



OHIO INJURY PREVENTION
PARTNERSHIP

Child Injury Action Group

Strategic Plan 2011-2016

Introduction:

The Child Injury Action Group (CIAG) is an action group of the Ohio Injury Prevention Partnership and consists of representatives from various disciplines including: children’s hospitals, local health departments, businesses, state agencies, professional associations and universities. Through a data-driven prioritization process, the CIAG has identified the five strategic priority areas that are contained in this plan. In addition to utilizing a data-driven approach, the CIAG also considered feasibility, partnerships, funding and other resources when drafting this plan. Strategic priorities include: teen driving safety, bicycle and wheeled sports helmets, infant sleep-related suffocation, sports-related traumatic brain injury and child restraint/booster seat law review/revision. With limited funding, the CIAG strives to make an impact through policy, systems and environmental changes. As resources become available, individual-based interventions will be considered. Subcommittees have been formed by interest area to address objectives and activities listed in this plan. Further documentation of those activities is available in the action plans for each subcommittee. While this five-year plan is intended to serve as guidance for CIAG activities for that timeframe, the members of the CIAG intend to address other relevant, timely child injury issues as the need arises.

Using this Plan:

This strategic plan covers the timeframe of 2011-2016 and includes five strategic priorities. Each priority begins with a description of the issue and a broad goal statement. Objectives are associated with each strategic priority and are numbered sequentially. Each objective allows for several tracking fields:

- **Group Members:** Refers to the CIAG group members who have taken responsibility for the objective
- **Status:** Indicates the overall status of the objective according to the following color coded key: **Not Begun**, **Planning**, **In Progress**, **Complete**
- **Schedule:** Provides an overview of the action planning cycle for this objective. Action plans will be developed for each objective with further detail regarding timeline and accountability.
- **Measure of Success:** Provides a broad “critical success factor” associated with the objective that can be used to assess overall success regarding the implementation of the action plan and achievement of the objective.

Priority 1: Teen Driving

In Ohio, motor vehicle crashes kill more teens than any other cause of death. In 2010, 114 youth occupants aged 16 – 20 were killed and 16,041 were injured in crashes, according to the 2010¹ Ohio Traffic Crash Report. These figures represent 11.5 percent and 15.1 percent of the total motor vehicle-related deaths and injuries, respectively, among Ohioans of all ages in 2010. Of the deaths, 73 were to drivers and 41 to passengers. In 2010, 160 youthful drivers aged 16-20 were involved in fatal crashes, 18,946 were involved in injury crashes and 48,378 were involved in property damage crashes.

Speed, alcohol use, driving at night and distractions including cell phones/texting and multiple passengers are all risk factors for motor vehicle crashes among teens. Graduated driver’s license (GDL) laws have been proven an effective way to reduce death and injury for teen drivers. A strong GDL is designed to maximize a new drivers experience while minimizing the risk.

Most GDL laws include a three-step approach including: supervised driving with a parent or other adult for at least 12 months, with practice at nighttime and in inclement weather. Teens are at a very low risk when they drive with an adult. The second phase should include restrictions during the provisional stage, when the teen is just beginning to drive without an adult including passenger limits and restricted driving hours. After successful completion of the second phase, the teen is a fully licensed driver.

Goal: Reduce motor vehicle traffic-related death and injury to teen occupants aged 16 to 20 from a baseline of 14.0 deaths per 100,000² and 1,975.3 injuries³ per 100,000 by 10% by September 30, 2016.

Objective	Status	Schedule		Measure of Success
		Begin	End	
1.1 Create CIAG teen driving subcommittee by soliciting new members with an interest in this topic by December 31, 2011.	Complete	9/1/2011	12/31/2011	Creation of committee.
1.2 Create a formal partnership with Ohio Teen Safe Driving Coalition to accomplish objectives 1.3 and 1.4 by September 30, 2011.	In Progress	9/1/2011	9/30/2011	Establishment of partnership.
1.3 Partner with the Ohio Teen Safe Driving Coalition to promote and support legislative changes to the GDL by December 31, 2014.	In Progress	9/1/2011	12/31/2014	Enactment of GDL changes.
1.4 Integrate safe teen driving messaging into existing programs for teens and identify existing avenues for reaching parents with safe teen driving messages across the state by December 31, 2016.	Planning	4/1/2013	12/31/2016	Number of programs reached.

