ALPHA Resolution 2004-2

Recommending the Alaska Legislature Approve A Primary Seatbelt Law

Whereas a primary enforcement allows a law enforcement officer to stop a vehicle and issue a citation when the officer observes an unbelted driver or passenger,

Recalling that it has been 13 years since a (secondary) seatbelt law has been introduced where enforcement can only be written after the officer stops the vehicle or cites the offender for another infraction;

Whereas 21 states and DC (July, 2004) have passed a primary seatbelt law; (National Highway Safety Association, 2004);

Recognizing that motor vehicle crashes are a leading cause of injury death to people between the ages of 10-34 years of age (Alaska Bureau of Vital Statistics, 2002);

Whereas 84% of people who wear seatbelts are more likely to walk away uninjured compared with only 60% of the unbelted occupants (DOT Alaska Accident Report, 2001);

Whereas $12 million, 71 major injuries prevented, and 6 lives saved in Alaska per year if a primary seatbelt was passed (BELTUSE software program, NHSTA);

Whereas studies show that patients who were not buckled up at the time of a motor vehicle crash were almost twice as likely to sustain a serious head injury and over one and half times more likely to be discharged with a permanent disability (Alaska Trauma Registry, 1991-2000 10 year data report);

Whereas 30% of the medical costs for people unrestrained at the time of the crash was paid by public funds ("Alaska Seatbelt Analysis", Sept. 2003, Alaska Injury Prevention Center);

Whereas a primary seatbelt law would increase seatbelt use by 11 points, from 71%-92%; NHSTA, spring, 2004);

Whereas a recent study reported that a primary law does not lead to an increase of police harassment; (Accident Analysis & Prevention, 36 (2004) 819-828;

THEREFORE BE IT RESOLVED that the Alaska Public Health Association urge the Alaska Legislature and Governor Murkowski to introduce and pass legislation that amends the secondary seatbelt enforcement to a primary enforcement law.

Statement of Desired Outcomes: Adoption of primary seat belt law by the legislature.

Fiscal Impact: Activities ALPHA could undertake at no additional cost:

1. Invite members to testify and write letters of support to the legislature.
2. Testify at public hearings on the public health benefits of seat belt use.
3. Distribute on its website and to its members information in support of a primary seat belt law, using public health injury surveillance data.

Approved at the ALPHA Annual Meeting Nov. 30, 2004

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February 14, 2005

Senator Con Bunde
State Capitol, Room 506
Juneau, Alaska 99801

Re: Senate Bill 87

Dear Senator Bunde:

On behalf of State Farm Insurance Companies, I would like to express support for SB 87. State Farm has long supported mandatory seatbelt laws and primary enforcement. This legislation will undoubtedly save lives. If there is any information we can provide to you, or anything else we can do in support of this bill, please let me know.

Sincerely,

Sheldon E. Winters

SEW/caf
SenBunde01SEW.wpd

Juneau Safe Kids Coalition
Box 110616, Juneau, Alaska 99811-0616

February 14, 2005

To Whom it May Concern

The Juneau Safe Kids Coalition which consists of volunteers and organizations concerned with reducing unintentional injuries for children 14 and under (the number one killer of children 14 and under) supports passage of SB 87

While it has been proven over and over again that seat belts do save lives many do not take the time or effort to do so especially if there is no enforcement from those who are responsible for our safety on roads and highways.

Adults who do not buckle up themself tend to not buckle their children after age 4 but with passage of SB 87 (supporting primary enforcement) it has been shown throughout the United States that seat belt usage increases to 82% in state that have primary enforcement for seat belt use.

In April 2004 the first Alaska Transportation Safety Stewardship Conference, which had members from all levels of government, non-profits, industry advocates and the private sector, recommended the passage of primary seat belt laws SB 87 will do just that

Thank you for your time and consideration on this life-saving piece of legislation.

Sincerely,

Karen Lawfer
Coordinator

ALASKA SAFE KIDS
Are no accident !

Alaska Seat Belt Cost Analysis

Alaska Injury
Prevention Center

Ron Perkins, MPH

Anchorage, Alaska
September 2003

This research was made possible with funding from the Automotive Coalition for Traffic Safety, Inc.

Alaska Seat Belt Cost Analysis
EXECUTIVE SUMMARY

OBJECTIVES
An average of more than 39,000 Alaskans are involved in motor vehicle crashes every year. It is an expensive and painful problem with no single cause. For the citizens of Alaska, the medical costs alone are estimated to be over $14.5 million per year, while property damage and long-term disabilities add millions more to this figure. Alaskans pay a significant portion of these costs through publicly funded programs.

It is well documented that wearing a seat belt significantly reduces the severity of injury and decreases the risk of death in a motor vehicle crash. The *Alaska Seat Belt Cost Analysis* attempted to quantify the medical costs associated with restrained and unrestrained occupants involved in motor vehicle crashes and the sources of payment for these hospitalizations.

RESULTS
With data supplied by the Alaska Department of Transportation and Public Facilities and the Alaska Trauma Registry (ATR), a thorough analysis of the health care costs to treat restrained and unrestrained vehicle occupants was undertaken. The data covered the years 1996 through 1999.

The study revealed that the decision not to wear a seat belt has economic consequences for everyone:

- ✓ During the time period analyzed, medical costs for those who were not wearing a seat belt at the time of the crash totaled $13 million. Of this amount, 50% was paid with public funds.
- ✓ Victims of crashes in Alaska spent a cumulative average of 2,672 days in the hospital each year. The majority of these individuals - 58% - were unrestrained at the time of the crash.
- ✓ Medicaid costs to treat 83 crash victims under the age of 20 totaled $1.6 million.
- ✓ Post-hospitalization care for victims of motor vehicle crashes is also expensive. Nineteen crash survivors were placed in "skilled nursing facilities" at a cost of $1 million, of which 77% was paid by public sources. Of those 19 individuals, 13 were not wearing a seat belt at the time of their crash.

More than $2.6 million in public funds is spent each year to care for unbuckled victims of motor vehicle crashes, and these are just the documented economic costs. Death and long-term disabilities involving the brain or spinal cord take their own toll on individuals and families and are very difficult to quantify.

CONCLUSIONS AND RECOMMENDATIONS
The *Alaska Seat Belt Cost Analysis* makes a compelling economic case for the use of seat belts. The most recent observational survey of seat belt use conducted in July 2003 showed that Alaskans are buckling up at a rate of 78.9%. While higher than previous years, there is a substantial segment of the population who is still not wearing a seat belt. Introduction and implementation of programs and public policies to encourage seat belt use will result in fewer injuries and deaths, ultimately reducing the financial burden on the taxpayers of Alaska.

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Introduction

Motor vehicle crashes are the leading cause of death for Americans between the ages of 2 to 33 years.[1] Every 13 minutes, someone in America dies in a traffic crash, and every 10 seconds, someone is injured.[2] Each year in the U.S., traffic crashes claim about 42,000 lives and result in approximately three million injuries. These crashes cost every person in the U.S. an average of $820 each.[3] The financial costs are minor compared with the pain and suffering of the victims or the loss of a loved one.

According to the National Highway Traffic Safety Administration (NHTSA), in the year 2002, 42,815 people were killed in motor vehicle-related crashes and 2.92 million were injured. The total cost was $230.6 billion.[4] NHTSA also reported that failure to wear seat belts led to approximately 9,200 deaths and 143,000 injuries, costing the U.S. economy $26 billion.

In 1999, Alaska had the highest unintentional injury death rate of all the 50 states. Of these deaths, motor vehicle-related fatalities were over twice as high as the next leading cause.[5] Seat belts are the single most effective safety device in preventing serious injuries and reducing fatalities in motor vehicle crashes. Research has shown that lap and shoulder safety belts, when used properly, reduce the risk of fatal injury to front-seat occupants by 45% and the risk of moderate-to-critical injury by 50%. Child safety seats, when used properly, reduced infant fatalities in passenger cars by 71%.[6]

A 1995 NHTSA study, *Safety Belt Use Laws: An Evaluation of Primary Enforcement and Other Provisions,* showed that states with primary enforcement laws have significantly higher safety belt usage than states with secondary laws. Belt use was about 15% higher in the states with primary enforcement laws. Primary enforcement allows a police officer to stop a vehicle when occupants are unrestrained, while secondary enforcement allows for citing the unbelted motorist only if another infraction resulted in the stop.

Given the documented effectiveness of seat belts in reducing fatalities, the severity of injuries in traffic crashes and, therefore, medical costs associated with those injuries, the Alaska Injury Prevention Center decided to investigate the economic implications of unrestrained vehicle occupants involved in crashes.

This report attempts to quantify the hospital costs associated with seat belt use and non-use in Alaska, as well as to determine what portions of those costs are borne by taxpayers. The research was conducted by the Alaska Injury Prevention Center with funding support from the Automotive Coalition for Traffic Safety, Inc.

Methods

The *Alaska Seat Belt Cost Analysis* project used data from the Department of Transportation and Public Facilities (DOT&PF) from 1990-2001, to compare seat belt usage patterns for all Alaskan motor vehicle occupants. The DOT&PF data are taken from police reports that document seat belt use, property damage, fatalities, time of day, weather conditions, passenger seat belt use, contributing factors, etc.

