($M=2.29$ minutes, $SD=2.41$). Not only did parents supervisory attention increase ($M_{pre} = 77.60\%$ of time, $SD_{pre} = 25.99$, $M_{post} = 87.45\%$ of time, $SD_{post} = 20.34$), but so did their level of proximity to their child ($M_{pre} = 71.83\%$ of time proximal, $SD_{pre} = 24.40$; $M_{post} = 87.95$, $SD_{post} = 18.32$). In particular, parents identified that their typical supervision pattern at the beginning of the intervention was ‘being in another room but listening closely to their child’, and at the end of the intervention, parents identified that they were typically ‘in the same room (in view of the child) but beyond reach’. Moreover, when assessing for behavioral change on a 5 point rating scale, there was a significant increase in the ‘action’ stage of change from pre intervention ($M=2.96$, $SD=1.16$) to post intervention ($M=4.10$, $SD=0.6853$) indicating a considerable shift in parents beliefs that they have the ability to change their supervisory behavior and actively use ALTER to do this.

Conclusion The SHS-Brief Program can be successfully delivered to vulnerable caregivers in community settings and can produce desirable changes that are expected to improve caregiver’s supervision practices.

Contribution To the best of our knowledge, this is the first safety program aimed at increasing parental supervision practices for vulnerable families. Given that improved supervision is associated with a decrease in children’s injuries, identifying programs that can create readiness for change to improve vulnerable caregiver’s supervision is essential. The current findings indicate that the ALTER for Home Safety-Brief is such a program.

Opioids: epidemiology and interventions

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CHANGES IN INITIAL OPIOID PRESCRIBING DOSES FOLLOWING THE RELEASE OF THE CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

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Statement of Purpose In 2016, the CDC released the Guideline for Prescribing Opioids for Chronic Pain. The guideline recommends using the lowest effective dose when opioids are started. We assessed changes in initial prescribing doses following the release of the CDC Guideline.

Methods/Approach We used data from the OptumInsights database (1/2012–6/2017), which contains all claims made by commercial and Medicare Advantage beneficiaries enrolled with UnitedHealth. We restricted to enrollees age ≥ 18 years (consistent with the intended patient population of the CDC Guideline), which comprises $\sim 7.7\%$ of US adults. We created a cohort of opioid naïve individuals (no opioid fills for twelve months) pre-guideline that were continuously enrolled through 6/2017 (fifteen months post-guideline). To establish the pre-guideline trend, we constructed three analogous control groups, but shifted back 1, 2, and 3 years, respectively. Statistical analyses focused on the difference between observed post-guideline initial high-dose (≥ 50 MME/day) prescribing rates, and those predicted from the pre-existing trend. We derived adjusted effects using logistic regression adjusted for

age, sex, race, insurer type, as well as state and time fixed effects.

Results There were 6,276,020 beneficiaries across the four cohorts, 792,591 (12.6%) of whom received a prescription opioid during their follow-up. Among those initiating opioids post-guideline, 18.7% were started with high-dose prescriptions, lower than the 19.8% predicted by the pre-existing trend. Adjusted analyses confirmed that the post-guideline cohort had a 6.3% (95%CI: 4.1%–8.3%) lower odds of high-dose initiation than expected. Sensitivity analyses around the 50MME/day threshold showed post-guideline dosage changes were primarily reflected in lowering moderate/high dosages (40–60 MME/day) to ≤ 40 MME/day.

Conclusions Changes in high-dose initial prescribing seen following release of the CDC guideline could not be explained by pre-existing secular trends.

Significance/Contribution to Injury Science Safer opioid prescribing has great potential to reduce injuries and other harms incurred by opioid misuse.

Innovation methods

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CATALYZING ADVANCEMENTS IN INJURY PREVENTION RESEARCH: DEVELOPMENT OF THE NEW JERSEY SAFETY AND HEALTH OUTCOMES (NJ-SHO) DATA WAREHOUSE

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Purpose Few existing injury data sources contain information spanning the pre-to-post-injury period, inhibiting research into underlying risk factors for and long-term outcomes of those injuries. We describe the development and capabilities of the NJ-SHO warehouse—a unique and comprehensive data source that integrates various state-level administrative databases to support critical, high-priority research questions in injury prevention.

Methods We obtained full identifiable data from six state-wide administrative databases: (1) driver licensing; (2) Administration of the Courts traffic-related citations; (3) police-reported crashes; (4) birth certificates; (5) death certificates; and (6) hospital discharges (emergency department, inpatient, outpatient) as well as (7) childhood electronic records from all 200K NJ residents who were patients of the Children’s Hospital of Philadelphia healthcare network, and (8) numerous census tract-level indicators. We undertook an iterative process to develop and execute a probabilistic linkage using LinkSolv 9.0 software for 2004–2018 and evaluated the quality of the linkage process using several metrics.

Results/Conclusions The NJ-SHO includes 82.8M records for 20.3M NJ residents over the 15-year study period. We will discuss (1) development of the NJ-SHO and our approach to intentionally structure the warehouse so it contains rich individual-level childhood data spanning the pre-to-post-injury period for leading injury mechanisms (e.g., motor vehicle crashes, poisonings, firearms, self-injurious behaviors); (2)