized Infants,
Christiane Lenzen, MD, San Diego, CA
Modifiable Sleep-Related Risk Factors in Non-Natural Infant Deaths,
Anna Briker, BS, Chicago, IL
As Easy as ABC: Do Crib Cards and Tracking Boards Improve Safe Sleep in a Free-Standing Pediatric Hospital?
Sarah Gard Lazarus, DO, Atlanta, GA
Sleep Baby Safe: Moving Safe Sleep from Campaign to Conversation,
Amanda Bagin, MPS, CHES, Milwaukee, WI
Racial and Ethnic Disparities in Sudden Unexpected Infant Deaths: Wide Variations in Large US Cities,
Kyran Quinlan, MD, Chicago, IL

10:15-10:25 Break

10:25-10:50 **Lightening Round Safe Sleep Posters: Know Better, Do Better: Exploring Educational Approaches to Improving Knowledge, Practice and Policies of Infant Safe Sleep**

Sudden unexpected infant deaths are the leading cause of post-neonatal mortality, resulting in ~3500 infant deaths per year. While the 1994 back-to-sleep campaign resulted in a steady decline in SUID, progress in prevention has slowed over the past several years. The majority of SUID involve modifiable sleep-related risk factors, including: bed-sharing, sofa-sleeping, soft bedding, cluttered sleep spaces, and tobacco smoke exposure. Clear and consistent education regarding these factors is a prevention approach targeted by these research teams that sought novel approaches to disseminating the key messages of infant safe sleep.

Participants in the session will learn to:

1. Recognize an innovative educational format for promoting safe sleep practices among nurses and staff.
2. Describe how risk-factor specific education changes parent perceptions of infant sleep safety.
3. Identify methods of engaging non-traditional stakeholders in the development of educational injury prevention interventions.
4. Discuss how cross-sector collaboration can accelerate educational goals and certification among hospitals with significant variation in infant safe sleep practices and policies.
5. Recognize the role of educational strategies in overcoming barriers to adoption of infant safe sleep practices and policies.

Moderators: Chuck Pruitt, MD, Salt Lake City, UT
Gina Lowell, MD, MPH, Chicago, IL

Presenters:
Not All Fun and Games: Providing Education to Healthcare Professionals Through a Safe Sleep Carnival,
Sarah Gard Lazarus, DO, Atlanta, GA
Effectiveness of a Safe Sleep Practice Educational Intervention to Promote Behavior Change,
Rochelle Thompson, MS, Philadelphia, PA
Infant Child Death Review: Moving from Recommendation to Action in Injury Prevention,
Dawn Porter, BS, Little Rock, AR
Creating a Statewide Network of Hospitals Addressing Safe Sleep,
Lessa Payne, BS, Little Rock, AR

10:50-11:30 **What Works?: The Many Facets of Effective Safe Sleep Promotion Panel Discussion**

Each year in the United States, approximately 3,500 infants die suddenly and unexpectedly. There has been no significant progress in the prevention of these sleep related infant deaths in the past 15 years. Much is known about risk factors for these sudden unexpected infant deaths (SUIDs) and what constitutes a safe sleep environment for infants. What we do not know is how to effectively promote safe infant sleep behaviors. This panel will discuss this complex issue from four perspectives: parents, hospital policy, community programs, and legislation.

Participants in this session will learn to:

1. Describe how parental perception of the risk of SUID relates to their practice of recommended safe sleep behaviors, and how the loss of an infant provides context for the importance of safe sleep.
2. Discuss the importance of a hospital policy in modeling safe infant sleep behaviors from the start, and what makes an effective policy.

Time & Room

3. Recognize the cultural aspects to common infant sleep behaviors such as bed-sharing, and how these factors need to be considered in the design of programs to promote safe sleep.
4. Identify opportunities in the legislative arena for the promotion of safe infant sleep.
5. Describe the complex interaction of parental and community factors, hospital policy and legislation in the risk of SUID in the United States.

Moderator: Kyran Quinlan, MD, Chicago, IL

Panel:

a. Parents: Sam Hanke, MD, Cincinnati, OH
b. Hospital Policy: Amber Kroeker, MA, CPST-I, Portland, OR
c. Community Programs: Adrienne Gallardo, MA, CPST-I, Portland, OR
d. Legislation: Michael Gittelman, MD, Cincinnati, OH

Salon E

11:30-12:00 **Safe Sleep Posters with Author Attendance**

Atrium

12:00 - 1:00 Lunch

Salons A-D

1:00-2:00 **General Injury/Firearm Injury Prevention Platform Presentations**

What's in the news? There is increased public attention on sports related head injuries, firearm injuries, and social determinants of health. Parents and coaches require children who sustain head injury while playing football to be removed due to concern of traumatic brain injury (TBI). Should we be more vigilant about children who sustain injury on the playground and other non-sports head injuries? Unfortunately, school shootings and school safety are in the news. However, children are more likely to sustain firearm injuries in their homes than schools. The AAP recommends that caregivers store their guns locked, unloaded, and with the ammunition in a separate place. According to the recent Rand Report analysis of gun policies, safe storage of firearms is effective in reducing injuries and deaths in children. Despite the evidence, most pediatricians do not provide gun safety counseling, a significant number of guns are unsafely stored, and young children continue to suffer unintentional shootings. How can we get parents to secure their firearms? Time constraints limit the ability of health providers to provide anticipatory guidance on all possible injuries. What are ways busy health providers can educate parents and provide resources, to best ensure the safety of their patients?

Participants in this session will learn to:

1. Recognize the epidemiology of traumatic brain injury due to non-sports compared to sports activities.
2. Discuss the effectiveness of a new targeted-screening for injury risk behavior, social determinants of health, and need for parent education resources.
3. Describe the effectiveness of a brief training module for medical students on firearm injury prevention counseling.
4. Discuss the impact of child access prevention laws on social work reporting practices for child neglect.
5. Recognize the value of quality intervention studies in the evaluation of new injury prevention methods.

Moderators: Pina Violano, PhD, MSPH, RN-BC, CCRN, CPST, New Haven, CT
Nina Agrawal, MD, New York, NY

Presenters:

ED Visits, Admissions, and Deaths for Pediatric Traumatic Brain Injury by Mechanism: A 10-Year Study,
Holly Hanson, MD, MS, Nashville, TN

Pilot of Primary Care Physician Discussion and Resource Allocation After Screening for Unintentional Injuries and Social Determinants of Health,
Mike Gittelman, MD, Cincinnati, OH

An Educational Intervention for Medical Students to Improve Firearm Injury Prevention Counseling,
Jacky Kwong, BS, Milwaukee, WI

Social Workers' Determination of When Children's Access or Potential Access to Firearms Constitutes Child Neglect,
Pam Hoogerwerf, BS, Iowa City, IA

Agenda, cont.

Time & Room

2:00-3:00 **Littlest Kids...Biggest Injuries**

The rich world of the developing child is rife with hazards and, sometimes, injuries. These epidemiologic reviews of common childhood injuries shed new light on some typical mechanisms of injury, particularly those involving the youngest age groups. During this session we will look in depth at predictable age-related injuries but from new perspectives including some interesting perspectives on preventive strategies. Join us as we dig deeper into the data concerning a kid's world of injury and gain insight on how to target preventive programs.

Participants in this session will learn to:

1. Identify mobile health intervention strategies through a virtual home safety visit.
2. Recognize a novel approach to preventing injuries in young children.
3. Discuss the epidemiology of unintentional pediatric poisonings.
4. Describe the effects of keeping medications in original packaging as a means to target anticipatory guidance.
5. Discuss the burden of scald injuries from instant soups and the need for more in-depth prevention strategies.
6. Recognize the trends in pediatric dog bite injuries and modifiable risk factors.

Moderators: Teresa Riech, MD, Peoria, IL
Andrew Kiragu, MD, Minneapolis, MN

Presenters:
Formative Qualitative Research for a Text and Video Messaging Home Safety Intervention for Young Mothers,
Dina Burstein, MD, Providence, RI
Revisiting Pill and Capsule Ingestions by Children: When, Where, How,
Maneesha Agarwal, MD, Atlanta, GA
Instant Soup Scald Injuries in Children,
Courtney Allen, DO, Atlanta, GA
Characteristics of Dog Bites in Pediatric Patients Presenting to the ED,
Johannah Merrill, MD, Rochester, NY

3:00-3:15 Break

Salons A & B
3:15-5:00 **PI Meeting, Wendy Pomerantz, MD, MS**

Salons C-D
3:15-5:00 **PC Meeting, Amy Hill, MS**

Aqua/ Terra
6:00-7:00 **Reception/Research Posters**
Using Data in a Program to Develop Open Water Drowning Prevention Policies,
Linda Quan, MD, Seattle. WA
Evaluating Retention Rate of Child Passenger Safety Education Three Months Post Car Seat Class,
Marjorie Diaz, BS, Los Angeles, CA
Pedestrian Safety: A Public and Private Partnership,
Chantel Lowery, MPH, CHES, Los Angeles, CA
Evaluation of the Homeless Shelter Home Safety Program,
Barbara Digirolamo, MEd, CPST-I, Boston, MA

Gulfstream
7:00-9:00 **Board of Director's Meeting**

Saturday December 1, 2018

Atrium
7:00-8:00 Breakfast

Salon E
7:00-8:00 Registration

Salons A-D
8:00-8:10 Introduction of Keynote Speaker: Barbara Barlow, MD, MA, New York, NY

Agenda, cont.

8:10-9:00 Keynote Speaker, Charles Branas, PhD, New York, NY

Gun Violence as Disease

We are in the midst of a gun violence crisis. When someone is shot in the US, there is often a necessary law enforcement response, but there is also a necessary response by prehospital and hospital providers and, for the most severe cases, medical examiners and coroners. Despite this, gun violence has long been under-appreciated as a biomedical and public health crisis. Greater appreciation of this clear connection could bring broader biomedical resources and innovative public health solutions to reduce what seems like an intractable US problem.

Participants in this session will learn to:

1. Recognize gun violence is a disease, with pathophysiologic and sociologic characteristics like other diseases.
2. Discuss the risk of gun violence.
3. Recognize that laws and law enforcement are but one approach to preventing gun violence.
4. Recognize that public health and biomedical attention to gun violence has been heavily stymied and could have a major impact.
5. Describe structural violence and the context within which gun violence first manifests and opportunities for prevention.

9:00-10:30 **Riding, Sliding and Biking: A Look at Recreational Injuries**

Recreational toys are prevalent in our current culture and have become part of childhood in many parts of the US. From powered vehicles to seemingly innocuous playground equipment, children are sustaining injuries that may be preventable. Every year in the United States, emergency departments (EDs) treat more than 200,000 children ages 14 and younger for playground related injuries. When it comes to bicycles children (5-14 years) and adolescents (15-19 years) have the highest rates of nonfatal bicycle-related injuries, accounting for more than one-third of all bicycle-related injuries seen in US emergency departments. Those are just two areas to be examined where exploration of epidemiological data and trends from the use of these “toys” may allow for increased injury prevention and educational efforts.

Participants in the session will learn to:

1. Recognize trends and characteristics of playground-related extremity fractures in children.
2. Identify the injuries most frequently seen by pediatric patients in snowmobile-related mishaps.
3. List at least three risk factors that increase the likelihood of crashing an ATV.
4. Recognize that accurate ATV injury prevalence is difficult to calculate in states without comprehensive state or county trauma reporting as national data is calculated based on a probability sample which does not identify highest risk pediatric age groups or counties.
5. Identify some potential strategies which might help EMS respond quicker to patients involved in ATV crashes off-road and in recreational areas.
6. Discuss an apparent mismatch between injury risk perception and actual risk among the parents of youth bicyclists.

Moderators: Barbara Gaines, MD, Pittsburgh, PA
David Juang, MD, Kansas City, MO

Presenters:

Trends and Characteristics of Playground-Related Extremity Fractures in Children,
Ashley Blanchard, MD, New York, NY

Pediatric Snowmobile-Related Injuries in the Emergency Department 2000-2017,
Issac Schwantes, BS, Iowa City, IA

The All-Terrain Vehicle Exposure and Crash Experiences of Iowa FFA Members,
Cole Wymore, Iowa City, IA

Gaps in ATV Injury Reporting in Alabama: A Case for Statewide Trauma Databases,
Reid Burks, MD, Birmingham, AL

Emergency Medical Services Responses to All-Terrain Vehicle Crashes: Increased Time Demands of Recreation Area Crashes,
Charles Jennissen, MD, Iowa City, IA

Perception of Injury Risk Among Parents of Youth Bicyclists,
Stephen Strotmeyer, PhD, MPH, Pittsburgh, PA

10:30-10:45 Break

Agenda, cont.

10:45-11:45

Motor Vehicle Injuries are the Most Significant Cause of Mortality in Children from 1 to 19 Years
After years of diminishing morbidity and fatality, there has been a 10% increase in these areas according to National Highway Traffic Safety Administration since 2016. Research in youth driver and passenger safety can lead to evidence-based changes in care with the potential for a high impact on outcomes. The research discussed during this session will elucidate novel ways to identify those who may benefit from child passenger education, discuss risk factors for failure of car seat tolerance screening, reveal strategies to increase awareness of driving safety programs, and look into the new challenges presented by the upward trend in state-level legalization of marijuana.

Participants in this session will learn to:

1. Describe how to use the electronic medical record as a tool to implement child passenger safety education.
2. Recognize the rate of agreement between teen survey reports of marijuana use and laboratory test results for THC.
3. Identify risk factors for failure of car seat tolerance screening.
4. Discuss Graduated Driver Licensing and how it effects the rate of motor vehicle crashes.
5. Identify strategies for approaching a comprehensive statewide education and awareness program for driving safety.

Moderators: Jessica Naiditch, MD, Austin, TX
Michael Hirsh, MD, Worcester, MA

Presenters:
Electronic Medical Record Screening for Appropriate Car Seat Utilization in Primary Care,
Jessica St. Onge, BS, CPST, Milwaukee, WI
To Test or Not to Test: A Retrospective Review of Infant Car Seat Tolerance Screening Outcomes at a Single Institution,
Benjamin Hoffman, MD, FAAP, CPST-I, Portland, OR
Marijuana Use in U.S. Teen Drivers: A Comparison of a Road-Side Survey of Reported Use and Fluid Tests for Tetrahydrocannabinol (THC),
Joyce Pressley, PhD, MPH, New York, NY
Improving Graduated Driver Licensing in Wisconsin,
Deena Liska, MEd, Milwaukee, WI

Causeway I-III

12:00-1:30 Lunch Round Table Discussions

Topics/Moderators:
Bike/Pedestrian: Pina Violano, PhD, MSPH, RN-BC, CCRN, CPST & Chuck Pruitt, MD
Bike/Pedestrian: Mary Beth Moran, PT, MS, MEd & Jim Dodington, MD
Firearm Injury Prevention: Cassie Simeona, MPH & Judy Schaechter, MD, MBA
Firearm Injury Prevention: Marie Crandall, MD, MPH, FACS & Eileen McDonald, MS
Home Safety: Terri McFadden, MD & Amy Hill, MS
Home Safety: Lois Lee, MD, MPH, FAAP, Hope Mullins, MPH & Dawne Gardner, MBA, CPST
Child Passenger Safety: Kathy Monroe, MD, MSQI & Garry Lapidus, PA-C, MPH
Child Passenger Safety: Benjamin Hoffman MD, FAAP, CPST-I & Dina Burstein, MD
Data/Program Evaluation: Joyce Pressley, PhD, MPH & Suzanne McLone, MPH
Data/Program Evaluation: Michael Levas, MD, MS & Michael Gittelman, MD
Safe Sleep: Kristen Bechtel, MD & Lessa Payne, BS
Safe Sleep: Sarah Gard Lazarus, DO & Adrienne Gallardo, MA, CPST-I

Salons A-D

1:30-1:35 **Introduction of Keynote Speaker & Pioneer Award Winner, Phyllis Agran, MD, MPH, FAAP**
Michael Gittelman, MD

1:35-2:00 **Keynote Speaker Pioneer Award Winner,** Phyllis Agran, MD, MPH, FAAP, Orange, CA
Pediatric Injury Prevention Policy Successes, Gaps and Opportunities:
Incorporating Social Determinants in Policy Formulation
Child health experts, pediatricians and pediatric health, education, and social service professionals are the voice of children. We can affect systems changes at the local, state, national and international levels. Effective strategies include advocacy partnerships with other public, private, community-based organizations and families. Incorporating the social determinants of health in the early stages of policy formulation will contribute to ensuring successful policy outcomes for all children. Examples

of policy successes, gaps and opportunities, drawing on child passenger safety and drowning prevention will be discussed. Both the Injury Free Coalition for Kids and the American Academy of Pediatrics are strong policy advocates and mentor the next generation of health professionals.

Participants in this session will learn to:

1. Discuss at least 2 national, state or local injury prevention policy successes and a brief history of the policy achievement.
2. Discuss at least two examples of policy gaps: how can you work as an individual and member of your organizations to advocate for change?
3. Develop an innovative injury prevention policy that incorporates the social determinants of health, such as poverty, environmental and other adverse childhood experiences.
4. Identify two organizational advocacy tool kits.
5. Name your U.S. Congressional Representative and Senator; your State Representatives, and local mayor.

2:00-2:15 Break

Salons A&B

2:15-3:15 **Workshop Session IA**
Race, Bias, and Injury

Moderator: Judy Schaechter, MD, MBA, Miami, FL
Presenters: Terri McFadden-Garden, MD, Beth Ebel, MD, MSc, MPH, Brandon Chatani, MD, Karen Sheehan, MD, MPH, Helen Arbogast, MPH, CHES, Erik Cliette, BA, MS

Remarkable disparity in injury incidence has been documented in general and for specific types of injury. Even where research has evidenced declines in overall injury rates, rates have remained higher for minority children, particularly Black and Native American children. Race, ethnicity, gender, and gender preference predict risk of violent injury. Crash and pedestrian injury risk vary by demographic group, as does child poisonings. Minority sexual identification poses increased risk of assault, self-harm and sexual trafficking. For some types of injury, such as drowning, exposure does not directly predict increased risk for minorities. Understanding specific findings within injury categories may help better target prevention efforts. This workshop will explore location and population variance as well as interventions designed to address injury disparity. In addition, it will explore the role of bias in creating, augmenting or neglecting to address the disparity gap. Which factors related to environment, design, behavior, education and resource allocation might be augmented or adapted to reduce injury disparities? Is enough being done to understand the inequities involved and the populations affected? What approaches are necessary to prevent trauma and close the disparity gap?

Participants in this session will learn to:

1. Describe childhood injury as a disparity health issue.
2. Identify potential etiologies for particular injury disparities in terms of environmental, mechanistic, educational, resource and social bias factors.
3. Discuss methods to eliminate injury disparities.
4. Describe disparities in childhood injury;
5. Discuss potential means to accelerate the reduction or elimination of injury disparities.

Salons C&D

2:15-3:15 **Workshop Session IB**
How to Get Your Work on Paper and Then to Presentation: How to Write a Scientific Abstract,
Moderator: Marlene Melzer-Lange, MD, Milwaukee, W
Presenters: Dina Burstein, MD, MPH, CPSTI, Pina Violano, PhD, MSPH, CPS-T, Michael N. Levas, MD, MS, Lois K. Lee, MD, MPH

Writing a scientific abstract is an important skill to learn, but also can be a daunting task. Showcasing your program or research study at professional meetings is dependent upon your abstract being accepted. Clear, high-quality and concise abstracts are the key to success. The basic format typically includes: Background (including objectives of program/study), Methods, Results, and Conclusions. In this workshop, first we will explain the content that should be included in each of these sections. We will review examples of abstracts. Then we will divide into small groups to practice writing each section of the abstract as well as reviewing some sample abstracts. Participants will be asked to bring some information, data, or a working abstract related to a program/study to use for their abstract writing practice. For those participants who do not have specific data, study examples will be provided.

Participants in this session will learn to:

1. Discuss the format behind writing a scientific abstract.
2. Describe the objectives, methods, and results of abstracts.
3. Recognize the techniques of writing and reviewing scientific abstracts.
4. Recognize how to write their own abstract with coaching.
5. Identify how to critique and review others' abstracts.

3:15-3:30 Break

Salons A&B

3:30-4:30

Workshop Session 2A
Race and Injury: Introducing New Framework for Thinking about Racial Disparities
Moderator: Sadiqa Kendi, MD, FAAP, Washington, DC, and Ibram Kendi, PhD
Ibram Kendi won the National Book Award in 2016 for his New York Times bestselling book "Stamped from the Beginning: The Definitive History of Racist Ideas in America". This book introduced a new way of thinking about racist ideas and racial disparities, reminding us that behind every racial disparity is a racist policy (or in many cases multiple racist policies). Ibram Kendi's wife, Sadiqa Kendi is a pediatric emergency medicine physician and injury prevention researcher. They will work together to facilitate this workshop, which will take some of the known racial disparities in injury, and create interactive sessions with participants to think about policies which contribute to those disparities, and potential solutions.

Participants in this session will learn to:

1. Recognize racial disparities within unintentional injuries.
2. Identify racist and discriminatory policies which contribute to racial disparities.
3. Describe action steps to address the discriminatory policies.
4. Describe how to initiate the action steps in the individual's role.
5. Describe how to initiate the action steps in the individual's institution or community.

Salons C&D

3:30-4:30

Workshop Session 2B
Integrating Patient Reported Outcomes and Interactive Dashboard Technology into Program Evaluation

Moderator: Michael Levas, MD, MS, Milwaukee, WI
Presenters: Marlene Melzer-Lange, MD, Brooke Cheaton, MS, Mark Nimmer, MS

Youth directly exposed to interpersonal violence are at risk for experiencing emotional/behavioral problems and future re victimization. Patient Reported Outcomes (PROs) enable researchers and clinicians to quantify and compare the effect of interventional programs. Previous work by this team has shown that 1) youth victims of violence suffer significant impairment in PROs compared to both healthy populations and youth with specific disease burdens; 2) social and environmental factors influence PROs in this population; and 3) brief hospital-based programming directed at violently injured youth resulted in improved violently injured youth enrolled in Project Ujima are evaluated upon intake and at 3-month intervals. Mean PRO scores have improved over time among program participants across multiple domains including anger (58.45 vs 45.15), psychological stress experience (56.64 vs. 46.7), emotional well-being (63.37 vs. 84.47), and psychosocial well-being (64.17 vs. 83.95). In multiple regression analyses the significance of time in programming remains important but were also associated with social determinants of health including community levels of violence, witnessing domestic violence, history of school troubles, and experiencing bullying. The integration of this data into case management and program evaluation through dashboard technology has allowed for more evidence-based approaches to intervening in the lives of youth victims of violence.

Participants of this session will learn to:

1. Discuss the development of an evidence-based evaluation process for programming using PROs beginning with the development of the evaluation battery.
2. Describe initial findings in feasibility and importance of the measures
3. Recognize measures needed for evaluation in electronic databases and tools.
4. Discuss the real-time integration of these measures into individual case management through the use of dashboard technology.
5. Identify barriers to developing evidence-based practice in youth violence intervention.

Agenda, cont.

Room 209

4:30-5:30 **Group Meeting**
Young Faculty: Maneesha Agarwal, MD, Atlanta, GA

Salon E

5:30-6:30 Reception

Causeway I-III

6:30 Dinner, Awards Presentations, and Drum Karaoke

Sunday December 2, 2018

Gulfstream A

8:00-9:15 IAMSBIRT Group Meeting: Michael Mello, MD, MPH, Providence, RI

Salons A&B

8:00-9:15 ASK/Gun Buyback Group Meeting: Michael Hirsh, MD, Worcester, MA

Salons C&D

8:00-9:15 Safe Sleep Group Meeting: Adrienne Gallardo, MA, CPST-I, Portland OR

9:15-9:30 Break

Salons A-D

9:30-10:00 **Business meeting:** Wendy Pomerantz, MD, MS, FAAP, Board Chairperson, Cincinnati, OH

10:00-11:15 **Lightening Rounds: Striking New Research Findings in the Injury Prevention World**
Cutting edge research and programming designed to address a variety of injuries contributing to injury being the number one killer of children. Included such hot topics as gunshot wounds and opioid addiction injuries. In addition, the session will also cover some classic topics like motor vehicle, pedestrian and home safety trends. We will learn about mobile injury prevention education and finally, our neighbors from the North, will tell us about developing trends in Canadian injury prevention.

Moderators: Steve Rogers, MD, MS-CTR, Hartford, CT
Maneesha Agarwal, MD, Atlanta, GA

Participants in this session will learn to:

1. Describe trends in rear facing restraint use before and after AAP recommendations encouraging rear facing restraints.
2. Characterize car seat observations with teen mothers and their support persons during home visits after an educational intervention.
3. Recognize the greater number of pediatric gunshot wounds in impoverished areas without significant change, signifying the need for alternative community-based firearm injury prevention efforts.
4. Describe methods to reach new audiences on injury prevention topics, including partnerships with WIC, residential drug treatment facilities, and use of an injury prevention van.
5. Demonstrate how a national injury prevention working group can advocate successfully for injury prevention awareness and related changes that reduce the burden of injury.
6. Describe and demonstrate how the Transtheroretical Model can be used during the planning and implementation of a community-based injury prevention program.

Agenda, cont.

11:15-12:00 **Manned Poster Session**

Poster Presentations:

This interactive poster session will have presenters provide the plenary session with a brief synopsis of work being done to address the number one killer of children. A few minutes of group discussion following each presentation. Following the presentation in the plenary session, poster session attendees will walk poster to poster in an arranged fashion so that all the presenter's posters will be viewed. Also, posters will remain visible throughout the day so that further questions by attendees can be brought forward to the researcher. Session moderators will lead the group

Restraint Use and Injury in Forward and Rear-Facing Infants and Toddlers Involved in a Fatal Motor Vehicle Crash,
Joyce C. Pressley, PhD, MPH, New York, NY
Creating a National Voice for Injury Prevention,
Jane Edwards, MSc, London, Ontario
Twenty years of Pediatric Gunshot Wounds in Our Community: Have We Made a Difference?,
Lilly Bayouth, MD, Greenville, NC
Falling rates of Television-Related Injuries in Children,
Maneesha Agarwal, MD, Atlanta, GA
Improving Home Safety Knowledge and Behaviors Among Low Income Women,
Purnima Unni, MPH, Nashville, TN
Presenting Injury Prevention to Opioid-Addicted Populations,
Tiffany Egan-Rojas, MPH, Indianapolis, IN
Knowledge of Nighttime Driving Restrictions in State Graduated Driver Licensing Laws,
Kathy Monroe, MD, MSQI, Birmingham, AL
Evaluating Outcomes of Car Seat Fittings with a Certified Child Passenger Technician,
Sherifatu Walton-Buford, MFT, Little Rock, AR
Application of the Transtheoretical Model to a Traffic, Pedestrian and Bicycle Safety Program,
Priscila Hegger, MPH, CPST, San Diego, CA
National Injury Prevention Day in Canada,
Tania Haidar, BSc, London, Ontario
Expanding Community Outreach with an Injury Prevention Van Program,
Barbara Digirolamo, MEd, CPST-I, Boston, MA
Characteristics of Pediatric Patients with Retained Bullet Fragments and Need for Routine Serum Lead Monitoring: A Prospective Cohort Study,
Todd Fleenor, MD, Huntsville, AL

Accreditation

Continuing Medical Education

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Cincinnati Children's and the Injury Free Coalition for Kids at the Center for Injury Epidemiology and Prevention, Mailman School of Public Health, Columbia University. Cincinnati Children's is accredited by the ACCME to provide continuing medical education for physicians. Cincinnati Children's designates this live activity for a maximum of 13 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure

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.

23rd Annual Injury Free Coalition for Kids® National Conference

Forging New Frontiers: Pediatric Injury Prevention – Process, Programs and Progress

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Amber Kroeker, MPH, CPST, Portland, OR
Jacky Kwong, BS, Milwaukee, WI
Garry Lapidus, PA-C, MPH, Hartford, CT
Sarah Gard Lazarus, DO, Atlanta, GA
Lois Lee, MD, MPH, FAAP, Boston, MA
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PLATFORM ABSTRACTS

Practicing What We Preach: Modeling a Safe Sleep Environment for Hospitalized Infants

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Background:

Sudden unexpected infant death is one of the major causes of infant mortality nationwide. From medical examiner reports for infants under age 1 in San Diego County, there were 83 deaths attributed to unsafe sleep conditions, compared to 7 due to motor vehicle accidents over a 15-year period (2000 to 2016). Car safety is a routine part of well child visit education; However, standard education on Safe Sleep recommendations and adherence to Safe Sleep practices in hospitals is highly variable. Objectives: Improve medical staff and parent knowledge of, and compliance with, Safe Sleep recommendations for hospitalized infants under age 1 in our tertiary care children's hospital.