The Alaska Trauma Registry (ATR) was used extensively for this study because it documents every trauma case resulting in at least one overnight stay in an Alaskan hospital. The ATR contains information about the length of stay, costs for treatment, source of payment, reported seat belt use, age, sex, injury severity, etc. The ATR does not contain information about outpatient visits, scene deaths, private physician contacts, chiropractor visits, and other costs for motor vehicle-related injuries.

Another database maintained by Medicaid, was explored but found to be of limited use because it did not track the cause of injury. If the Medicaid data could be linked with DOT&PF and ATR by age, sex, date of injury, etc., some of the long-term expenses beyond the hospital stay could potentially be tracked.

Hospitalization costs (from the Alaska Trauma Registry) for belted and unbelted occupants injured in a motor vehicle crash in Alaska, for the years 1996 – 1999 were compared. Hospital costs were analyzed by seat belt use or non-use, source of payment, days spent in the hospital, discharge location, and fatalities.

Restraint use was categorized into either the YES group or the NO group in the following manner:

YES	NO
Air Bag and Seat Belt	Air Bag Only (not restrained)
Seat Belt only	None
Infant/Child Restraint	

Many of the entries listed restraint use as UNKNOWN. The case narrative field in the ATR was used to re-categorize a few of the unknowns, but restraint use or non-use could not be determined for most of the unknowns, therefore they were analyzed separately.

In a landmark publication, *The Cost of Injury in the United States*, Rice and MacKenzie documented motor vehicle-related injuries per victim as the most costly of all unintentional injury categories. The average cost for each person

hospitalized for motor vehicle-related injuries was calculated to be $43,409.[7] Several studies have estimated the loss of productivity or quality of life costs for various types of injury, but for this analysis only the quantifiable hospital related costs were examined.
Costs attributed to the "general public" included payments from programs such as Medicaid, Medicare, Indian Health Service, military, CHAMPUS (military dependents), and no-pay patients. We could not adequately define uninsured motorists' costs which could also be attributed to public costs.

Results

Observational surveys completed by the University of Alaska's Institute for Social and Economic Research showed that in the Year 2000, 62% of the front seat occupants of motor vehicles were wearing seat belts. In the Year 2001, 63% of the front seat occupants of motor vehicles were wearing seat belts. These statistically valid surveys represent the driving population of the state and are important when examining seat belt use percentages among motor vehicle crash victims who are injured, hospitalized, or merely involved in a crash.

According to Alaska DOT&PF data from 1998 through 2000, an annual average of 39,613 motor vehicle occupants were involved in traffic crashes, and approximately 62 of these occupants lost their lives each year.[8] Of all the motor vehicle occupants involved in a crash, only 6% reported not wearing a restraint, 66% were wearing a restraint, and 28% had unknown restraint use (see Table 1). When all of the cases with documented restraint use were analyzed separately, 9% were reportedly not wearing a seat belt, while 60% of the fatalities were unrestrained.

Table 1
Alaska Seat Belt Use (DOT&PF Data)
1998, 1999, 2000 Combined and Averaged

	All Motor Vehicle Occupants	All Occupants Where Seat Belt use Documented	All Fatals	Fatals Where Seat Belt use Documented	Major Injuries	Minor Injuries	No Injuries
No Restraint	6% (7,641)	9%	54% (34)	60%	37%	15%	5%
Restraint Used	66% (77,936)	91%	37% (23)	40%	49%	74%	65%
Unknown Use	28% (33,263)		9% (5)		12%	11%	31%
Annual Average	39,613		62				

The Alaska Trauma Registry provided additional information on the more seriously injured occupants after they were admitted to a hospital. Of all the motor vehicle occupant hospitalizations, 48% were not wearing a restraint, 43% were wearing a restraint, and 9% had unknown restraint use (see Table 2). When all cases with documented restraint use were analyzed separately, 53% were unrestrained, and of the fatals who died in the hospital, 56% were unrestrained.

Table 2

Alaska Trauma Registry Data

Hospitalizations

1996 – 1999 Combined

	All Motor Vehicle Occupant Hospitalizations	Cases with Seatbelt Use Documented	Fatals	Fatals with Seatbelt Use Documented
No Restraint	48% (887)	53%	49% (30)	56%
Restraint Used	43% (790)	47%	39% (24)	44%
Unknown Use	9% (167)	0%	11% (7)	

Another measure of severity used in this analysis was total number of hospital days for restrained and unrestrained occupants. An average of 2,672 days was spent in hospitals every year for motor vehicle occupant injuries in Alaska. Of the total hospital days where restraint use was documented, 58% of the patients had been unrestrained at the time of their crash and 42% were restrained (Table 3).

Table 3

Hospital Days

1996 – 1999 Average

	Avg. Hospital Days per Year	%	% by "Known" Use
No Restraint	1402	52%	58%
Restraint Used	1009	38%	42%
Use Unknown	261	10%	

In 1994, the Federal Highway Administration published a technical report, *Motor Vehicle Accident*, and included the following lifetime injury costs by Abbreviated Injury Severity (AIS) score:

Severity	Descriptor	Cost per Injury
AIS 1	Minor	$ 5,000
AIS 2	Moderate	$ 40,000
AIS 3	Serious	$ 150,000
AIS 4	Severe	$ 490,000
AIS 5	Critical	$1,980,000
AIS 6	Fatal	$2,600,000

When correlating the AIS scores with seat belt use in Alaska, 60% of the patients with the lowest score of AIS 1, were wearing restraints at the time of their crash. The most severely injured patients, having scores of AIS 5, had the lowest percentage of restraint use at 45%.

Post-hospitalization costs are substantial, but difficult to measure. The most severe non-fatal cases are discharged to "skilled nursing" facilities which typically require round-the-clock monitoring. Of the patients discharged to skilled nursing, 13 had been unrestrained and 6 were restrained during the motor vehicle crash. The hospital costs for these 19 patients before they were discharged were nearly $1 million, of which 77% was derived from public sources. Unfortunately, it was impossible to track post-hospitalization costs.

Costs

The costs for hospitalized motor vehicle occupants in Alaska were analyzed by the source of payment data in the ATR. These costs are not considered to be complete, since some of the costs are billed by sources outside of the hospital, such as medical specialists, chronic care facilities, pharmacies, medical and prosthetic equipment companies, etc. Generally, costs were paid by one or more of the following sources: motor vehicle property and casualty insurance, private health and medical insurance, CHAMPUS insurance for military dependents, military branches, Medicaid, Medicare, IHS for Alaska Native beneficiaries, and workers compensation insurance.

The Alaska Department of Health and Social Services, Section of Community Health and EMS recently completed a research project that analyzed injuries among Medicaid-eligible youth ages 0-20. [9] The report compiled hospital costs for various types of injuries for the years 1995-1999.

Motor vehicle occupant injuries are the most expensive injury category for Medicaid. During the four-year period, there were 83 Medicaid-eligible Alaskans who were 0-20 years old and involved in motor vehicle crashes.

The breakdown of the medical costs to treat these individuals included:

- The average cost per case was $20,000.
- Average cost per hospital day was $3,300.
- Average number of days in the hospital was 6 days per case.
- Total number of Medicaid patients was 83, with a total estimated cost of $1.6 million.

For the years 1996 through 1999, an analysis of hospital costs documented in the ATR for motor vehicle occupant injuries was undertaken. Only 66% of the patients had medical costs reported in the ATR because several of the hospitals serving federal beneficiaries and a few of the public hospitals did not report costs associated with individuals. Of the cases where costs were reported, over $22.2 million was spent on direct medical care. When extrapolating average costs per case, the four-year costs were:

- $21.8 million for unrestrained occupants and
- $15.8 million for restrained occupants.

When including the "unknowns," an additional $6.1 million is added, for a total of $43.6 million. Of the total hospital costs reported, 59% represented unrestrained occupants (see Table 4).

Table 4

Alaska MV Hospital Costs

1996 - 1999

	Total Costs	Total Cases	Average Costs per Case	% of Total
No Restraint Used	$13,039,797	534	$24,419	59%
Restraint Used	$9,177,849	460	$19,952	41%

Of the total ATR costs for motor vehicle-related hospitalizations, 44% was paid by the general public through programs such as Medicaid, Medicare, Indian Health Service, military, CHAMPUS, and no-pay patients. Of this 44% paid by the public, 69% of the costs were for unrestrained occupants (see Table 5).

Table 5

Public Costs for Alaska MV Hospitalizations
1996 - 1999

	Total Costs	Total Cases	Average Costs per Case	% of Total
No Restraint Used	$6,514,907	181	$35,994	69%
Restraint Used	$3,226,035	263	$12,266	31%

There is well over $2.6 million dollars spent each year on beneficiaries of public programs who are hospitalized for motor vehicle-related injuries. This number excludes the very costly pedestrian and bicycle victims injured by motor vehicles.

Conclusions

A substantial body of research demonstrates that seat belt use greatly reduces the number of traffic crash-related fatalities and the severity of injuries. In general, the more severe the injury, the less likely it will be that the individual was buckled up. The *Alaska Seat Belt Cost Analysis* shows that restraint use or non-use also affects the number of hospitalizations, length of stay in the hospital, and the overall cost of hospitalizations for motor vehicle occupants involved in crashes.

The analysis also shows that 44% of motor vehicle crash-related hospital costs are borne by the citizens of Alaska. Close to 40,000 vehicle occupants are involved in traffic crashes each year in Alaska. More than $2.6 million dollars is spent each year for beneficiaries of public programs who are hospitalized for motor vehicle related injuries. Thus, the decision to wear or not wear a seat belt is not just a matter of personal choice, but a decision that has economic implications for all Alaskans.

