

Conclusions: UFOV selective attention may be predictive of some visual behavior in adolescent drivers, and this appears to depend in part on the adolescent's VA. Since VA alone has not been directly associated with MVCs or hazard detection in adolescents, further investigation is needed to determine UFOV's role in adolescent visual behavior while driving. Future research should include adolescents of wider ranging VA scores to examine the relationship between UFOV 4 and VA on visual glance reaction time and to better examine the predictive ability of UFOV in adolescent drivers.

Objectives: 1. The effects of UFOV4 and Visual Acuity on visual reaction time in adolescents. 2. The difference in effectiveness of UFOV testing between adolescents and older adults. 3. Further recommendations in determining fitness to drive for adolescents.

Continuing Conversations about Alcohol and Drugs with Injured Adolescents



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Background: Screening, Brief Intervention and Referral to Treatment (SBIRT) for alcohol or drug (AOD) misuse has been effective in a variety of healthcare settings. The American College of Surgeons Committee on Trauma (ACS-CoT) adopted a requirement for certification as a level one trauma center that mandated universal screening for alcohol misuse and delivery of a brief intervention for those screening positive. Our study objective was to determine if adolescent trauma patients who screened positive for AOD use were directed to and engaged in follow-up AOD conversations after hospital discharge, and if this changed after implementation of a structured SBIRT program.

Methods: This study was part of a larger implementation study of SBIRT (IAMSBI RT: NIAAA R01AA025914) with adolescent trauma patients admitted from 2018-2022 to ten level one pediatric trauma centers. The study utilized a stepped-wedge design in which sites implemented the SBIRT program at different time points. A convenience sample of adolescent trauma patients (12-17 years), which oversampled AOD positive adolescents, was enrolled to receive a survey within 30 days of discharge. Adolescents were surveyed about advice they received from trauma staff to have follow-up conversations with their primary care provider (PCP) on AOD following discharge, and whether or not they had acted on that advice. Additionally, electronic health record (EHR) data on all admitted trauma patients were collected to identify those documented as screening positive for AOD, and whether they received indicated brief intervention and referral for continued AOD discussion following discharge.

Results: Adolescent assent and parent consent for study enrollment was obtained on 430 patients (62.6% of approached patients), 6 withdrew and 329 (77.6%) completed the 30-day

post discharge patient survey. Of those enrolled before implementation, 16.7% of AOD positive adolescents reported being advised to have follow-up AOD discussions with their PCP. This increased to 21.7%, but not significantly ($p=0.22$), following implementation of the IAMSBI RT study protocol. AOD positive adolescents referred for other non-PCP AOD counseling was low both before (15.6%) and after (14.6%) IAMSBI RT implementation. Of those referred, 33% at baseline and 30% after IAMSBI RT had accessed AOD counseling at 30 days. EHR data demonstrated increased screening using a validated screening tool (25.5% to 47.7%, $p<0.001$), increased identification of AOD positive adolescent trauma patients (20.2% to 23.9%, $p=0.02$) after IAMSBI RT implementation, but no change (3.1% to 2.0%) in referral to PCP or non-PCP for AOD discussions or counseling services.

Conclusions: Our study found encouraging increases in AOD screening, but no change in referrals for post-discharge AOD discussions or counseling services. ACS-CoT has mandated AOD screening and brief intervention for trauma patients but requiring linkage to continued AOD discussion for those adolescents screening positive may be necessary to improve referral and subsequent AOD discussion practices. Further research to best accomplish the RT part of the SBIRT model is needed.

Objectives: 1. Screening and brief interventions for AOD use is required for admitted patients at ACS level one trauma centers. 2. An implementation strategy can improve AOD screening and BI delivery, but challenges persist for referrals. 3. Additional efforts are needed to continue adolescent AOD discussions after trauma center discharge.

Doctor for a Day: Community Teddy Bear Clinic



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Background: The purpose of the Teddy Bear Clinic is to use children's play to educate school aged children on health and safety topics. The clinic takes place at a school where each child receives a teddy bear when they check in. Next, they have one hour to visit various stations with their bear to practice common hospital activities such as vital signs and first aid. The goal is to increase familiarity of the environment and medical tools during hospital or clinic visits. This gives children a sense of mastery and control in an environment they may be unfamiliar with. Other stations are dedicated to safety. Here they learn about disaster preparedness, water and other summer safety topics. Educational resources are given to the students to take home and share with parents.

Methods: This program was a partnership between trauma services and the child life department. Child life specialists can develop and deliver developmentally appropriate education on sensitive topics related to trauma injury prevention. Each station was run by nurses, EMT's or child life specialists. Funding for the bears was secured through a private donor with the help of the hospital foundation. If funding isn't available, the students can alternatively bring their own stuffed animal from home. Some play medical supplies were purchased by the