Methods:

An interdisciplinary team was created, and a formal hospital policy was established and disseminated. To achieve stakeholder, buy-in from nursing, house staff, NICU staff, and outpatient physicians, several presentations about the importance of Safe Sleep were given. Nurses, residents, pediatric attendings and nurse practitioners were asked to complete an Ishikawa (Fish bone) diagram to assess perceived barriers to adherence to Safe Sleep AAP guidelines for hospitalized infants. Plan-Do-Study-Act (PDSA) interventions were informed by this key stakeholder input. Cycle1: training; policy; audits; Cycle 2: Grand Rounds; Cycle 3: parent intake questionnaire; Cycle 4: simplified Failure Mode Effect Analyses (anonymous online survey for nurses). Regular audits of cribs for hospitalized children under one year of age were performed and analyzed.

Results:

The greatest number of violations of Safe Sleep practices occurred with extra bedding (53%), followed by toys (11%), extra diapers (6%), wipes (6%) and pillows (6%). Initial interventions included education to staff and policy implementation; however, proportion of Safe Sleep-perfect beds remained at a median of 7%. The simplified Failure Mode Effect Analyses asked nurses about their perceptions about Safe Sleep in the hospital.

65 nurses responded and rated the 5 most dangerous safe sleep errors in the following order:
1. Co-sleeping,
2. Pillow in crib,
3. Side rails down,
4. Fluffy blanket in crib,
5. Sleeping on the belly

It was felt that the 5 easiest errors to address in the hospital were:
1. Putting side rails up,
2. Removing pillow from crib,
3. Addressing bed-sharing,
4. Removing fluffy blanket from crib,
5. Having infant in crib, not adult bed.

Conclusions:

Twelve months into this QI project, the use of extra bedding has been identified as the most common violation. However, despite implementation of a Safe Sleep policy and education to key stakeholders, adherence to these practices remains low. Higher level interventions are needed. Next steps include: Audits to investigate which extra bedding types are most commonly used, implementation of infant sleep sacks, parent questionnaire about home adherence to Safe Sleep on admission, parent questionnaire at discharge to assess if safe sleep was discussed during hospitalization and if parents are implementing changes at home as well as ongoing education for parents and all staff.

Objectives:

Attendees will learn:
1. To Recognize difficulties of implementing safe sleep environment for all hospitalized infants in a large children's hospital.
2. To discuss strategies to achieve key stakeholder buy-in (nurses, parents, physicians).
3. To understand different ways to evaluate the impact of programs tailored to improve adherence to safe sleep guidelines.

Modifiable Sleep-Related Risk Factors in Non-Natural Infant Deaths

Anna Briker, BS, Suzanne McLone, MPH, Maryann Mason, PhD, Karen Sheehan, MD, MPH, Nana Matoba, MD, MPH

Background:

Each year, approximately 3,500 infants in the United States die from sleep-related deaths. The number of sleep-related infant deaths has decreased overall since the 1990s, but disparities in sleep-related deaths persist between different populations. The purpose of this study is threefold: to establish the magnitude of preventable sleep-related infant deaths in a large metropolitan area; to identify possible trends among the cases; and to establish a baseline for possible interventions.

Methods:

We conducted a retrospective study of the epidemiology of infants less than 6 months of age

who died in a metropolitan county (5.3 million people) in 2015 and 2016, in which there was at least one modifiable sleeping risk factor present and the manner of death was undetermined. Data was obtained from the state's Violent Death Reporting System (VDRS), a surveillance system that compiles relevant information about the circumstances of unnatural deaths, including information from the medical examiner, law enforcement, and crime lab. Among the cases, race/ethnicity, gender, month of birth, and age of the children were identified. Trends in location in the county and the circumstances of the deaths (for instance, co-sleeping) were also evaluated. Frequencies, percentages, and Chi-square analysis were used to describe and characterize distribution of these deaths by person and place to identify specific populations at increased risk.

Results:
In this county in 2015 and 2016, 116 infants less than six months of age died in an undetermined manner. The median age of death was two months. Of these deaths, 54.3% of the infants were boys. 65.7% of the infants who died in an undetermined manner were African American and 21.3% were Hispanic. (Of note, African Americans comprised 31% and Hispanics comprised 36.7% of children less than five years of age in this county in the same time period.) In 72% of the cases, at least one known sleeping risk factor was present. 67% of the infants who died were co-sleeping and 31% were sleeping with pillows, blankets, or other items. In 16.4% of the cases, it could not be determined whether a sleeping risk factor was present or not.

Conclusions:
The presence of modifiable sleep-related risk factors indicates that these deaths were preventable. The characterization of the deaths can help to identify key populations at risk; African-Americans were disproportionately represented. These data can be used as a baseline comparator in the future when evaluating the utility of interventional programs to prevent sleep-related infant deaths in the county.

Objectives:
Attendees will learn:
1. To recognize that the majority of unnatural infant deaths in this urban population in 2015 and 2016 involved at least one sleeping risk factor.
2. To determine that infant deaths involving sleeping risk factors are potentially preventable.
3. To recognize that in this urban population, African American infants were disproportionately affected by deaths in which the manner of death was undetermined.

As Easy as ABC: Do Crib Cards and Tracking Boards Improve Safe Sleep in a Free-Standing Pediatric Hospital?

Sarah Lazarus, DO, Manon Billaud, MPH, Terri Miller, MPH, CHES, Terri McFadden, MD, Jonathan Johnson, BSN

Background:
Sudden unexpected infant death (SUID) and sudden infant death syndrome (SIDS) remain leading causes of infant death despite numerous efforts promoting the ABC's of safe sleep (alone, on back and in a crib). With an average of three sleep-related deaths weekly, Georgia is 6th in the nation for infant mortality. A recent Georgia Department of Public Health (DPH) campaign provided education to all 78 birthing hospitals in the state, improving nursery compliance with current American Academy of Pediatrics (AAP) "Recommendations To Reduce the Risk of SIDS and Other Sleep-Related Infant Deaths". In October 2017, a tertiary-care free-standing pediatric facility partnered with the DPH to include a children's hospital in their campaign to model safe sleep for infants under 12 months hospitalized after the newborn period. To promote safe sleep compliance, safe sleep signs with a checklist were utilized.

Methods:
Using the DPH crib audit tool, 100 crib audits were conducted in October 2017, using a non-random convenience sampling. This audit evaluated all hospitalized infants including intensive care patients. Following the results of this evaluation, crib cards with check marks were created to emphasize the ABC's of safe sleep. The crib cards were laminated and hung on cribs of infants admitted to two general pediatric floors and served as a nudging technique to remind staff caregivers and families to provide a safe sleep environment for the infant. After application of the signs, 102 audits were performed over a four-week period. Progress was tracked and displayed to show compliance rates.

Results:
100 cribs were audited prior to intervention and 102 cribs post-intervention. The results showed a significant increase in compliance with overall AAP sleep position and environmental recommendations from pre to post intervention from 2% to 18% ($p < 0.01$). Although there was not a significant change in adherence to the sleep position recommendation, 47% to 48%, ($p = .95$), there was a significant increase in adherence to the safe sleep environment recommendation, from 4% to 34% ($p < .01$). Interestingly, infants with a safe sleep sign on their cribs were not more likely to be in compliance with AAP recommendations. Only one infant with a safe sleep sign displayed was in compliance with

recommendations (1%), as compared to 17 infants in compliance who did not have a safe sleep sign present (17%, p=0.95)

Conclusions:
Crib cards may be a helpful adjunct to education to promote safe sleep practices in the hospital environment. However, crib cards alone did not play a significant role in this change. Future research is needed to understand what factors caused the improvement in compliance, and to understand what additional educational materials should be used for a larger impact. More training and education are necessary to understand barriers to safe sleep in the tertiary care setting.

Objectives:
Attendees will learn:
1. To describe an intervention that is a visual cue to assist healthcare providers and nurses in following AAP recommendations.
2. To evaluate change in safe sleep patterns on two general pediatric floors after initiation of a safe sleep program in a tertiary-care pediatric hospital.
3 .To determine if crib cards were effective tools in improvement of compliance rates with safe sleep recommendations.

Sleep Baby Safe: Moving Safe Sleep from Campaign to Conversation

Amanda Bagin, MPH, CHES, and Amy Parry, MPT, MPH

Background:
Families report receiving mixed messaging on how to safely sleep their infants from many sources, including pediatricians, lactation consultants, family members and others. Improving safe sleep practices has been a public health campaign but many families have circumstances that prevent them from following the American Academy of Pediatrics (AAP) guidelines. Sleep Baby Safe uses trainings and resources that increase professionals' knowledge and confidence to have effective conversations with families about safe sleep.

Methods:
Data collected through Child Death Review and Fetal Infant Mortality Review meetings showed that most infants in Wisconsin dying suddenly and unexpectedly were in a sleep environment with at least one unsafe sleep factor as defined by the AAP. The Sleep Baby Safe training and resources are based on information collected through focus groups that were held throughout Wisconsin in late 2014. The training was then piloted in 2015 in five communities before being disseminated statewide in 2016. The training and resources have since been adapted by local public health departments and tribal agencies in Wisconsin working on safe sleep as a maternal and child health grant objective.

Results:
Pre and post-tests from 2016 and 2017 have shown an increased rate of confidence and knowledge on safe sleep. On the pre-test, 51 percent of participants could not list any of the ABCs and only 10 percent listed all four of the ABCs: alone, on the back in a crib and in smoke-free air. During the post-test, the majority (93 percent) could list either three of four, and 81 percent listed all four ABCs. Based on the results of the data from the pre- and post-tests, the three areas with the greatest improvement in knowledge are: (1) the ABCs of safe sleep, (2) appropriate safe sleep environments, and (3) the fact that breastfeeding reduces the risk of sudden and unexpected infant death. During the post-test, the greatest proportion of participants rated themselves highly confident in speaking with families about safe sleep (58 percent) and in answering families' questions about safe sleep (57 percent).

Conclusions:
Data from the first two years of implementation shows that professionals who receive training have an increased knowledge and confidence on having conversations with families about safe sleep. Additionally, the tools that are distributed along with the training have shown to be useful to these professionals. Sleep Baby Safe equips professionals with knowledge and confidence to have conversations with families about adopting safe sleep practices for every sleep period. Professionals receiving this training will provide a consistent safe sleep message to parents and caregivers.

Objectives:
Attendees will learn:
1. To discuss Sleep Baby Safe training and implementation in Wisconsin.
2. To recognize methods to incorporate safe sleep conversation skills into safe sleep messaging.
3. To identify resources and ideas for your community.

Racial and Ethnic Disparities in Sudden Unexpected Infant Deaths. Wide Variations in Large US Cities

Douglas Roehler, PhD, MPH, and Kyran Quinlan, MD

Background:
Sudden unexpected infant deaths (SUIDs) are a serious public health problem in the United States. With making little progress over the past two decades at lowering the SUID rate, researchers must continue to

seek new angles and perspectives to information SUID interventions. In the US, living in urban areas tend to be protective from ill-health. A recent CDC study found that Americans living in rural areas are more likely to die from the five leading causes compared to those living in urban areas. However, in an earlier study we found that when comparing Chicago SUID rates to national rates, this urbanicity protective factor disappears. Nationally, non-Hispanic Blacks (NHB) are at more than double the risk of SUIDs compared to non-Hispanic Whites (NHW), however, in Chicago we found that NHBs are at 10 times the risk compared to NHWs. The objective of this study is to explore SUID rates in some of the most populated urban centers in America, and to compare national SUID rates based on city population size.

Methods:
SUID cases were obtained from the 2013-2015 US period-linked birth-infant death databases. SUIDs were defined using the International Classification of Diseases (ICD-10) codes for sudden infant death syndrome (R95), other ill-defined and unspecified causes of mortality (R99), and accidental suffocation and strangulation in bed (W75). The authors received a customized US period-linked birth-infant death database that included population statistics for the city where the death occurred. The authors selected four cities with over 1 million inhabitants for in-depth investigation: Chicago, New York City (NYC), Phoenix, and Philadelphia. Rates are reported per 100,000 live births.

Results:
Of the four cities studied, Philadelphia had the highest overall SUID rate per 100,000 live births (126) and NYC had the lowest overall SUID rate (43). The NHB-NHW racial disparity was greatest in Chicago: 235 SUIDs (NHB) and 18 SUIDs (NHW) per 100,000 births for a rate ratio of 12.8. For the other 3 cities, NHB-NHW rate ratios varied from 1.9 in Phoenix to 4.3 in NYC. While the national Hispanic SUID rate (per 100,000 live births) is 53, Philadelphia had the highest Hispanic SUID rate (126) and Chicago had the lowest Hispanic SUID rate (35). In cities with over 1 million inhabitants, the Hispanic SUID rate is 55.2 per 100,000 births, and 53.1 in smaller cities. Comparatively, the NHW SUID rate is 41.9 and the NHB rate is 166.8, comparatively for cities < 1,000,000 inhabitants, the rates are 87.3 and 182.2, respectively.

Conclusions:
There is dramatic variation in race/ethnicity disparities of SUID in large US cities, with a greater than 12 times higher rate in NHBs compared to NHWs in Chicago. Hispanic SUID rates also vary widely with particularly high Hispanic rate in Philadelphia. Deconstructing the national SUID rate by race/ethnicity and by urbanicity may help to provide insights useful to focus prevention efforts.
Objectives:
Attendees will learn:
1. To understand the SUID risk for 4 of the largest cities in America.
2. To recognize the dramatic racial disparities associated with SUIDs.
3. To begin to identify the intersection of population and race related to SUIDs.

Not All Fun and Games: Providing Education to Healthcare Professionals Through a Safe Sleep Carnival

Sarah Lazarus, DO, Cheryl McCarthy, BSN, RN, RNC-NIC, Terri McFadden, MD, Terri Miller, MPH, CHES, Naomi Warnick, JD, Jonathan Johnson, BSN

Background:
Sudden unexpected infant death (SUID) and sudden infant death syndrome (SIDS) remain leading causes of infant death despite numerous efforts promoting the ABC's of safe sleep (placing babies alone, on their backs and in a crib). With an average of three sleep-related deaths weekly, Georgia is 6th in the nation for infant mortality. A recent Georgia Department of Public Health (DPH) campaign provided education to all 78 Georgia birthing hospitals, improving nursery compliance with the current American Academy of Pediatrics (AAP) "Recommendations To Reduce the Risk of SIDS and Other Sleep-Related Infant Deaths". To date, free-standing children's hospitals in Georgia have not been included in this initiative. Partnering with DPH in April 2018, a tertiary-care suburban hospital hosted a "safe sleep carnival" as a unique educational experience for healthcare professionals.

Methods:
The carnival was hosted at a free-standing children's hospital. Modules included a "safe swaddle" station, breast feeding station, poster sessions, and a "find the mistake" station, where staff could identify what was wrong in a crib. Educational stations were intermingled with carnival games, such as a bean-bag toss and football throw. A slideshow presentation was done in a "movie theatre" with popcorn and cotton candy. Clinical nursing education credits were awarded and prizes were given for participation. Costs were covered by donor funds from the intensive care units. Post-participation evaluations were collected for each session to measure satisfaction and learning. Additional safe sleep initiatives concurrently took place, including crib audits, crib signs with check-lists and tracking boards, resulting in improved compliance with AAP recommendations.

Results:
Three provider sessions were completed with 73 attendants. These included 60 nurses (82%), 4 patient care technicians (5%), 5 nursing students (6%) and, 4 ancillary staff (5%). Of the 73 attendants, 60 post-participation evaluations were completed. Attendants of the sessions ranked responses on a Likert scale, (1-->5), with 1 being "strongly disagreed" and 5 "strongly agreed". Participants felt that the program met their professional needs (μ=4.75) and the environment was conducive to learning (μ=4.82). After the sessions, they felt they could identify barriers to back sleeping (μ=4.83) and they could describe 2 ways to effectively communicate SIDS reduction message to parents and care-givers (μ=4.81). 53/57(93%) and respondents stated that they anticipated that the information presented in the session would lead to a change in practice.

Conclusions:
A safe sleep carnival is an innovative way to promote improved nursing and staff understanding and modeling of safe sleep. The vast majority of attendants felt that the information given in this format would change their practice. The majority of attendants rated the carnival environment conducive to learning.

Objectives:
Attendees will learn:
1. To recognize a safe sleep carnival as an innovative way to promote improved nursing and staff understanding and modeling of safe sleep.
2. To describe why a vast majority of attendants of a carnival felt that the information given in this format would change their practice.
3. To identify why attendants rated the carnival environment conducive to learning.

Effectiveness of a Safe Sleep Practice Educational Intervention to Promote Behavior Change

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Background:
Sudden Unexpected Infant Death (SUID) is a leading cause of post-neonatal mortality in the United States resulting in approximately 3,500 deaths per year. According to the American Academy of Pediatrics (AAP; 1992), safe sleep environments are modifiable risk factors that can reduce SUID. To educate the community about best practices and decrease infant mortality, our institution utilized funds from a $25,000 grant by the Ronald McDonald House to start the North Philadelphia Cribs for Kids program to provide parents with AAP best practice recommendations and pack 'n play pens to create safe sleep environments.

Methods:
Local organizations, social workers, healthcare providers, and the Injury Prevention Coordinator (IPC) identified 46 families in need of a safe place for a child to sleep through home safety needs assessments performed between April and October 2017. Caregivers were scheduled for a one-on-one or group workshop with the IPC concentrating on the dangers of co-sleeping, sleeping on sofas, sleeping with blankets, pillows, soft toys, sleeping on stomach and exposure to smoke. Prior to the workshop, caregivers were administered a seven-item questionnaire to determine their baseline knowledge about safe sleep practices. Following the workshop, a post-test with the same seven items as the pre-test, and two additional questions related to intentions of future safe sleep practices, were administered and completed by caregivers. Lastly, caregivers were provided with a Pack 'n Play pen with demonstration of proper set-up and breakdown. Results from the pre-test and the post-test were compared using paired samples t-tests.

Results:
In a six-month period, 46 caregivers participated in safe sleep workshops; however, only caregivers who completed both the pre-intervention and post-intervention questionnaire were included in analyses. Caregivers (n = 30) were mainly middle age (Male = 29.59 years) African-American individuals, earning between $0-10,000 annually. A two-tailed paired samples t-test was performed to determine if the workshop improved caregivers' knowledge about safe sleep practices. Results revealed that there was a statistically significant increase in safe sleep knowledge from the pre-test (M = 75.17, SD = 21.50) to the post-test (M = 84.33, SD = 20.53); $t(29) = -2.96$, $p = 0.006$. Further, 76% of caregivers were "extremely likely" to place their baby on their back for every sleep, and 100% of participants were convinced that it was safest for their baby to sleep in their own separate, uncluttered sleeping area, and that they intended to conform to this practice after the workshop.

Conclusions:
Results suggest safe sleep education workshops increase caregivers' knowledge about safe sleep and motivate them to engage in best practices following the workshop.

Objectives:
Attendees will learn:
1. To identify the effectiveness of safe sleep education intervention workshops by measuring a parents pre- and post-test knowledge.
2. Ways to motivate caregivers to follow AAP safe sleep recommendations.
3. How to demonstrate the convenience and practices of the travel pack 'n play system.

Infant Child Death Review: Moving from Recommendation to Action in Injury Prevention

Dawn Porter, BS, Mary Aitken, MD, MPH, Samantha Mullins, MPH, Beverly Miller, MEd

Background:
Child Death Review (CDR) programs began as early as 1978. CDR programs conduct multi-disciplinary case reviews to better understand circumstances of unexpected deaths to children and to make recommendations of how similar deaths can be prevented in the future. A 2011 paper suggested that CDR programs have the capacity to move beyond recommendations into action-driven injury prevention that responds to the needs of their community. Coordinating a state CDR program that is <10 years in existence and administered through an injury prevention center afforded the opportunity to demonstrate this finding.

Methods:
We applied the Prochaska and DiClemente's Transtheoretical or Stages of Change model to guide the maturation of the local CDR teams and their readiness to conduct injury prevention. Similar to an individual's readiness for change, teams move through stages of change, developing from an awareness that child deaths are a problem (pre-contemplation), empowering a team to address the problem (preparation), taking action to prevent child deaths using team recommendations (action), and sustaining evidence-based messages (maintenance). Using this framework, a statewide educational campaign on safe sleep was designed and implemented with assistance from local CDR teams. A pre/post campaign survey was administered to determine effectiveness of the campaign in changing knowledge, attitudes, and beliefs and exposure to messaging.

Results:
Criteria for each of the five stages was established. An assessment revealed that 6 of the 10 teams met in the action stage. Safe sleep was prioritized as a need due to 94% of the 131 infant deaths reviewed being sleep-related. The campaign consisted of a highly publicized kick off and a tailored multi-media message campaign statewide. The safe sleep message was displayed on 19 billboards in CDR regions with the highest rates of sleep-related deaths, with an estimated exposure of 258,000 citizens per day. Over 21,000 pieces of print material with safe sleep messaging were distributed through health and social services outlets. Social media generated by local CDR teams and radio PSAs was used. Seventy participants from 7 of the 10 local ICDR team regions completed the 10-item pre-campaign survey in July and August 2016. There was an increase in knowledge of co-sleeping sleeping not safe (82% pre, 97% post) and back to sleep is safest (75% pre, 95% post).

Conclusions:
Utilizing CDR teams is an effective method to disseminate injury prevention campaigns and interventions, especially in a state with limited capacity for injury prevention. In addition to a statewide effort, CDR teams who were in the action stage are now maintaining consistent messages through localized strategies specific to circumstances of death reviewed by the team. Building on this success, the area of emphasis for FY 18 is suicide prevention. A strategic planning committee was formed in 2018 to further teams' ownership in the maintenance stage.

Objectives:
Attendees will learn:
1. To identify to Child Death Review teams.
2. To recognize how the Child Death Review teams were utilized to disseminated education campaign materials.
3. To describe how to engage Child Death Review teams in injury prevention.

Creating a Statewide Network of Hospitals Addressing Safe Sleep

Lessa Payne, BS, and Beverly Miller, MEd

Background:
The state SIDS rate is 4 times higher than the national rate. Forty-two infants would not die if the rate was improved to the national rate. In 2013, a task force was convened with the nurseries of two hospitals to improve compliance with AAP recommendations and resulted in a toolkit for implementation. In 2015, a collaborative effort between the injury prevention program at a pediatric hospital, the Maternal Health COIIN network within the state's public health department, and the state's hospital advocacy organization began an effort to replicate the process statewide with an end goal of increasing the number of hospitals that complete some level of the Cribs for Kids Safe Sleep Hospital Certification.

Methods:
An electronic survey was distributed to all birthing hospitals in the state. The purpose of the survey was to determine current policies, implementation of guidelines, evaluation of compliance, educational activities, and interest in learning more. Site visits were conducted with hospital that were receptive to learning more and training was conducted with designated staff. Technical assistance was provided to the hospitals in completing their applications for certification.

Results:
Twenty-seven of 40 hospitals completed the survey. 61.5% of the respondents stated they did not have a written policy or guideline on how to place an infant for sleep while in the care of the facility. Audits of implementation are conducted at only 36.4% of the hospitals with standardized tools for measurement and regular intervals of audits used less frequently, 33.3% and 25.0%, respectively. All hospitals reported some type of staff education. A surprisingly high percentage of hospitals reported having a policy to educate parents (82.8%), although most of this was in the form of print materials given to parents (91.7%) predominately given to parents at the time of admission (25%) and discharge (50%).

Conclusions:
COIIN partnerships can be effective in promoting compliance with safe sleep recommendations at birthing hospitals. Endorsement from a state's hospital advocacy organization can enhance interest.

Objectives:
Attendees will Learn:
1. To describe methods used towards safe sleep certification.
2. To recognize the importance of collaboration when developing a state-wide safe sleep program.
3. To identify ways to engage partners in safe sleep certification.

ED Visits, Admissions, and Deaths for Pediatric Traumatic Brain Injury by Mechanism: A 10-Year Study

Holly Hanson, MD, MS, Wendy Pomerantz, MD, MS, FAAP, Michael Gittelman, MD

Background:
Studies have reported that Emergency Department (ED) visits for pediatric traumatic brain injury (TBI) caused by sports are increasing. Consequently, many educational tools, return to play and activity guidelines, and prevention efforts are focused on a sports mechanism for TBI. The objective of this study was to perform a ten-year analysis of the trends in ED visits, hospitalization, and deaths for non-sport TBI compared to those caused by sports.

Methods:
A retrospective study of children 5-18 years of age was performed at a pediatric, level 1 trauma center from 2002-2012. Subjects with a primary or secondary diagnosis of TBI were identified from the hospital's trauma registry, and mechanism of injury, disposition from the ED, injury severity score, and length of stay were recorded. Frequencies were used to characterize the population, Chi-square analysis was performed to determine differences between groups, and linear trend lines were calculated for sport-related and non-sport related TBI by year.

Results:
13,291 subjects were seen in the ED between 2002-2012 for a TBI; 71.7% were from a non-sport mechanism and 28.3% were from a sport mechanism. Subjects with a non-sport TBI were more likely to be younger, female, African American, or have Medicare/Medicaid. ED visits for sport-related TBI increased 92% and non-sport TBI increased 22% over 10 years. Those with a non-sport TBI were more often hospitalized or died. Sport had the lowest injury severity score and the shortest length of stay for TBI of any mechanism.

Conclusions:
ED visits for sport and non-sport TBI have increased over the past 10 years. TBI from a non-sport mechanism is more likely to result in hospitalization or death. Prevention efforts should be expanded to include all high-risk TBI mechanisms, not just sports.

Objectives:
Attendees will learn:
1. To define the most common mechanisms for TBI that present to the pediatric emergency department.
2. To understand that while ED visits for TBI related to sports injuries are increasing, as are those related to non-sport injuries.
3. To recognize prevention efforts and anticipatory/return guidelines should include non-sport related TBI.

Pilot of Primary Care Physician Discussion and Resource Allocation After Screening for Unintentional Injuries and Social Determinants of Health

Mike Gittelman, MD, Sarah Denny, MD, Samantha Anzeljc, PhD, Melissa Wervey Arnold, BSJ

Background:
Standardized screening tools, used by pediatric providers, can help to determine a child's risk for injuries and social determinants of health (SDH). This study determined if an office-based quality improvement (QI) program could increase targeted anticipatory guidance (AG) and community resource distribution to families for injury and SDH risks.

Methods:
Pediatric practices, recruited from the Ohio Chapter, American Academy of Pediatrics' database, self-selected to participate in a pilot QI program. Two age-appropriate screening tools, with corresponding talking points and local resources for birth–1 year and 1-5 year aged children were developed from unintentional injury questions used in a previous study combined with SDH screening questions from the Safe Environment for Every Kid (SEEK™) parent questionnaire. After a one-day learning collaborative, practice teams worked to implement the provided tools into every well-child care visit. During the 7-month collaborative (2 months of baseline data collection from reviewing charts), practices randomly reviewed 5 screening tools monthly for each age category to identify unintentional injury and SDH risks. An increase in targeted counseling and resource distribution was calculated over time. Providers received Maintenance of Certification (MOC) IV credit for participation.

Results:
Three practices (5 providers) participated. During the 5-month collaborative, 140 tools (n=69, birth-1-year tools, n=71, 1-5-year tools) were reviewed. For birth–1 year, the most common risky behaviors were unintentional injuries: not learning child CPR 45(65%), not having the car seat installed/checked by a healthcare professional 32(34%) and not securing furniture to walls 24 (35%). For 1-5 year screens, unintentional injuries were also most common: not learning child CPR 45(63%), not having the car seat installed/checked by a healthcare professional 44(62%) and child's access to choking hazards 34(48%). Families reported to practice riskier behaviors for all unintentional injuries compared to SDH for both age groups (birth – 1 year, SDH questions 48/897 (5%), unintentional questions 216/1449 (15%) and 1- 5 years, SDH questions 51/923 (6%), unintentional questions 227/1349 (17%). Also, families with older children reported to practice riskier behaviors compared to younger children (birth to 1 year, 264/2346 (11%), 1-5 years, 279/2272 (13%). Baseline discussions and resources provided for birth – 1 year was 22%; discussions about risky behaviors and providing appropriate resources increased to 100%. For 1-5 year families, at baseline discussions and resources provided was 25%; discussions about risky behaviors and resources provided increased to 100% by program conclusion.