This study only analyzed hospitalization costs of vehicle occupants involved in crashes. For those suffering some types of injuries, including those to the brain and spinal cord, long-term care and rehabilitation costs vastly exceed the initial hospitalization costs. Thus, the total cost to the public is significantly higher than those documented in this study.

Fortunately, seat belt use in Alaska is on the rise. The most recent observed seat belt use survey found that belt use was 78.9% in 2003 up from 66% in 2002. Still, experience from other states and Canada suggests that the largest reductions in

fatalities, injury severity (and thus medical costs) do not occur until belt use rates reach the 90 percent range.[10]

Most frequently, those who refuse to buckle up also tend to exhibit other high-risk behaviors like speeding and driving while impaired. It is critical that all drivers and passengers use seat belts and child restraints, as appropriate, if hospital and other medical costs resulting from motor vehicle crashes are to be substantially reduced. Programs and policies that result in higher restraint use will reduce traffic crash fatalities as well as the severity of injuries and costs to individuals and to the taxpayers of Alaska.

References

[1] NHTSA, Traffic Safety Facts, 2002

[2] NHTSA, Status of Occupant Protection in America, Buckle Up America Report, Nov. 2001.

[3] USDOT&PF, News Release, July 17, 2003.

[4] Ibid.

[5] CDC, WISQARS, Injury Mortality Report, All Injury Deaths and Rates per 100,000 by State.

[6] NHTSA, Traffic Safety Facts 2001 – Occupant Protection, DOT&PF HS 809 474.

[7] Rice DP, MacKenzie EJ, et. al., Cost of Injury in the United States, Report to Congress 1989.

[8] Alaska Traffic Accidents, Annual reports from the Alaska Department of Transportation and Public Facilities.

[9] Report on Injury Prevention Activities of Community Health and EMS Targeting Medicaid-Eligible Youth, by Martha Moore and the State Injury Prevention staff, 2003.

[10] NHTSA, Status of Occupant Protection in America, Buckle Up America Report, Nov. 2001.

Sixth Report to Congress
Fourth Report to the President

The National Initiative for Increasing Safety Belt Use

June 2004

Prepared By

The National Highway Traffic Safety Administration — U.S. Department of Transportation

Letter from Secretary Mineta

As in past years, the *Buckle Up America* (BUA) campaign has continued to make strides in increasing safety belt and child safety seat use. Throughout the country, safety belt use rates rose to 75 percent in 2002, 2 percentage points higher than in 2001. In States that had primary enforcement laws, the average safety belt use rate rose for the first time to 80 percent.

This increase in the national belt use rate translates into an estimated additional 6 million safety belt users. Especially noteworthy is the increase in safety belt use among African Americans. From 2000 to 2002, their safety belt use increased 8 percentage points from 69 to 77 percent. Our BUA campaign partners in the African American community deserve special acknowledgement for their hard work and commitment to helping achieve this increase.

Restraint use among young children reached record levels in 2002. A 99-percent use rate for infants and a 94-percent use rate for toddlers were noted in our National Occupant Protection Use Survey. To maintain these high rates, we continue to support regional and State efforts to increase the availability of permanent child passenger safety seat inspection stations and the number of certified child passenger safety technicians to conduct inspections. With the publishing of *A National Strategy: Increasing Booster Seat Use for 4- to 8-year-old Children* in October 2002, we look forward to increased occupant protection usage rates for all child passengers.

Also during 2002, the National Highway Traffic Safety Administration (NHTSA) was able to measure the effectiveness of the BUA campaign's full *Click It or Ticket* mobilization model that included paid media. Our research showed an average safety belt use increase of 8.6 percentage points among States that implemented the full mobilization model. This again reinforces one of the campaign's fundamental tenets that highly publicized enforcement, in combination with paid media, can achieve a substantial increase in a State's overall safety belt use rate.

With a commitment from the Bush Administration to achieve a 78-percent usage rate in 2003, I encourage our many public- and private-sector partners to continue their support of the BUA campaign and I applaud them for their past efforts. Together we can continue to save lives on America's highways and share in the knowledge that we are contributing to the strength and well-being of our country.

Norman Y. Mineta
Secretary of Transportation

Overview of the *Buckle Up America* Campaign

National Goals

- To increase the national safety belt use rate to 78 percent by the end of 2003.
- To reduce the number of child occupant (from birth to age 4) fatalities by 25 percent by the end of 2005 (using the 653 fatalities in 1996 as a baseline).

Four-point Plan

- Enact strong legislation.
- Maintain active, high-visibility law enforcement.
- Build public-private partnerships.
- Conduct well-coordinated, effective public education.

This Report

The following report is submitted in response to Executive Order 13043 and the House and Senate Appropriations Committees' directive to the Secretary of Transportation and the Administrator of the National Highway Traffic Safety Administration (NHTSA) to keep the President and the Committees apprised of the activities of the national *Buckle Up America* campaign. This report highlights the activities of the campaign from January 1, 2002, through December 31, 2002.

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The Status Of Occupant Protection In America

Vehicle occupants account for 87 percent of all traffic deaths. When used properly, safety belts help prevent deaths and reduce injuries. In 2002, safety belts prevented an estimated 14,164 fatalities, saving more than $50 billion in medical care, lost productivity, and other injury-related costs. If ALL passenger vehicle occupants over age 4 were restrained in safety belts, an additional 7,153 lives could have been saved in 2002.

Motor Vehicle Crashes—The Scope of the Problem

In 2001, deaths and injuries resulting from motor vehicle crashes were the leading cause of death for persons of every age from 4 through 33-years-old. On average, every 13 minutes, someone in America dies in a motor-vehicle-related crash, and every 10 seconds, someone is injured. In 2002, traffic crashes claimed 42,815 lives and resulted in nearly 3 million injuries. Each year, crashes lead to about 4 million emergency department visits and 500,000 hospitalizations. Approximately 2 million Americans are disabled by crashes each year.

Potential Benefits of Safety Belt Use

Increasing the national safety belt use rate from 75 percent (the rate observed in 2002) to 90 percent would:

- Prevent an estimated 4,100 fatalities annually.
- Prevent an estimated 60,000 serious injuries annually.
- Prevent an estimated 50,000 minor injuries annually.
- Save our economy approximately $11.6 billion annually.

The economic cost-savings cited above are derived from reduced productivity losses, property damage, medical costs, rehabilitation costs, legal and court costs, emergency services costs, insurance administration costs, traffic delay, and reduced costs to employers.

The Effectiveness of Safety Belts

From 1975 through 2002, safety belts are estimated to have saved 164,753 lives. Research has shown that lap/shoulder belts, when used properly, reduce the risk of fatal injury to front-seat passenger car occupants by 45 percent and the risk of moderate to critical injury by 50 percent. For light-truck occupants, safety belts reduce the risk of fatal injury by 60 percent and moderate-to-critical injury by 65 percent.

Safety belts are 80-percent effective in reducing fatalities in light trucks (including sport utility vehicles [SUVs]) during rollover crashes. They also help prevent individuals from being totally ejected during a crash, thus reducing the risk of a fatal injury. Despite the effectiveness of safety belts in preventing injuries and fatalities, 59 percent of passenger vehicle occupants killed in 2002 were unrestrained.

The Effectiveness of Child Safety Seats

Child safety seats, when used correctly, are extremely effective in preventing injuries and deaths during crashes. From 1975 through 2002, an estimated 6,567 young lives were saved by child restraint systems. An estimated 376 lives of children under age 5 were saved in 2002 alone. If 100 percent of children younger than 5 years of age were properly placed in child safety seats, an estimated 485 lives (that is, an additional 109 lives) could have been saved in 2002.

Research on the effectiveness of child safety seats has found them to reduce fatal injury in passenger cars by 71 percent for infants and 54 percent for toddlers. For infants and toddlers in light trucks, the corresponding reductions are 58 percent and 59 percent, respectively. In 2002, 459 children younger than 4 years of age were killed in passenger vehicle crashes. Of these fatalities, 185 children (or 40 percent) were totally unrestrained.

In spite of these high use rates, the challenge of educating parents and other caregivers on the correct use of child restraints still remains. According to data from the National SAFE KIDS Campaign, the vast majority of child restraints are used incorrectly. The campaign analyzed errors identified while checking nearly 38,000 child safety seats and safety belts from February 2001 to May 2002.

Overall, 81.6 percent of the child restraints were used incorrectly, with an average of three errors per restraint. The SAFE KIDS data found the highest proportion of errors in rear-facing infant seats and forward-facing toddler seats with harnesses, as follows:

- The safety belt did not lock the seat tightly for 62 percent of children in rear-facing seats and 67 percent of children in forward-facing seats.
- Harness straps were loose for 65 percent of children in rear-facing seats and 67 percent of children in forward-facing seats.

For safety belts, the most common errors were:

- The shoulder belt was not over the center of shoulder (78.9 percent).
- The child's legs did not bend over the vehicle seat without slouching (75.1 percent).
- Lap belt was not over upper thighs (70.6 percent).

Additional information on these findings is available at www.safekids.org.

State and Regional Trends in Safety Belt Use

According to NHTSA's National Occupant Protection Use Survey (NOPUS), safety belt use continued an upward trend in 2002, reaching 75 percent--its highest level since national surveys began in 1994. Up 2 percentage points from 2001, this increase in belt use translates into an additional 6 million users and the saving of approximately 500 lives. States with primary safety belt laws averaged an 80-percent belt use rate, while States with secondary laws averaged a 69-percent use rate. Primary safety belt laws allow a police officer to stop a vehicle in which passengers are not in compliance with the State safety belt law.

