Preventing Injury through Law and Policy: At Home, at School, at Play

Presented in collaboration with the Mid-Atlantic Regional Public Health Training Center and the Johns Hopkins Center for Injury Research and Policy.

Thursday, September 29, 2016
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Thursday, September 29th, 2016
Moderator

Jon Vernick, co-director, Center for Gun Policy and Research, Johns Hopkins Bloomberg School of Health; deputy director, Johns Hopkins Center for Injury Research and Policy

- J.D., George Washington University
- M.P.H., Johns Hopkins University Bloomberg School of Public Health

Areas of expertise:
- Injury prevention
- Gun violence prevention
- Motor vehicle safety
- Public health law
Presenter Introduction

Kerri Lowrey, Deputy Director, Network for Public Health Law – Eastern Region

- J.D., University of Maryland School of Law
- M.P.H., Johns Hopkins University Bloomberg School of Public Health

- Research interests/areas of expertise:
  - Injury prevention
  - Youth sports concussion
  - Social determinants of health
Presenter Introduction

Shannon Frattaroli, Associate Professor, Johns Hopkins Bloomberg School of Public Health

- Ph.D., Johns Hopkins Bloomberg School of Public Health
- M.P.H., Johns Hopkins Bloomberg School of Public Health

Areas of expertise:
- Injury prevention
- Implementation research
- Violence prevention
Presenter Introduction

**Mathew Swinburne**, Senior Staff Attorney, Network for Public Health Law – Eastern Region

- J.D., University of Maryland Francis King Carey School of Law
- Areas of expertise:
  - Injury prevention
  - Food safety and security
  - ACA
Keeping Our Heads Up: Implementation and Evolving Youth Sports-Related TBI Law

Kerri McGowan Lowrey, JD, MPH

Deputy Director, Network for Public Health Law, Eastern Region
University of Maryland Francis King Carey School of Law

Mid-Atlantic Public Health Training Center
September 29, 2016
Youth sports-related injury as a public health problem

- Impact on child/adolescent health is significant and worldwide
  - >7.7 million high school athletes in U.S. (NFSHSA, 2012-13)
  - ~35 million kids play organized sports each year
  - For young people aged 15-24, sports are 2nd leading cause of TBI (after MVCs)
- Girls have more symptoms and longer recovery time (Covassin, et al)
Youth sports-related injury as a public health problem

- Risk greater for young, developing brains
- Innate risk of injury
  - Kids are specializing younger, “select” teams
  - Life-long impacts (education, work)
- Concussion rates per 1,000 athletic exposures, regardless of time played (Lincoln, et al.):
  
<table>
<thead>
<tr>
<th>Sport</th>
<th>Rate (per 1,000 athletic exposures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Football</td>
<td>0.60</td>
</tr>
<tr>
<td>Girls’ soccer</td>
<td>0.35</td>
</tr>
<tr>
<td>Boys’ lacrosse</td>
<td>0.30</td>
</tr>
<tr>
<td>Girls’ lacrosse</td>
<td>0.20</td>
</tr>
<tr>
<td>Boys’ wrestling</td>
<td>0.17</td>
</tr>
<tr>
<td>Girls’ basketball</td>
<td>0.16</td>
</tr>
</tbody>
</table>
State Youth Sports Concussion Laws Enacted/Adopted by Year

- Laws that became effective in year indicated
- Total laws effective

<table>
<thead>
<tr>
<th>Year</th>
<th>Laws Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>1</td>
</tr>
<tr>
<td>2010</td>
<td>8</td>
</tr>
<tr>
<td>2011</td>
<td>23</td>
</tr>
<tr>
<td>2012</td>
<td>8</td>
</tr>
<tr>
<td>2013</td>
<td>7</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
</tr>
<tr>
<td>Before 2009</td>
<td>1</td>
</tr>
</tbody>
</table>
Early adopters

<table>
<thead>
<tr>
<th>State</th>
<th>Month/Year Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky</td>
<td>March 2009</td>
</tr>
<tr>
<td>Washington</td>
<td>May 2009</td>
</tr>
<tr>
<td>Oregon</td>
<td>June 2009 (Regs in June 2010)</td>
</tr>
<tr>
<td>New Mexico</td>
<td>March 2010</td>
</tr>
<tr>
<td>Virginia</td>
<td>April 2010</td>
</tr>
<tr>
<td>Connecticut</td>
<td>May 2010</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>May 2010</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>June 2010</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>July 2010</td>
</tr>
</tbody>
</table>

*Original KY law required coaches to take and pass a training course and required one trained person to be present at every practice and competition.
Common Provisions of RTP Laws