Conclusions:
Using standardized screening tools, in an office setting, to determine SDH and unintentional risky behaviors for children < 5 years, enables pediatric providers a way to target discussions and offer resources to families. By incorporating a QI program into practice, screening for these risks and counseling occurs at a more consistent rate.

Objectives:
Attendees will learn:
1. To discuss new tools developed to screen for injury risk and social determinants of health in the pediatric office setting.
2. To recognize topics that pediatric providers need to emphasize in their counseling.
3. To understand limitations in a pilot program and how to develop next steps.

An Educational Intervention for Medical Students to Improve Firearm Injury Prevention Counseling

Jacky Kwong, BS Jennifer Gray, BS, Lisa Rein, ScM, Ying Liu, PhD, Marlene Melzer-Lange, MD

Background:
Limiting children's access to firearms is a fundamental challenge to pediatric injury prevention. Studies examining patient attitudes indicate significant concern about firearm injuries and willingness to discuss prevention strategies in patients with children. Most physicians support counseling patients about firearm injury prevention (FIP) but infrequently do so due to discomfort and lack of training. Current initiatives examine extensive training modules for residents but rarely investigate the benefits of providing similar training to medical students. This study aims to determine if a 20-minute educational intervention promotes FIP counseling in third-year medical students.

Methods:
This was a prospective study performed at a medical school associated with a tertiary care children's hospital during the 2016-17 academic year. Groups of 12-15 different third-year medical students were selected to receive either a 20-minute intervention

or control during a monthly pediatric lecture series rotation. The intervention consisted of two clinical vignettes, a brief discussion about the importance of FIP, and suggestions for clinical integration. Students also received gun locks and additional web-based resources. The control session was a case-based lecture about pediatric emergencies. All students completed baseline electronic assessments and those in the intervention group also completed post-intervention assessments immediately following the session. All students then completed a similar assessment after 6 months. Assessments evaluate students' beliefs, self-efficacy, and knowledge of FIP counseling.
Data was analyzed using Wilcoxon signed-rank tests (to compare within control and intervention groups) and Wilcoxon rank-sum tests (to compare between control and intervention groups). Participants with missing data were excluded by pairwise deletion.

Results:
We surveyed a total of 130 students – 54 from the control and 76 from the intervention group. 65 students completed the entire series of assessments (22 and 43 students respectively).
There were no significant differences in demographics or any of the measures (beliefs, self-efficacy, etc.) between the control and intervention at baseline. Immediately after the intervention, students felt more self-efficacious, had improved knowledge of FIP risk factors, and had beliefs more consistent with FIP counseling ($p < 0.001$ for all three measures). After 6 months, students still felt ready to counsel patients and retained knowledge of FIP risk factors ($p < 0.05$ for both). However, students were no longer confident in providing advice and resources to patients and their beliefs did not significantly favor FIP counseling. Additionally, students who received the intervention and resources were not more likely engage in a conversation about firearm safety.

Conclusions:
A 20-minute educational intervention moderately improved FIP counseling in third-year medical students. Students were adept at retaining FIP knowledge and modestly self-efficacious at providing counseling. But without further training, the beneficial effects of a one-time intervention will likely wane with time.

Objectives:
Attendees will learn:
1. To define a brief and dynamic firearm injury prevention training module.
2. To identify how to incorporate firearm injury prevention counseling into a medical school curriculum.
3. To determine further initiatives in maintaining firearm injury prevention counseling.

Social Workers' Determination of When Children's Access or Potential Access to Firearms Constitutes Child Neglect

Erin Evans, MD, Gerene Denning, PhD, Alycia Karsjens, LMSW, Charles Jennissen, MD

Background:
Pediatric firearm-related deaths and injuries could potentially be reduced by child access prevention (CAP) laws and a consensus in society that a child's access or potential access to a loaded firearm represents child neglect. The objective of this study was to determine social workers' assessment of child neglect with respect to access or potential access to a loaded firearm.

Methods:
Members of the National Association of Social Workers (N=4933) who had designated their practice as being "child/family welfare" were invited by e-mail to complete a survey in October and November, 2015. 485 completed the survey. Demographics, attitudes regarding CAP laws, and the ages at which social workers deemed several scenarios as child neglect were determined. Comparisons were performed using the chi-square test.

Results:
Child/family welfare social workers agreed or strongly agreed (≥92%) that there should be laws in place requiring firearms to be stored so that unwanted access cannot be obtained by a child, even up to 15 years of age. In a scenario where a child had potential access to a loaded firearm but never gained access, the presence of a CAP law pertinent to the child in the scenario significantly increased the likelihood that respondents would find the situation child neglect for all ages. Moreover, 20% felt they could not deem the situation child neglect without the presence of a CAP law, no matter the age of the child. In a scenario where a child had gained access to a loaded firearm, the vast majority found this to be child neglect (82-97%, with the percentage varying by the age of the child involved), regardless of the presence or absence of a CAP law and/or an injury being sustained. In addition, when a CAP law was in place, social workers were significantly more likely to find neglect if the child had sustained a firearm-related injury as well. For children injured after access to a loaded firearm, the majority of social workers found this to be child neglect and the additional presence of a CAP law only significantly increased the finding of child neglect for 14-year olds, the oldest age studied.

Conclusions:
The vast majority of child/family welfare social worker found it to be child neglect when youth accessed or had potential access to a loaded and unsecured firearm. Results of the study provide support for the passage of universal CAP laws to help protect children equally across states and ensure the safe storage of firearms in homes.

Objectives:
Attendees will learn:
1. To recognize the vast majority of child/family social workers believe there should be child access prevention (CAP) laws requiring firearms to be stored so that unwanted access cannot be obtained by a child, even up to 15 years of age.
2. To describe why a significant percentage of child/family social workers (20%) do not feel they can make the determination of child neglect when a child of any age has potential access to a loaded firearm without a pertinent CAP law in place.
3. To recognize the vast majority of child/family social workers would determine child neglect when a child obtains access to a loaded firearm but were significantly more likely to determine child neglect when a CAP law was in place and the child was injured versus when they were not injured.

Formative Qualitative Research for a Text and Video Messaging Home Safety Intervention for Young Mothers

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Background:
Unintentional injury is the leading cause of death for children age 1-5 years in the United States. The risk of injury in infants and young children is elevated in the offspring of young mothers. In developing a behavior change intervention designed to enable young mothers to reduce injury risk in their young children, we need to understand not only what informational content must be included, but also the most appropriate methods of framing and delivering that content. In the past, interventions addressing young children's risk of injury in the home have utilized home visits, which are costly and have limited ability for dissemination. Mobile health (mHealth) interventions have been successful in promoting behavior change across many health conditions. The purpose of this study was to conduct semi-structured interviews with a sample of young mothers to examine the acceptability of receiving a text and video injury prevention intervention including information on format, content, frequency of messages, acceptability of doing a "virtual home safety visit" and duration of program.

Methods:
A trained research assistant conducted semi-structured interviews with 20 young mothers (ages 15-20). Participants were asked both closed and open-ended questions to elicit opinions about their willingness to utilize mSafety. Participants were recruited at a health clinic for teen mothers and their children, and at a local public charter high school which serves pregnant teens and young mothers. To be eligible, participants had to be between the ages of 15 and 20, have a child between the ages of 6 and 36 months, and be able to speak, read and write in English.

Results:
Participants ranged in age from 15 – 20, with eight stating that they were 17. A majority (13/20) identified themselves as Hispanic and 17 participants stated that they had just one child. Participants were enthusiastic about receiving information about preventing childhood injuries via text message. Young mothers stated that they would be willing to share the Safety messages with family and friends, serving to both spread their knowledge as well as to empower them within their communities. Participants were most interested in learning about the prevention of falls, poisonings, and safe sleep. Many emphasized that the language of the messages should be simple and that videos should be included to demonstrate methods of injury prevention. In addition, a majority of interviewees said that they would be willing to participate in a "virtual home safety visit" in which participants would text home photos to an expert to evaluate home safety practices.

Conclusions:
The concept of an mHealth intervention that would provide young mothers the tools to prevent injuries among their children received positive feedback. This offers a novel opportunity to potentially reduce unintentional household injuries in this high-risk group.

Objectives:
In this session attendees will learn:
1. To describe a novel approach to preventing injuries in young children.
2. To identify the acceptability of a mobile health intervention directed at young mothers.
3. To recognize the acceptability of a virtual home safety visit.

Revisiting Pill and Capsule Ingestions by Children: When, Where, How

Maneesha Agarwal, MD, Robert Geller, MD, Brent Morgan, MD, Adam Pomerleau, MD

Background:
Annually, > 60,000 children less than 6-years-old are evaluated in EDs for unintentional (unsupervised) medication ingestions; solid dose medications, such as pills, tablets, and capsules (SDMs), comprise 70% of these exposures. However, little is known about the circumstances permitting ingestion of these SDMs, hindering development of further prevention efforts. We sought to characterize circumstances and characteristics of unsupervised SDM ingestions to better design relevant injury prevention strategies.

Methods:
This was a cross-sectional study of exposure calls to 5 poison centers (PCs) serving about 40 million people in three states from 2/1/17-9/30/17. Calls involving children < 6-years-old in which an ingestion of a human SDM was reported were analyzed. Such a call automatically triggered an electronic medical record real-time alert notification, instructing the PC staff member to offer enrollment into the study. Participants were presented with up to five additional contextually appropriate questions. Outcome variables include use of original containers, unit-dose packaging, alternative containers, and intended recipient of medication. "Medications with high potential for harm" were considered as belonging to one of the following classes: Opioid Analgesics, Sedative/ Hypnotic Agents, ADHD Medications, Cardiovascular Agents, Oral Hypoglycemic Agents, Antidepressants, Antipsychotic Agents, or Anticonvulsants.

Results:
There were 7,280 eligible calls during the study period, of which 4,523 (62.1%) calls involving 5,101 substances were enrolled. Callers from a residence were more likely to participate compared to those from healthcare (66% vs. 44%, x^2=163, df=1, p <.0001). Most exposures involved a single substance (92.3%) and occurred in the child's residence (94.0%). Only 1.5% of participants experienced a moderate or major effect. Parents were the most common intended recipient of the SDM (n=2,011; 47.5%), followed by grandparents in 677 cases (16.0%). Cases were also analyzed by medication class. Medications with high potential for harm (n=1,039; 20.4%) were transferred to alternate containers in 64% of calls, more often than other medications (x2=485, df=1, p <.0001). Additional statistical analysis of the dataset is pending.

Conclusions:
In this study, 61.9% of unsupervised SDM exposures in young children occurred from original packaging. However, for high harm potential medications, only 26.4% of unsupervised SDM exposures occurred from original containers. Improvements in child-safety packaging of SDMs are likely to further restrict child access. Because many medications originally dispensed in CRC packaging had been removed from their original containers, packaging changes to decrease the frequency of adult choice to take SDMs out of original containers may help to reduce these exposures with particularly high harm potential.

Objectives:
Attendees will learn:
1. To understand the epidemiology of unintentional pediatric poisonings, including the burden of solid dose medications.
2. To recognize the capability of smaller poison control center collaborations using a united electronic medical record system to capture additional data to study problems in a more intensive manner than data collected in the national dataset.
3. To describe how original packaging is involved in the overwhelming majority of solid dose medication exposures, but transfer of medications to alternate containers is problematic, specifically in medications with high harm potential.

Instant Soup Scald Injuries in Children

Courtney Allen, DO, Wendalyn Little, MD, MPH, Maneesha Agarwal, MD

Background:
Scald burns are a major cause of preventable injury in the pediatric population. Prior studies have estimated that each year approximately 100,000 children sustain scald burns because of spilled food and beverages in the United States. Microwaveable instant soups have been previously identified as one source of scald burns. The objectives of this study are to quantify the risk of these injuries in pediatric patients and to describe the patient characteristics, mechanisms of injury and injury patterns in pediatric patients sustaining scald injuries from instant soup products.

Methods:
The National Electronic Injury Surveillance System (NEISS) database was queried from January 2006 - December 2016 for cases of scald burns in patients ages four to twelve years. Data extracted included age, sex, race, ethnicity, body location of injury, case narratives, and disposition from the ED. A single author reviewed all case narratives to identify additional

cases that involved the transport of instant soups from microwaves. Instant soups were defined as those specified in the case narrative as: “instant soup”, “instant noodles”, “cup of soup”, or water for making soup. Location of scald injuries was grouped by region as face, trunk, upper extremity or lower extremity.

Results:
During the 11-year period, there were a total of 4,518 cases of scald burns identified in the NEISS dataset, yielding a national estimate of 9,521 cases per year in the United States in this age group. On review of case narratives, there were 972 (21.5%) cases related to instant soup burns. The mean patient age was 7.22 years (median 7 years, mode 4 years); 43.1% were male. Patient race was specified in 747 cases; of these, black was the most commonly reported race (N = 365, 48.8%). The most common location of injury was the trunk comprising 40.1% of the injuries. Most cases (90.4%) were treated and released from the ED visit and there were no recorded fatalities.

Conclusions:
In this large, national dataset, instant soup injuries accounted for over 20% of scald burns. Younger children from 4 to 7 years were the most commonly injured, and the most commonly injured body region was the trunk. Further investigation of the risk of instant soup-related scald burns in pediatric patients could lead to targeted injury prevention strategies including changes in product design and educational outreach to caregivers.

Objectives:
Attendees will learn:
1. To describe data regarding children who are cooking and transporting instant soups.
2. To recognize the burden of scald injuries from instant soups.
3. To identify the importance of more in-depth research to target injury prevention strategies.

Characteristics of Dog Bites in Pediatric Patients Presenting to the ED

Linda Lou, MD, Johannah Merrill, MD, Daniel Stratz, MD, Molly McCann, MS, Courtney Jones, PhD, MPH, Anne Brayer, MD

Background:
Children are the most frequent victims of dog bites and often sustain the most severe wounds, including traumatic and disfiguring ones to the face. There have been a few studies on the situational characteristics of dog bites, however little investigation has been done into detailed risk and complication factors. In this study, we examined risk factors including seasonal variance and social settings of bite occurrences, as well as nature of lacerations sustained and those necessitating admission.

Methods:
We conducted a retrospective medical record review of a registry encompassing all dog bite cases for pediatric patients presenting to our region’s Level I Trauma Center. All patients aged 18 and younger presenting with an initial presentation of dog bite were included in the registry. A data collection form was designed specifically for the purposes of the current study and included demographic and clinical characteristics as well as circumstances surrounding the injury (e.g., place, time, situational factors). Manual medical record abstraction was conducted by three independent physician reviewers who underwent rigorous training procedures to minimize variation in abstraction. Data were analyzed using descriptive statistics and proportions were used to describe patterns surrounding the dog bite event.

Results:
Data from 594 patients were analyzed. Characteristics of the sample included: 69.9% white race, 18.5% age 2 or younger, and 51.7% female. The most commonly injured body region included the face (59.4%) and upper extremities (19.0%) and 40.2% of the sample had 3 or more wounds. The majority of the sample was treated in the ED and discharged home (92.4%). Saturdays and Sundays comprised a higher frequency of dog bite injuries compared to weekdays, and summer months also had the highest frequencies with August having the most cases (13.1%) compared to January (4.0%). Contextual factors surrounding the injury included the dog bite occurring at a social gathering (24.6%), being witnessed by an adult (49.2%), and involvement of food at the time of injury (9.1%).

Conclusions:
We found a significant association between weekend days and summer months with frequency of dog bite injuries. Nearly half of incidents were witnessed by an adult, and nearly a quarter were sustained during a social gathering. The majority of lacerations involved the face or upper extremities, and were treatable in the ED, while approximately a tenth required admission for consultant follow-up and OR closure. These results have provided our team with the information needed to counsel families and to design educational preventative materials for distribution in our pediatric ED.

Objectives:
Attendees of this session will learn:
1. To describe the temporal and situational trends of dog bite injuries in a pediatric population.

2. Ways to evaluate the characteristics and management of these injuries.
3. How to identify modifiable risk factors for the prevention of these injuries in pediatric patients.

Saturday December 1, 2018

Trends and Characteristics of Playground-Related Extremity Fractures in Children

Ashley Blanchard, MD, Ava Hamilton, BA, Thitphalak Chounthirath, MS, Guohua Li ,DrPH, MD, Peter Dayan, MD, MSc

Background:
Despite updated playground equipment and improved industry standards, playgrounds remain a common source of childhood injury. Extremity fractures account for the largest proportion of playground injuries presenting to emergency departments (EDs). Little is known, however, about recent trends and injury circumstances of playground-related extremity fractures. Our primary aim was to determine the trends and characteristics of playground related extremity fractures in children seen in US emergency departments. Our secondary aim was to determine the association between the type of playground equipment, specifically monkey bars, and the risk of extremity fractures overall and those that require hospitalization in children.

Methods:
We analyzed data from the National Electronic Injury Surveillance System between 2006 through 2016. We included children ≤14 years who sustained playground-related extremity fractures as their most severe diagnosis and presented to EDs. US Census Bureau population estimates for children <14 years were used to determine annual rates of injury. Weighted complex survey analysis was used to describe the characteristics and severity of playground-related extremity fractures. Severe fractures were defined as fractures requiring admission or hospital transfer. We conducted a complex samples logistic regression, including variables with a $p<0.05$ from the bivariate X^2 analysis, to identify independent risk factors for playground-related extremity fracture. Finally, we used Joinpoint Regression Program to perform trend analysis for fracture rates using weighted linear regression.

Results:
An annual average of 72,889 children were treated in US EDs for playground-related extremity fractures during the study period, yielding a national annual incidence rate of 119.2 playground-related fractures per 100,000 children. Playground-related extremity fractures accounted for 33.9% of all playground-related injuries and 78.7% of all playground-related hospitalizations. Of patients with extremity fractures, 87.4% had upper extremity fractures and 11.2% had severe fractures. Monkey bars and climbing apparatus accounted for the highest number of all extremity fractures and severe extremity fractures (see Appendix: page 64). On multivariable analysis, injuries on monkey bars or climbing apparatus (adjusted odds ratio [OR]: 2.1; 95% CI: 1.9-2.2) were independently associated with a playground-related extremity fracture, in comparison to injuries from other playground equipment, when adjusted for age. The annual rate of ED visits due to playground-related extremity fractures remained stable (annual rate of change = 0.74, p=0.14) from 2006–2016, while the rate of ED visits for other playground-related injures increased slightly (annual rate of change = 4.05, p=0.03).

Conclusions:
Extremity fractures remain the most common type of playground injury and are the most common reason to be admitted to the hospital for a playground-related injury. Despite updated playground equipment, national rates of playground-related extremity fractures have remained stable over the past decade. Prevention strategies might target equipment most frequently associated with severe fractures, namely monkey bars and climbing apparatus.

Objectives:
Attendees will learn:
1. To recognize extremity fractures, remain the most common type of playground-related injury presenting to U.S. emergency departments.
2. To recognize improved playground equipment, rates of playground-related extremity fractures and playground-related injuries have not decreased.
3. To describe how Monkey bars are associated with an increased odds of playground-related extremity fracture.

Pediatric Snowmobile-Related Injuries in the Emergency Department 2000-2017

Issac Schwantes, BS and Charles Jennissen, MD

Background:
Snowmobiling is a popular form of recreation in the winter, but adverse events can lead to significant injury. There are no recent studies which have looked at national data on snowmobile-related emergency department (ED) visits in children. The objective of this study was to determine the demographics and risk factors for pediatric snowmobile-related injuries.

Methods:
ED visits related to snowmobiles from 2000-2017 were identified through the National Electronic Injury Surveillance System (NEISS) database which collects information from a national probability sample of U.S. hospitals. Injuries that did not occur during snowmobile operation were excluded. Descriptive and statistical analyses were performed with use of the chi-square test.

Results:
The database had 3,210 snowmobile-related injuries which correspond to a national estimate of 228,156 ED visits during the study period. Children <18 years of age comprised 17% of all snowmobile injured ED patients. Of pediatric patients, 18.2% were 0-9 years old, 26.5% were 10-13 years old, 24.7% were 14-15 years old, and 30.6% were 16-17 years old. There was a trend of decreasing injuries over time during the study period for all age groups. About three-fourths of injured children were male, 98% were Caucasian. Children 0-13 years had a greater proportion of their injuries occur on the weekend (61%) as compared to those 14-17 years (45%), p=0.0003. The most common mechanisms of injury involved rolling/flipping the vehicle (32%), striking a stationary object (31%), and falling off or being ejected (19%). The mechanism of injury varied by pediatric age group (p=0.0017) with those 0-13 years having greater proportions with having struck an obstacle (42% vs. 27%) and having fallen off or been ejected (30% vs. 19%) as compared to those 14-17 years.

Older youth had higher percentages of rollovers and having been hit by a motor vehicle as compared to those younger. Youth also had greater percentages of rollovers as compared to adults (32% vs. 21%), p=0.0051. The most frequent body part injured was the upper extremities (34%), then lower extremities (20%). Youth were different from adults with regards to body part injured (p<0.0001); children had higher percentages of injuries to the head/neck/face (20% vs. 3%) and less injuries to the torso (17% vs. 33%). The injuries suffered by children 0-13 years old differed from those 14-17 years (p=0.006); 0-13 year olds had greater proportions of lacerations (23% vs. 12%) and fractures/dislocations (28% vs. 22%), and less contusions/abrasions (22% vs 29%). Youth also had differences in injuries relative to adults (p<0.0001) with youth having greater percentages of contusions/abrasions (26% vs. 20%) and lacerations (17% vs. 8%) and adults having more strains and sprains (24% vs. 10%). Admitted or transferred patients were 12%.

Conclusions:
Differences in snowmobile-related crash mechanism and injuries sustained between two youth age groups and between youths and adults indicate the importance of targeted injury prevention efforts. Youth had a significantly greater percentage of injuries to the head/face/neck as compared to adults emphasizing the importance of helmet use by children.

Objectives:
Attendees will learn:
1. To describe differences in crash mechanisms between younger and older pediatric patients, as well as between youth and adults.
2. To recognize injuries most frequently seen by pediatric patients in snowmobile-related mishaps.
3. The importance of youth wearing helmets while riding snowmobiles given their propensity to head/neck/face injuries.

The All-Terrain Vehicle Exposure and Crash Experiences of Iowa FFA Members Iowa FFA Members

Charles Jennissen, MD, Pam Hoogerwerf, BS, Lauren O'Donnell, BA, Cole Wymore, Nicholas Stange, Mitchell Hooyer, BA, Kristel Wetjen, RN, BSM, Gerene Denning, PhD

Background:
All-terrain vehicles (ATVs) continue to be popular among adolescents and are used by them for both recreational and occupational purposes, especially in rural areas. About 30% of all serious injuries due to ATVs in the state of Iowa are suffered by children <16 years of age. The objective of this study was to better understand the ATV-related exposure and crash experiences of Iowa adolescents.

Methods:
Attendees of the 2017 Iowa FFA Leadership Conference were surveyed at the Iowa ATV Safety Task Force booth. Data was collected with regards to when FFA members first rode an ATV as a passenger and as a driver, when they had their first ATV crash as a passenger and as a driver, the total number of ATV-related crashes they had been in, and whether they ever had to seek medical attention due to an ATV-related crash and, if so, at what age. Descriptive and comparative analyses were performed.

Results:
A total of 603 FFA members 12-19 years old completed the survey. The vast majority of participants (95.5%) had ridden an ATV. Nearly all reported having ridden as a passenger. Mean age at which respondents first

rode as a passenger was 6.1 years, and as an operator was 8.9 years. Nearly 20% and about 30% reported having crashed on an ATV when riding as a passenger and as a driver, respectively. The mean age at which they first crashed as a passenger was 10.5 years and as a driver was 11.0 years. On average, males first drove ATVs about a year earlier than females. Both those that lived on farms or whose families owned an ATV were significantly younger when they first rode an ATV than those that lived elsewhere or did not own an ATV, respectively. Overall, one-third had been in at least one ATV crash. Males and those who lived in the country had higher percentages that had been in a crash. Over one-fifth of those in an ATV crash required getting medical attention and the mean age at the time of their first crash that required medical attention was 11.5 years.

Conclusions:
Iowa FFA members reported nearly universal exposure to ATVs and commonly practice unsafe behaviors such as riding as or with a passenger. Those who lived on farms started riding on ATVs much younger on average than those who lived elsewhere, and higher percentages of those who lived in the country reported having had an ATV-related crash. Families are routinely not enforcing safe ATV practices and are allowing children to ride and drive ATVs at ages which are not developmentally appropriate and against manufacturer recommendations.

Objectives:
Attendees will learn:
1. To identify the ages at which most FFA members first rode as a passenger on or drove an ATV.
2. To identify at least three risk factors that increase the likelihood of crashing an ATV.
3. To describe some of the variables associated with adolescents having had an injury severe enough to require medical attention after an ATV crash.

Gaps in ATV Injury Reporting in Alabama: A Case for Statewide Trauma Databases

Allison Reid- Burks, MD, Kristyn Jeffries, MD, Ann Klasner, MD, Michele Nichols, MD, Kathy Monroe, MD

Background:
In 1998 Alabama passed legislation requiring hospitals to submit data regarding head and/or spinal cord injuries; collection began in 1999. That same year this was extended to include all traumatic injuries but only head and spinal cord reporting was mandated. In 2007-2008 the Alabama Trauma System (ATS) was established, data is entered by EMS in the field or from hospital entry; this is optional reporting. ATS and head/spinal injuries are recorded in same database. Currently there is no state plan to expand or mandate recording of pediatric trauma injuries in Alabama. The purpose of this study was to compare data from multiple reporting agencies within the state of Alabama, including chart review from the state's pediatric trauma center, regarding ATV injuries to determine if accurate reporting is being achieved.

Methods:
Data from 4 sources in the state of Alabama was reviewed from 01/01/16 to 12/31/16 for patients aged 0-18 years old who sustained an injury from an ATV related accident. Data was compared between sources to establish if accurate reporting of ATV injuries is being achieved. Keywords and diagnosis codes were searched through the National Electronic Injury Surveillance System (NEISS), Children's of Alabama retrospective chart review, Alabama Trauma System (ATS), and Alabama pre-hospital EMS records.

Results:
National Electronic Injury Surveillance System reported 30 injuries, 73% male, 27% female, median 12.5 years (mean 11.7). Children's of Alabama chart review revealed 104 injuries, 60% male, 40% female and one unknown gender, median 12 (mean 11.5). Alabama EMS recorded 25 injuries 56% male, 44% female, median age 12 (mean 12.2). Alabama Trauma System reported 5 injuries, 80% male, 20% female, median age 14 (mean age 11).

Conclusions:
Injuries are the leading cause of death in pediatric patients. The current reporting of ATV injuries in Alabama demonstrates large gaps in accuracy. Without a uniform reporting system, it is difficult to track the number of ATV accidents, or other traumatic injuries, occurring in the state. National data is compiled using NEISS probability sample and are calculated estimates. Prevention of injuries is key to decreasing pediatric mortality and a statewide comprehensive trauma database would allow development of targeted prevention programs, education and outcome monitoring.

Objectives:
Attendees will learn:
1. To identify why accurate ATV injury prevalence is difficult to calculate in Alabama without comprehensive trauma reporting.
2. To recognize National data is calculated based on a probability sample which does not identify highest risk pediatric age groups or counties in Alabama.
3. To describe Comprehensive trauma databases accomplished by other states.

Emergency Medical Services Responses to All-Terrain Vehicle Crashes: Increased Time Demands of Recreation Area Crashes

Brandon Wubben, MD Gerene Denning, PhD, Charles Jennissen, MD

Background:
Emergency medical services (EMS) responses to all-terrain vehicle (ATV) crashes are often complicated by incidents occurring off-road and within recreational areas. The manner in which the location of the crash affects EMS responses has not been well-described, especially with respect to EMS time demands.

Methods:
Retrospective analyses of the Iowa EMS Registry, the Iowa Trauma Registry, and the Iowa Department of Transportation and Department of Natural Resources crash databases were conducted to identify ground ambulance runs to ATV crash scenes where the patient was treated and transported by EMS between 2004-2014. Descriptive and comparative analyses were performed.