Three States and Puerto Rico had safety belt use rates that were 90 percent or higher in 2002: California (91 percent), Hawaii (90 percent), Washington (93 percent), and Puerto Rico (91 percent). The District of Columbia and 12 States had rates that were 80 percent or higher: District of Columbia (85 percent), Iowa (82 percent), New Jersey (81 percent), New Mexico (88 percent), New York (83 percent), North Carolina (84 percent), Oregon (88 percent), Maryland (86 percent), Michigan (83 percent) Texas (81 percent), Utah (80 percent), and Vermont (85 percent). The majority of States that have usage rates above 80 percent also have enacted primary enforcement safety belt use laws.

Of special note, Washington was the only State that passed a primary law in 2002 and the State's safety belt use rate rose 10 percentage points, from 83 percent in 2001 to 93 percent in 2002.

The Northeast, historically the lowest region for safety belt use, showed the largest gain in safety belt use, up 8 percentage points from 2001 to 69 percent in 2002. However, drivers and passengers in the West still buckle up at the highest rate nationwide at 79 percent—up 2 percentage points from 2001. The South maintained the 76-percent usage rate it achieved in 2001, up 7 percentage points from 2000, while the Midwest showed an increase from 72 percent in 2001 to 74 percent in 2002.

National Trends and Initiatives in Child Passenger Safety

Restraint use by young children reached record levels in 2002. NHTSA's observational studies (NOPUS) showed that 99 percent of infants and 94 percent of toddlers were restrained. Occupant fatalities for children under age 5 declined by 9 percent in 2002. For the first time, the number of fatalities among this age group dropped below 500, to 459. This continued decrease in the number of child occupant deaths is in large part due to the significant increase in child restraint use since the *Buckle Up America* campaign began. In 1996, just before the campaign began, restraint use among

infants (1- to 12 months of age) was 85 percent and only about 60 percent of toddlers (1- to 4-years-old) were restrained while riding in vehicles.

In spite of the strides that have been made, the need for ongoing outreach and education remains. NHTSA's 2002 NOPUS surveys also showed that too many young children—15 percent of infants, 10 percent of 1-3-year-olds, and 29 percent of 4- to 7-year-olds continue to be placed in the front seat, which is the most dangerous seating position.

Restraint Use Among Older Children

The odds of injury for children riding in booster seats were 59 percent lower than the risks children face when using safety belts alone, according to a study published in the June 4, 2003, edition of the Journal of the American Medical Association. The study, conducted by Partners for Child Passenger Safety (PCPS), a research project at The Children's Hospital of Philadelphia, and supported by State Farm Mutual Automobile Insurance Company, examined insurance claim data from December 1998 through May 2002 concerning 3,616 crashes in 15 States involving 4,243 children. The study also found that none of the 4- to 7-year-olds who were in belt-positioning booster seats had any injuries to the abdomen, neck, spine, and back. Such injuries did occur, however, in children who used safety belts alone.

The PCPS study also found that only 16 percent of 4-year-olds, 13 percent of 5-year-olds, and 4 percent of 6- and 7-year-olds were using booster seats. NHTSA recommends that children who have outgrown child safety seats be properly restrained in booster seats from about age 4 and 40 pounds to at least age 8, unless they are 4 feet 9 inches tall.

National Strategy to Increase Booster Seat Use

In 2002, NHTSA published *National Strategy to Promote Booster Seat Use*, modeled after the four elements of the BUA campaign. That document called for the expansion of current occupant restraint initiatives to: 1) promote the use of booster seats for 4- to 8-year-old children and 2) increase the use of occupant restraints for all children. A major focus of the strategy is the need to inform the public that the safest occupant restraint for 4- to 8-year-old children is an age/size-appropriate, belt-positioning booster seat.

To obtain national input for developing the strategy, on June 6, 2001, NHTSA announced a public meeting and request for comments in the *Federal Register*. Many of the tools and tactics that shaped the development of the document came from docket comments, along with recommendations obtained during the public meeting.

New Rule for the Annual Rating of Child Safety Seats

During 2002, NHTSA announced issuance of a final rule to begin a program for the annual rating of child safety seats based on their ease of use by consumers. (In early 2003, NHTSA began posting ease-of-use ratings for child safety seats on the agency's Web site.) NHTSA also will publish a brochure listing all of its ease-of-use ratings. Under the new rating system, child safety seats, including booster seats, will each be given an overall "A," "B," or "C" ease-of-use rating. Such letter grades will also be used to rate seats in each of five categories:

- Whether the seat is pre-assembled or requires assembly after purchase.
- Clarity of labeling attached to the seat.
- Clarity of written instructions on the seat's proper use.
- Ease of installation of the seat in a vehicle.
- Ease of securing a child correctly in the seat.

Full Implementation of LATCH

Lower Anchors and Tethers for Children (LATCH) is a restraint system designed to work independently of the vehicle safety belt system and to make it easier to install a child safety seat correctly. Once it has been fully phased in, NHTSA estimates that the LATCH system will eliminate as much as half of the misuse associated with the incorrect installation of child safety seats.

Since September 1, 2000, all vehicle manufacturers have been required to install a top tether anchor to secure forward-facing child safety seats. Most child safety seats come equipped with a top strap or tether that attaches to the tether anchor.

As of September 1, 2002, nearly all newly manufactured passenger vehicles were also required to have lower anchors installed in at least two rear seating positions. In addition, also as of September 1, 2002, all new child safety seats were required to come equipped with a pair of lower attachments that fasten to the vehicle anchors.

On August 28, 2002, NHTSA Administrator Dr. Jeffrey W. Runge joined with officials from DaimlerChrysler, Graco Children's Products, and Toys R Us/Babies R Us to call the public's attention to the new LATCH requirements, to explain their benefits and demonstrate their use. The event received extensive media coverage and boosted public awareness about this important new technology.

Reductions in Child Deaths from Air Bags

From 1996-2001, the rate of child air bag deaths declined a remarkable 96 percent, despite a five-fold increase in the number of passenger air-bag-equipped vehicles on the road, according to the Air Bag & Safety Belt Safety campaign (a *Buckle Up America* partner organization). Based on the number of rear-seated fatalities and a conservative 30 percent estimated effectiveness of moving children to the rear seat, research has found that more than 1,700 child deaths have been prevented since 1996 (an average of about 340 per year).

Air bags contributed to 1 child fatality for every 8.9 million-passenger air bags in 2000, compared with 1 child fatality for every 870,000 passenger air bags in 1996. In 1996,

26 children were killed by air bags; in 2000, 9 were killed. Nearly all the children killed were either completely unrestrained or improperly buckled in the front seat.

This reduction in deaths is another positive outcome of many of the activities undertaken as part of the *Buckle Up America* campaign. These activities include the passage of stronger State safety belt and child restraint laws, stepped-up law enforcement, and intense public education about air bag safety.

On September 1, 2003, 20 percent of all new motor vehicles sold in the United States must be equipped with advanced air bag technologies and by September 1, 2006, the requirement will apply to *all* new light trucks and cars.

Strong Legislation—the Key To Saving Lives

Having a strong, well-written safety belt law is crucial to increasing safety belt use. Current recommendations for safety belt laws include the following:

- Provisions for primary enforcement.
- Coverage of all occupants in all seating positions while the vehicle is in motion (unless there is documentation from a physician for physical disability).
- Coverage of all passenger vehicle types, including taxicabs, pickup trucks, vans, SUVs, and cars.
- Penalties of not less than $50.
- Assignment of points on the driver's license in those States with point systems. (In those States without point systems, not wearing safety belts should be considered a minor moving offense for the purpose of driver's license records).

The Importance of Primary Occupant Protection Laws

Primary enforcement allows a law enforcement officer to stop a vehicle and issue a citation when the officer observes an unbelted driver or passenger. Secondary enforcement means a citation can be written only after the officer stops the vehicle or cites the offender for another infraction.

Virtually all traffic safety laws—and other laws, for that matter—are primary, except secondary enforcement safety belt use laws. In States with secondary laws, a law enforcement officer can stop a motorist for a burnt-out taillight or an expired license tag, for example, but he cannot stop a motorist for violating the State's safety belt law, unless the officer observes another infraction.

Under the *Buckle Up America* campaign, NHTSA provides technical assistance and, upon request, expert testimony to States and national organizations on the benefits of primary occupant restraint laws. These benefits are well documented, as evidenced below.

In June 2002, for the first time, the average safety belt use rate in States with primary safety belt laws was 80 percent, compared with 69 percent in States without primary enforcement laws. Forty-nine States, Puerto Rico, and the District of Columbia have had safety belt use laws since December 31, 2001, but only a third provided for primary enforcement. Increases in safety belt use have been made without a primary safety belt use law, but the greatest gains are possible when a primary law works in conjunction with enforcement, education, and partnership efforts.

An upgrade in a State's safety belt law to primary enforcement will significantly raise safety belt *and* child safety seat use because increasing adult safety belt use has a significant impact on whether children are appropriately restrained. Observational surveys show that when drivers wear safety belts, children are restrained significantly more often than when drivers are unbuckled.

In 2002, NOPUS found that fully 92 percent of the time when a driver is belted his or her child passengers are restrained. In contrast, when the driver is not wearing a safety belt, children are restrained only 72 percent of the time.