¹ 2010 Ohio Traffic Crash Reports, Ohio Department of Public Safety

² Ohio Department of Health, Office of Vital Statistics

³ Ohio Hospital Association

Objective	Status	Schedule		Measure of Success
		Begin	End	
1.5 Identify gaps in existing educational materials and pursue resources to develop as needed, a set of approved educational materials to make available on the CIAG section of the OIPP Web site, by December 31, 2014.	Not Begun	1/1/2014	12/31/2014	Number of gaps identified. Number of materials posted.
1.6 Build partnerships with Ohio Department of Public Safety Driver Training Program and/or private driving schools and provide recommendations for driver training program standards by December 31, 2016.	In Progress	3/15/2013	12/31/2016	Number of recommendations made.

Priority 2: Bicycle and Wheeled Sports Helmets

Each year, about 200 Ohio children between the ages of 5 and 15 are admitted as hospital inpatients for injuries they received while riding a bicycle and thousands more are treated in emergency departments (EDs). An average of five Ohio children in this age range die from bicycle-related injuries each year. Among Ohio children aged 5 to 14 from 2002 to 2005, falls from skateboards, roller skates and non-motorized scooters resulted in 10,440 ED visits and 112 hospital inpatient admissions.

From 2002-2009, ED visits for bicycle and wheeled recreation related traumatic brain injury (TBI) increased 64 percent in Ohio. A total of 9,383 Ohio youth were treated in EDs and 723 were hospitalized for bicycle and other wheeled recreation related TBIs from 2002-2009. Bicycle-related injuries were responsible for the greatest proportion of hospitalizations for sports/recreation TBIs. ED visits and hospitalizations for bicycle/wheeled recreation related TBIs from 2002-2009 in Ohio were associated with more than \$32.2 million in treatment charges. During this time period, 5 to 14 year olds were responsible for 76% of the ED visits and 73% of the hospitalizations for bicycle/wheeled recreation-related TBIs.³

Prevention of TBIs is key. Helmets are 85 to 88 percent effective in mitigating head and brain injuries, making the use of helmets the single most effective way to reduce bicycle and other wheeled sports related TBIs. Yet, helmet use among Ohio youth remains low. In 2008, only 46.7% of BRFSS respondents indicated that the oldest child in the household always or nearly always wore a helmet when cycling, while 43.1% indicated that the oldest child seldom or never did.⁴

Helmet laws and ordinances combined with community helmet distribution and education programs have shown the best results in increasing helmet use and reducing bicycle-related injury.⁵

Goal: Increase bicycle helmet use (always or nearly always use) from a baseline of 46.7 to 55% for Ohioans 18 years and younger by July 31, 2016.⁴

Objective	Status	Schedule		Measure of Success
		Begin	End	
2.1 Create CIAG teen bicycle helmet and wheeled sports subcommittee by soliciting new members with an interest in this topic by December 31, 2011.	Complete	9/1/2011	12/31/2011	Creation of committee.
2.2 Create a formal partnership with Ohio Chapter AAP statewide collaborative to accomplish objectives 2.3-2.7 by December 31, 2011.	Complete	9/1/2011	12/31/2011	Establishment of partnership.
2.3 Promote and support the introduction of state legislation for required bicycle helmets in children under 18 by July 31, 2016.	In Progress	1/1/2012	7/31/2016	Introduction of state legislation.

⁴ Ohio Behavioral Risk Factor Surveillance System, 2008

⁵ Karkhaneh, M., Kalenga, JC. Et al. *Effectiveness of Bicycle Helmet Legislation to Increase Helmet Use: A Systematic Review*. Injury Prevention 2006; 12:76-82.

Objective	Status	Schedule		Measure of Success
		Begin	End	
2.4 Establish baseline helmet usage rates to support bicycle helmet state initiative and to support tracking and evaluation efforts by actively participating in data gathering via survey or direct observations by December 31, 2011.	Complete	9/1/2011	12/31/2011	Completion of baseline observational survey. Participation in annual observational surveys.
2.5 Recognize and promote State Helmet Awareness Week on September 21, 2011, and on an annual basis through the OIPP/CIAG.	In Progress	9/1/2011	12/31/2016	Implementation of annual campaign.
2.6 Develop partnerships with the Ohio Department of Education, State PTA, and Ohio Education Association to promote and support <i>bicycle helmets-to-schools</i> campaigns by December 31, 2013.	Planning	1/1/2012	12/31/2013	Number of partnerships established.
2.7 Support efforts to distribute helmets and educate pediatricians and their staff on helmet use and appropriate fitting of helmets by July 31, 2013.	In Progress	1/1/2012	7/31/2013	Number of pediatricians reached. Number of helmets distributed.
2.8 Increase the proportion of Ohio children whose communities are covered by a local bicycle/wheeled-sports helmet ordinance by 7% from baseline of 15% by July 31, 2016.	In Progress	1/1/2012	7/31/2016	Number of local helmet ordinances enacted.