Results:
Of the 322 cases identified, 12% were in recreation areas, 24% were on roadways, 38% were off-road, and for 26% of cases the location could not be determined. The proportion of EMS runs where arrival on the scene to patient time was ≥ 5 minutes was significantly higher for recreation area crashes (34%) than those on roadways (0%), off-road (10%) or at unknown locations (5%). Similarly, the proportion of runs where on-scene time was >30 minutes was significantly higher for recreation areas (18%) than on roadways (5%), off-road (7%) or at unknown locations (6%).

Similarly, the proportion of runs where on-scene time was >30 minutes was significantly higher for recreation areas (18%) than on roadways (5%), off-road (7%) or at unknown locations (6%). The following were not significantly different by crash location: percentage of BLS vs. ALS runs, median number of total procedures performed and initial patient GCS score, and the percentage of patients receiving spinal immobilization, undergoing intravenous or intraosseous access, or applied to cardiac monitoring. In the database, 58 EMS responses were for children <16 years of age. Children in crashes were more likely to be female as compared to adults (p=0.041). No child was positive for alcohol, while 30% of adults who were tested were.

Child victims of off-road crashes had overall longer arrival on the scene to patient times but shorter on-scene with patient times as compared to crashes occurring on roadways (the latter despite no differences found in procedures performed). Overall, adults had longer on-scene times than children and were more likely to have spinal immobilization and IV placement performed than child victims. Notably, the median age of patients from roadway crashes (18 yo) was significantly younger than of those from off-road (26 yo) or at recreation area crashes (29 yo).

Conclusions:
ATV crashes in recreation areas appear to present unique time demands for EMS crews, as they had longer on-scene times than other locations despite having a similar number of procedures performed, crew training level, and patient initial GCS scores. Our findings also suggest pediatric ATV victims may be approached differently than adults by EMS given the differences seen in procedures performed in the field. Additional research is needed to determine if the increased time demands of ATV crashes in recreational areas are associated with adverse patient outcomes, and to identify potential strategies to reduce this time burden.

Objectives:
Attendees will Learn:
1. To describe how EMS response and on-scene times vary by ATV crash location.
2. To describe differences in EMS response, on-scene times and procedures performed between ATV crashes involving children as compared to adults.
3. To identify potential strategies which might help EMS respond quicker to patients involved in ATV crashes off-road and in recreational areas.

Perception of Injury Risk Among Parents of Youth Bicyclists

Stephen Strotmeyer, PhD, MPH, Christine Vitale, RN, MSN, Barbara Gaines, MD

Background:
The purpose of this study is to examine the injury risk perception among parents of youth bicyclists.

Methods:
Parents of elementary school students living in the most vulnerable zip codes as indicated by trauma admissions were invited to complete an online survey. They rated the perceived risk of injury in a range of different sports, including bicycling. The perceived comparative risk was obtained indirectly by subtracting perceived risk of injury to one's child from the perceived risk of injury to a peer. Data were analyzed using descriptive statistics, comparison of means, and ordinal logistic regression.

Results:
One-hundred ninety-one parents completed the online survey. The median age of the respondents' children was 8 (interquartile range (IQR): 7 to 10) years. The frequencies and proportions of respondents by self-reported race (n=157) were as follows: 62 (39.5%) White, 5 (3.2%) Asian, 2 (1.3%) Hispanic/Latino, 62 (39.5%) African-American, and 26 (16.6%) 'other race'.

Overall, the parents reported the biking experience as 3 (IQR: 2 to 5) years. Only 13 (6.8%) of the parents reported a child having been injured while riding a bike, and only 3 of those children were wearing a helmet. Regarding the statement 'Bicycling is safer than most other sports," the frequencies and proportions of responses were as follows: 64 (33.5%) agreed, 36 (18.8%) disagreed, and 91 (47.6%) were neutral. A table (see appendix: page 65) provides an overview of respondents' perceived risk of injury in Bicycling (referent) versus other sports using paired t-tests. The respondents rated an equal referent's chance of getting injured while participating in Bicycling to be slightly above average. The risk of injury in bicycling was rated significantly lower than for American football (p=.0000) and soccer (p=.043), but higher than basketball (p=.939).

On average, parents perceived their child's injury risk to be significantly lower compared to their peers (p = 0.0000). Regarding perceived comparative risk, the frequency and proportion of respondents by category were as follows: 22 (11.5%) comparatively optimistic, 111 (58.1%) neutral, and 42 (30.4%) comparatively pessimistic. Ordinal logistic regression analyses were undertaken to explore the relationships between perceived risk to oneself (PRSELF), perceived risk of injury to an equal referent (PROTHER), or perceived comparative risk (PCR) and potential demographic predictor variables. No significant relationships were detected between demographic variables and PRSELF, PROTHER, or PCR.

Conclusions:
Contrary to the best available epidemiological evidence, parents perceived the risk of injury in their child while bicycling to be average and significantly lower than that in other collision and contact sports, including common sports such as football (p=.0000) and soccer (p=.013). Among parents of younger children, there appears to be a mismatch between injury risk perception and actual risk while riding a bike.

Objectives:
Attendees will learn:
1. To discuss an apparent mismatch between injury risk perception and actual risk among the parents of youth bicyclists.
2. To recognize perceived rather than actual risk may lead to an increased frequency of injury.
3. To recognize future injury prevention strategies in recreational activities should consider educational- and psychosocial-based interventions that include efforts to correct erroneous beliefs and attitudes about the actual risk of injury.

Electronic Medical Record Screening for Appropriate Car Seat Utilization in Primary Care

Michael Levas, MD, MS, Jane Howard, MS, Jessica St. Onge, BS

Background:
In June 2015 a multi-disciplinary group was created to improve patient and family utilization of current and potentially new injury prevention resources through enhanced identification of needs and streamlined referral processes. Motor vehicle crashes (MVC) were the most prominent injuries presenting to primary care providers (PCP) within the hospital system. The hospital system already had child passenger safety programs and staff in place that could be leveraged to address this need. The injury statistics in our system's primary care clinics revealed a high burden of visits for 4-8 year old children seen following MVCs. Interventions to identify at risk individuals/families and to improve both referral to current programming and patient education were developed and packaged into a pilot that leveraged physician education, electronic medical record (EMR) tracking and referral to a child passenger safety technician (CPST) for follow up. Success was defined as increased referral rates and injury reduction specific to motor vehicle crashes.

Methods:
The pilot phase for this program began in July 2017 at a primary care clinic selected for its diverse population. Screening for the correct child restraint occurs annually for children ages 4-9 at their well-child visit and begins at check-in. Upon arrival the guardian with the child receives a questionnaire inquiring about what seating position the child rides in, what child restraint the child rides in and how often the child rides in that child restraint. A nurse or medical assistant then enters those responses in the child's EMR which automatically generates an alert to the PCP if the child is not in adherence with recommended guidelines. The PCP can then choose to council the family in clinic, provide the family with a teaching sheet and/or place a referral to the car seat educator who will follow up with the family via phone call. The car seat educator then documents barriers to compliance and the outcome.

Results:
From July 2017-March 2018 screening for car seats during well-child visits was implemented at three primary care clinics. 1,728 children were able to be screened and out of those 70.56% were adherent. Out of the children not in adherence, 53 children were referred to the car seat educator. While our screening rate is high, the referral rate to the car seat educator is low.

Conclusions:
Improper restraint in the car leads to unintentional injuries resulting in children aged 4-9 requiring medical attention. It is feasible to properly identify these children beforehand through the use of the EMR. Appropriate referrals can provide education and an early intervention to get the child properly restrained. However, it is difficult to change provider behavior to increase active referrals. Moving forward, we plan to automate referrals to the car seat educator once a child is identified as not in adherence with recommended guidelines.

Objectives:
Attendees will learn:
1. To demonstrate the steps to implementation of a pilot booster seat education program in a primary care setting.
2. To identify the electronic medical record as a tool to implement child passenger safety education in primary care.
3. To describe how automatic referrals were generated through Best Practice Alerts to an expert outside of primary care.

To Test or Not to Test: A Retrospective Review of Infant Car Seat Tolerance Screening Outcomes at a Single Institution

Benjamin Hoffman, MD, Tess Gilbert, MHS, Brianna Ennis, BS, Kelsi Chan, BS, Kathleen Carlson, MD

Background:
The American Academy of Pediatrics (AAP) recommends all neonates born at <37 weeks gestational age (GA), and all infants at risk for cardiorespiratory compromise while seated in a semi-reclined position, undergo Car Seat Tolerance Screening (CSTS) prior to discharge. This test requires significant staff time and resources to complete, and there is tremendous variation in not only criteria and methodology for testing, but also for what constitutes passage or failure. To inform best-practice recommendations, we examined CSTS outcomes among infants tested over a 33-month period at a single institution with a uniform policy and testing algorithm.

Methods:
We conducted a retrospective medical record review of all (n=1,072) infants that underwent CSTS between November 2013 and July 2016 at a single academic medical center. We estimated incidence of CSTS failure among all infants and, separately, for those born preterm but without hemodynamically significant congenital heart disease (HSCHD) or significant comorbidities. Potential predictors of failure were examined using bivariable logistic regression to generate odds ratios and 95% confidence intervals. Variables of interest included sex, race, GA, chronological age, gestational size, HSCHD, apnea, chronic lung disease, and other major comorbidities. To further examine associations between chronological age and odds of CSTS failure, we used regression analyses stratified by categories of GA (24-27, 28-31, 32-34, and 35-36 weeks). Predicted probabilities of CSTS failure were then estimated at clinically probable time points for each group.

Results:
Among all infants tested, the incidence of CSTS failure was 9.2%. Most infants were tested due to prematurity (n=798, 74%). Among all infants tested, 79 (7%) had HSCHD that required intervention prior to discharge, 57 of whom were >37 weeks GA. Among all infants tested, HSCHD, apnea, chronic lung disease, and being small for GA were associated with increased likelihood of CSTS failure (see Appendix: page 66-67). Among preterm infants without HSCHD or other comorbidities (n=731), those born at 24-27 weeks GA were 3.5 times more likely to fail compared to those 35-36 weeks GA, while infants born at 28-34 weeks GA were half as likely to fail. Among these same preterm infants, CSTS failure tended to increase slightly as infants' chronological age increased; however, when stratified by age group (see Appendix: page 66-67), the observed direction and magnitude of slopes varied by GA group.

Conclusions:
This was the largest single-institution analysis of CSTS outcomes to date. We observed an overall higher incidence of failure than previously reported, and an increased likelihood of failure for infants with key risk factors. Larger, prospective studies are needed to better understand these risk factors. This work will help inform policy development to ensure infants at highest risk of CSTS failure are screened, despite its resource intensity.

Objectives:
Attendees will learn:
1. To discuss outcomes in infant car seat tolerance screening
2. To identify factors that increase the risk for failure of car seat tolerance screening

3. To recognize the impact of hemodynamically significant congenital heart disease on car seat tolerance screening

Marijuana Use in U.S. Teen Drivers: A Comparison of a Road-Side Survey of Reported Use and Fluid Tests for Tetrahydrocannabinol (THC)

Joyce Pressley, PhD, MPH, and Raina Sarmah, MPH

Background:
There is upward trend in state-level legalization of marijuana for medicinal and recreational purposes. While laws are aimed at increasing accessibility for adults, one fear is that it may also increase availability in younger populations. Marijuana use can impact driving performance including impaired reaction times, coordination, concentration, problem solving and judgement. Self-reports of activities, such as marijuana use, pose validation challenges. This analysis examines factors associated with teen driver marijuana use using a roadside data collection design and examines agreement of self-reported use by teen drivers and oral and blood tests.

Methods:
Methods. The National Roadside Survey of 2013-2014 (NRS) conducted by the National Highway Traffic Safety Administration (NHTSA) was used to investigate marijuana use in drivers aged 16-19 years. Of 11,100 drivers surveyed at 300 U.S. locations in 24 states, 718 were drivers aged 16-19 years. In addition to survey reports of ever used and time since last used marijuana, oral fluids were sampled in participants aged 16-19 years and blood from 18 and 19-year olds. Both were tested for the psychoactive substance in marijuana, delta 9 tetrahydrocannabinol and its active metabolite, 11-OH-THC (THC). We employed NHTSA definitions for a positive test for both fluids. We examined both weighted and unweighted data, but present unweighted findings below. Kappa statistics for agreement and logistic regression were used to assess independent predictors of a positive THC (odds ratios with 95% confidence intervals).

Results:
Results. Nearly one-third (31.2%) of teen drivers reported using marijuana in the last year or were THC positive. In addition to 26.8% of teen drivers reporting use, 4.4% who denied ever using or using in the past year and who received a fluid test, tested positive for THC. Of the 45 teen drivers reporting use in the last 24 hours, two thirds (66.7%) were positive for THC. Disagreement between the oral and blood test for the 305 teen drivers who had both tests was 17/305 (5.6%), with a Kappa for agreement of 0.78 (95% CI 0.69-0.88). Overall incidence of a positive THC was 13.7%, but tended to varied regionally from 11.5% (South) to 17.5% (Northeast), (p=0.45). Of drivers with a positive THC, nearly 20% started drinking alcohol by age 14 and more than 70% were drinking by age 16 years. The majority of drivers positive for THC smoked tobacco, 93% overall, with 62% smoking in the last 48 hours.

Conclusions:
More than 1 in 7 teen drivers had a positive fluid test for THC, with 2 of 3 drivers reporting recent use, testing positive. Although specific THC thresholds for safe driving have not been established, taken in the wider context of teen crash statistics, documented impairments associated with THC and the rapid state-level shifts in marijuana laws, these findings suggest the need for increased vigilance and stepped-up surveillance, particularly in high risk teen drivers.

Objectives:
Attendees will learn:
1. To discuss agreement between teen survey reports of marijuana use and laboratory test result tests for THC and its active metabolite.
2. To recognize areas of agreement and disagreement in between oral fluid and blood THC tests as measured using roadside oral swab compared to concurrently-collected blood analysis.
3. To identify risk factors for being positive for THC by either oral fluid or blood of teen drivers.

Improving Graduated Driver Licensing in Wisconsin

Deena Liska, MEd and Carissa Hoium, MPH

Background:
Wisconsin first adopted a Graduated Driver Licensing (GDL) law in 2000. In the first 3 years that the law was in effect, Wisconsin saw a 15% decrease in the number of motor vehicle crashes involving 16-year-old drivers. According to a report from the Wisconsin DOT fatalities, injuries, and property damage crashes were significantly reduced as a result of GDL. Still, many parents and teens do not understand GDL or the things that pose the highest risks for teen drivers, and community members lack tools and resources needed to provide support in this area. We developed a comprehensive statewide program to provide education and awareness about the GDL law and risk factors for teen drivers. We used a coalition-based approach to create and distribute standardized messaging to a wide variety of local, state, and federal partners. Our aim was to create a climate in Wisconsin

where people realize the value of GDL and support "best practice" measures that result in policy change.

Methods:
Our target audience was parents of teens, teens of driver licensing age (15-17), and the communities they engage with: schools, health care providers, law enforcement, employers, churches, sports clubs, and driver education schools. Key messages included 1) Motor vehicle crashes are one of the leading causes of deaths and injuries to teens 2) Limiting nighttime driving, restricting teen passengers, and making sure teens get quality practice can reduce the risk 3) GDL laws reduce risk by making sure teens gradually build driving experience under lower-risk conditions 4) We all share the same common goal of safe teen drivers. Promotional elements created included: wallet cards, fliers, press releases, newsletters, social media and website content, car magnets, posters, and banners.

Results:
From 9/1/17 to 12/31/17, we distributed 17,000 wallet cards, 6000 fact sheets in English and 1200 in Spanish. Materials were used as part of student-led NTDSW activities in 17 participating schools. Electronic distribution reached 220 elected officials, and 520 contacts including high school administrators. We reached 73,000 mid-day and morning viewers through 2 TV segments, and a radio interview. We had 1800 website page views (111% increase over same period last year), 1200 Tweet impressions, 1300 Facebook views, and 50,000 additional views through Children's Hospital of Wisconsin social media platforms.

Conclusions:
Three factors made this a successful campaign. First, we started with a clear vision of how the campaign contributes to our system of improvement; GDL is an evidence-based strategy, goals were informed by national and state data/surveys, and it crosses all areas of the social-ecological model. Second, we spent time aligning support from key stakeholders including the Department of Health, Department of Transportation, and State Farm and we leveraged multiple funding sources. Third, we engaged state and local partners to share the message; materials were distributed to stakeholders, partner agencies, diverse media venues, and integrated within our existing programs. This program is continuing in 2018 with additional resources and data to share in November.

Objectives:
Attendees will learn:
1. To recognize the role of GDL in preventing teen traffic deaths and injuries.
2. To describe key components in the Wisconsin GDL campaign.
3. To identify possible strategies for application in their own community.

Sunday December 2, 2018

Restraint Use and Injury in Forward and Rear-Facing Infants and Toddlers Involved in a Fatal Motor Vehicle Crash

Yu-Yun Huang, MD, MPH, Chang Liu, MPH, Joyce Pressley, PhD, MPH

Background:
Restraint use reduces injury in infants with rear facing restraints showing a greater impact than forward facing. This report examines trends and predictors of restraint non-use and of compliance pre- and post- American Academy of Pediatrics (AAP) recommendations for rear-facing restraints.

Methods:
Data from the Fatality Analysis Reporting System (FARS) from 2008 to 2015 were used to examine the restraint status and injury of infants and toddlers aged 0 to less than 2 years old who were rear-seated motor vehicle occupants of vehicles involved in a fatal collision (N=4,966). A subpopulation analysis was conducted on 1,557 children with recorded facing directions. Multivariable logistic regression was used to generate odds ratios with 95% confidence intervals (CI).

Results:
Approximately 6.7% of 4,996 infants and toddlers were unrestrained and mortality was approximately triple for unrestrained versus restrained (40.0% vs 13.7%, P<0.0001). In multivariable adjusted models, predictors of an infant being unrestrained included younger drivers (2.43, 1.56-3.79), unrestrained driver (3.22, 2.40-4.32), alcohol (2.05, 1.29-3.27), center-seated infant (1.52, 1.15-2.01) and weekday crashes (1.52, 1.12-2.05). Rear-facing car seat compliance among infants and toddlers aged 0-2 years increased from 5.0% to 23.2% (P<0.0001), but only 40.6% had restraint direction recorded. In the subpopulation analysis of children with direction of child restraint recorded, children in a rear-facing restraint system were less likely to be injured or to die compared to passengers in a forward-facing restraint system (57.5% vs. 42.5%, $X^2 = 10.4$, p = 0.01). The odds of rear-facing restraint increased post-AAP guideline among infants aged 0-1 year (2.70, 1.46, 4.97) while compliance for ages 1-2 remained unchanged.

Conclusions:
Trends in rear facing restraint use improved over the timeframe of this study, but remain unacceptably low despite introduction of the AAP guideline and recent changes in state child restraint laws.

Objectives:
Attendees will learn:
1. Discuss outcomes of infants and very young children involved in a fatal motor vehicle collision who are properly restrained.
2. To describe risk factors of an infant/young child being unrestrained in a motor
vehicle involved in a fatal crash.
3. To recognize trends before and after the American Academy of Pediatrics recommendations to place infants in rear facing restraints.
4. To discuss data deficiencies associated with being able to analyze motor vehicle fatality involving infants and children aged 2 and younger.

Creating a National Voice for Injury Prevention

Jane Edwards, BSCc, MSc, Brandon Batey, BSc, MSc, Zahra Hussein, MPH, Neil Merritt, MD

Background:
Regional and national injury prevention (IP) groups exist across Canada, however no specific group represents trauma hospitals. The Trauma Association of Canada's (TAC's) mission is to reduce the incidence and relieve the burden of injury by bringing together multidisciplinary health care professionals. Although TAC recognizes IP as an important priority, only recently has there been a formalized IP sub group. Leveraging a collective hospital voice for IP strategies will improve national advocacy for injury prevention.

Methods:
In February 2017 IP stakeholders from across Canada were identified through an e-mail distribution list for the TAC 2017 Conference and invited to attend an inaugural meeting in Vancouver. Following the meeting a TAC – IP working group (TAC– IP WG) was created with the guidance of the TAC Board of Directors, along with a Terms of Reference. The effectiveness of this working group will be evaluated by attendance, membership, consultations, and collaborations on National IP strategies.

Results:
Since the inception of the TAC – IP WG in February 2017, 5 teleconference meetings have happened with an average attendance of 60% (8/13 centres, 20 members) representing 13 trauma centres across 7 provinces. These meetings have fostered improved communications between trauma centres; facilitating a national trauma centre voice for IP. July 5th was Parachute Canada's National Injury Prevention Day (NIPD). The TAC – IP WG identified an opportunity to collaborate in aiding Parachute Canada's NIPD, ensuring trauma centres across the country were sharing similar IP messages. All members were made aware of NIPD and many trauma centres participated in NIPD through social media and by commissioning buildings in their communities to "light up" in Parachute green to bring attention to the prevention of injury.

In addition to a unified approach to national injury prevention work, the TAC – IP WG will advocate for important legislative changes. In September the group was presented with an opportunity to advocate for proposed changes to national building codes in an effort to reduce child falls from windows. The TAC - IP WG group, with the support of all its members, submitted a letter unifying a Trauma Centre voice to influence changes to Canada's National Building Codes.

Conclusions:
With this novel and cohesive group, injury prevention will continue to be recognized as an integral component of the trauma system while garnering support and resources for important National IP initiatives. Collectively, the TAC – IP WG will advocate for important strategies to improve IP across the country. With many early successes, the group continues to share best practices and lessons learned while working collaboratively on IP strategies to ultimately achieve a goal of zero injuries.

Objectives:
Attendees will learn:
1. To demonstrate the importance of a national trauma hospital working group focused injury prevention.
2. To recognize how a national injury prevention working group can advocate successfully for changes that assist in reducing the burden of injury.
3. To discuss collaboration and learning from other national injury prevention groups to move the injury prevention message forward.

Twenty Years of Pediatric Gunshot Wounds in Our Community: Have We Made a Difference?

Lilly Bayouth, MD, Katryne Lukens-Bull, MPH, Lori Gurien, MD, MPH, Joseph Tepas III, MD, FACS, FAAP, Marie Crandall, MD, MPH, FACS

Background:
Pediatric gunshot wounds (GSWs) are a public health concern of rising incidence and mortality, despite the emergence of local firearm safety programs and crime prevention initiatives. We evaluated 20 years of pediatric GSW injury demographics seen at our institution and constructed a risk map model, triangulating areas of high pediatric GSW incidence with risk factors and outcomes.

Methods:
Children, 0-18 years, suffering a GSW between 1996-2016 (n=898), were identified using this level 1 trauma center's trauma registry. Demographic, socioeconomic, and institutional variables were retrospectively reviewed. Hospital charges were normalized to 2016 values prior to analysis. Multi-variable logistic regression models identified predictors of mortality. Geographic information system (GIS) mapping of incident location and residence identified hot spots of higher GSW incidence.

Results:
The cohort, predominantly male (86.4%), had a mean age of 15.6±3.4 years. Mean Injury Severity Score (ISS) was 9.51±10.26. The majority (52.9%) required procedural and/or operative intervention. GSWs were most frequently from assault (81.5%) and unintentional injury (12.8%). Despite normalizing for inflation and controlling for injury demographics, hospital charges showed significant annual increase. Annual incidence of GSWs showed marked variation without longitudinal trend (p=0.89). GIS mapping revealed significant clustering of GSWs in known lower socioeconomic areas; yearly and total GSWs were highest in one particular zip code (see Appendix: page 68). The only significant predictor of mortality (n=18) was ISS (OR 1.19, 95% CI 1.15-1.22, p < 0.001).

Conclusions:
We conclude the impoverished areas of this community have higher incidence of pediatric gunshot wounds, unchanged over 20 years, despite firearm safety programs and crime suppression efforts. Gun violence carries significant morbidity/mortality and rising financial burden. Alternative community-based firearm injury prevention efforts, aimed at neighborhood capacity building, economic strengthening, and recognition of guns as a disease vector are needed.

Objectives:
Attendees will learn:
1. To identify why pediatric gunshot wounds are a public health concern.
2. To identify gun violence carries significant morbidity/mortality as a rising financial burden for families.
3. To recognize impoverished areas have higher incidence of pediatric gunshot wounds, remain unchanged despite firearm safety programs and crime suppression efforts; and alternative community-based firearm injury prevention efforts are needed.

Falling rates of Television-Related Injuries in Children

Domenica Garcia, MD, and Maneesha Agarwal, MD

Background:
Prior research has shown an escalating number of injuries associated with televisions (TVs) in children. However, in the past decade there have been changes in the TV sales market and implementation of prevention strategies. There has not been an evaluation of whether the incidence of TV related injuries has varied in the past several years. The objective of this study was to investigate the recent changes in trends in TV related injuries in children presenting to US emergency departments (EDs).

Methods:
Data regarding TV related injuries in children <18 years of age were obtained from the National Electronic Injury Surveillance System for calendar years 2008 through 2017. Sample weights were applied to estimate yearly national injury trends; unweighted cases were used for comparison of injury patterns. Data included demographics, body regions injured, and ED disposition.

Results:
In the 10-year period, there were 5,851 recorded cases of TV related injuries; this corresponds to an estimated national total of 156,675 (95% CI 131,360 - 181,991). There was a statistically significant decrease in the number of annual injuries during this period, with a correlation of -0.95 (95% CI -0.99, -0.77; p<0.001). The mean rate of TV related injuries was 2.24 per 10,000 children per year (range 3.0 to 1.18). Children 2-5 years old were most frequently affected, with median and mode ages of 4 and 2 years respectively. There was a slight predominance of males (59%) and white race (32.3%). Most injuries occurred at home (77%). The head and neck were the body parts most commonly injured (56.2%), with the most frequent diagnoses including soft tissue injury (31.1%), closed head

injury (22.8%), and laceration (21.9%). The majority of patients (92%) were discharged from the hospital, however for those admitted or held for observation, head and neck injuries were most common (71.8% and 86.2% respectively), including mainly closed head injury and fractures. Additional statistical analysis is pending completion.

Conclusions:
Recent data shows a decreasing number and rate of TV related injuries in children requiring treatment in the ED. This decline may be attributed to the increasing presence of flat screen TVs (FST) in American households, as well as the growing use of wall mounts and anchors. Additionally, given the lighter weight of FSTs compared to older TV models, injuries may not be severe enough to warrant ED evaluation. Finally, educational campaigns raising awareness about furniture tip overs may be having positive effects in making Americans more conscientious about the potential hazards from TV tip-overs.

Objectives:
Attendees will learn:
1. To describe how the number of TV related injuries in children is decreasing.
2. To understand the possibilities and limitations associated with using a publicly available national dataset to study product-related injuries.
3. To recognize how evolving the incidence of TV-related injuries might impact additional messaging and efforts.

Improving Home Safety Knowledge and Behaviors Among Low Income Women

Purnima Unni, MPH, CHES, Sonja Church, BA, Dai H. Chung, MD

Background:
A majority of pediatric injuries occur in and around the home. Home safety programs are used to modify knowledge and behaviors to reduce injuries. Settings for delivery of these programs are usually through primary care, hospitals or home visiting programs where time to educate parents is limited. The objective of this study was to assess effectiveness of a home safety program to low-income women in WIC centers.

Methods:
This quasi-experimental study recruited participants from four Women Infants and Children (WIC) Programs in a metropolitan region in the Southeast between 2015-2017. They were either first-time pregnant women or had a child less than 5 years of age in their home. The home safety program consisted of a 60-minute workshop, brief demonstrations, and home safety educational material. Participants were also provided some home safety equipment. A baseline survey consisting of 30 questions was used to assess safety knowledge and current behaviors. This was followed by an intervention and the post survey. A phone follow-up survey was conducted eight weeks after the intervention. Univariate analysis of categorical data was done using the ?2 test in IBM SPSS.

Results:
A diverse sample of 234 women (47% Black, 25% White, 9% Hispanic, and 15% African and Arabic ethnicities) participated in the program. Sixty-seven percent (n=156) completed the follow up telephone survey. About 26% were first-time pregnant women.
In the post survey, a significant increase was seen in awareness of risks associated with infants sleeping on the stomach (X^2= 20.87, p < 0.001), having blankets in the crib (X^2= 40.54, p < 0.001), and adults co-sleeping with infants (X^2= 19.325, p <.001). In the telephone follow-up survey, behaviors and knowledge about safe sleep were assessed. Despite high awareness about use of cribs for infants in the pre-survey (95%), only 76% of the mothers indicated they had always placed their infants in the crib. However, awareness of risks associated with sleeping on stomach remained high (97%).