The National Status of Safety Belt Laws

All States except New Hampshire have an adult safety belt law. (Only children younger than 18 are required to wear a safety belt in New Hampshire.) In 2002, Washington was the only State to pass a primary enforcement law. Primary enforcement legislation was considered by legislatures in Idaho, Illinois, Minnesota, Ohio, Wisconsin, Rhode Island, Vermont, and Maine.

With the passage of its primary law, Washington became the 18th State to enact a primary safety belt law by December 31, 2002. The other States with primary laws in effect include Alabama, California, Connecticut, Georgia, Hawaii, Indiana, Iowa, Louisiana, Maryland, Michigan, New Jersey, New Mexico, New York, North Carolina, Oklahoma,

Oregon, and Texas. Puerto Rico and the District of Columbia also have primary safety belt laws in effect.

Tribal Legislation

Motor vehicle crashes continue to be the leading cause of death among Native Americans/Alaska Natives (NA/AN) from 5- to 34 years of age. They are also the third leading cause of death among NA/AN of all ages. As part of the *Buckle Up America* campaign, NHTSA continues to work with tribes to provide education on safety belt and child safety seat use through its partnerships with the Indian Health Service and the Bureau of Indian Affairs.

In 2002, after the passage of a primary restraint law in Washington, the Portland Area, and two Area reservations reported an increase in restraint use. Observational surveys on the Warm Springs Reservation indicated that restraint use increased from 16 percent to 46 percent among drivers and from 12 percent to 36 percent among passengers. The Yakima Nation passed a primary law in 2001. Observational surveys in 2002 indicated that restraint use continued to increase since the law went into effect. Restraint use was reported at 62 percent.

Two Tribes in the Bemidji Area passed primary restraint laws in 2002 and in April 2002 the Hannahville Tribal Council (Wilson, Michigan) passed a resolution adopting restraint use for all ages.

In July 2002, the Menominee Tribe (Keshena, Wisconsin) passed a primary restraint use law in a State with a secondary law. Enforcement of the new law is strong. One month after the law was passed Tribal Police had issued 70 verbal warnings as a precursor to the issuance of citations.

As of March 1, 2002, all components of the Reno/Sparks Indian Colony (in the Phoenix Area) 2001 Traffic Safety Law became effective. The new law included primary child restraint device use provisions for children 5 years of age or younger or less than 60 pounds, and required children 6 years of age or older or 60 pounds to be properly secured in a child passenger restraint device. It also included a primary safety belt provision requiring any person driving a vehicle and any person 5 years of age or older or over 60 pounds to wear a safety belt.

The National Status of Child Passenger Safety Laws

All 50 States, Puerto Rico, and the District of Columbia have enacted child restraint laws, and all of these laws are primary, although the provisions vary from State to State. For example, some laws cover only infants, and others fail to cover all children in all seating positions. Among other deficiencies, some States do not require out-of-State vehicles to comply with their laws and others fail to address the problem of child passengers riding in pickup truck cargo areas.

To achieve reductions in injuries and fatalities among America's children, child restraint laws should be strengthened to close these and other gaps. All such laws should include provisions that:

1. Require children 12-years-old and younger to be secured by an age-appropriate child restraint system in the rear seat of the vehicle, and eliminate exemptions related to "exceeding the number of available belts or restraints in the vehicle."
2. Require all children up to age 16 (or the State's driving age) to be properly restrained in all seating positions.
3. Require all children who have outgrown child safety seats to be restrained in booster seats until they are at least 8-years-old, unless they are 4 feet 9 inches tall.
4. Make the driver responsible for ensuring that children are placed in age- and size-appropriate restraints.
5. Ban passengers from the cargo area of pickups and other light trucks.
6. Include out-of-State vehicles, drivers, and children.
7. Assess a reasonable fine for noncompliance and earmark a portion of the revenues to help support State child passenger safety programs.

8. Eliminate exemptions and medical waivers because today's child restraint systems can accommodate children with almost any type of physical impairment.

States That Amended Their Child Restraint Laws in 2002

Illinois: Illinois's amended child restraint law now requires that a person transporting a child under age 4 secure the child in a federally approved child restraint system.

Rhode Island: Penalties were increased for all primary and secondary violations from $50 to $75. All references to the back seat were changed to "rear seating position." The exemptions from the rear-seating-position requirement were clarified.

Maine: Requires children 4-8 and under 80 pounds to be in a federally approved booster seat (see page 13).

Booster Seat Laws

Colorado, Maine, and Maryland passed booster seat laws in 2002. Colorado's law, which was passed in June 2002, requires that children who are 4- or 5-years old and less than 55 inches tall be properly restrained in a booster seat or with a child safety-belt-positioning device. Under the new law, children ages 6 through 15 must be properly restrained in a safety belt. The law took effect on August 1, 2003. This effective date was preceded by a year of education before enforcement began. When enforcement began, officers gave warnings, not tickets, to drivers for one year.

Maine made considerable upgrades to its child passenger safety law, including a new booster seat requirement. The new law was passed in April 2002 and took effect January 1, 2003. The law requires that a child who weighs less than 40 pounds be secured in a child safety seat. The new law also requires that a child who weighs 40 pounds to 80 pounds and is under 8-years-old be placed in a booster seat.

Maryland adopted a law requiring that children under age 6 be properly restrained in child safety seats while riding in a vehicle, an upgrade of the State's previous law that includes booster seats. Prior to passage, Maryland law only required children under 4 to use child safety seats. The law passed the Maryland Legislature in April 2002 and was signed into law by the governor in May 2002. The law took effect in October 2003.

Public Support and Awareness of Occupant Protection Laws

In 2000, NHTSA conducted its Motor Vehicle Occupant Safety Survey (MVOSS) among a national sample of approximately 6,000 people age 16 and older to determine attitudes, knowledge, and reported behaviors regarding occupant protection. The results were enormously positive (see below). The next such survey was conducted in 2003, the results of which will be reported in the *Buckle Up America Seventh Report to Congress and Fifth Report to the President*, which will cover campaign activities from January 1, 2003, through December 31, 2003.

Support for Safety Belt Laws and Enforcement

- The vast majority of the public (87 percent) favored laws that require drivers and front-seat passengers to wear safety belts.
- Among persons who supported front safety belt laws, 78 percent also supported applying safety belt laws to back-seat adult passengers.
- About three-fifths (62 percent) supported fines for drivers who did not wear safety belts. Support for fines was greater among Hispanics (6[illegible] percent) compared with African Americans (62 percent) and whites (62 percent). Among those who supported fines, 45 percent favored fines of $100 or more for a repeat safety belt law violation.
- Respondents were asked how they would likely react to getting a ticket for a safety belt violation. The interviewers gave respondents two choices and asked which was more likely: that they would believe they deserved the ticket because they broke the law, or that they would believe the ticket was undeserved because wearing a safety belt should be a personal choice. According to the survey data, 70 percent would be more likely to believe that they deserved the ticket. Hispanics (76 percent) and African Americans (73 percent) were more likely than whites (69 percent) to answer that they likely would feel they deserved the ticket.
- Overall, 61 percent of the population surveyed believed that law enforcement officers should be allowed to stop a vehicle if they observe only a safety belt use violation (primary enforcement).
- Perhaps not surprisingly, support for primary enforcement was higher in primary enforcement States (70 percent). However, even in States with secondary enforcement, the majority ([illegible] percent) favored primary enforcement.
- Overall support for primary enforcement was greatest among Hispanics (72 percent), followed by African Americans (68 percent), and whites (59 percent).

Support for Child Passenger Safety Laws

- Nearly three in five (58 percent) believed that the police should give a ticket at every opportunity for violations of child safety seat laws. Almost as many (56 percent) believed that the fine should be $50 or more.
- 94 percent agreed that children should be required by law to wear safety belts once they have outgrown child safety seats; only 3 percent disagreed.

These data are supported by a survey of 800 adult drivers conducted by the Air Bag & Seat Belt Safety Campaign in 2000. The survey found that 70 percent of the respondents become angry when they see unbuckled children in a car, and 78 percent agreed with the following statement: "People who fail to buckle up their child passengers should be considered guilty of child endangerment."

Support for Primary Laws Among Organizations Representing Diverse Populations

The Congressional Black Caucus has stated that increasing safety belt use among African Americans is an "urgent national health priority," and the National Urban League has expressed its support for primary safety belt laws. The National Black Caucus of State Legislators and the National Conference of Black Mayors have also expressed support for strong laws that increase safety belt use and include safeguards for uniform enforcement.

Recognizing the contribution that primary laws make to safety belt use among all groups, many minority group legislators have supported primary law upgrades in their States. Some of these legislators have testified publicly that following their upgrades to primary safety belt laws, they have seen neither backlash in their communities nor evidence of differential enforcement of the new laws.

ASPIRA, a national organization dedicated to the education and leadership development of Hispanic youth, also has expressed its support for primary safety belt legislation. ASPIRA passed a resolution supporting primary enforcement of State safety belt and child safety seat use laws and efforts to promote compliance with such laws.

High-visibility Enforcement

The year 2002 provided clear evidence that *very* intense safety belt enforcement, backed up by heavy, well-targeted publicity, continues to drive belt use up. It also demonstrated that *Click It or Ticket* works nationwide.