1. Education for student athletes and their parents (with signed information form)
2. Immediate removal of concussed athlete
3. Return-to-play restrictions with medical evaluation

Mandatory training for coaches and officials
Data collection
Return-to-learn provisions
Provisions specific to state processes/infrastructure
Innovative Provisions of RTP Laws

- Training for school nurses and educators
- Sideline testing
- Return-to-learn
- Medical personnel required on field
- Primary prevention
  - Limits on full-contact practices
  - Limits on scrimmages

Source: www.technorati.com/sports
States’ Participation in Concussion Implementation Survey

- Blue: Participated
- Green: No Law/Ineligible
- Gray: Declined
- No Response

Lowrey & Morain, JLME, 2014
Findings

- An almost universal belief that greatest impact of the law will derive from increased **awareness** and “culture change” in sports

- **Standardized** RTP protocol

- Several states voluntarily increasing **coverage** of law
  - Recreational sports, middle schools, etc.

- Some **primary prevention** initiatives have emerged
  - Requiring rules re: less dangerous play
Implementation Facilitators

- **Clear delegation of authority** or responsibility in law

- **Preexisting resources and partnerships**
  - Grants, data collection programs
  - Local NFL team, brain injury association, universities

- **Prior state-level activity** re: youth concussions

“I need to underscore that we, like many states, have been working on this issue before the law. This law didn't just "flip a switch," people have been doing this work for years.”
Implementation Inhibitors

- **Vagueness** of statutory language
  - Definition of *youth*, which medical providers can authorize RTP, etc.

- **Limited time** to comply (emergency legislation or immediate effective date)
  - “Football had already started, so we had to scramble to get all the schools in compliance.”

- **Decentralized** nature of recreational sports
  - “We can catch the high school athletic leagues. We’ll probably get the big soccer clubs. But we may miss the church basketball league.”
Implementation Inhibitors

- **Mismatch** between text of law and organizational authority, existing principles or procedures
  - Middle school-age covered by law, but high school AA charged with implementation
  - “Qualification” requirement for providers

- **Unfunded** mandate
  - Lack of attached fiscal note

- **Implementers not involved** in lawmaking process
  - Associations/agencies that were involved in process reported fewer barriers to implementation
Compliance challenges

- Rural areas
  - Less access to medical personnel authorized to make RTP determination (e.g., AK)

“Because most of our schools in Alaska are small, remote communities with fewer than 50 students in the high school and few medical providers available, restricting the numbers who were willing to sign off made it even more difficult.”
Other challenges

- **Parents**
  
  “We’re finding that our biggest problem is the parents—they want their kids to go back in before the coaches do.”
  
  - “Doctor shopping”

- **“Other” activities**
  
  - Ex., CT federal court ruling that cheerleading is not a “sport” under Title IX

- **Enforcement**

- **Data collection**

Source: The Augusta Chronicle, 2007
Evolving State Youth Sports-Related TBI Laws

- As of March 31, 2016, **23 states** have made substantive changes to their RTP laws (8 states more than once)

- Most amendments can be categorized into **3 types**: 
  - Expanded coverage
  - Tighter requirements/clarification of provisions
  - Primary and secondary prevention
Evolving State Youth Sports-Related TBI Laws

Expanding coverage

- **Arkansas** (2013)—included recreational youth sports in 2013
- **California** (2013)—expanded to charter and private schools
- **Indiana** (2014) and **Virginia** (2014)—expanded to sports organizations using school property
- **New Jersey** (2011)—expressly included cheerleading
Evolving State Youth Sports-Related TBI Laws

Primary prevention and early detection

- **Connecticut** (2014)—Coaches’ training must include efforts at reducing concussive and subconcussive hits
- **Vermont** (2013)—Coaches’ training must include best practices on # of games and appropriate minutes of full-contact practices and scrimmages
- **New Jersey** (2013)—Physical exam and concussion hx prior to athletic activity to identify students at > risk
- **California** (2014)—Limits full-contact practices to 2x/wk; limits full-contact portion of a practice to 90 min/day
Evolving State Youth Sports-Related TBI Laws

Strengthening/Streamlining

- **Alaska** (2012)—added ATs to list of individuals qualified to make RTP decisions and clarified that “return to play” includes return to practice
- **Connecticut** (2014) and **Vermont** (2013)—included provisions for concussion data collection and 24-hour parental notification
- Several other states strengthened education/informed consent for parents and training for coaches and officials
Return-to-Learn Provisions

Hawaii (2012 Hawaii Laws Act 197)
- Physician clearance must include return to academics