Mothers were aware of the risks associated with leaving a child unattended on a countertop (94%) and the need to use safety straps in a high chair (96%).
In the post-survey, there was a significant increase in awareness of risks associated with window falls (X^2= 48.265, p<.001), baby walkers with wheels (X^2= 48.27, p <.001), furniture tip-overs (X^2= 36.16, p <.001), and unlocked cabinets (X^2= 36.07, p < .001). Despite high awareness and intentions to use anchors to prevent tip-overs, there was a significant decline (76%) in reported use of these in the follow-up survey.

Conclusions:
WIC centers can be effectively used to provide home safety education when combined with their programs. Results indicate significant increases in awareness of risks associated with home safety. Safe behaviors reported in the follow-up phase indicate effectiveness of this program. Further examination of usability of equipment, especially in low-income households is warranted.

Objectives:
Attendees will learn:
1. To identify core components of a home safety program directed to vulnerable populations.
2. To describe preliminary effectiveness of this program.
3. To understand factors that strengthen home safety programs.

Presenting Injury Prevention to Opioid-Addicted Populations

Tiffany Egan-Rojas, MPH, Jodi Raymond, MPH, CSTR, CAISS, Joseph O'Neil, MD, MPH, FAAP, Dawn Daniels, PhD, RN, PHCNS-BC

Background:
Children of addicted parents are at an increased risk for hospital admission. Injury Prevention for Your Baby was created to provide education and resources to mothers recovering from opioid-abuse. The program objective was to reduce the risk of injury and mortality related to unsafe sleep, child maltreatment, unsafe child passenger practices, and limited supervision in the home.

Methods:
The target population was mothers residing in a residential drug treatment facility that had abused any type of opioid. Mothers attended an injury prevention class for six hours where they received education for safe sleep, child protection, child passenger safety, and home safety. Resources were also provided. Pre-and post- knowledge assessment surveys and a baseline behavior survey were given. While still living in the center, mothers received a short-term follow-up survey at two weeks. Six months and twelve months post-teaching, mothers will be invited back to the center to learn CPR and first aid for their children and receive new car seats if needed for their children's development. For the full year post-teaching, mothers also received a monthly safety reminder text.

Results:
During the first six months, 86 mothers attended the class and 38 (44.19%) were present for the full six hours of teaching. Fifty-two (60.47%) consented to follow-up and gave demographic information. Short-term follow-up at two weeks post-teaching was completed by 21 of the mothers who consented (40.38%). Mothers were 19-40 years old, 78.8% White and 96.0% Non-Hispanic.
Pre- and post-knowledge surveys showed an overall increase in the frequency of correct answers. Of mothers that completed the two-week surveys, 95.24% self-reported always making sure their children are properly harnessed in the car seat; 90.48% self-reported always making sure their car seat is properly installed into the vehicle; and 90.48% self-reported having used one or more items that they had received. For mothers who had infants and completed the two-week surveys (N = 7), 100.00% of mothers who indicated they did not always place their baby on a safe sleep surface at baseline changed at two-weeks and 40.00% changed to always offering a pacifier. There was no change in always placing their infants on their backs, never co-sleeping with baby, and never having cords near the sleep environment. For all mothers who completed the two-week surveys (N = 21), 66.67% changed to never exposing their children to smoke, alcohol, or illicit drugs, 76.92% changed to always implementing a coping mechanism, 60.00% changed to always wearing a seat belt, and 50.00% changed to always supervising their children in the home.

Conclusions:
Injury Prevention for Your Baby is a promising program that can meet mothers in their recovery and empower them with safety skills for raising their children. The major challenge working with this population is follow-up because their situations are often transient. The results demonstrated positive change in many safety situations, warranting further programming and evaluation.

Objectives:
Attendees will learn:
1. To identify a socially disadvantaged population in which the potential to educate, provide resources, and prevent injury exists.
2. To describe a promising injury prevention program and its efforts for program evaluation.
3. To recognize the challenge to follow-up with a transient population such as those recovering from substance abuse.

Knowledge of Nighttime Driving Restrictions in State Graduated Driver Licensing Laws

Grace Spears, MSIII, Altamish Daredia, BS, Michele Nichols, MD, Kathy Monroe, MD, MSQI

Background:
Graduated Drivers' Licensing (GDL) laws place limitations on newly licensed drivers. Fifty-six percent of teen crash deaths occur between 6pm and 6am. Most states include a nighttime driving restriction in GDL laws. Studies show that curfew laws reduce motor vehicle related deaths among 16- and 17-year-old drivers by 10 percent. Since there is no nationwide GDL system, the laws vary among states. Prior research has shown that states with the strongest laws enjoy the biggest reductions in fatal crashes among

15-17-year-old drivers and the biggest reductions in collisions reported to insurers among 16-17-year-old drivers, compared with states with weaker laws.

Methods:
Adolescents were surveyed in a pediatric urban emergency department (ED) and at an area high school teen driving event. Parents were also surveyed in the ED. The survey questions were "what is the current state GDL law curfew?" and "what is your age?" Surveys were anonymous and voluntary. Data were entered into Excel® database.

Results:
There were a total of ninety adolescents (41 in ED and 49 at teen driving event) and 40 parents.
Only 7 (8%) of the teens and one (2.5%) of the adults knew the correct answer of midnight. The majority of teens thought the curfew is earlier than it is (46/90 (51%)) with 6 (6%)reporting they did not know the answer. 30 adults (75%) thought the curfew was earlier with 14 (35%)admitting they did not know the correct answer.

Conclusions:
Very few adolescents and parents know the state GDL curfew law. The majority of individuals think the curfew is earlier. This suggests that the state law could be strengthened to enact an earlier curfew.

Objectives:
Attendees will learn:
1. To recognize basics of GDL laws.
2. To dentify the effects of Curfews as part of GDL laws.
3. To describe knowledge of GDL laws among teens and parents.

Evaluating Outcomes of Car Seat Fittings with a Certified Child Passenger Technician

Serifatu Walton-Buford, MFT, Chris Peralta, BS, Hope Mullins, MPH, Mary Aitken, MD, Beverly Miller, MEd

Background:
Car crashes continue to be a leading cause of death among infants less than 1 year of age. Child restraints used correctly significantly reduce risk of serious injury or death in car crashes. Utilizing 1:1 child passenger safety education and then asking the participant to return the demonstration is a health education best practice. An extensive literature search found only one prior study with a small sample size that provided education with a follow-up observation. We report on preliminary results to date.

Methods:
Pregnant teenage girls under age 20 and a female support person of their choice, age 30 or older, who a teen reports she would go to for advice, were invited to a pre-birth car seat education appointment. Six to eight weeks pre-birth the teen was given a rear-facing infant car seat. She and her support person were educated on how to appropriately use and install the rear-facing infant seat. Education was provided by a certified child passenger safety technician using standard check-up forms on an iPad. A home visit was conducted up to three months post-birth with the teen, support person and baby present. The home visit, conducted by a certified child passenger safety technician, included a car seat check to observe the teen's installment of the car seat.

Results:
To date 51 post-birth car seat observations have been conducted at a home visit to assess teen's use and installation of a car seat. Ninety-eight percent of participants installed their car seat rear-facing, 90% of infants were observed with the harness at or below their shoulders, and 66% utilized the chest clip correctly. The harness passed the "pinch test" to indicate snugness on only 56% of infants. Participants could choose either a seatbelt or LATCH installation. Fourteen dyads chose to use the seat belt, and thirty-two chose LATCH, and 5 had missing data. Of those that chose to use the seatbelt, 86% installed the seat correctly. Of those that chose LATCH 93% installed the seat correctly, meaning the seatbelt was in the correct belt path or latch was clipped on correctly. Seventy-five percent of the car seats (seat belt and LATCH installations combined) observed to be installed tightly (< 1 inch at the belt path).

Conclusions:
Providing child passenger safety education that includes return demonstration by the participants during the pre-birth period to teen mothers and their support people is an effective way to reduce car seat misuse. However, some misuse is still present. Results indicate a need for increased emphasis on the importance of chest clip placement and shoulder strap tightness.

Objectives:
Attendees will learn:
1. To describe how to conduct car seat observations with teens and their support persons during home visits.
2. To recognize limitations to conducting observations of car seat use and installation with teens and their support people.
3. To identify barriers to conducting pre-birth education and post-birth observations of car seat use among teens and their support people.

Application of the Transtheoretical Model to a Traffic, Pedestrian and Bicycle Safety Program

Priscila Hegger, MPH, CPST

Background:
Evidence is emerging that demonstrates the positive impacts of using behavioral sciences to improve community health. Though many community-focused injury prevention programs exist throughout the United States, the translation of theories into practice has not been significantly addressed. This program used the Transtheoretical Model (TTM) as a framework for evaluating, planning and implementing a school-based program focused on traffic, pedestrian and bicycle safety.

Methods:
Local traffic injury and obesity rates were used to select participating school. The timeframe was 1.5 years with funding through federal grants. The TTM explains behavioral changes over time and through stages of change. Overall baseline evaluations were conducted and average results showed that participants were in the pre-contemplation or contemplation stages. The program phases were aligned with the TTM stages of change. Theory-specific strategies were applied and emphasized at various phases. During phase one, emphasis was placed on "Consciousness Raising", "Perception of Benefits", "Self /Environment Evaluation" and "Dramatic Relief".

Educational materials and events focused on transportation, pedestrian and bicycle safety, riding techniques, local laws, the benefits of biking and walking, and the importance of parental role models were provided. To support change from Contemplation to Preparation stages, phase two activities promoted "Self-efficacy", "Modeling" and "Positive Framing". A bike-rodeo skill training event and a school-based biking program were offered for students to develop safe skills. Phase three included guided Walk/ Bike to School activities for on-street experiences. "Reinforcement Management" and "Stimulus Control" processes were used to reinforce change from Preparation to Action/Maintenance stages. Weekly incentives and reminders were provided to participants of the Walk to School activities. Attendance, photos, and surveys were used to measure the program's success.

Results:
Over 240 children and 120 adults participated in the educational activities offered by phase one of this program. More than 40 children learned to bike through the school- based biking program and 110 students participated in the bike rodeo event offered during phase two of the program. Approximately 300 people attended the Walk to School Day event and 50 individuals attended the Bike to School Day event. Over a 6-month period, an average of 35 individuals attended weekly Walk to School activities. Participants' changes in walking and biking confidence level and knowledge of safe behaviors will be reviewed. Lack of bicycles in low income families, distance from school and parents' work schedules were barriers for participation in some program activities.

Conclusions:
Every year, people's lives are cut short as a result of pedestrian, bicycle and traffic incidents. Proper application of health behavior change theories and methods has the potential to strengthen the impact of community-based injury prevention programs and this program demonstrates how the TTM model can be used as a valuable tool during the program cycle.

Objectives:
Attendees of this session will learn:
1. To briefly describe the Transtheoretical Model.
2. How this model can be used during the planning and implementation of community-based injury prevention program.
3. How to evaluate the success of the demonstrated program.

National Injury Prevention Day in Canada

Pamela Fuselli, MSc, Neil Merritt, MD, Jane Edwards, MSc, Zahra Husein, MPH

Background:
The inaugural National Injury Prevention Day (NIPD) in Canada was held July 5, 2017 to shine a spotlight on the issue of preventable injuries – the leading cause of death to Canadians aged 1 – 44 years. NIPD galvanized communities across the country to 'light up' in Parachute green and 'Stop the Clock' on preventable injuries.

Methods:
Parachute reached out to have NIPD formally recognized as Observance day by Health Canada. Our communications team submitted requests to various landmarks such as the CN Tower (Toronto), Peace Bridge (Fort Erie), Vancouver City Hall. Parachute developed a social media guide with a hashtag (#NIPD), posting recommendations, sample Tweets and Facebook posts. A broadcast email was sent to partners across the country, including the TAC Injury Prevention Committee.

Results:
The response from partners across the country was overwhelming, with a number proposing new

landmarks and pursuing approval on behalf of Parachute. Partners contacted us for more information on how to spread the word and share our messaging. A dedicated NIPD webpage was created that provided information on the event and activities. A total of 10 Canadian landmarks participated, lighting up Parachute green. These landmarks included: CN Tower, 3D Toronto sign, Calgary Tower, Peace Bridge, London City Hall, High Level Bridge, Vancouver City Hall, Science World, North Bay City Hall, Caesars Windsor.

During the day, Parachute raised our flag at Toronto City Hall flag raising ceremony in honor of NIPD. Partners supported NIPD through social media, using #NIPD and linking the national initiative to local issues and events. NIPD social and traditional media outreach resulted in: • 1,263 Tweets • Total 4,324,848 social media impressions • 555 people participating • #1 Trending topic • 30 traditional media stories; total 3,146,106 traditional media impressions.

Conclusions:
The inaugural NIPD was a significant success, galvanizing partners across the country to spread the message of preventable injuries and actually spotlighting landmarks in Canada. This national social media initiative was able to link with local injury issues and activities raising awareness of the burden of injuries in Canada and highlighting the work that is being done to Stop the Clock so Canadians can live long lives to the fullest.

Objectives:
Attendees will learn:
1. To identify the partnerships and collaborations on a national level to assist in advocating for injury prevention awareness.
2. To describe-Demonstrate how to use social media to leverage national injury prevention messaging.
3. To recognize steps necessary to develop a national injury prevention campaign.

Expanding Community Outreach with an Injury Prevention Van Program

Barbara DiGirolamo, MEd, CPSTI, Maria McMahon, MSN, PNP PC/AC, Meg McCabe, BA, CPST, Lois Lee, MD, MPH, David Mooney, MD, MPH

Background:
One of the most effective ways to combat preventable injuries is to educate parents and families about safety both in the hospital as well as in the community. Transportation for personnel and equipment is one of the challenges of providing injury prevention education in the community. The objective of this program evaluation is to examine the impact of a new Injury Prevention Van upon our community injury prevention efforts.

Methods:
In May 2017 we acquired an Injury Prevention Van and developed a safety van program to broaden our community injury prevention outreach. With the Injury Prevention Van we were able to bring safety equipment and materials to health centers, preschools, schools, and health fairs without relying on car services or rental vehicles. As a part of the safety van program we purchased car seats, sports helmets, and injury prevention educational materials, which we were able to keep in the vehicle, making it readily available for community events. We maintained a log of how many community injury prevention events were held, the amount of materials delivered, and the number of ThinkFirst participants (see Appendix: page 69). We compared outreach efforts in the years before we acquired the Van to the 11-month period afterward.

Results:
Since May 2017, our Injury Prevention Van has been on the road, spreading our message of “Safe Play Starts Here!” Our community injury prevention events, materials distributed and participants (see appendix: page 66).

Conclusions:
Our Injury Prevention Van has allowed us to expand our community injury prevention efforts, dramatically increasing the number of children and parents we reached with safety messaging and the amount of safety materials we were able to distribute.

Objectives:
Attendees will learn:
1. To describe the impact including an Injury Prevention Van in community injury prevention programs.
2. To recognize how inclusion of an outreach van can increase visibility of programs.
3. To identify how to utilize large company sponsorships to effectively broaden injury prevention reach.

Characteristics of Pediatric Patients with Retained Bullet Fragments and Need for Routine Serum Lead Monitoring: A Prospective Cohort Study

Todd Fleenor, MD, Nipam Shah, MBBS, MPH, Joshua Haupt, MD, Kathleen Richard, MD, Michele Nichols, MD

Background:
There are several case reports of lead toxicity related to retained bullet or bullet fragments in both pediatric and adult patients. Elevated lead levels can have a significant impact on the developing brain in children, thus it is important to identify those at increased risk of toxicity. We set out to determine: 1. The demographic and clinical characteristics of young patients with retained bullet fragments. 2. How could gunshot wound victims be classified in to a high or low risk category. 3. Whether routine serum lead monitoring is necessary.

Methods:
A prospective cohort study was conducted in which patients less than 18 years of age who presented to a tertiary care children's hospital after an injury related to a gunshot wound were screened for eligibility. Initial criteria included any gunshot wound, however after 3 months our protocol was changed to include only those with retained bullets or bullet fragments. Non-English-speaking patients were excluded given difficulty in coordinating follow up. A baseline serum lead level was drawn at initial presentation. Patients were brought back for a repeat serum lead level within 6 months post injury. Data points that were analyzed included age, gender, race, disposition, wound locations and lead levels at baseline and follow up. We used descriptive statistics to calculate means and proportions.

Results:
Thirty-two patients were identified as having a gunshot wound, 20 patients underwent formal enrollment. Ten subjects declined to take part in the study, 1 wound was fatal, and 1 excluded as non-English speaking. Enrolled patients were aged 20 months to 18 years of age with a mean age of 8.5 ± 4.5 years. 90% of our subjects were male and 80% were African American and 20% Caucasian. 15 patients (75%) had injuries either in lower or upper extremity of which 9 patients required admission, whereas almost all injuries involving head, chest or abdomen required admission. 65% of enrolled patients were admitted to the hospital while the remaining 35% were discharged from the Emergency Department. All patients had a normal initial blood lead level. Eight of 20 patients were lost to follow up. Those who completed follow up had serum blood lead levels 5μg/dL at 6 months post injury.

Conclusions:
Our findings suggest that most pediatric gunshot wound victims are African American males and that baseline lead levels are normal. These patients are likely to be admitted to the hospital for observation particularly if injury involves head, chest or abdomen which might be deemed high risk. This patient cohort was extremely difficult to follow up. Further research with larger sample size is needed to identify kids with high risk injury and if follow up lead level monitoring is necessary.

Objectives:
Attendees will learn:
1. To identify the demographic and clinical characteristics of young patients with retained bullet fragments.
2. To discuss the suggested classification for high/low risk GSW injuries in pediatric patients.
3. To discuss lead toxicity related to retained bullet fragments.

RESEARCH POSTERS

Poster authors must be present to address attendees at posted agenda times.

Using Data in a Program to Develop Open Water Drowning Prevention Policies

Linda Quan, MD, Elizabeth Bennett, MPH, MCHES, Anthony Gomez, RS

Background:
Although the majority of drownings occur in open water (OW) (lakes, rivers, oceans, ponds), OW drownings have been poorly studied; few policies address their prevention unlike swimming pool drownings. We describe the data we developed and/or assessed and used during a 5-year program to develop policy around preventing OW drownings.

Methods:
With Partnership a program major goal, we created subcommittees for each policy area comprised of representatives from WA state's public health, law enforcement, injury prevention, academic, state agencies, boating and swimming organizations.

We identified/collected/analyzed data for each of four interventions: 1)Swimming competency: a)existing policies requiring swimming lessons or swim competency in public high schools and colleges; b)high school students' reported swim ability in the state's Healthy Youth survey (HYS); 2) Life jacket (PFD) use: a)high school students' reported use of PFDs when boating in HYS surveys; b)observations of PFD use among boaters throughout the state; c)observations of PFD use among swimmers with/without PFD loaner programs; and d) observations of various types of flotation devices used among swimmers at designated open water swim sites. 3)BUI: survey of western states' BUI laws and penalties; 4) Designated swim sites: a) other states' policies and drowning rates in natural waters.

Results:
Swimming competency- a) No public schools surveyed required swim lessons or testing. b) Surveyed White and American Indian/Alaska Native high school students reported statistically significantly higher levels of comfort in water over their head compared to other racial groups. A history of formal swimming lessons was strongly associated with multiple measures of socioeconomic status. PFDs- Two findings showed effectiveness but limits of mandated PFD use for children: a) PFD use increased among high schoolers between 2002-1010 and was highest in 8th graders compared to 12th graders.

Observed teen use in boats was 50% although unmandated. b) observed increased PFD use by i) Children when an adult wear one in a boat supports mandating parent use; ii) Boaters launching from a PFD loaner site compared to other sites supports placing loaner sites; and iii) boaters at specific sites/seasons when mandated. c) 25% of swimmers in all age groups observed at a swim site used some type of flotation device. BUI- Finding that WA State had the lowest BUI penalties facilitated passing a new law with stronger penalties and implied consent. Designated swim sites- Found that states with the most policies for swim site safety had lowest drowning rates in natural water. Pending statistical analysis will inform state agencies' work on developing new state codes.

Conclusions:
Data were powerful drivers for development and passage of policy and legislation- BUI, designated swim sites. Data demonstrated effectiveness of mandating PFD wear by boaters and alternative policies to mandate wear such as increasing age, addressing specific boater groups, sites and activities. Data identified potential alternative opportunities for novel solutions- safer floatation devices/PFDs for swimmers).

Objectives:
Attendees will learn:
1. To recognize how data is a valuable tool in developing policy/legislation.
2. To discuss how what data is needed depends on the status of the policy development.
3. To identify how important partnerships with stakeholders are in understanding what data can be helpful.

Evaluating Retention Rate of Child Passenger Safety Education Three Months Post Car Seat Class

Marjorie Diaz, BS, Jeffrey Upperman, MD, Helen Arbogast, DrPH, MPH, CHES, Chantel Lowery, MPH, CHES, Christina Solis, BS

Background:
Research by the Center for Disease Control demonstrates that using car seats reduces the risk of death in children by up to 71%, yet three out of four car seats are not being used or installed correctly. Car seat education has become prominent for all caregivers since reoccurring community events reveal the lack of child passenger safety knowledge from parents in all socioeconomic and education backgrounds. The Kohl's Safety and Injury Prevention Program at Children's Hospital Los Angeles conducts a 2-hour car seat class twice a month where participants are educated on current California laws, usage, and installation of car seats- all provided by a nationally certified child passenger safety technician. The objective of the class is to not only educate and provide applicable information regarding car seat safety during this time, but also communicate with caregiver's post class to ensure retention of education.

Methods:
Car seat class registration began in August of 2017 at the start of the grant year, and class times were offered in English and Spanish. The class provides one car seat per family if proof of public assistance is shown at the time of class. Majority of attendees are low-income families in the Los Angeles County. Although the car seat is incentive, we find that certain caregivers also assist for educational purposes. The instructor for each class is responsible for collecting pre and post-tests, which assesses caregivers' knowledge prior to the class and after their participation in the 2 -hour period. Additionally, participants are contacted 3 months post class to retake the test over the phone. At this time, scores are evaluated for retention rate of knowledge from post-test at class site to a 3 month follow up phone call.

Results:
Since data collection began in November of 2017, 3 months after the initial class, our results have not only shown that car seat education information has been retained by participants, but their knowledge has additionally improved. When comparing test scores, not only was overall retention rate 100%, data showed an additional increase of %5 in test scores.

Conclusions:
Results from data collection of the program's 3-month follow up calls have confirmed the significance of our car seat class to the community. Improvement in scores may be due to various factors such as: sufficient instruction time to review test answers-which vary on the speed of each instructor's class, caregivers may find additional information after being educated, attendees are provided with a folder of additional educational material that may be reviewed post class. Nonetheless, data reveals the positive impact our child passenger safety class has on participants.

Objectives:
Attendees will learn:
1. To identify ways to achieve improved retention rates of child passenger safety education post car seat classes.
2. To recognize ways to evaluate pre and post data.
3. To discuss the significance of child passenger safety community education.

Pedestrian Safety: A Public and Private Partnership

Chantel Lowery, MPH, CHES, Helen Arbogast, DrPH, MPH, CHES, Cory M McLaughlin, MD, Jeffrey Upperman, MD

Background:
The Los Angeles Street Smarts (LASS) project is a life sized, interactive set designed to teach students in grades first through third on pedestrian safety. There are four learning areas: crossing the street at a stoplight, crossing the street with no stop light, avoiding dart outs, and walking near driveways. The objectives of the program revolve around instilling proper pedestrian safety behaviors in young children who are walking to and from school alone. Pre and Post Tests are given on questions on the four learning areas as well as community policing feelings. Pre and Post Observations are also conducted to see if there is behavior change from the set education. LASS is funded through a KOHL's grant.

Methods:
For 6 years the LASS set has been taught by injury prevention professionals at Children's Hospital Los Angeles (CHLA). In 2017, the CHLA staff partnered with Los Angeles Police Department (LAPD) officers to assist in teaching as well as gauge the student's interaction with the presence of the officers. Schools are selected by looking at pedestrian versus auto data and targeting schools that have incidents. Principals or coordinators are contacted at the school and meetings are set to assess the space requirements and location needs for the set to be brought. The first assessment of pedestrian safety behaviors at the school are done through pre-observations of the students prior to the deployment of LASS, usually the day before.

Students are given a pre-test then brought to the set for education. Throughout the day classes are taught the 4 learning areas by members of LAPD on the set. A post-test is given after to see if there is knowledge change. Post observations are done to assess if there is also behavior change, usually the day after. A preliminary evaluation has been done to look into several components. The first was on the effect of police involvement in the set education, whether their presence increased participation or discouraged it. The second was the results of the pre and post-test to find knowledge change. The third was an analysis of the pre and post observations, looking at if education can also influence immediate behavior change.

Results:
Out of the 1424 students who completed both the pre and post-test, correct answers increased significantly for nine out of ten of the questions after they went through the set. The greatest knowledge increase came in the question asking students, "How do you know if a driver can see you?"

Conclusions:
The findings from this program expand the importance of collaboration to spread education on unintentional injury safety. The use of the LAPD has not only helped with interaction with the students but has also helped display them in a light opposite of current external views. The set itself is a useful tool to educate and increase student's knowledge on pedestrian safety practices.

Objectives:
Attendees will learn:
1. To identify benefits of collaborating with law enforcement.
2. To describe the components of an interactive pedestrian safety set.
3. To identify how to effectively conduct and use pre and post data.

Evaluation of the Homeless Shelter Home Safety Program

Barbara DiGirolamo, MEd, CPSTI, Maria McMahon, MSN, PNP PC/AC, Meg McCabe, BA, CPST, Lois Lee, MD, MPH, David Mooney, MD, MPH

Background:
Homeless children have increased medical visits compared to children with low income housing. They are also at risk for home related injuries while living in shelters. We developed a homeless shelter safety program that provides home safety education and materials to homeless families to prevent these injuries. The program exists in three phases: the initial shelter home safety assessment, an educational course for parental residents, and the installation of safety supplies. The objectives of this program evaluation are to: 1) highlight program expansion; 2) compare intervention types; and 3) illustrate program challenges/areas of improvement.

Methods:
An Injury Prevention Specialist completed a home safety assessment for the homeless shelters and provided an interventional home safety program to shelter residents. Educational training was conducted at all shelters followed by one of two safety equipment installation intervention types: 1) safety equipment installed by shelter staff; and 2) safety equipment installed by Injury Prevention Program volunteers. In addition some shelters in either intervention type had safety bags provided for individual families. Intervention type was chosen based on shelter size, staff and volunteer availability, and resident schedules. Surveys were provided to shelter directors 30 days after the intervention to assess use of safety equipment and improvement in shelter safety.

Results:
Thirty-four sites have had an initial assessment, 23 sites have had the installation done, and 16 sites have completed a 30-day post evaluation (Table). Nine sites had installation, education, and safety bags provided. This program has reached 404 families, including 572 children, for a total of 1,070 homeless individuals. Challenges for the program include scheduling time for the educational sessions and installation, ensuring ongoing safety materials use due to overuse, and the transient nature of the residents. When surveyed, shelter directors attributed removal of safety equipment to the equipment obstructing everyday activities, such as outlet covers, stove knob covers, toilet locks, and refrigerator locks.

Since May 2017, our Injury Prevention Van has been on the road, spreading our message of "Safe Play Starts Here!" Our community injury prevention events, materials distributed and participants (see appendix: page 70).

Conclusions:
Homeless shelters and their residents have home safety needs. This type of shelter home safety program is feasible and well received by the shelters with the potential for reaching a large number of families. Understanding challenges for safety equipment installation and use over time will be important in sustaining this program for at-risk families.

Objectives:
Attendees will learn:
1. To recognize the home safety needs of families in homeless shelters.
2. To identify and compare home safety intervention types for a shelter home safety program.
3. To discuss shelter home safety program strengths and challenges.