Operation ABC Mobilizations – New and Improved

As in the previous four years, NHTSA joined with the Air Bag & Seat Belt Safety Campaign, the Highway Safety Offices of the States, the District of Columbia, and Puerto Rico and over 12,000 law enforcement agencies in two Operation ABC Mobilizations. The first centered on the Memorial Day holiday; the second around Thanksgiving. As before, law enforcement partners were committed to stopping and ticketing as many safety belt and child passenger safety violators as they could find. Print, broadcast, and other media partners across the country communicated this message to the public.

However, in 2002, the mobilizations took on a significant new look. First, they were longer. In past years, law enforcement mobilized for one week during each holiday period. This year, NHTSA asked for a two-week effort, and 35 States, the District of Columbia, and Puerto Rico responded to this request. Second, they made extensive use of paid advertising. In 2001, the eight States of NHTSA's Region IV experimented with paid advertising to augment earned news coverage and public service announcements. This year, 37 States, the District of Columbia, and Puerto Rico spent over $9.8 million on paid ads in May, and another $3.5 million in November, to get their message across. In most cases, that message was *Click It or Ticket*. And most of the ads were aired on TV and radio programs known to reach 18-34-year-old males, the lowest safety-belt-using demographic group.

Operation ABC continued to receive support from Mothers Against Drunk Driving (MADD), the National Transportation Safety Board (NTSB), and all major law enforcement associations, including the International Association of Chiefs of Police (IACP), the National Sheriffs Association (NSA), the National Organization of Black Law Enforcement Executives (NOBLE), and the Hispanic American Police Command Officers Association (HAPCOA). More than 1,000 business and community organizations in all States gave vocal and material support to the mobilizations, as did the Emergency Nurses Association (ENA) and the National Safety Council (NSC).

The intensity and visibility of the 2002 mobilizations differed between the Memorial Day and Thanksgiving events. Although the numbers of law enforcement agencies participating were approximately the same for the two waves, only about two-thirds as many safety belt checkpoints were conducted in the fall as compared to the spring (12,000 versus 17,700, based on reports from 37 States and Puerto Rico). Safety belt citations in the reporting States totaled nearly 420,000 in the May mobilization, but fell to fewer than 250,000 in November. In addition, the States collectively spent nearly $10 million on their paid advertising campaigns in May, but only about $3.5 million in November.

Click It or Ticket was the rallying cry of 29 States and the District of Columbia in May, and of 31 States and the District of Columbia in November. Most other States employed alternative enforcement-focused messages such as "Buckled or Busted," "No Exceptions, No Excuses," or "Buckle Up or Pay Up." Comparing their use rates for 2002 and 2001, the *Click It or Ticket* States enjoyed an average increase of 3.1 percentage points. States that used alternative messages had an average gain of less than 1 percentage point.

120 Million More Americans Heard the Message... *and Responded!*

In May 2002, nearly 120 million Americans living in 22 States and the District of Columbia saw and heard the *Click It or Ticket* message for the first time on their TVs and radios, and in their newspapers. That is in addition to the residents of six of the Region IV

States and Michigan, who had seen and heard the message during the 2001 mobilizations. Safety belt use among those newly exposed citizens increased by 3.9 percentage points – more than 4.5 million Americans who buckled up in 2002! In contrast, safety belt use in the other 28 States and Puerto Rico rose by less than 1 percentage point.

Ten *Click It or Ticket* States achieved belt use gains in 2002 that were at least 5 percentage points above their 2001 rates. Leading the group were West Virginia (up 19.3 points), Vermont (17.5 points) and Washington (10.0 points). Among States that did not deliver the *Click It or Ticket* message, only Puerto Rico (up 7.4 points) and Minnesota (6.2 points) exceeded gains of 5 percentage points. The three States with the largest *losses* in belt use from 2001 to 2002 were all non-*Click It or Ticket* messages in the May mobilization. They included Massachusetts (down 5.0 points), with the message "Please Buckle, It's the Law"; South Carolina (down 3.3 points), with the message "Fasten for Life"; and Wisconsin (down 2.6 points), with the message "Click It, Why Risk It."

In 2002, the data were very clear: when fully implemented, *Click It or Ticket* works! Other messages don't work nearly as well.

Contrasting the Gains and Losses

As Table 1 shows, heavy enforcement, a clear message, and significant publicity proved to be a winning combination in 2002.

In Table 2, it is clear that an unfocused message, little or no paid media and/or low levels of enforcement may result in safety belt use decreases.

Table 1

State	Gain '01-'02	Message	Citations*	Paid Media*
West Virginia	19.3 percent	Click It or Ticket	1.7	$135.80
Vermont	17.5 percent	Click It or Ticket	2.1	$324.15
Washington**	10.0 percent	Click It or Ticket	0.7	$85.35
Arkansas	9.2 percent	Click It or Ticket	1.2	$128.70
Hawaii	7.9 percent	Click It or Ticket	3.6	$95.47
Rhode Island	7.6 percent	Click It or Ticket	0.9	$27.56
Puerto Rico***	7.4 percent	Si Lo No Usas, No Hay Escusas	10.9	$9.19

Table 2

State	Loss '01-'02	Message	Citations*	Paid Media*
Massachusetts	-5.0 percent	Please Buckle It's the Law	0.7	$0
South Carolina	-3.3 percent	Fasten For Life	0.9	$75.57
Wisconsin	-2.6 percent**	Click It Why Risk It	Not reported	$93.88
Georgia****	-2.0 percent	Click It or Ticket	3.4	$67.30
Virginia	-1.9 percent	Buckle Up Now Virginia	0.4	$14.29
Tennessee****	-1.6 percent	Click It or Ticket	1.1	$35.35
Alabama****	-0.7 percent	Click It or Ticket	3.1	$59.54

* Citations are given in Tables 1 and 2 as *safety belt tickets per 100,000 residents*. Similarly, Paid Media is expressed as *advertising purchases per 100,000 residents*.

** Washington achieved a 10 percentage point increase with relatively low levels of citations and paid media; however, much of the increase was recorded after the State's new primary law went into effect subsequent to the May mobilization.

*** Puerto Rico's paid media expenditures were noticeably lower than those of other States that recorded substantial belt use increases, although this is explained in part by the fact that media purchases are substantially less expensive in the Commonwealth than on the mainland; in addition, the extremely high level of ticketing appears to have helped boost public awareness of the mobilization.

**** Although Georgia, Tennessee, and Alabama combined the *Click It or Ticket* message with reasonably high levels of enforcement, their lower-than-average media purchases may have kept the message from penetrating as effectively as was desired.

An Additional Benefit of Safety Belt Enforcement

According to the *San Antonio Express-News*, Texas State Trooper Joe Hogue thought he had just another routine *Click It or Ticket* stop underway when he spotted the unbuckled driver of a 2002 Nissan Altima on Interstate 35. Instead, he ended up seizing more than a million dollars. The 59-year-old driver consented to a search of her vehicle, which resulted in Trooper Hogue's discovery of three duffel bags containing $1,440,000.

Indiana's Enforcement Zones—A New Way to Ticket Unbuckled Drivers

Indiana has successfully used enforcement zones to convince unbuckled drivers that they *will* get a ticket. They are a practical alternative tor high visibility enforcement in jurisdictions that don't allow safety belt checkpoints. The concept is as follows:

- Pick a stretch of roadway that has a history of crashes involving unbuckled operators.
- Locate a controlled intersection that has a stop sign or traffic light.
- Station officers, deputies, and troopers at the intersection, and place roadside signage upstream, proclaiming "Enforcement Zone Ahead, *Click It or Ticket*."
- Watch carefully as cars pull up to the intersection, and ticket the unbuckled.

Marion County, Indiana, began pilot-testing Enforcement Zones in 2000. In 2002, they went statewide, with 250 participating law enforcement agencies. Indiana's belt use increased 5 percent over the 2001 level. Enforcement Zones will work anywhere, but Indiana officials strongly recommend that strict guidelines be followed to ensure continuing, maximum effectiveness. These guidelines include:

- Conducting the zones at high-crash and/or low-belt-usage locations.
- Implementing a strong public information and education program.
- Inviting the media to visit the zones to fully inform them why, when, and where the zones are being conducted.
- Stopping only those vehicles in which an officer observes a violation.

Buckle Up New York (BUNY)

Another successful BUNY enforcement wave took place during the *Click It Or Ticket* mobilization in May. All of New York's 572 enforcement agencies committed to participate in the campaign; of the 367 reporting agencies, 275 received funding from the Governor's Traffic Safety Committee and 92 agencies participated and reported even though they received no special funding.

Informal surveys conducted by the New York State Police showed an increase in belt use from a pre-mobilization rate of 85.9 percent to 91.4 percent—the highest use rate ever recorded by the State Police. The State's statewide observation survey (fully compliant with NHTSA's Uniform National Criteria and the Section 157 program) showed belt use increasing from 80 percent to 84.6 percent. In all, 763 checkpoints were conducted statewide, with 3,049 officers working 3,963 hours to support this effort, and 56,554 occupant restraint summonses were issued.

The BUNY campaign used a variety of public information program activities to raise the level of awareness among New Yorkers and increase the perception among motorists that unbelted drivers will be ticketed. These included the influential New York State Broadcasters Association's non-commercial sustaining advertisement (NCSA) program and a limited paid media buy directed at Hispanic cable stations. Another important part of the State's public information outreach was an aggressive earned media campaign that included a press release from the Governor and a tri-State kickoff event at the Empire State Building.