Illinois (105 ILCS 5/22-80)
- Concussion oversight team in each school and RTL protocol

Maryland (MD Code, Education, § 7-432)
- Appropriate accommodations

Massachusetts (105 CMR 201.000 et seq.)
- Clearance protocol to include return to academics; Written recovery plan w/ accommodations

Nebraska (Neb.Rev.St. §71-9104)
- RTL protocol for concussed students

New York (Ed. L § 305; NY PUB HEALTH § 206)
- Must publish guidelines re: returning to school on Web site

Oklahoma (70 Okl.St. Ann 24-155)
- Policies and procedures re: guidelines for teachers and school staff on classroom reentry after TBI

Vermont (16 V.S.A. § 1431)
- Action plan must include RTL protocol

Virginia (VA Code Ann. §22.1-271.5)
- State BOE must add effects of concussion to guidelines/policies
Other Legal Considerations: Fraudulent and Misleading Claims

- **Protective head gear**
  - No evidence that helmets, mouth guards, etc. protect against concussion (Consensus statement on concussion in sport, Zurich, November 2012)

- **Dietary supplements**
  - 2012 FDA warning letters to dietary supplement firms in Colorado and Texas for marketing unapproved products with “concussion curing” claims
Contact

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http://www.networkforphl.org
Residential Sprinkler Systems in the United States:
Opportunities for Public Health and the Law

Network for Public Health Law Webinar

Shannon Frattaroli
September 29, 2016
Understanding Fire and Residential Sprinkler Systems
Epidemiology of Fire in the United States

• In 2014, 2,745 civilians in the U.S. died in residential fires; (2006-2010: .85/100,000).
• ~ 84% of all fire deaths occurred in the home.
• Almost 12,000 additional people were injured during residential fires and survived.
• Residential fires are an important source of firefighter injuries.
• Residential fires caused an estimated $6.8 billion in home property loss in 2014.

Source: Haynes, 2015, NFPA
A Solution: Residential Sprinkler Systems

- Sprinkler technology has been used for more than a century.
- Field tested and effective.
- Most states and/or localities have adopted codes that require sprinklers in new commercial structures, high rise buildings, hotels, and multi-family residences.
- One- and two- family homes are subject to fewer sprinkler mandates.
A Solution: Residential Sprinkler Systems

- Other benefits associated with residential sprinklers
  - Firefighter safety
  - Suppression addresses reduced mobility challenge
  - Suppression addresses reduced escape time of new home construction
    - Interior contents
    - Open floor plans
    - Environmental impact
Policy and Residential Sprinklers
U.S. Policy Landscape: Residential Sprinkler Systems

- Local policies
  - Over 350 local ordinances passed by communities across the country.

- Model Codes: ICC and NFPA

- State policies
  - California and Maryland
  - Washington, DC
  - Mandatory option
Challenges

- Anti-sprinkler legislation has been introduced in at least 25 states.
- Preemption as a tool for prohibiting localities from passing sprinkler mandates.
- Legislation restricting agency power has been enacted.
- Executive authority blocking legislative initiatives
- Efforts to change the ICC code to exclude sprinklers.
Your Role in the Residential Sprinkler Conversation

• Raise awareness through education and advocacy
  – Residential fire as a preventable public health problem
  – Policy is at the center of the residential sprinkler debate

• Leverage your expertise
  – Legislation
  – Regulation
  – Litigation
  – Research

• Participate in the discussion
Many Thanks

Shannon Frattaroli

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Food Allergies and State Epinephrine Access Laws

Mathew Swinburne, JD
Senior Staff Attorney
The Network for Public Health Law - Eastern Region
In the United States food allergies result in 150 deaths, 2,000 hospitalizations, and 30,000 episodes of anaphylaxis.

-National Institute of Allergy and Infectious Diseases
An exaggerated immune response triggered by a specific food

Eight foods account for 90% of Food Allergies

15 million people in the United States suffered from food allergies

- 6-8 Percent of Children
- 3.7 percent of Adults
Anaphylaxis - a serious whole body allergic reaction that is rapid in onset and may cause death.
Prevention and Treatment

- No Cure for Food Allergies
- Focus on Management of Condition

1. Prevent reactions by avoiding exposure to allergen
2. Recognize and treat allergic reactions
   - Epinephrine/Adrenaline auto-injector with pre-measured dose
   - Very safe-mild and short lasting side effects: pallor, tremor, palpitations, headache anxiety, and nausea
State Legal Interventions

1. Epinephrine Auto-Injectors in Schools
   - Student Administration
   - Emergency Stock Piling

2. Epinephrine Entity Stocking Laws
   - Increasing Access Outside of the School Setting
Schools: An estimated 6 million children in the United States have food allergies.
Food Allergies and Children

1. The prevalence of food allergy among children is increasing.
   A. Prevalence of reported food allergies increased 18% from 1997-2007 and now 1 in 25 school age children are affected by food allergies.