Injury Free Coalition for Kids®
23rd Annual Injury Free Coalition for Kids® Conference
Forging New Frontiers:
Pediatric Injury Prevention -
Process, Programs, and Progress
November 30 - December 2, 2018
Ft. Lauderdale Embassy Suites

WORKSHOPS

Workshop 1A

Race, Bias & Injury

Moderator: Judy Schaechter, MD, MBA,
Presentors: Terri McFadden-Garden, MD, Beth Ebel, MD, MSc, MPH, Brandon Chatani, MD, Karen Sheehan, MD, MPH,
Helen Arbogast, MPH, CHES, Erik Cliette, BA, MS

Description:

The surviving students of the Marjory Stoneman Douglas (MSD) massacre brought unprecedented attention to the issue of gun violence. They spoke up to broadcasters and out through social media, resulting in previously unseen change in policy, business habits, and collective citizen action. Proximate to the Save Our Lives March, black student leaders at MSD and elsewhere have communicated that they don't feel heard, critiquing media and society for an relative lack of response to gun violence against black youth as opposed to white students.

That the Parkland shootin g took place in a school, claiming 17 victims in six minutes, likely factored among the reasons why it claimed the attention it did. However, the concern that everyday firearm violence affects our minority and impoverished communities without sufficient attention or support is not unjustified.

Disparity in injury incidence is well recognized, both overall and for specific types of injury. Boys are more commonly prey to most injury, and are the more likely perpetrators of intentional injury. Even while IFCK researchers have documented declines in injury rates, those rates have remained higher for Black and Native American children. Race remains a significant predictor of appropriate child restraint use among Latino and African-American populations, factoring into disparities in mortality and morbidity. A recent study by the New York City Poison Control Center found that nearly 3/5 unintentional poisonings of young children were among black children. In Miami-Dade County, 51% of LGBTQ youth were bullied at school but never told anyone and 34% of LGBT youth were kicked out of their homes, increasing their risk of violence, sexual trafficking and exposure injuries.

Understanding specific findings within injury categories may help target prevention efforts. Drowning disproportionately affects minority youth, and the gap is largest for pool drownings. Research on pedestrian risk has documented differences in driver behavior depending on the race of the pedestrian at a crosswalk, a finding unrelated to the race of the driver, but associated with neighborhood SES. The disparity gap for firearm homicide varies by state and is impressively higher than the gap for non-firearm homicide, which may have implications for prevention promoting conflict resolution vs. means reduction. While enforcement efforts, particularly in the area of MVC, are often shown to be effective, the consequences of racial profiling can be profound and even deadly.

This workshop will explore the role of bias in creating or augmenting the disparity gap, the design and application of prevention strategies and the allocation of resources. Are we doing enough to understand the inequities involved and the populations affected? Are we sufficiently listening to youth? What approaches are necessary to prevent trauma and close the disparity gap?

Objectives:

Participants in this session will learn to:

1. Describe childhood injury as a disparity health issue.
2. Identify potential etiologies for particular injury disparities in terms of environmental, mechanistic, educational, resource and social bias factors.
3. Discuss methods to eliminate injury disparities.
4. Describe disparities in childhood injury;
5. Discuss potential means to accelerate the reduction or elimination of injury disparities.

Workshop 1B

How to Get Your Work on Paper and Then to Presentation: How to Write a Scientific Abstract

Moderator: Marlene Melzer-Lange, MD, Milwaukee, W
Presenters: Dina Burstein, MD, MPH, CPSTI, Pina Violano, PhD, MSPH, CPS-T, Michael N. Levas, MD, MS, Lois K. Lee, MD, MPH

Description:
Writing a scientific abstract is an important skill to learn, but also can be a daunting task. Showcasing your program or research study at professional meetings is dependent upon your abstract being accepted. Clear, high-quality and concise abstracts are the key to success. The basic format typically includes: Background (including objectives of program/study), Methods, Results, and Conclusions. In this workshop, first we will explain the content that should be included in each of these sections. We will review examples of abstracts. Then we will divide into small groups to practice writing each section of the abstract as well as reviewing some sample abstracts. Participants will be asked to bring some information, data, or a working abstract related to a program/study to use for their abstract writing practice. For those participants who do not have specific data, study examples will be provided.

Objectives:
Participants in this session will learn to:
1. Discuss the format behind writing a scientific abstract.
2. Desctibe the objectives, methods, and results of abstracts.
3. Recognize the techinques of writing and reviewing scientific abstracts.
4. Recognize how to write their own abstract with coaching.
5. Identify how to critique and review others' abstracts.

Workshop 2A

Race and Injury: Introducing New Framework for Thinking about Racial Disparities
Moderator: Sadiqa Kendi, MD, FAAP, Washington, DC, and Ibram Kendi, PhD

Description:
Ibram Kendi won the National Book Award in 2016 for his New York Times bestselling book "Stamped from the Beginning: The Definitive History of Racist Ideas in America". This book introduced a new way of thinking about racist ideas and racial disparities, reminding us that behind every racial disparity is a racist policy (or in many cases multiple racist policies). Ibram Kendi's wife, Sadiqa Kendi is a pediatric emergency medicine physician and injury prevention researcher. They will work together to facilitate this workshop, which will take some of the known racial disparities in injury, and create interactive sessions with participants to think about policies which contribute to those disparities, and potential solutions.

Objectives:
Participants in this session will learn to:
1. Recognize racial disparities within unintentional injuries.
2. Identify racist and discriminatory policies which contribute to racial disparities.
3. Describe action steps to address the discriminatory policies.
4. Describe how to initiate the action steps in the individual's role.
5. Describe how to initiate the action steps in the individual's institution or community.

Workshop 2B

Integrating Patient Reported Outcomes and Interactive Dashboard Technology into Program Evaluation
Moderator: Michael Levas, MD, MS, Milwaukee, WI
Presenters: Marlene Melzer-Lange, MD, Brooke Cheaton, MS, Mark Nimmer, MS

Description:
Youth directly exposed to interpersonal violence are at risk for experiencing emotional/behavioral problems and future re-victimization. Patient Reported Outcomes (PROs) enable researchers and clinicians to quantify and compare the effect of interventional programs. Previous work by this team has shown that 1) youth victims of violence suffer significant impairment in PROs compared to both healthy populations and youth with specific disease burdens; 2) social and environmental factors influence PROs in this population; and 3) brief hospital-based programming directed at violently injured youth resulted in improved Violently injured youth enrolled in Project Ujima are evaluated upon intake and at 3 month intervals. Mean PRO scores have improved over time among program participants across multiple domains including anger (58.45 vs 45.15), psychological stress experience (56.64 vs. 46.7), emotional well-being (63.37 vs. 84.47), and psychosocial well-being (64.17 vs. 83.95). In multiple regression analyses the significance of time in

programming remains important but were also associated with social determinants of health including community levels of violence, witnessing domestic violence, history of school troubles, and experiencing bullying. The integration of this data into case management and program evaluation through dashboard technology has allowed for more evidence based approaches to intervening in the lives of youth victims of violence.

Objectives:

Participants of this session will learn to:

1. Discuss the development of an evidence-based evaluation process for programming using PROs beginning with the development of the evaluation battery.
2. Describe initial findings in feasibility and importance of the measures
3. Recognize measures needed for evaluation in electronic databases and tools.
4. Discuss the real-time integration of these measures into individual case management through the use of dashboard technology.
5. Identify barriers to developing evidence-based practice in youth violence intervention.


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APPENDIX

APPENDIX

Trends and Characteristics of Playground-Related Extremity Fractures in Children

Table 1: National annual average estimates and rates of ED visits for playground-related extremity fractures and other playground-related injuries among children ≤14 years.

	Total	Playground related extremity fracture				All other playground injuries, excluding extremity fractures			
	n	n	%	Rate per 100,000	95% CI	n	%	Rate per 100,000	95% CI
Total	214,788	72,889	100.0	119.2	95.7-142.8	141899	100.0	232.1	188.7-275.5
Age, y									
0-4 years	60,053	14,979	20.6	74.1	56.3-91.9	45,074	31.8	222.9	173.1-272.6
5-9 years	120,904	48,728	66.9	240.7	194.7-286.7	72,176	50.9	356.6	292.2-420.9
10-14 years	33,831	9,182	12.6	44.4	36.3-52.6	24,649	17.4	119.3	100.2-138.4
Disposition from ED*									
Discharged	202,792	64,645	88.7	105.8	84.9-126.7	138,146	97.4	226.0	183.7-268.3
Admitted	10,377	8,172	11.2	13.4	10.3-16.5	2,206	1.6	3.6	2.6-4.6
Left AMA	1,590	65	0.1	0.1	0.0-0.2	1,525	1.1	2.5	1.6-3.4
Equipment Type									
Monkey bars	79,157	36,296	49.8	59.4	46.7-72.1	42,861	30.2	70.1	55.8-84.5
Swings	48,655	12,960	17.8	21.2	17.5-24.9	35,695	25.2	58.4	49.1-67.7
Slides	45,827	13,904	19.1	22.7	18.6-26.9	31,923	22.5	52.2	42.4-62.1
Seesaw	3,813	677	0.9	1.1	0.9-1.4	3,136	2.2	5.1	4.1-6.1
Other playground equipment	16,918	3,884	5.3	6.4	4.2-8.5	13,034	9.2	21.3	14.8-27.9
Playground equipment not specified	20,418	5,168	7.1	8.5	5.3-11.6	15,250	10.7	24.9	16.5-33.4
Injury Location									
Place of recreation	73,048	25,565	35.1	41.8	32.5-51.1	47,483	33.5	77.7	62.2-93.1
School or daycare	61,048	21,154	29.0	34.6	25.2-44.0	39,894	28.1	65.3	49.5-81.1
Home	29,118	8,725	12.0	14.3	10.8-17.7	20,393	14.4	33.4	26.1-40.6
Other property	7,183	2,240	3.1	3.7	2.2-5.1	4,943	3.5	8.1	5.9-10.3
Not recorded	44,391	15,205	20.9	24.9	17.1-32.6	29,186	20.6	47.7	32.4-63.1

*15 fatalities (all non-extremity fracture playground injuries) and 14 patients (7 playground related extremity fractures, 7 non-extremity fracture playground injuries) without disposition information.
**Estimates less than 1,200 are considered possibly unstable.

* see corresponding abstract on page 38

Perception of Injury Risk Among Parents of Youth Bicyclists

Table 1

Frequency and proportion of respondents' perceived risk of injury for an equal referent participating in a range of sports, mean rating of risk with 95% confidence interval (CI), and comparison of mean rating of risk in Bicycling versus (referent) versus other sports using paired t tests

Chance of getting injured							
Sport	**Very low**	**Low**	**Average**	**High**	**Very high**	**Mean [95%CI]**	***p*-value**
Collision							
American football	13 (6.8%)	6 (3.1%)	36 (18.8%)	71 (37.2%)	62 (32.5%)	-1.047 [-.163, .152]	.000
Contact							
Soccer	26 (12.6%)	22 (11.5%)	93 (48.7%)	37 (19.4%)	13 (6.8%)	−.131 [−0.305, .044]	.043
Basketball	21 (11%)	32 (16.8%)	104 (54.5%)	29 (15.2%)	5 (2.6%)	−0.005 [−0.163, .152]	.984
Limited-contact							
Bicycling	16 (8.4%)	19 (9.9%)	103 (53.9%)	40 (20.9%)	13 (6.8)	−.267 [−.410, −.125]	.000

* see corresponding abstract on page 41

To Test or Not to Test: A Retrospective Review of Infant Car Seat Tolerance Screening Outcomes at a Single Institution

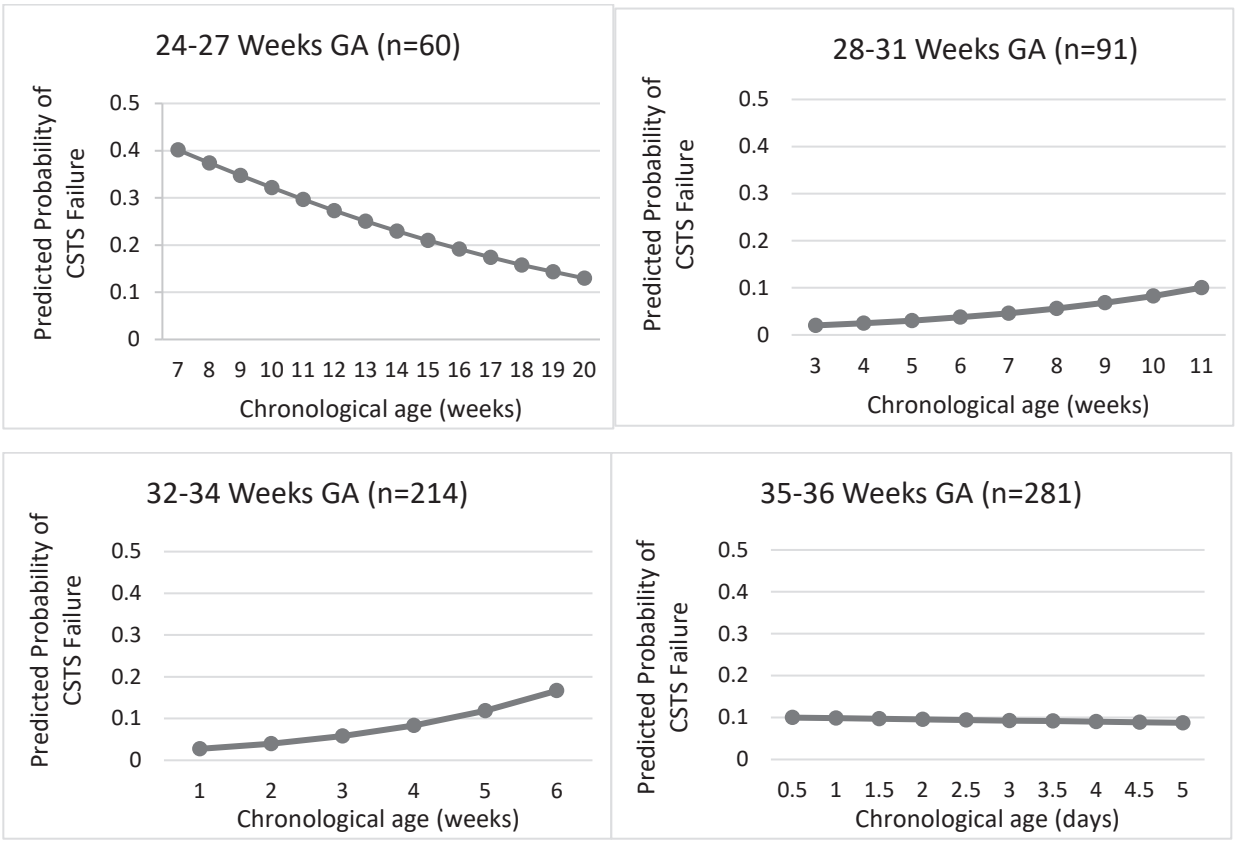
Table 1. Bivariable Models of Predictors for Car Seat Tolerance Screening (CSTS) Failure Among a) All Infants Tested and b) Preterm Infants without HSCHD or Other Cardiorespiratory or Neurologic Risk Factors

	CSTS Result					
	Fail		Pass		Total	Bivariable Models*
CHARACTERISTIC	**n**	**(%)**	**n**	**(%)**	**N**	**OR (95% CI)**
A. All infants tested (n=1,072)						
Total	**99**	**(9.2)**	**973**	**(90.8)**	**1,072**	
Sex						
Male	59	(10.0)	532	(90.2)	591	1.2 (0.8-1.9)
Female	40	(8.3)	441	(91.7)	781	ref
Race						
White, non-Hispanic	64	(9.6)	603	(90.4)	667	ref
Other/missing/unknown	35	(8.6)	370	(91.4)	405	0.9 (0.6-1.4)
Gestational Age (weeks)						
24-27 weeks	18	(24.0)	57	(76.0)	75	**2.7 (1.4-5.1)**
28-31 weeks	6	(5.8)	98	(94.2)	104	0.5 (0.2-1.3)
32-34 weeks	12	(5.0)	230	(95.0)	242	**0.4 (0.2-0.9)**
35-36 weeks	34	(9.0)	342	(91.0)	377	0.8 (0.5-1.4)
≥ 37 weeks	29	(10.6)	245	(89.4)	274	ref
Chronological Age (days)	M=36.4; Med=14 (SD=46.7)		M=28.6; Med=13 (SD=71.2)			1.00 (0.99-1.00)
Gestational Size						
Large	7	(11.3)	55	(88.7)	62	1.4 (0.6-3.2)
Normal	72	(8.3)	795	(91.7)	867	Ref
Small	19	(13.7)	120	(86.3)	139	**1.7 (1.0-3.0)**
HSCHD						
Yes	18	(22.8)	61	(77.2)	79	**3.3 (1.9-5.9)**
No	81	(8.2)	912	(91.8)	993	ref
Apnea						
Yes	19	(14.5)	112	(85.5)	131	**1.8 (1.1-3.1)**
No	80	(8.5)	861	(91.5)	941	ref
Chronic Lung Disease						
Yes	10	(25.6)	29	(74.4)	39	**3.7 (1.7-7.8)**
No	89	(8.6)	944	(91.4)	1,033	ref
Other Diagnosis						
Yes	21	(12.0)	154	(88.0)	175	1.4 (0.9-2.4)

* see corresponding abstract on page 43

To Test or Not to Test: A Retrospective Review of Infant Car Seat Tolerance Screening Outcomes at a Single Institution

Figure 1. Predicted Probabilities of CSTS Failure at select Chronological Age Time Points* among Premature Infants without HSHD and Other Comorbidities, by GA Category**

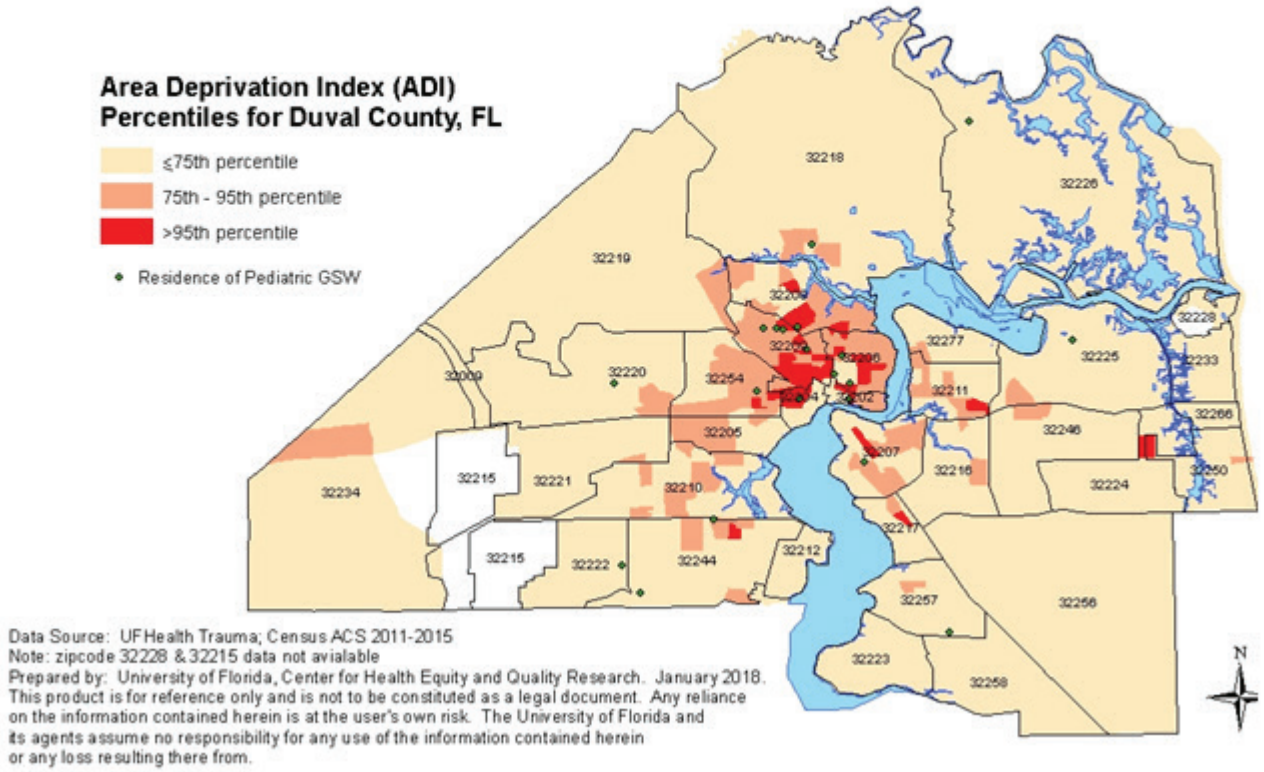


* X-axes vary by GA and reflect ranges of observed values in data.

**Outlying observations have been removed.

* see corresponding abstract on page 43

Pediatric Patients (<18 years) seen at UF Trauma for a GSW by Residence and ADI Score, Duval County, FL, 1996



Data Source: UF Health Trauma; Census ACS 2011-2015
Note: zipcode 32228 & 32215 data not avialable
Prepared by: University of Florida, Center for Health Equity and Quality Research. January 2018.
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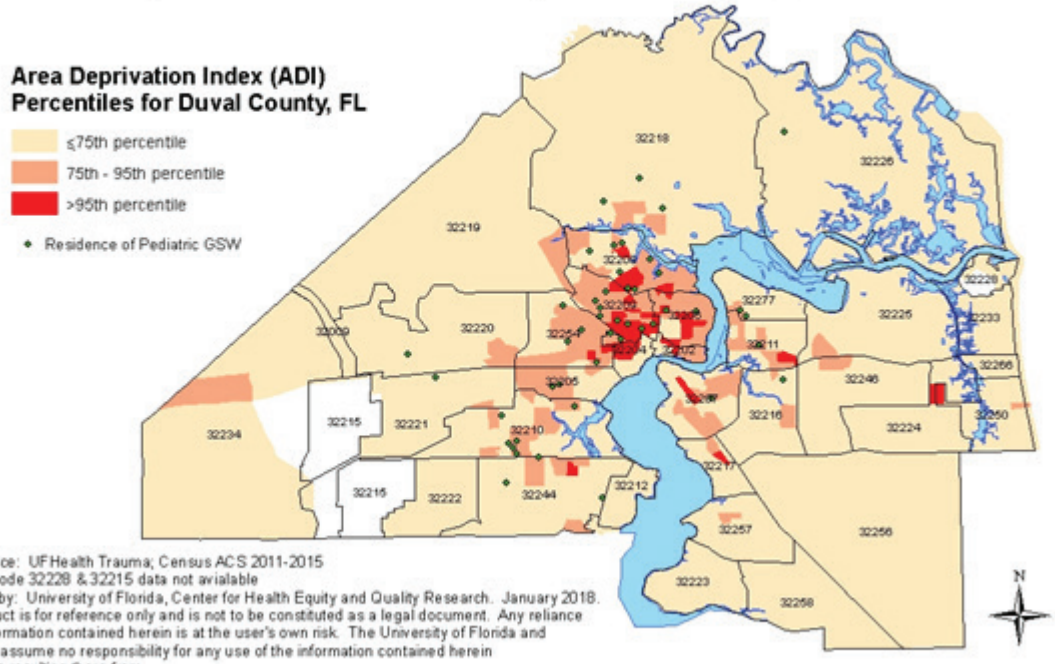
Pediatric Patients (<18 years) seen at UF Trauma for a GSW by Residence and ADI Score, Duval County, FL, 2015



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* see corresponding abstract on page 47

Venues	2015	2016	May-December 2017	January-March 2018
Health Centers/Head Start	6	32	33	4
Schools	10	6	11	8
Community Health/safety fairs	6	5	20	3
Other Outreach - Customized events - Shelters	3	14	29	21
Number of Days on the Road	N/A	N/A	81	31
Number of Miles on the Road	N/A	N/A	2,800	1,300

Deliverables	2015	2016	2017 May-December	2018 January-March
Helmets distributed (inpatient, community events, health centers)	892	500	503	350
Car Seats distributed (inpatient and health centers)	306	447	905	67
ThinkFirst	845	1000	1,075	1,015

* see corresponding abstract on page 52

Evaluation of the Homeless Shelter Home Safety Program

	Shelters (n/N)
Intervention type (N=23)	
Shelter staff install	10/23 (43%)
Injury Prevention Program install	13/23 (57%)
All items in use after 30 days (N=16)	11/16 (69%)
Shelter staff installation	4/4 (100.0%)
Shelter Staff installation +Safety Bags	1/1 (100%)
Injury Prevention Program installation	5/8 (62%)
Injury Prevention Program installation + Safety Bags	1/1 (100%)
Shelters with items removed	5/16 (31%)
Shelter safety improvement (5=Safety improved overall) (N=16)	
Rated 4/5	5/16 (29%)
Rated 5/5	11/16 (69%)

* see corresponding abstract on page 58


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Injury Free Coalition for Kids®
23rd Annual Injury Free Coalition for Kids® Conference
Forging New Frontiers:
Pediatric Injury Prevention -
Process, Programs, and Progress
November 30 - December 2, 2018
Ft. Lauderdale Embassy Suites

BIOS

2018 Bios

23rd Annual Injury Free Coalition for Kids® Conference

Forging New Frontiers: Pediatric Injury Prevention - Process, Programs, and Progress

Maneesha Agarwal, MD, FAAP, Atlanta, GA

Dr. Agarwal received her undergraduate and medical school degrees from the University of North Carolina at Chapel Hill. She completed her pediatrics residency at the Boston Combined Residency Program and her fellowship in pediatric emergency medicine at Carolinas Medical Center. She is currently an assistant professor at Emory University School of Medicine and works clinically at Children's Healthcare of Atlanta. She was founding member of the Children's Injury Prevention Program (CHIPP) in Atlanta, which she continues to lead today. Her specific interests include poisoning prevention, large data set research, and the mentoring of future generations of pediatric injury prevention advocates including graduate students, residents, fellows, and faculty.

Nina Agrawal, MD, New York, NY

Nina Agrawal is an active advocate for children's health and safety from local to national levels. The tragedy at Sandy Hook elementary school prompted her to jump-start the gun violence prevention campaign for Doctors for America (DFA), a grassroots health advocacy organization. In this capacity with DFA, Dr. Agrawal organizes physicians across the country in legislative advocacy efforts to keep children safer from firearm injuries. The focus of DFA's gun violence prevention campaign is to repeal the Dickey Amendment, which has stifled federally funded gun violence prevention research since 1996.

Dr. Agrawal completed a pediatrics residency at Cornell Medical Center and fellowship in Academic Pediatrics at New York University. She is a child abuse pediatrician at Lincoln Medical Center in the South Bronx, New York. As a child abuse pediatrician, she has encountered many cases of child injury due to neglect. With this experience, she has developed innovative ways to deliver injury prevention education to children and families, often affected by poverty and other social determinants of health. She created an interactive shaken baby prevention program, "Loving Arms", which educated mothers and fathers on how to soothe a crying baby. She mentors pediatrics residents on educating caregivers in the pediatric clinic waiting room on various injury prevention topics. She was the principal investigator on a project to assess the effectiveness of the ASK (Asking Saves Kids) gun violence prevention campaign in the pediatric clinic. In her personal time, she has done national legislative advocacy work for health care reform, gun safety legislation, and, most recently, immigration health. In the wake of the San Bernardino shooting, she spoke on Capitol Hill and on CNN about the need for gun violence prevention research. Since the Parkland shooting, she has been speaking to various health provider groups on the need for evidence based polices and how to advocate as a physician.

Phyllis Agran, MD, MPH, MA, FAAP

Dr. Agran is American Board of Pediatrics certified in General Pediatrics and Pediatric Gastroenterology. She is Professor Emeritus, UC Irvine School of Medicine and a practicing physician. She founded the Child Injury Prevention Research Group at UCI focused on translating research into policy. She is a past president of California Chapter 4, American Academy of Pediatrics. She serves on the American Academy of Pediatrics, Executive Committee of the Council on Injury and Violence Prevention. Her current work, a Healthy Tomorrows Partnership for Children project, Clinic in the Park •Connect •Screen •Educate, is a one-stop health collaborative model designed to promote health and prevent disease, targeting vulnerable children. (www.clinicinthepark.org). She has been an advocate for public health policies aimed at reducing trauma and injury to children. She received her BA degree from UC Berkeley, a Masters Degree in Biology from Boston University, an MPH from Harvard University, and her medical degree from UC Irvine.

Courtney Allen, MD, Atlanta, GA

Courtney received her undergraduate degree from University of Miami and her medical school degree from Nova Southeastern University in Fort Lauderdale. After completing her pediatric residency at Miami Children's Hospital, she is currently a third-year fellow at Emory University. Courtney is actively involved the Children's Injury Prevention Program (CHIPP) program in Atlanta, specifically the intentional injury committee. Her specific interests include injury prevention and firearm safety.