As in the past, in 2002, BUNY promoted safety belt messages to all communities. The campaign was featured at the *African American Family Day* celebration in the capital region, the Hispanic legislators' *Somos El Futuro* conference, and at the many bilingual child safety seat clinics in the State.

Click It or Ticket a Huge Success in West Virginia

Surveys measuring safety belt use before and after the May 2002 *Click It or Ticket* campaign showed an incredible inc. ase in compliance in West Virginia. Before the effort, 52.3 percent of West Virginians wore safety belts. Immediately after the enforcement blitz period, which combined enforcement with public education and paid advertising, 71.6 percent of vehicle occupants were buckling up.

An important key to the success of West Virginia's campaign was the efforts of highway safety office staff to gain support and commitment from the law enforcement community. To this end, staff traveled around the State and held seven regional meetings. Their efforts paid off. Statewide during the two-week enforcement period, officers wrote more safety belt and child passenger safety citations than the combined total for the previous *two years*.

While the role of law enforcement was critical to the success of the campaign, the media component was also vital. People did not necessarily have to receive a ticket to be convinced to buckle up. They saw and heard the *Click It or Ticket* message so often that they perceived they would be ticketed. West Virginia aired the television spot during prime time hours on network and cable channels over 8,000 times during the two-week period. For radio, four different enforcement spots were played over 25,000 times during the blitz.

Three Consecutive Years of *Click It or Ticket* in Florida

Florida developed and implemented a comprehensive action plan for boosting safety belt use since 2000. This plan focuses on the "full implementation model" of *Click It or Ticket*, incorporating the components of leadership, political permission, highly visible enforcement, paid and earned media, diversity outreach, and evaluation. Florida also recruited a Statewide Law Enforcement Coordinator and seven Law Enforcement Liaisons to enroll law enforcement agencies in waves of enforcement across the State.

The Coordinator and the Liaisons also provide leadership to State and local agencies, the media, and private sector groups. A network of 45 Community Traffic Safety Teams, covering over 85 percent of the State's population, was recruited to assist in advancing the *Click It or Ticket* campaign.

As a secondary law State, Florida could not conduct checkpoints. Nevertheless, troopers, deputies and officers remarkably wrote more than 37,000 safety belt citations during the 2002 Memorial Day *Click It or Ticket* campaign and safety belt use increased to an all-time high of 75 percent.

Evaluation of the *Click It or Ticket* Model

Based on the success of the *Click It or Ticket* campaign in Region IV during May 2001, a number of States, as highlighted above, went beyond the typical ABC mobilization and implemented a full *Click It or Ticket* mobilization model that included an intense paid media campaign. NHTSA evaluated the effectiveness of this model making comparisons between "Full Implementation" States, "Other Implementation" States and "Comparison" States [see Table 3]. These groups were defined as follows.

Full Implementation States – Ten States: Alabama, Florida, Illinois, Indiana, Mississippi, Nevada, Texas[1], Vermont, Washington, and West Virginia conducted full implementation campaigns. Each conducted a statewide program employing all elements of the *Click It or Ticket* model including:

- Defined periods of earned media, paid media, and intensive enforcement;
- Paid advertisement placement using *Click It or Ticket* or similar direct enforcement messages;
- Program evaluations involving before-, during-, and after-observation surveys of belt use and surveys of public perceptions of the program.

Among the full implementation States, the amount spent on paid advertising ranged from a low of $200,000 in Vermont to a high of $2,112,921 in Florida.

Other Implementation States – Four States: Colorado, Michigan, Ohio, and Rhode Island conducted campaigns similar to the full implementation States; however, they had limited paid advertisement placement. Among these States, the amount spent on paid advertising ranged from a low of $27,000 in Rhode Island to a high of $650,000 in Michigan.

Comparison States – Four States: Iowa, New York, Oregon, and western Massachusetts. These States conducted campaigns similar to the full implementation States; however, they did not purchase any advertising.

Safety belt use increased 8.6 percentage points averaged across the 10 *Click It or Ticket* model States. There was a 2.7 point increase averaged across the limited paid media States and only 0.5 point safety belt use increase averaged across the States not using direct advertisement placement. Among the Full Implementation group, increases in safety belt use occurred in all 10 States (both primary and secondary with either high- or low-safety-belt-use baselines). Safety belt use increased in three of the four States that had limited paid media and in two of the four comparison States.

[1] The Texas program centered around the 10 largest cities in the state. An estimated 80 percent of the state's population was covered.

Table 3 — Observed Changes in the Safety Belt Use Rate by State

Number of Observed Users	Baseline Usage Rate	Post-Activity Rate	Estimated Change in Usage Rate
Full Implementation	(N=312,172)	(N=324,895)	
AL (116,064)	70.3	78.7	+8.4
FL (60,705)	66.5	75.1	+8.6
IL (69,025)	70.6	74.3	+3.7
IN (39,491)	69.2	72.2	+3.0
MS (218,347)	53.8	61.5	+7.7
NV (40,000)	70.6	76.4	+5.8
TX (30,016)	80.5	86.4	+5.9
VT (19,779)	66.2	84.9	+18.7
WA (12,089)	80.8	89.5	+8.7
WV (31,551)	56.5	71.6	+15.1
Average	**68.5**	**77.1**	**+8.6**
Other Implementation	(N=185,173)	(N=188,857)	
CO (291,450)	72.1	73.2	+1.1
MI (30,248)	82.3	80.0	-2.3
OH (44,240)	64.2	70.3	+6.1
RI (8,092)	62.6	68.6	+6.0
Average	**70.3**	**73.0**	**+2.7**
Comparison	(N=118,761)	(N=122,247)	
IA (23,898)	81.4	83.0	+1.6
NY (175,328)	78.3	82.8	+4.5
OR (36,115)	88.5	87.8	-0.7
West MA (5,667)	60.6	57.2	-3.4

Among the 18 study States, approximately 250,000 safety belt citations were reported during the enforcement period. As Table 4 indicates, the rate of ticketing per resident ranged widely in all three study groups: 9 to 40 per 10,000 residents in Full-implementation States; 5 to 19 in Other-implementation States; and 10 to 36 in Comparison States. Generally, the States with primary safety belt use laws (AL, LA IN, MI, NY, OR, TX) issued tickets at a greater per-resident rate. Highest ticketing rates included Alabama (31), Indiana (40), and Texas (40) among the Full-implementation States; in Comparison States, New York (36) had the highest ticketing rate.

Table 4 — sTEP Wave Enforcement Summary

	Safety Belt Citations	Tickets per 10,000 Residents
Full Implementation		
AL	13,664	31
FL	37,063	23
IL	22,073	18
IN	24,697	40
MS	2,486	9
NV	3,570	17
TX (Ten Largest Cities)	27,260	40
VT	1,304	21
WA	5,505	9
WV	3,104	17
Other Implementation		
CO	3,026	7
MI	5,463	5
OH	21,790	19
RI	1,301	12
Comparison		
IA	3,033	10
NY	9,034	36
OR	5,745	17
West MA	818	24

Educating The Public Through Partnerships

The success of the *Buckle Up America* campaign has depended on the hard work and dedication of hundreds of partners in both the government and the private sector. The following are just some of the highlights of the outreach activities conducted by our many partners. This section is by no means a complete listing of all the organizations that have played an important role in the far-reaching impact of this campaign.

Federal Initiatives

NHTSA works with agencies outside the U.S. Department of Transportation, along with those within the Department, to promote the *Buckle Up America* campaign. These agencies use internal and external communications channels—newsletters, Web postings, e-mails, posters, and signs—to deliver messages to their employees and customers about safety belt and child safety seat use. Highlights of some of the activities that agencies within the U.S. Department of Transportation have undertaken are presented below. These highlights are followed by samples of support undertaken by other Federal agencies.

The U.S. Department of Transportation's Intermodal Support for the *Buckle Up America* Campaign

A department-wide Intermodal Safety Belt Team facilitates communication about the *Buckle Up America* campaign to promote the use of safety belts among all Department employees and their customers. Throughout the year, the team promoted *Buckle Up America* Week and the *Click It or Ticket* campaigns, the BUA planner, and the BUA Web site. The following highlights provide examples of the types of activities undertaken.

In preparation for BUA Week/CIOT and the July 4th Impaired Driving mobilization, messages were included on earnings and leave statements, 10 different messages were displayed on closed-circuit TV in the Headquarters building, articles were printed in NHTSA Now, and BUA graphics for the headquarters electronic message boards were displayed.

The Office of the Inspector General (OIG) sent an e-mail message about BUA Week to all OIG employees. The message, which emphasized the *Click It or Ticket* campaign, was also posted on the OIG intranet site.

NHTSA staff participated in the implementation of a DOT Worklife Wellness Health Fair held at the Headquarters' plaza. They conducted demonstrations on the correct use of child safety seats and hosted a traffic safety information exhibit. DOT employees asked questions about car seat safety; parents and grandparents took home games on traffic safety for children; and cyclists and motorcyclists picked up safety information. NHTSA Region III facilitated participation by the Washington, DC, Metro Police Department which helped answer questions about safety belt use and child passenger safety.

Representatives from NHTSA, NTSB, and Health and Human Services jointly chair a Low-income Child Passenger Safety Working Group. The group includes representatives from the Indian Health Service, Agency for Families and Children, Center for Medicaid and Medicare Services, CDC, and others.

The group developed an action plan on child passenger safety for the President's Task Force on Protecting Children from Environmental and Health Safety Risks. NHTSA staff participated at the Senior Staff Planning Committee of the Task Force to present the plan.