2. At a greater risk of a reaction from undiagnosed food allergy because of less exposure to potential allergens.
   A. 25% of anaphylaxis reactions in schools occur among students without a previous allergy diagnosis

3. Less consistent with their efforts to avoid exposure and less aware of presence of allergens.
   A. Between 16-18% of children with food allergies have had allergic reactions resulting from accidental ingestion of an allergen while at school
State Legislative Approaches to Food Allergies in School

1. Self Administration of Medication

2. Emergency Stockpiling of Epinephrine
Self Administration

- Every State except Alabama and West Virginia
- Majority of States Require
  - A prescription
  - Written parental consent
  - Written physician authorization
  - Annual renewal of authorization
  - Student must prove capable of administering the auto injector
  - Discipline for improper use of medication
School Liability

1. Legislation has an express provision stating that the school will incur no liability.
2. Written acknowledgement by parents will indemnify the school and employees from loss or damage resulting from misuse.
Emergency Stockpiling

“When a child is having an anaphylactic reaction, the only thing that can save her life is epinephrine, 911 doesn’t get there fast enough.”

-Maria L. Acebal, the chief executive of the Food Allergy and Anaphylaxis Network.
Emergency Stockpiling

• 11 Jurisdictions in 2013
• 28 Jurisdictions in 2015

• Issues to Consider
  1. Who can administer the epinephrine?
  2. Who can receive the epinephrine?
  3. Where is the epinephrine stored?
  4. What training is required for staff?
  5. How is the medication obtained?
  6. Reporting Requirements?
Illinois’ Emergency Epinephrine Act

- Allows schools to maintain a supply in locked secure locations
- Authorizes physicians to write prescriptions in the name of the school district
- **School nurse** may administer to **any student** who they in **good faith believe** is experiencing an anaphylactic reaction.
- Allows **authorized personnel** to administer to any student who has their **own personal prescription**
- A student with authorization to self-administer may also utilize emergency medication from the stockpile.
Illinois’ Emergency Epinephrine Act

• To administer epinephrine to students without prescriptions, a school nurse must follow a standing protocol issued by a physician

  • a definitive set of treatment guidelines
  • State has issued sample protocol for physicians
  • Statute exempts physicians who issue prescription and standing protocol from liability
Epinephrine Entity Stocking Laws: Moving Beyond Schools

Permits certain entities to stock undesignated epinephrine for use in an emergency

- 29 states have laws
- California and Ohio passed legislation this year
Who Can Stock Emergency Epinephrine?

Laws permit health care professional with prescriptive privileges to issue prescriptions for epinephrine to...

“an entity or organization at which allergens capable of causing anaphylaxis may be present.”

Statutes generally provide a non-exclusive list of examples:

- Recreation camps
- Youth sports leagues
- Amusement parks
- Sports arenas
- Restaurants
Requirements for Stocking

Every jurisdiction has a training requirement

• Nationally recognized course or training approved by the state health department
  • Recognition of systemic allergic reactions
  • Proper administration of an epinephrine auto-injector.

• Some states require training to be renewed every two/four years

• Some states allow online training
Liability Provisions

Every state provides some form of good faith immunity from negligence claims

1) the entity administering (e.g. restaurant)
2) the employee who administers the epinephrine; and
3) the health care professionals who prescribe and dispense the drug
Mathew Swinburne, JD
Senior Staff Attorney
The Network for Public Health Law - Eastern Region
mswinburne@law.umaryland.edu
Q&A

Please type your questions in the Q&A panel.
Thank you for attending

Please join us for this upcoming webinar on October 20:

**Electronic Health Information: State and Local Approaches to Data Sharing**

**Moderator**
- Rachel Hulkower, J.D., M.S.P.H., Legal Analyst/ORISE Fellow, Public Health Law Program, Office for State, Tribal, Local, and Territorial Support, CDC

**Speakers**
- Lily Kan, M.P.H., Sr. Director, Infectious Disease and Informatics, National Association of County and City Health Officials
- Cason Schmit, J.D., Research Assistant Professor and HIPAA Compliance Officer, Department of Health Policy and Management, Texas A&M University
- Jennifer Bernstein, J.D., Deputy Director, The Network for Public Health Law, Mid-States Region

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