Amanda Bagin, MPS, CHES, Milwaukee, WI

Amanda Bagin is a Project Manager for the Injury Prevention and Death Review initiative at Children's Health Alliance of Wisconsin. In her role, Amanda provides technical assistance to child death review teams in Wisconsin. She also leads the Sleep Baby Safe and Newborn Nest projects at Children's Health Alliance of Wisconsin and provides technical assistance to local health departments and tribal agencies working on infant safe sleep. Amanda received a master's degree in public health from A. T. Still University and a bachelor's degree in sociology from University of Wisconsin-La Crosse.

Lilly Bayouth, MD, Greenville, NC

Dr. Bayouth was born and raised in Orlando, FL, completed my undergraduate degree in Biology at the University of Florida and medical school at the University of Central Florida College of Medicine. I have since moved on to my general surgery residency at East Carolina University Vidant Medical Center where I am in my 3rd clinical year of training. I came back to the University of Florida to the Shands Jacksonville campus for two years of research focused on pediatric trauma, which was completed this past summer. I look forward to completing my surgical training and will be pursuing a career in pediatric surgery.

Kristen Bechtel, MD, New Haven, CT

Dr. Bechtel is an Associate Professor of Pediatrics and Emergency Medicine at Yale School of Medicine. Dr. Bechtel is Medical Director, Pediatric Sexual Assault Forensic Examiner (SAFE) Program; Chairperson, Yale Traffic Safety Subcommittee; Co-Chairperson, State of Connecticut Child Fatality Review Panel; and Co-Principal Investigator, Injury Free Yale-New Haven Children's Hospital She received her Medical Degree from the University of Medicine and Dentistry of New Jersey-Rutgers Medical School; completed her pediatric residency at St. Christopher's Hospital for Children and completed her fellowship training at Children's Hospital of Pittsburgh.

Ashley Blanchard, MD, New York, NY

Ashley Blanchard is a 3rd year pediatric emergency fellow at Morgan Stanley Children's Hospital at Columbia University Medical Center. She has worked with the Columbia Center for Injury Epidemiology and Prevention throughout her fellowship and is completing a master's in-patient oriented research. Her interests within pediatric injury prevention are in pediatric falls and musculoskeletal injuries and adolescent distracted driving.

Charles Branas, PhD, New York, NY

Dr. Branas is the Anna Cheskis Gelman and Murray Charles Gelman Professor of Epidemiology, Chair of the Department of Epidemiology at the Columbia University Mailman School of Public Health, and Co-Director of the Center for Injury Epidemiology and Prevention at Columbia University. Dr. Branas has conducted research that extends from urban and rural areas in the US to communities across the globe, incorporating place-based interventions and human geography. He has led win-win science that generates new knowledge while simultaneously creating positive, real-world changes and providing health-enhancing resources for local communities. His pioneering work on geographic access to medical care has changed the healthcare landscape, leading to the designation of new hospitals and a series of national scientific replications in the US and other countries for many conditions: trauma, cancer, stroke, etc. His research on the geography and factors underpinning gun violence has been cited by landmark Supreme Court decisions, Congress, and the NIH Director.

Dr. Branas has also led large-scale scientific work to transform thousands of vacant lots, abandoned buildings and other blighted spaces in improving the health and safety of entire communities. These are the first citywide randomized controlled trials of urban blight remediation and have shown this intervention to be a highly cost-effective solution to persistent urban health problems like gun violence. He has worked internationally on four continents and led multi-national efforts, producing extensive cohorts of developing nation scientists, national health metrics, and worldwide press coverage.

Anna Briker, MD Candidate, Chicago, IL

Anna Briker is a medical student in her second year at Northwestern University Feinberg School of Medicine. She holds a B.S. in biochemistry and minors in Humanities and Spanish from Villanova University. She graduated summa cum laude and as a member of the Phi Beta Kappa Society in 2017. At Feinberg Anna tutors high school students through Chicago Youth Programs (CYP). She also serves as a student clinic co-coordinator of CYP's pediatric clinic. This past summer Anna traveled to Puerto Escondido, Mexico to study women's reproductive health and to work with traditional midwives in the region. She is interested in infectious diseases, health disparities, and pediatrics. In her free time Anna enjoys practicing yoga, reading, and exploring Chicago.

Serifatu Walton-Buford, MFT, CHES, CPST-I, Little Rock, AR

Serifatu Walton-Buford is the Health Education Coordinator for Generations in Families Talking Safe Sleep (GIFTSS), a NIH funded study at Arkansas Children's Hospital. She has been a certified child passenger safety instructor for 18 years. Serifatu holds a Bachelor of Science degree in Health Science with a concentration in Community Health Education from California State University at Long Beach. She also holds a Master of Arts degree in Marriage and Family Therapy from Christian Theological Seminary in Indianapolis, IN. Combining both skill sets gives her a unique perspective for developing health education interventions.

Reid Burks, MD, Birmingham, AL

Allison "Reid" Burks graduated from the University of New Mexico with a degree in finance and went on to attend medical school at the University of Colorado Denver. She is currently a 3rd year pediatric resident at the University of Alabama Birmingham and will be a chief resident at UAB next year. She then plans to pursue a fellowship in Pediatric Critical Care. Her research in residency has been focused on ATV safety.

Dina Burstein, MD, MPH, FAAP, CPSTI, Providence, RI

Dina Burstein, MD, MPH, FAAP, CPSTI is a research associate and an assistant professor of emergency medicine (research) at The Warren Alpert Medical School of Brown University. She is principal investigator on the Rhode Island Foundation supported Seat Checks in Pediatric Practice project. She also coordinates community outreach activities at the Injury Prevention Center (IPC), including the Injury Free Providence program, the Safe Kids RI program and the car seat safety program. Dr. Burstein earned her medical degree at the University of Massachusetts Medical School and completed a residency in pediatrics at Yale-New Haven Hospital. Dr. Burstein has practiced as a primary care pediatrician and earned a master of public health degree from the University of Massachusetts Medical School. She enjoys working at the IPC to help keep kids safe throughout Rhode Island.

Marie Crandall, MD, MPH, FACS, Jacksonville, FL

Marie Crandall, MD, MPH, FACS is Professor of Surgery at the University of Florida Jacksonville, Associate Chair for Research for the Department of Surgery, and Associate Program Director for the General Surgery Residency. She is currently a member of the Division of Acute Care Surgery. Dr. Crandall performs emergency general and trauma surgery, staffs the SICU, and is an active health services researcher. She has published extensively in the areas of injury risk factors and outcomes, disparities, geographic information systems in trauma research, gun violence, and violence prevention.

Marjorie Diaz, BS, CPSTI-I, Los Angeles, CA

Marjorie Diaz received her BS in Public Health from UC Irvine in 2016. She became a Nationally Certified Passenger Safety technician through her pediatric internship with Children's Hospital Los Angeles in 2014, and has been an active tech in the community since. Now as a hired health educator at CHLA's Trauma Program, Marjorie recently became a certified instructor for the national CPST course. Being the oldest sibling to two young sisters and a camp counselor during her vacation time, she has always enjoyed working with children and families. She takes pride in reaching out to families throughout LA County and provides health education in a variety of Injury Prevention topics to Spanish-speaking communities.

Barbara Digirolamo, MEd, CPST-I, Boston, MA

Ms. Digirolamo currently serves as the is the Injury Prevention Coordinator at Boston Children's Hospital. In this role, Barbara serves as the MA State Chapter Director & National Secretary for the ThinkFirst Boston program where she delivers brain & spinal cord safety programming to area youth through high school and elementary school assemblies. She is also a Child Passenger Safety Technician and Instructor where she coordinates car and booster seat education and installations through inpatient programming and community events, as well as teaches CPST certification classes in MA and RI.

James Dodington, MD, New Haven, CT

Dr. Dodington, is an Assistant Professor of Pediatrics and Emergency Medicine at the Yale School of Medicine and an attending physician in the Pediatric Emergency Department at Yale-New Haven Children's Hospital (YNHCH). He serves as the Co-Medical Director of the Injury Prevention, Research and Community Outreach Program for Yale New Haven Hospital and is the Associate Medical Director for Pediatric Trauma at YNHCH. His research interests include injury and violence prevention with a focus on qualitative methods, injury epidemiology and developing and evaluating hospital-based violence intervention programs. He was the research director for an NIH-funded youth violence prevention project called Youth Haven, in collaboration with the Robert Wood Johnson Foundation Clinical Scholars Program at Yale. He is currently working to develop a Hospital-Based Violence Intervention Program at Yale-New Haven Hospital.

Jane Edwards, BSc, MSc, London, Ontario

Jane is an Injury Prevention Specialist for the Trauma Program at Children's Hospital, London Health Sciences Centre (LHSC). She is a graduate of Western University with a BSc (Hons) degree in Microbiology & Immunology and the University of London/London School of Hygiene and Tropical Medicine with a MSc in Infectious Diseases. During her schooling, Jane worked at LHSC's pediatric and adult emergency departments and learned firsthand the devastation of traumatic injury. She is the Injury Free London, Ontario, Program Coordinator for Children's Hospital, Chair of the Trauma Association of Canada's Injury Prevention working group and as well as Co-Chair of London Middlesex Road Safety Committee, 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, Helmet Giveaway Program in the ED and the Home Safety Device Program for first time parents.

Todd Fleenor, MD, Huntsville, AL

Dr. Todd Fleenor is originally from the rolling hills of Franklin, TN. He migrated south to complete his undergraduate degree at Samford University in Birmingham, AL. Between college and medical school, he worked as a research assistant at Vanderbilt University Medical Center in the Cardio-thoracic department. He attended American University of the Caribbean School of Medicine, where for the first 2 years of school, he lived on the tropical island of St. Martin before spending his 3rd and 4th years in the cold North of Long Island, NY and Detroit, MI. He found his way back to the South to the University of Alabama Birmingham for Pediatric Residency and Fellowship in Pediatric Emergency Medicine. He is now a pediatric emergency medicine attending physician at Huntsville Hospital in Huntsville, AL.

Barbara A. Gaines, MD, 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 the 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 childhood injury prevention.

Adrienne Gallardo, MA, CPST-I, Portland, OR

Adrienne Gallardo is the Program Manager for the Tom Sargent Safety Center at OHSU Doernbecher Children's Hospital in Portland, Oregon. Adrienne completed undergraduate studies in Social Work and obtained a Masters in Organizational Management. She has dedicated her professional focus to Injury Prevention and advocating for children. She has been a Child Passenger Safety Technician since 2002, and an Instructor since 2012. Adrienne has led the development of the Injury Prevention Program at OHSU Doernbecher Children's Hospital which includes an Injury Control Program benefiting patients and their families along with an Injury Prevention outreach program serving Oregon, SW Washington and Portland Metro communities. Services provided through the Safety Center include community outreach programs providing education and resources in areas including safe sleep, child passenger safety, home and bike safety, as well as providing a car seat inspection station at Doernbecher Children's Hospital, and monthly car seat clinics throughout the community. Adrienne also manages and coordinates the Kohl's Sleeping Safely and Buckle Up for Life programs at OHSU/Doernbecher Children's Hospital. Adrienne was the coordinator for patient recruitment, data collection and assessment for the Unsafe from the Start: Critical Misuse of Car Safety Seats at Newborn Discharge research study. Adrienne presents locally and nationally in areas of child passenger safety, special needs transportation, and program development and design. Adrienne spends every spare moment away from work enjoying her four amazing kids and loving husband.

Dawne Gardner, MBA, CPST, Cincinnati, OH

Keeping kids safe is Dawne's passion. As an Injury Prevention Specialist at Cincinnati Children's Hospital Medical Center, Dawne has helped to develop and implement community outreach that has measurably decreased the frequency of pediatric home injuries treated in local emergency rooms. She has been the Program Coordinator for Injury Free Cincinnati and Greater Cincinnati Safe Kids for over 10 years, organizing and successfully building twelve playgrounds in various Cincinnati neighborhoods and leading multiple home, bike, pedestrian, playground, poison, water and child passenger safety initiatives both in the community and in the hospital. In 2014 Dawne received the Injury Free Coalition for Kids National Injury Prevention Coordinator of the Year for her focused work on helping to eliminate disparities in home injuries and was invited to speak at the 2015 International Safe Communities in Nan, Thailand on her injury prevention work with high-risk communities. Dawne currently serves on the Safe Kids Worldwide President's Advisory Council and looks forward to sharing her expertise to support global advances in the field of injury prevention. In her free time, she enjoys spending time with family and is currently putting her injury prevention knowledge and Ohio Certified Child Passenger Safety Technician certification to good use with her 4-year-old grandson.

Michael Gittelman, MD, Cincinnati, OH

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

Mike used to serve on the Injury Free Coalition for Kids Board, and prior to their formation of a Council, he served as the Chairperson for the American Academy of Pediatrics' (AAP)Section on Injury, Violence and Poison Prevention. He is currently the President of the AAP's Ohio Chapter. With this Chapter, he has developed a state-wide bicycle helmet intervention, a gun safety program in the pediatric office setting, a hospital-based safe sleep QI program, and an injury QI program for practicing pediatricians. His area of research expertise has been to study the impact of screening and counseling families about injury risk, in the office and ED setting, in an attempt to promote safer behaviors and prevent future injuries. He has published his efforts extensively in peer-reviewed journals.

Tania Haidar, BSc, London, Ontario

Tania is an Injury Project Associate in the Trauma Program at Children's Hospital-London Health Sciences Centre (LHSC). She has been in this role for 3 years, but started in the Adult and Pediatric Emergency Department at LHSC. Tania attended Western University and graduated with a Specialization in Health Sciences Bachelor Degree. She is also a certified Car Seat Technician at London Health Sciences Centre and has provided education to parents in the NICU on car seat safety. She also sits on multiple committee including those in hospital and within the community including Talk Trauma, London Middlesex Road Safety Committee, Ontario Lead Trauma Hospital Pediatric Collaborative, Regional Trauma Networks, Trauma Association of Canada Injury Prevention Committee, Pediatric Trauma Simulation Committee, Helmets on Kids and others.

Sam Hanke, MD, MS, Cincinnati, OH

Dr. Samuel Hanke is a pediatric cardiologist and an assistant professor in clinical pediatrics in the Heart Institute at Cincinnati Children's Medical Center. He received his medical degree from the University of Louisville and completed his pediatric residency, chief residency and cardiology fellowship at Cincinnati Children's. He currently provides medical care to fragile infants and children with congenital and acquired heart disease in both inpatient and outpatient environments. He also completed additional training in quality improvement science and currently holds a faculty appointment in the Anderson Center for Health System's Excellence at Cincinnati Children's. When not providing pediatric cardiac care, Dr. Hanke serves as president of Charlie's Kids foundation. An organization he and his wife founded after the untimely loss of their first son Charlie in 2010 to Sudden Infant Death Syndrome (SIDS) and an unsafe sleep environment. His organization has been committed to educating families about SIDS and Safe Sleep to help prevent other parents from suffering the sudden and unthinkable loss of an infant.

Holly Hanson, MD, MS, Nashville, TN

Dr. Holly Hanson is a Pediatric Emergency Medicine attending on faculty at Monroe Carell Jr. Children's Hospital at Vanderbilt. Holly graduated medical school from Northeast Ohio Medical University then went on to complete Pediatric Residency and Pediatric Emergency Medicine Fellowship at Cincinnati Children's Hospital. Holly has an interest in clinical research and completed her Masters of Clinical and Translational Research at the University of Cincinnati. She has an interest in research focused on sports injuries and resuscitation.

Priscila Hegger, MPH, CPST, San Diego, CA

Priscila Hegger joined the Rady Children's Hospital-San Diego Center for Healthier Communities team in 2014. She received her undergraduate degree from the University of Illinois at Urbana-Champaign in sociology and economics and earned her Master of Public Health degree in community health practice from the University of Texas – Health Science Center at Houston. She has worked with injury prevention for about 4 years, focusing on Road Traffic Safety, Child Passenger Safety, Bicycle Safety, Pedestrian Safety and Helmet Safety. She holds a Child Passenger Safety Technician certificate; she is the secretary from SafeKids San Diego and the Co-chair from the San Diego Safe Routes to School Coalition. Priscila has experience with the planning, implementation and evaluation of health- focused programs, including injury prevention and physical activity promotion programs, worksite wellness programs, lactation supportive programs and HIV/AIDS prevention and care.

Amy Hill, MS, Chicago, IL

Amy Hill is project manager for the Injury Free Chicago at Lurie Children's Hospital. Prior to joining the staff at Lurie Children's thirteen years ago, Ms. Hill was a staff member and volunteer at several Chicago-area nonprofit organizations including Chicago Cares, Heartland Alliance for Human Needs and Human Rights/Neon Street Programs and Literacy Chicago. Most recently, she was the Associate Director of Chicago Youth Programs, an organization dedicated to improving the health and life opportunities of at-risk youth in three Chicago communities. Ms. Hill has experience in nonprofit finance and administration, fundraising and program management. She holds a Bachelor of Arts in Communication from Loyola University

of Chicago and a Master of Science in Public Administration from DePaul University. She is currently a member of the Illinois Child Passenger Safety and Emergency Medical Services for Children Boards.

Michael Hirsh, MD, Worcester, MA

Dr. Hirsh is the Co-Director of the Injury Free Worcester. He is a native New Yorker who is a Professor of Surgery and Pediatrics at the UMass Medical School and Surgeon-in-Chief of the UMass Memorial Children's Medical Center in Worcester, Ma. He is Division Chief of Pediatric Surgery and Trauma and Associate Surgical Director of the Trauma Center and Pediatric Intensive Care Unit. He is the Co-Director of the Injury Free Worcester and a Past President of the Injury Free Coalition for Kids National Program Office from 2009-2011. He formerly served as Principal Investigator of Injury Free Pittsburgh from 1993-2000. His experience is in developing and applying innovative interventions to prevent pediatric injury. He is also a co-founder of Goods for Guns, a firearms exchange program. His prevention work saw him invited in 2012 to serve as the Medical Director for the Department of Public Health for the Central Massachusetts Regional Public Health Alliance, a consortium of 7 municipalities in Central Massachusetts including Worcester, New England's 2nd largest city. Injury prevention is now one of the 5 top priorities of the region's Community Health Improvement Plan (CHIP) aiming to make the region the healthiest in New England by 2020.

Benjamin Hoffman, MD, CPST-I, Portland, OR

Benjamin Hoffman is a semi-native of New Mexico. He majored in Anthropology at the University of California at Berkeley, and attended Harvard Medical School. He completed residency training, and a year as Chief Resident, at Seattle Children's Hospital. Following training, he and his wife, Jane, also a pediatrician, spent 4 years on the Navajo Nation with the Indian Health Service, where he worked with the community to develop a child passenger safety program. He has been certified as a CPS technician since 1997, and an instructor since 2001, the only practicing pediatrician so certified. From 2000-2011, he was at the University of New Mexico, where he was director of the pediatric residency program, developed and ran a community advocacy training program for pediatric residents, and worked to draft and advocate for childhood injury prevention legislation.
Ben is a nationally recognized expert in child passenger safety, and leader in the field of community health and advocacy training for pediatric residents. He is a Professor of Pediatrics at Doernbecher Children's Hospital and Oregon Health and Science University. There, he is the Director of the Oregon Center for Children and Youth with Special Heath Care Needs, Medical Director of the Tom Sargent Safety Center, and Director of Professional Development. He is also currently he Chair of the American Academy of Pediatrics Council on Injury Violence and Poison Prevention, and Director of the Community Pediatrics Training Initiative. He remains very active in child health policy and community advocacy. Ben and Jane are most proud of their 3 hilarious kids, although all of them are adults.

Carissa Hoium, MPH, Milwaukee, WI

Ms. Hoium is the Motor Vehicle Safety Coordinator for Children's Hospital of Wisconsin Community Education and Outreach. She began working with the Crossroads Teen Driving program for Children's Hospital in August of 2016 through partnerships with the Wisconsin DOT, Wisconsin Department of Health Services, and State Farm. She has also been a certified Child Passenger Safety Technician since 2016. Carissa has a BA in Biology and obtained her Master of Public Health degree from the Medical College of Wisconsin. She is passionate about public health education, programs and advocacy for Wisconsin's children and teens.

Pam Hoogerwerf, BS Iowa City, IA

Ms. Hoogerwerf is the Director of the Community Outreach and Injury Prevention program at the University of Iowa Stead Family Children's Hospital. She grew up in Cedar Rapids, Iowa and completed her undergraduate studies at the University of Iowa receiving a B.S. degree in Communication Studies. Her passion is injury prevention as she leads many efforts at the hospital including All-Terrain Vehicle Safety, Bike Safety, Safe Sleep and Child Passenger Safety to name a few. She serves on many state, regional and national committees for the Children's Hospital and injury prevention.

Charles Jennissen, MD, Iowa City, IA

Dr. Jennissen is a Clinical Professor in the Department of Emergency Medicine at the University of Iowa Carver College of Medicine in Iowa City, Iowa. Dr. Jennissen grew up on a dairy farm in central Minnesota. This plays a large part in his interest in safety and injury prevention, particularly regarding children and teens, and those who work and live on farms. Most of his research projects have addressed injury-related issues with a heavy emphasis on off-highway vehicles (OHVs) such as all-terrain vehicles (ATVs). His 12-year-old first cousin and another neighborhood boy were killed while on an ATV as they drove out of a farmyard driveway and were hit by a pick-up truck just a few miles from his family's farm. Dr. Jennissen is very active in the Iowa ATV Safety Taskforce and is a member of a national OHV on Roads coalition led by the Consumer Federation of America. This coalition has been working to decrease the number of OHV crashes and injuries on roadways and is making efforts to inform the public and governing officials of the dangers of OHVs on public roads. He is proud to have received the SAFE KIDS Iowa "People Who Make a Difference" Award in 2006.

E. Lenita Johnson, MA, Kansas City, MO

Ms. Johnson is the National Marketing, Programming and Communications Director for the Injury Free Coalition for Kids. After a 20-year career of reporting, producing and anchoring, the five-time Emmy Award-winning Broadcast Journalist began working for the Injury Free Coalition for Kids. Prior to leaving the industry, Ms. Johnson worked as the Special Projects Producer for KMBC-TV where she produced primetime specials and documentaries. Much of her work centered around Harmony in a World of Difference, a program designed to heighten community awareness of cultural, ethnic, and religious differences. It was what she saw from behind the camera which led her to move into the injury prevention effort. Ms. Johnson received her Bachelor of Arts degree in News Editorial from the University of Texas, at Arlington and completed her Master's in Communications at Northern Illinois University of DeKalb. In March of 2000, Governor Mel Carnahan appointed her to a six-year term on the Board of Governors of Central Missouri State University. Ms. Johnson became the first African American female president of the board. While serving on the board, she helped to institute the "Summer Bridge Program," a program to prepare first generation college students. Johnson has also established the Mae W. Lovingood Scholarship in honor of her mother. In addition, she serves on the editorial advisory board for Our Health Magazine, and she is the Co-Chair of the Communications Ministry at St. James United Methodist Church. Among the nearly 50 awards acknowledging her work, she was recognized as one of Kansas City's Most Influential African Americans. However, Ms. Johnson's proudest achievement is the building of two playgrounds, which are the Coalition's first two in Kansas City.

David Juang, MD, Kansas City, MO

Dr. Juang is the Director of Critical Care, Burns & Trauma at Children's Mercy Hospital in Kansas City, Missouri. He is board certified in general surgery, pediatric surgery and surgical critical care. His early interest in trauma and critical care led him to complete a one-year residency in Surgical Critical Care at Children's Hospital of Pittsburgh, Pittsburgh, PA during his general surgery training. He then completed his general surgery residency at the University of Pittsburgh Medical Center before entering his two-year Pediatric Surgery residency at Children's Mercy Hospital, Kansas City, Missouri in 2009. He joined the staff at Children's Mercy at the completion of his pediatric surgery training, and was appointed the Director of the trauma program. He was appointed the Program Director of the Surgical Critical Care Residency training program in 2012. Dr. Juang is a member of numerous professional and surgical societies, including the American Pediatric Surgical Association, International Pediatric Endosurgical Group, American Academy of Pediatrics, Association for Academic Surgery, American College of Surgeons, and Pediatric Trauma Society.

Sadiqa Kendi, MD, Washington, DC

Sadiqa Kendi joined the faculty at Children's National Health System in 2017. She works as an attending in the Emergency Department (ED) at the Sheikh Zayed and United Medical Center campuses, and serves as medical director of Safe Kids District of Columbia. Dr. Kendi participates in injury prevention research and advocacy, with a focus on health equity and child passenger safety. She is in the process of starting a Safety Center to provide injury prevention equipment and education to families, with the ultimate goal of making Washington, D.C. the safest city for children in the country. When she is not working in the ED or on injury prevention efforts, Dr. Kendi enjoys spending time with her family, enjoying the District's amazing restaurants, dancing and yoga.

Andrew Kiragu, MD, Minneapolis, MN

Dr. Kiragu is Co-Principal Investigator of the Injury Free Minneapolis. He is currently the Interim Chief of the Department of Pediatrics and Medical Director of the Pediatric Intensive Care Unit at Hennepin County Medical Center (HCMC) in Minneapolis. He is an Assistant Professor of Pediatrics at the University of Minnesota. He completed his undergraduate studies at Dalhousie University in Nova Scotia, Canada and subsequently graduated from Howard University College of Medicine in Washington, DC. He served his residency in Internal Medicine and Pediatrics, followed by a fellowship in Pediatric Critical Care at the University of Minnesota. As a pediatric intensivist at HCMC, one of Minnesota's premier Level 1 Pediatric Trauma Centers, he has considerable expertise in the management of critically injured children particularly those with severe traumatic brain injuries. He is also engaged in injury prevention efforts with Injury Free Minneapolis and serves on the boards of Safe Kids Minnesota and the Midwest Injury Prevention Alliance. Dr. Kiragu is an active advocate for children at the state level and is President-Elect of the board of directors of the Minnesota Chapter of the American Academy of Pediatrics.

Amber Kroeker, MPH, CPST, Portland, OR

Ms. Kroeker is the Co-Program Coordinator of Injury Free Portland. She is the child injury prevention program coordinator at Randall Children's Hospital in Portland Oregon. Amber fell in love with the public health side of injury prevention. Her efforts in evaluation and research focus on the behavioral and public health aspects of injury prevention, in particular the reasons why parents make the choices they do about safety. Amber is trained in Motivational Interviewing and has brought this practice to the field of injury prevention with a goal of empowering caregivers to make safer choices. Amber's other programs include The Period of PURPLE Crying, CLICK for Babies, Infant Safety Classes, Nurse Family Partnership home safety kits, Safe Sleep for Babies and The Safety Center.

Jacky Kwong, BS, Milwaukee, WI

Jacky Kwong was born and raised in Singapore and immigrated to Northern California in 1999. He graduated from UCLA in 2014 and served a year in AmeriCorps in Chicago prior to attending medical school at the Medical College of Wisconsin. He is currently a fourth-year medical student and applying to General Surgery residency programs with hopes of becoming a pediatric surgeon. In his spare time, he loves to play water polo, cook, and spend time with his friends.

Garry Lapidus, PA-C, MPH, Hartford, CT

Mr. Lapidus is the Director of the Injury Prevention Center at Connecticut Children's Medical Center / Assoc. Prof. of Pediatrics & Public Health, UConn School of Medicine where the Injury Free Hartford is housed. He is a physician assistant and provides care to sick and injured children in the Pediatric Emergency Department. Mr. Lapidus is a member of the faculty at Connecticut Children's Medical Center. He is a national leader in injury prevention research, education and training, community outreach programs, and public policy. He is a published author in the field with over 60 peer reviewed journal articles and has given numerous presentations to local, national, and international audiences. He is past Chair of the Injury Control and Emergency Health Services section of the American Public Health Association. Mr. Lapidus has served as a member of the several grant scientific review panels. He is the instructor for the "Injury and Violence Prevention" course currently offered as part of the Master of Public Health Program at the University of Connecticut School of Medicine. He also serves as a preceptor for medical and public health graduate students engaged in injury research and practicum projects.

Sarah Gard Lazarus, DO, Atlanta, GA

Dr. Gard Lazarus is a pediatric emergency physician in Atlanta, Georgia. She works for Pediatric Emergency Medicine Associates and is affiliated with Children's Healthcare of Atlanta. Her focus is on injury prevention specifically in infants under 6 months of age, safe sleep education, and drowning prevention. She lives with her sportswriter husband and her 5-year-old twin boys.