Priority 3: Infant Sleep-related Suffocation

Suffocation is the leading cause of injury death for infants. From 2006 to 2009, there were 228 infant unintentional suffocation deaths in Ohio.⁶ According to 2009 Ohio Child Fatality Review data, 93% (50) of the 54 asphyxia deaths to infants less than 1 year were sleep-related. 14% of the reviews for infant deaths from all causes were sleep-related, more than from any other single cause of death except prematurity.⁷

Promoting a safe sleep environment for infants is an important step in preventing infant suffocation. Current best practice recommends placing infants to sleep on their back in a bare crib. In 2009, 58% (88) of infant deaths occurred in adults beds, on couches or chairs, while only 28% (43) occurred in cribs or bassinets.⁷ More than half (51%, 78 deaths) of the infants were sharing a sleep surface with an adult, another child or both at the time of death.

Infants are at greatest risk of sleep-related suffocation during their first 6 months; 87% (133) of the infant sleep-related deaths in 2009 occurred during this early age. Therefore, it is critical that parents of newborns be provided with current best practice information on a safe sleep environment.

Goal: Reduce unintentional sleep-related deaths for infants aged 0 to 12 months from 38.0 per 100,000 by 10% by September 30, 2016.

Objective	Status	Schedule		Measure of Success
		Begin	End	
3.1 Create CIAG infant sleep-related suffocation subcommittee by soliciting new members with an interest in this topic by December 31, 2011.	Complete	9/1/2011	12/31/2011	Creation of committee.
3.2 Promote and support amending Claire's Law to include safe sleep policies and parent education policies in birthing hospitals and licensed child care centers by December 31, 2016.	Planning	2/1/2013	12/31/2016	Enactment of Claire's Law changes.
3.3 Partner with at least one baby product retailer to promote safe sleep to customers by December 31, 2014.	Not Begun	1/1/2014	12/31/2014	Number of partnerships established.
3.4 Ensure that prenatal care providers and pediatric health care providers are promoting and distributing current safe sleep messages and materials by December 31, 2014.	In Progress	7/1/2012	12/31/2014	Number of providers reached.
3.5 Collaborate with other organizations to conduct a statewide safe sleep campaign December 31, 2013.	In Progress	1/1/2012	12/31/2013	Completion of campaign.

⁶ Ohio Department of Health, Office of Vital Statistics

⁷ 2009 Ohio Child Fatality Review Data

Objective	Status	Schedule		Measure of Success
		Begin	End	
3.6 Partner with the Early Childhood Advisory Council to enact a policy requiring all identified state agencies with a role in parent education, early intervention or child care to follow and promote current safe sleep recommendations by December 31, 2014.	In Progress	1/1/2013	12/31/2014	Number of policies enacted.

Priority 4: Sports-related Traumatic Brain Injury (TBI)

On average from 2002-2009, nearly 4,000 Ohio youth were treated in emergency departments for sports/recreation (S/R) related TBIs each year, with a dramatic rise from 2,859 in 2002 to 6,040 in 2009, a total increase of 111 percent. Sports-related TBIs alone were associated with both the greatest number of emergency department visits each year as well as the greatest increase, 142 percent from 2002-09.

A concussion is a TBI caused by a blow, bump, or jolt to the head or by any fall or hit that “jars” the brain. Children should be removed from play following a suspected TBI/concussion until they can be evaluated by a qualified medical professional. An appropriate licensed health professional will be able to determine how serious the TBI/concussion is and when it is safe for a child to return to sports and other daily activities. No child should be allowed to return to activity on the same day he/she sustains a TBI/concussion or if he/she has any remaining symptoms.

Returning to play too early and experiencing repeated TBI may cause Second Impact Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS is a catastrophic condition that occurs when a second blow to the head happens before the child has completely recovered from a concussion. This second impact causes brain swelling, resulting in severe consequences such as brain damage, paralysis, and even death. PCS is the condition of having long-term concussion symptoms; risk for PCS is increased if a person sustains a second brain injury before the first one has healed.

Educating parents, coaches and players on the signs and symptoms of concussion/TBI and the dangers of returning to play too quickly or without medical evaluation is a key activity.