Lois K. Lee, MD, MPH, FAAP, Boston, MA

Dr. Lee is a board-certified pediatric emergency medicine specialist with a clinical and research focus on injury prevention, trauma care, and health policy. She graduated magna cum laude from Emory University, where she majored in chemistry and music, and she received her M.D. from the Perelman School of Medicine at the University of Pennsylvania. Then she completed her internship and residency in pediatrics at the Children's Hospital of Philadelphia. This was followed by a fellowship in pediatric emergency medicine at Boston Children's Hospital. During that time she obtained her Masters of Public Health (MPH) from the T.H. Chan Harvard School of Public Health. She is currently a staff physician in the emergency department at Boston Children's Hospital. There she pursues her academic interests in pediatric trauma care and injury prevention with teaching, research, and advocacy. She is an Executive Committee member for the American Academy of Pediatrics (AAP) Council on Injury, Violence, and Poison Prevention. She recently completed the Nick Littlefield health policy fellowship at the Network for Excellence in Health Innovation (NEHI), which included working as a health policy staffer for Senator Sheldon Whitehouse (D-RI). She has published extensively on pediatric trauma care and injury prevention, and on the effects of legislation on injuries in the U.S. Dr. Lee is the PI for the Injury Free Boston. She is the guest editor for the annual meeting supplement published in Injury Epidemiology. Currently she is Chair of the Program Committee and is President-Elect of the Injury Free Coalition for Kids.

Christiane Lenzen, MD, San Diego, CA

Dr. Lenzen is a Clinical Assistant Professor in the Division of Hospital Medicine at the University of California/ Rady Children Hospital in San Diego. Her research and advocacy interests include pediatric transport medicine, medical education, pediatric global health, optimized hospital care for infants and safe sleep practices. Prior to completing her fellowship in Pediatric Hospital Medicine, she was a NICU hospitalist at Brigham and Women's Hospital in Boston for several years. She is board certified in Pediatrics in Germany and the US. Her passion for international pediatric health led her to the great lake region of Africa, where she spent 2 years as a pediatrician for Doctors Without Borders.

Michael Levas, MD, MS, Milwaukee, WI

Dr. Levas is an Associate Professor of Pediatrics in the Section of Emergency Medicine at the Medical College of Wisconsin where Children's Hospital of Wisconsin is located. Dr. Levas has been with the Medical College of Wisconsin's Section of Pediatric Emergency Medicine since 2011. He is a local product from the south side of Milwaukee and completed his undergraduate work at Saint Norbert College in De Pere, WI. Following graduation from the Medical College of Wisconsin, he completed his residency and fellowship training in Kansas City, MO. He completed his Masters in Clinical and Translational at the Medical College of Wisconsin. Since joining the faculty at the Medical College, Dr. Levas has been intimately involved with health care disparities, youth violence, and injury prevention policy and research. He is the assistant medical director of Project Ujima, the premier hospital-based youth violence prevention/intervention program in the United States. He currently serves as co-chair of the Injury Reduction Initiative at Children's Hospital of Wisconsin.

Deena Liska, MEd, CPST-I, Milwaukee, WI

Ms. Liska is the Teen Driving Coordinator for Children's Hospital of Wisconsin Community Services. She coordinates the Crossroads Teen Driving safety program for Children's Hospital of Wisconsin Community Services, through partnerships with the Wisconsin Department of Transportation, Department of Health, and State Farm. Deena has a Bachelor of Arts in Communication and a Master of Art in Education. She began her career in injury prevention as a Firefighter and Emergency Medical Technician, and retired after 15 years at the rank of Captain. She served her community for another decade as a City Council Member and representative on several committees. In addition, she has been a certified Child Passenger Safety Technician/Instructor for more than ten years.

Gina Lowell, MD, MPH Chicago, IL

Dr. Lowell is a general pediatrician at Rush University Medical Center in Chicago with specialty interests in childhood injury and child abuse and neglect. She has conducted research in unintentional injury prevention using both hospital-based and national data systems to gain a clearer understanding of burn-related injuries in young children to guide innovative prevention strategies. She has joined in research efforts to better understand the epidemiology of sudden unexpected infant death and has analyzed infant safe sleep practices of mothers engaged in home visiting programs. As Director of Community Health for Pediatrics since 2016 she has worked to develop maternal-child health initiatives directed at improving the health of Chicago's communities through addressing the intersection of the social determinants of health and maternal-child health outcomes. She practices general pediatrics at the Rush Pediatric Primary Care Center and as consultant for Rush's Child Protection Team, providing care for children who have suffered maltreatment and those who have entered the foster care system. She also teaches evidence-based medicine to medical students, pediatric residents and faculty.

Chantel Lowery, MPH, CHES, CPST-I, Los Angeles, CA

Ms. Lowery has worked at Children's Hospital Los Angeles for 5 years and is the Coordinator for the Injury Prevention Program. She has worked as a Child Passenger Safety Technician and Instructor for the past 5 years. Chantel's content expertise includes, child passenger safety, home safety, water safety, pedestrian safety, etc. At Children's Hospital Los Angeles she coordinates the home safety vending machine program, the Pediatric Injury Prevention Scholars summer internship, coordinates the annual Injury Prevention symposium, and leads the pedestrian safety Los Angeles Street Smarts set. Her passion of working with children is displayed everyday as she works to prevent injuries and share a wealth of public health knowledge.

Eileen McDonald, MS, Baltimore, MD

Ms. McDonald is senior scientist in the Department of Health, Behavior and Society at the Johns Hopkins Bloomberg School of Public Health, where she directs the master's program in health education and health communication. She is also Assistant Director of Translation for the Johns Hopkins Center for Injury Research and Policy. Her injury research focuses on the application of innovative health education methods, health communication technology, and other hospital- and community-based interventions aimed at reducing pediatric injuries. Among her currently active research projects is an evaluation of an app designed to teach children and adolescents about the dangers of opioids and a survey of scald burn prevention and burn first aid response among parents whose children are being seen in a burn follow up clinic.

Ms. McDonald was a co-creator of the Johns Hopkins Children's Safety Center, in operation since 1997, a first-of-its-kind, hospital-based safety resource center, that provides free injury prevention education and promotes the use of safety products to reduce injuries among children and families. In recognition of her public health practice contributions, McDonald was named the first to receive the Faculty Excellence in Baltimore-based Public Health Practice Award from the Johns Hopkins Bloomberg School of Public Health in May of this year. Ms. McDonald has authored a nationally distributed guidebook for child safety and published over fifty peer-reviewed research articles on injury prevention and health education topics. Ms. McDonald holds a bachelor's degree in health education and a master's degree in health administration. Ms. McDonald is the PI of Injury Free Baltimore.

Terri McFadden-Garden, MD, Atlanta GA

Dr. McFaden-Garden is Co-Principal Investigator for The Injury Free Atlanta. She is a general pediatrician and assistant professor at Emory University School of Medicine. She has a Bachelor of Science degree from Spelman College and a medical degree from Johns Hopkins School of Medicine. Dr. McFadden-Garden serves as Director of Ambulatory Pediatrics for Hughes Spalding Children's Hospital of the Grady Health System. In addition to her administrative responsibilities at Hughes Spalding Children's Hospital, she teaches medical students and pediatric residents in the outpatient and inpatient settings. She also sees her own patients as part of the Emory Pediatric Faculty practice. Dr. McFadden-Garden's academic and community outreach interests include childhood injury prevention and preschool literacy promotion. She is also co-founder of the Ready Set Read literacy program at Hughes Spalding Children's Hospital.

Suzanne McLone, MPH, Chicago, IL

Ms. McLone is the lead epidemiologist for the Illinois Violent Death Reporting System (IVDRS), and the State Unintentional Drug Overdose Reporting System (SUDORS) for Illinois. IVDRS and SUDORS are projects of the Injury Prevention & Research Center at the Ann & Robert H. Lurie Children's Hospital of Chicago. Ms. McLone has twenty years of experience conducting epidemiological analyses of factors which affect the health and well-being of children and adolescents in Chicago and Illinois; evaluating interventions to improve children's health and well-being; and providing analytic and statistical support to clinical faculty working in community health and persons working in child and adolescent advocacy and public policy working on risk factors and protective factors associated with child and adolescent health. She has eight years of experience managing data of and conducting epidemiological analyses with state-based surveillance systems, i.e. IVDRS, and more recently SUDORS. Her areas of expertise include adolescent pregnancy, violence and injury prevention, and the epidemiology of 'deaths of despair': homicide, suicide, and opioid overdose.

Marlene Melzer-Lange, MD, Milwaukee, WI

Dr. Melzer-Lange is Professor of Pediatrics at the Medical College of Wisconsin, an Attending Physician at the Emergency Department/Trauma Center of Children's Hospital of Wisconsin and Medical Director of Project Ujima, a program for victims of interpersonal violence.
As a native of Milwaukee, she is interested in promoting safe, injury free neighborhoods for children and families. She is a graduate of Marquette University and the Medical College of Wisconsin. Her academic interests include injury prevention, violence prevention, adolescent emergencies and adolescent pregnancy. She is married and has two children.

Johannah Merrill, MD, Rochester, NY

Dr. Merrill is currently a third year Emergency Medicine resident at Strong Memorial Hospital. Johannah earned her medical degree from the University of Virginia and is pursuing a fellowship in Emergency Medical Services following completion of her residency in June 2019. She also acts as the resident coordinator for local high school volunteer outreach programs.

Kathy Monroe, MD, MSQI, Birmingham, AL

Dr. Monroe is a Professor of Pediatrics at the Children's Hospital of Alabama where she is an attending physician in the Emergency Department. Her job consists of Clinical (actively seeing patients in the Pediatric Emergency Department), Research and Education (co-director for the Injury Prevention and Advocacy week for all interns). Dr. Monroe is the chair for the Alabama Academy of Pediatrics (AAP) Committee on Injury Prevention. In this role she has created a listserv for her committee to routinely discuss issues and topics of importance. She is working with the state AAP office and the Children's Hospital of Alabama to promote legislative changes in the teen driving bill and to do outreach education in the area of All Terrain Vehicle Safety. She is actively involved in outreach injury prevention activities in an area of high risk in Alabama and is working toward expanding those efforts to the rest of the state.

Mary Beth Moran, PT, MS, MEd, San Diego, CA

Mary Beth was the Program Coordinator of Injury Free San Diego for 10 years (2007- 2018) as the Manager of Injury Prevention. She recently assumed the role of Director of the Center for Healthier Communities, which houses the injury prevention program at Rady Children's Hospital. Mary Beth joined the injury prevention community at Rady Children's Hospital from a clinical background as a physical therapist. After 20 years of treating injuries after the fact she decided to use her background in health care, education and evaluative sciences toward preventative interventions.

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

Hope Mullins, MPH, CPST, Little Rock, AR

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

Jessica Naiditch, MD, Austin, TX

Dr. Naiditch is a pediatric general surgeon and Trauma Medical Director at Dell Children's Medical Center of Central Texas. She is an Assistant Professor of Surgery and Perioperative Care at the University of Texas-Austin Dell Medical School. She completed her undergraduate degree in Biological Sciences at Carnegie Mellon University in Pittsburgh, PA, and received her medical degree from the University of Pittsburgh-School of Medicine. She then completed her general surgery residency at Northwestern University in Chicago, IL, and finished her graduate medical training in pediatric surgery at the University of Texas-Southwestern. Dr. Naiditch's clinical interests include trauma clinical care, pediatric surgical oncology and other congenital anomalies.

Jessica St. Onge, BS, CPST, Milwaukee, WI

Ms. St. Onge is the Injury Prevention Coordinator for Children's Hospital of Wisconsin Community Education and Outreach. Jessica has a Bachelor's of Science in public health from Carroll University. She started her career at Children's Hospital working with the Kohl's Cares Grow Safe and Healthy Program and transitioned to her current role in 2017. Jessica works from primary care clinics on a car seat initiative and is a certified Child Passenger Safety Technician.

Lessa Payne, BS, CPST-I, Little Rock, AR

Ms. Payne is the Infant Mortality Prevention Coordinator through the Injury Prevention Center at Arkansas Children's Hospital. Lessa earned a BS in Psychology/Sociology from the University of Central Arkansas at Conway and has 30 + years of experience working in Prevention with at risk youth. Lessa facilitates Safety Baby Shower training across the state and serves on Safe Sleep and Period of Purple Crying Task Force at Arkansas Children's Hospital. Lessa is also a certified Child Passenger Technician and Instructor and maintains the fitting station at the Injury Prevention Center.

Wendy Pomerantz, MD, MS, FAAP, Cincinnati, OH

Dr. Pomerantz serves as President of the Board of the Injury Free Coalition for Kids and Co-Principal Director of Injury Free Cincinnati. She received her undergraduate degree from the University of Texas at Austin and her medical school degree from the University of Texas Southwestern Medical School in Dallas, Texas. She completed a Pediatrics Residency at Children's Medical Center of Dallas, a Pediatric Emergency Medicine Fellowship at Children's Hospital Medical Center in Cincinnati, and a Master's of Science in Epidemiology at the University of Cincinnati. Currently, she has a faculty appointment as a Professor of Clinical Pediatrics at the University of Cincinnati School of Medicine and Children's Hospital Medical Center in Cincinnati, Ohio. She has been a pediatric emergency medicine physician since 1998. She has published many peer-reviewed articles in the fields of injury and poison prevention. Her interests include poison prevention, concussions, program evaluation, education, and geographic information systems.

Dawn Porter, BS, Little Rock, AR

Ms. Porter is the Infant and Child Death Review Program Coordinator. She earned a BS in Health Education at University of Arkansas at Little Rock. She has five years' experience working at the Injury Prevention Center at Arkansas Children's. She facilitates local ICDR team case review meetings, collaborates with the ICDR Panel on policy and procedure recommendations and other organizations on injury prevention strategies.

Joyce Pressley, PhD, MPH, New York, NY

Dr. Pressley is an Associate Professor of Epidemiology and Health Policy and Management at Columbia University Medical Center. Her experience in research, teaching and injury prevention is multidisciplinary--crossing the disciplinary boundaries of public health policy, epidemiology, emergency medicine, critical care, economics and health care management. Her ongoing research interests include evaluating the impact of legislative regulatory policies and laws on motor vehicle safety, the impact of alcohol and drugs, technological advances for motor vehicle occupant protection, injury-related health disparities and injury in vulnerable populations. Her recent and upcoming publications include evaluating the impact that laws and policies exert on motor vehicle occupant injury as well as the economic burden—particularly for front- and rear-seated motor vehicle occupants, risk factors for poor crash outcomes including same side crashes and the contribution of comorbid disease risk to poor injury outcomes. She is currently PI of a CDC-funded small research project examining crash injury and costs in front and rear seated motor vehicle occupants across the age span. On the national front, she has been active with Transportation Research Board of the National Academy of Science, Engineering and Medicine where she is currently Chair of the Occupant Protection Committee and serves on the Alcohol and Other Drug Committee. She formerly served in the leadership of several national injury prevention organizations including as Chair of the Injury Control and Emergency Health Services Section of the American Public Health Association and as Chair of the Council of Centers for the Society for the Advancement of Violence and Injury Research.

Chuck Pruitt, MD, Salt Lake City, UT

Dr. Pruitt is the Principal Investigator of Injury Free Salt Lake City at Primary Children's Medical Center.
He obtained his baccalaureate at Case Western Reserve University and his doctorate at The Ohio State University School of Medicine. He was trained in general pediatrics at Children's Hospital Los Angeles of the University of Southern California and in pediatric emergency medicine at The Children's Hospital Denver of the University of Colorado; he is certified by the American Board of Pediatrics in both specialties. He is currently Associate Professor of Pediatrics at the University of Utah and is Medical Director of Child Advocacy at Primary Children's Hospital. He is a member of numerous professional and academic societies, president of the Utah chapter of the American Academy of Pediatrics, has written several scientific articles, textbook chapters, and policy statements, and serves on a variety of national and regional expert and advisory committees including the conference planning committee for Injury Free Coalition for Kids.

Linda Quan, MD, Seattle WA

Dr. Quan is Professor of Pediatrics at the University of Washington School of Medicine and a pediatric emergency medicine physician at Seattle Children's Hospital, Seattle, WA where she was chief of the emergency department for 26 years. She has received federal and foundation funding for her research and projects in prehospital care and drowning prevention involving adolescents, ethnic/racial minorities, and life jacket use. Her research has focused on the epidemiology of drowning, pediatric and drowning resuscitation. She has worked with the CDC, the American Academy of Pediatrics, the American Heart Association, ILCOR, World Health Organization and led statewide drowning prevention programs in Washington State identifying the problem of open water drowning prevention and continues to work on legislative and policy approaches to drowning prevention. She is presently vice-chair of the Scientific Advisory Council of the American Red Cross and a member of its Aquatic sub council. She is also a member of the Medical Committee of the International Lifesaving Society, Irish Lifesaving Foundation and WatersafetyUSA.

Kyran Quinlan, MD, MPH, Chicago, IL

Dr. Quinlan is an academic general pediatrician and immediate past Chair of the Executive Committee of the American Academy of Pediatrics Council on Injury Violence and Poison Prevention. He is an Associate Professor of Pediatrics at Rush University Medical center in Chicago. Dr. Quinlan completed the Epidemic Intelligence Service at CDC focused on child injury epidemiology and prevention at the National Center for Injury Prevention and Control. His publications include a study in the Journal of the American Medical Association showing that the majority of child passengers killed by drinking drivers in the United States were riding in the same vehicle with them. He has published numerous studies on child safety in the peer-reviewed literature 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 was a Physician Advocacy Fellow of the Center on Medicine as a Profession of Columbia University working on child pedestrian safety in low-income areas on the south side of Chicago.

Teresa Riech, MD, MPH Peoria, IL

Dr. Teresa Riech completed her undergraduate training in Biology at Southern Illinois University. She then went on to the University of Illinois College of Medicine at Rockford, completing a combined Doctorate of Medicine and Masters of Public Health program. The focus of her Masters degree is Health Policy and Administration. She completed the combined Internal Medicine and Pediatrics program at Indiana University, and then completed Emergency Medicine Residency at the University of Illinois College of Medicine at Peoria. She is an attending physician in the Emergency Department at OSF Saint Francis Medical Center, and since 2011 has served as the Director of the Pediatric Emergency Department. She is currently an Associate Clinical Professor of Surgery and Pediatrics. In addition to her civilian career, Dr. Riech also served in the Illinois Air National Guard and US Air Force for 21 years, recently retiring as a Lieutenant Colonel. During her military career, she served as a flight medic, and then an F-16 Flight Surgeon, Her military career took her on medivac and disaster response missions in locations such as Iraq, Afghanistan, Bosnia, and Guyana South America, as well as Hurricanes Katrina and Rita. She also served as an emergency response physician for NASA's shuttle program. Her research interests include pain management in the Pediatric ED population, disaster preparedness, and Virtual Reality training programs, most recently in development of virtual reality training programs for mass casualty disaster response. Her husband, also a pediatrician and internist, is helping her raise 3 rambunctious children, ages 3, 5 and 7. They are 5 minutes from an ED visit at all times.

Steve Rogers, MD, MS-CTR, Hartford, CT

Dr. Rogers is a Pediatric Emergency Medicine physician at Connecticut Children's Medical Center and an Associate Professor of Pediatrics and Emergency Medicine at the University of Connecticut School of Medicine. He is the Director of Emergency Mental Health Services and Associate Director of Research. He is also the Co-PI for Injury Free Hartford and a research scientist at the Connecticut Children's Injury Prevention Center. These positions provide him with a unique perspective on treating as well as preventing illness and injury for children.

His academic and research activities in injury prevention have involved motor vehicle/pedestrian safety, drowning, suicide and violence. In order to conduct high quality effective research, he recently completed a Master of Science in Clinical and Translational Research program. This program has helped to enhance his research skills and focus his efforts on preventing suicide. Currently, he is bringing together suicide prevention experts from state and community programs, the university health science center, and the Injury Prevention Center to improve the care and prevention of high risk suicidal youth in the emergency department. He is developing new protocols and programs that will enhance clinicians' as well as caregivers' ability to identify and prevent injury and violence.

Tiffany Egan-Rojas, MPH, Indianapolis, IN

Ms. Egan-Rojas is the Injury Prevention Coordinator for the Trauma Services Department at Riley Hospital for Children in Indianapolis, Indiana. She has a Bachelor of Arts degree from Franklin College and she received a Master of Public Health Degree from Indiana University Richard M. Fairbanks School of Public Health. Tiffany has worked at Injury Free Indianapolis for almost two years and carries out the majority of injury prevention programming on child passenger safety, safe sleep, home safety, child protection, and violence intervention and prevention. Tiffany has focused on vulnerable populations including those of low socioeconomic level and those children whose mothers are recovering from opioid addiction. Lastly, Tiffany has worked to get safety and injury prevention messaging intertwined with her hospital's Marketing and Public Relations Department.

Judy Schaechter, MD, MBA, Miami, FL

Dr. Schaechter is the professor and chair of the Department of Pediatrics at the University of Miami Miller School of Medicine and chief of service at Holtz Children's Hospital at Jackson Memorial Medical Center. Dr. Schaechter is a general pediatrician with special interests in adolescence, injury and violence prevention, education, and community health. She currently or recently served as senior advisor to the Florida Children's Movement, president of the national Injury Free Coalition for Kids, gubernatorial appointee to the Florida Children and Youth Cabinet, and board member of The Children's Trust, where as chair of the Health Committee, she led the creation of HealthConnect, launching health teams in 170 schools and initiation home visitation for families in Miami-Dade County. Dr. Schaechter served as the child health policy expert on the Florida Healthy Kids Corporation board for eight years, chairing the Finance/Audit and Satisfaction/Quality Committees. She is an elected member of the American Academy of Pediatrics Council on Injury, Violence, and Poison Prevention and a member of the American Pediatric Society. As a board member of the Early Learning Coalition of Miami-Dade and Monroe Counties, Dr. Schaechter, chairs the Program and Policy Committee as well as the Early Head Start Health Advisory Task Force. Dr. Schaechter has a national reputation advocating for child safety, access to care, health promotion, professional diversity and wellness. She has affected policy change in firearm injury prevention, vaccination supply and scheduling, quality education and freedom of speech. Judy continues to care for patients, both in the office and the hospital.

Issac Schwantes, BS, Iowa City, IA

Mr. Schwantes is a third-year medical student at the University of Iowa Carver College of Medicine. He grew up in Rockford, Iowa and completed his undergraduate studies at St. Ambrose University where he majored in Biology and Chemistry. He spends his free time competing in triathlons, playing piano, and volunteering with the local Boy Scout Troop. Issac hopes his research in injury prevention will bring more attention to primary safety mechanisms in public policy while increasing public awareness of the prevalence of injuries from recreational sports.

Cassie Simeona, MPH, Seattle WA

Ms. Simeona serves as a senior communications specialist for External Affairs and Guest Services at Seattle Children's with a focus on injury prevention. She is responsible for coordinating the firearm tragedy prevention and safe firearm storage programs. She is also a member of the research teams assessing and evaluating community safe firearm storage giveaway events. Ms. Simeona completed her undergraduate studies in public health with an emphasis on community health education at Central Washington University and obtained a Master's in Public Health from George Washington University.

Stephen Strotmeyer, PhD, MPH, Pittsburgh, PA

Dr. Strotmeyer is a Trauma Epidemiologist at the Benedum Pediatric Trauma Program at the Children's Hospital of Pittsburgh. Stephen holds a Masters in Public Health and a Doctorate in Epidemiology from the University of Pittsburgh. He has nearly 15 years of experience in injury prevention research, with expertise in sports and recreational injury and clinical research studies. Currently Dr. Strotmeyer serves as the epidemiologist for several funded studies and the Injury Prevention Program at Children's Hospital.

Rochelle Thompson, MS, CPST, Philadelphia, PA

Ms. Thompson has a Master's Degree in Psychology from the University of Phoenix. She is currently the Injury Prevention Coordinator since 2017 at St. Christopher's Hospital for Children located Philadelphia, Pennsylvania. She is a certified car seat technician. Rochelle was born and raised by both her parents; her dad Philadelphia Police Officer where she experienced living in a high-risk crime area and often wondering the safety of her father's career to protect the community. Rochelle has personally experienced an automobile versus pedestrian trauma incident when a 16-year-old darted out across the street to catch a public transit bus on her way to school on a red light. Unfortunately, she struck her causing traumatic injuries. That experience has changed not only her driving behaviors, but some of those closest to her as well. Rochelle volunteers at her church working with 3rd to 6th grade girls in the AWANA program. She enjoys spending time with her family a 15year old daughter who is actively involved in basketball, soccer, and track and her husband of 18years.

Purnima Unni, MPH, CHES, Nashville, TN

Ms. Unni is the Pediatric Trauma Injury Prevention Manager at the Monroe Carell Jr. Children's Hospital at Vanderbilt, Nashville, Tennessee. Ms. Unni has a Master of Public Health degree from Portland State University, Oregon, and undergraduate degrees in Education and Psychology from the University of Mumbai, India. She is also a Certified Health Education Specialist (CHES). Ms. Unni is a strong advocate for injury prevention in her community and has been active in the field for more than 20 years. She was instrumental in securing the Injury Free Nashville for Kids site designation for her hospital. She has developed and implemented innovative programs in Nashville and its surrounding counties such as the "Be in the Zone" teen motor vehicle safety program that has garnered national interest. She has been a strong advocate for ATV Safety and is currently the co- chair of the Tennessee ATV Safety Coalition. Faced with the issue of limited resources, she has secured funding through gifts and grants from external agencies and leveraged resources available in Vanderbilt University through student projects and internships.

She actively works to form partnerships with local agencies to tackle injury prevention issues. She is a member of several national and state committees. She has been selected to be on the expert panel for the Governor's Highway Safety Administration's new report on "Other influencers" pertaining to teen driver safety. She was recently selected by Ford Motor Company Fund as one of six finalists to receive the "Unsung Hero of Highway "Safety award to be received in September at the nation's capital. At the state level, she has been appointed by the Tennessee Governor, Bill Haslam to serve as the safety expert on the newly created Tennessee OHV Advisory Committee. She is also on the advisory board for "The Safer Tennessee Project," a gun violence prevention organization focused on reducing the number of gun-related injuries and deaths in Tennessee. She is a member of Committee on Pediatric Emergency Care (COPEC), Tennessee Committee on Trauma and the Tennessee Commissioner's Council on Injury Prevention and Control. She is also a member of the American Public Health Association and the Pediatric Trauma Society. Ms. Unni has a strong interest in research and has published in the Journal of Trauma and Acute Care Surgery, American Journal of Emergency Medicine, and the Journal of Pediatric Surgery. She has also presented her work at numerous state and national conferences. She also serves as a reviewer for "Pediatrics" and several APHA conferences.

Pina Violano, PhD, MSPH, RN-BC, CCRN, CPST, New Haven, CT

Dr. Violano is the Manager of the Injury Prevention, Community Outreach and Research Department at Yale New Haven Hospital. She is also the Co-Director of Injury Free Yale-New Haven. She has longstanding leadership and expertise in reducing the impact of preventable injuries and death through community outreach and violence prevention efforts locally in the City of New Haven, regionally and nationally. Her research has centered on the use of community based participatory research principles to reduce gun related injuries and death; gun buy-back programs; safe storage of firearms; educating gun shop owners on risk factors for suicide; adapting a disaster-preparedness approach to gun violence more specifically, the relationship between perceived collective efficacy, its subscales of social cohesion and informal social control, and exposure to gun violence. Dr. Violano is a registered nurse with over 30 years' experience, a child passenger safety technician, holds a PhD in Public Health and is an appointed member of CT's Child Fatality Review Panel.

Cole Wymore, BS, Iowa City, IA

Mr. Wymore is from Des Moines, Iowa, and is currently in the process of applying to medical school. He is a senior at the University of Iowa, pursuing a B.S in Human Physiology with a minor in Chemistry. Cole is interested in injury prevention, and how statistical data can be used to create awareness of risky daily activities. He hopes his work will lead to implementation of injury prevention strategies at the individual and population levels.

EVALUATION & CME CERTIFICATION

ACCREDITATION

Accreditation

Continuing Medical Education
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Cincinnati Children's and the Injury Free Coalition for Kids at the Center for Injury Epidemiology and Prevention, Mailman School of Public Health, Columbia University. Cincinnati Children's is accredited by the ACCME to provide continuing medical education for physicians. Cincinnati Children's designates this live activity for a maximum of 13 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure
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.