Goal: Monitor the impact of state policy changes related to sports/recreation, physical activity and injury prevention on medically consulted SR TBI emergency department visits to establish a baseline. In 2009, 6,040 youth aged 18 and under were treated for SR TBI in emergency departments.

Objective	Status	Schedule		Measure of Success
		Begin	End	
4.1 Create CIAG sports-related TBI subcommittee by soliciting new members with an interest in this topic by December 31, 2011	Complete	9/1/2011	12/31/2011	Creation of committee.
4.2 Promote and support legislation requiring the following: 1) youth athletes in school and recreational leagues to be removed from practice or play if they are suspected of sustaining a concussion; 2) requiring any athlete suspected of sustaining a concussion to be cleared by an appropriate licensed health professional before returning to play; and 3) education requirements for coaches, parents and athletes on recognizing the signs and symptoms of a possible concussion by December 31, 2012.	Complete	9/1/2011	12/31/2012	Enactment of return to play legislation.

Objective	Status	Schedule		Measure of Success
		Begin	End	
4.3 Identify, adapt and develop sport-related “recognition and prevention of traumatic brain injury” educational materials for coaches, parents, players and appropriate licensed health professionals to be posted to the ODH website by December 31, 2012.	Complete	9/1/2012	12/31/2012	Number of materials posted.
4.4 Identify existing grant opportunities and inform the educational and recreational sports communities of their availability by December 31, 2013.	In Progress	3/15/2013	12/31/2013	Number of opportunities identified. Number of communities reached.

Priority 5: Child Restraint Law Review and Revision

From 2006-09, motor vehicle crashes remained the leading cause of injury death for Ohio children ages 5 to 9 and the third-leading cause for ages 1 to 4.⁸ From 1999 to 2007, at least 58 Ohio children under the age of 8 were killed as occupants in motor vehicle traffic crashes.⁹

Proper use of child safety seats and booster seats is one of the most important preventive measures to reduce motor vehicle-related death and injury; yet it remains a challenge in Ohio. Using a booster seat instead of a seat belt alone reduces the risk of death in a crash by 59%.¹⁰ In 2007, Ohio’s booster seat use rate for children aged 4 to 7 was only 18%, one of the lowest in the country.¹¹

The CDC Task Force on Community Preventive Services recommends primary child restraint laws based on strong evidence of their effectiveness. This means that law enforcement is able to stop and cite drivers for failure to properly restrain a child in a child restraint or booster seat as required by law. Proper enforcement combined with education and safety seat distribution programs provide the greatest evidence of success in reducing these preventable deaths among children.

Goal: Establish an Ohio-specific baseline for child restraint use for ages birth to 8 years when data becomes available. As part of a national effort, increase age appropriate child restraint use for ages birth to 12 months from 86 to 95% restrained in rear-facing child safety seats. As part of a national effort, increase age appropriate child restraint use for ages 1 to 3 years from 72 to 79% restrained in front-facing child safety seats. As part of a national effort, increase age appropriate child restraint use for ages 4 to 7 years from 43 to 47% restrained in booster seats.

Objective	Status	Schedule		Measure of Success
		Begin	End	
5.1 Create CIAG child passenger safety (CPS) subcommittee to address Ohio child restraint/booster seat legislation by September 30, 2011.	Complete	9/1/2011	9/30/2011	Creation of committee.
5.2 Review current statewide child restraint/booster seat law to identify existing gaps in the law by December 31, 2011.	Complete	9/1/2011	12/31/2011	Number of gaps identified.
5.3 Introduce a pilot training program with Ohio State Highway Patrol to integrate training on enforcement of child restraint law into training academy curriculum by December 31, 2013.	Planning	10/1/2012	12/31/2013	Creation of training program. Implementation of training program.

⁸ ODH Office of Vital Statistics

⁹ CDC WISQARS

¹⁰ National Highway Traffic Safety Administration

¹¹ Partners for Child Passenger Safety Study, Children’s Hospital of Philadelphia

Objective	Status	Schedule		Measure of Success
		Begin	End	
5.4 Educate law enforcement agencies to increase enforcement of current law and amount of money collected from child restraint/booster seat fines by 15% statewide by June 30, 2013.	In Progress	10/1/2012	6/30/2013	Creation of educational materials. Number of agencies reached.
5.5 Promote and support identified changes to the current child restraint/booster seat law by December 31, 2014.	Planning	1/1/2013	12/31/2014	Enactment of child restraint/booster seat law changes.