Additional Federal Agencies Supporting the *Buckle Up America* Campaign

NHTSA continues to work with Federal agencies in addition to the Department of Transportation to promote the *Buckle Up America* campaign. The following agencies continued to support the campaign during 2002:

Department of Defense (DOD)—DOD continues to work with NHTSA on all aspects of motor vehicle safety. DOD safety office distributed information about BUA Week and *Click It or Ticket* to the safety offices of each branch of the military.

Department of Labor (DOL)—DOL set up a BUA Week display in its Headquarters lobby.

Department of Housing and Urban Development (HUD)—At the request of HUD Secretary Martinez, NHTSA staff conducted a child passenger safety presentation and exhibited materials at HUD's 4th National Conference on Resident Involvement in Crime Prevention in San Francisco, California. (This request stemmed from the need to educate residents in public housing about child passenger safety.)

Occupational Safety and Health Administration (OSHA)—OSHA began working with NHTSA on the development of a model safety belt program for businesses. NHTSA provided OSHA staff with an overview of CIOT, a safety belt fact sheet, sample safety belt policy, employer checklist for traffic safety, sample employer materials, and information about NETS. As part of the program, OSHA plans to establish a link to the NHTSA web site, co-publish employer traffic safety materials, and post these materials and other information about key traffic safety initiatives on the OSHA web site.

Also participating:

- Centers for Disease Control and Prevention
- Central Intelligence Agency
- Department of Health and Human Services
- Department of the Air Force
- Department of the Army
- Department of Labor
- Department of the Navy
- Department of State
- Department of Veterans Affairs
- Export-Import Bank
- Indian Health Service
- National Aeronautics and Space Administration
- Nuclear Regulatory Commission
- Office of Personnel Management
- Smithsonian Institution
- Social Security Administration
- Tennessee Valley Authority
- The Undersecretary of Defense
- United States Marine Corps
- United States Soldiers' and Airmen's Home
- United States Agency for International Development

Activities Of Private Organizations

SEATCHECK Child Safety Seat Inspection Locator Service Launched

DaimlerChrysler Corporation launched the first nationwide toll-free hotline (1-866- SEAT-CHECK) dedicated exclusively to directing parents to local car seat inspection resources. The hotline is part of a new campaign to aggressively promote the need for safety seat inspections. The company also created a new Web site (www.seatcheck.org) to complement the hotline and to provide child passenger safety seat educational materials that can be downloaded easily.

Motor Carrier Support for *Click It Or Ticket*

Landstar, a national motor carrier company, posted *Click It Or Ticket* campaign advertisements on 2,000 newly manufactured 53-foot tractor-trailers. These tractor-trailers will carry the *Click It Or Ticket* message throughout all 50 States, Canada, and Mexico. Landstar also conducted in-house training programs on the importance of safety belt use.

Keeping BUA on the Road

The American Trucking Association worked with NHTSA to distribute information about the BUA campaign to its State trucking associations.

Research on Safety Belt Use Behavior

State Farm Insurance Company awarded a $10 million grant to Meharry Medical College. The resources will enable Meharry to examine the factors that may contribute to low safety belt use rates among African American populations and develop ways to increase African American safety belt use.

Buckling Up in Hispanic Communities

The Nationwide Insurance Company, along with NHTSA, funded development of a Spanish-language campaign, *Corazón de mi vida* to make buckling up a habit for Latino parents and their children. The National Latino Children's Institute (NLCI) developed the campaign, which means, "You are the center of my life." During 2002, the NLCI promoted the campaign in selected cities in New York and North Carolina.

WHALE Program Expanded

The American Society for Directors of Volunteer Services (ASDVS), working with the Greater Federation of Women's Clubs (GFWC), finalized the child safety seat identification component of its WHALE (We Have A Little Emergency) program. The program will be distributed through certified child passenger safety technicians, law enforcement agencies, emergency medical services professionals, and the members of both ASDVS and GFWC.

Youth Outreach Continues

Members of the National Organizations for Youth Safety (NOYS) and NHTSA jointly conducted a workshop at the Annual School Health Conference of the American School Health Association. Titled "Youth Saving Youth: America's Youth Leading the Way in Preventing Teen Deaths," the workshop focused on strategies for reducing the toll of motor-vehicle-related injuries and deaths. The NOYS youth presenters discussed the need to involve young people in problem identification and the development of solutions.

Buckle Up and Smile for Life

In 2002, the National Dental Association (NDA) launched its first community education program, titled "Buckle Up and Smile for Life." All 70 NDA societies were encouraged to undertake community outreach activities during the months of February and April—February being Dental Health and Black History Month, and April being National Minority Health Month. As part of the campaign, NDA distributed its brochure, "Leading the Way, Lighting the Future— Buckle Up and Smile For Life," at its 89th annual convention in Dallas, TX.

Activities Of Health-Related Organizations

Ongoing Child Passenger Safety Inspections

Members of the Air Surface Transport Nurses Association (ASTNA) in Charlottesville, VA - partnering with local police, firefighters, EMS workers and the University of Virginia Health System - established an on-going program to conduct monthly child passenger safety inspections. Funds from a NHTSA mini-grant, along with private funding, allowed the nurses to purchase a trailer to store the supplies and materials necessary for conducting the checkpoints. At their first checkpoint event on February 16, 2002, during National Child Passenger Safety Week, they installed 164 seats, noted an 85 percent misuse rate of child safety seats, and gave away 22 new seats.

Healthy Mothers and Babies Buckle Up

In 2002, the National Healthy Mothers Healthy Babies Coalition adopted child passenger safety as one of its core focus areas for the next five years.

Permanent Inspection Stations at Hospitals

The American Hospital Association's Society for Hospital Strategy and Market Development received over 50 applications for 10-15 mini-grants to establish CPS fitting stations at hospitals. Awardees were announced during CPS week. Grant recipients include the following organizations: Adirondack Medical Center, Saranac Lake, NY; Baystate Medical Center, Springfield, MA; Grinnell Regional Medical Center, Grinnell, IA; Hennepin County Medical Center, Minneapolis, MN; Jefferson Regional Medical Center, Pine Bluff, AR; Lutheran Children's Hospital, Fort Wayne, IN; Mercy San Juan Medical Center/Catholic Health Care West, Carmichael, CA; Mount Clemens General Hospital, Mt. Clemens, MI; Northeast Alabama Regional Medical Center, Anniston, AL; Peninsula Regional Medical Center, Salisbury, MD; Pleasant Valley Hospital, Point Pleasant, WV; St. Vincent Hospital, Center for Childhood Safety, Green Bay, WI; Vanderbilt Children's Hospital, Nashville, TN; Wake Forest University Baptist Medical Center, Winston-Salem, NC; and Watertown Area Health Services, Watertown, WI. The total amount to be awarded is $37,795. Individual grants range from $500 to $3,500.

Emergency Nurse Association (ENA) and Emergency Nurses CARE, Inc. (ENCARE) Support ABC Mobilizations

ENA/ENCARE nurses helped conduct car seat checkpoints and educated parents about the use of child safety restraints during both ABC mobilizations. They also presented information in schools and partnered with law enforcement to educate communities on the dangers of drinking and driving.

Spanish-Speaking Spokespersons for Child Passenger Safety Week

During CPS Week the National Hispanic Medical Association (NHMA) provided media-markets for Spanish-speaking audiences.

Outreach to African American Communities

The National Medical Association developed and distributed community outreach kits on safety belts and child passenger safety to its members. The Association also continued its work with the International Center for Injury Prevention, Heart to Heart, and the National Football League by providing speakers at events directed at African American youth.

Activities Of Faith-based Organizations

Safety on Sundays

The Congress of National Black Churches (CNBC) conducted a demonstration project, "Safety On Sunday," to develop a model program for church leaders to promote occupant protection. The project engaged church leadership in the planning and implementation of church-based child safety seat clinics, safety belt checkpoints, and traffic safety forums for teens.

CNBC Florida

CNBC provided the *Buckle Up America* Faith Leader's Guide and other traffic safety resources to attendees at the Annual Women in Ministry Conference of its Florida affiliate. The Director of CNBC's National Health Program also presented findings from the Safety on Sunday demonstration project, which resulted in more than a 50-percent increase in occupant protection usage rates.

CNBC Kentucky

CNBC's Kentucky affiliate in partnership with the Kentucky Organ Donor Association hosted the third annual Health and Wholeness Conference at the Pleasant Green Missionary Baptist Church. Approximately 100 clergy and lay leaders participated. CNBC provided the *Buckle Up America* Faith Leader's Guide and other traffic safety resources to attendees.

A New Faith-based Partner

The National Alliance of Baptist Churches joined NHTSA's Faith Outreach Initiative. The Alliance serves more than 140 Baptist congregations in 24 States across the country. NHTSA set up an exhibit at the Alliances national faith leadership conference in Winston Salem, NC, and distributed *Buckle Up America* and Child Passenger Safety information.

Outreach To Diverse Populations

Give Kids a Head Start

Meharry Medical College pilot-tested its occupant protection project with the Head Start Program in Nashville, TN. The purpose of the project is to measure the effectiveness of an occupant protection educational intervention designed for parents of Head Start children. The educational intervention includes workshops on the proper use of child passenger and adult occupant restraints. Based on the success of the pilot program, Meharry plans to expand the project nationally with the National Head Start Association.

Continued Council Support for BUA

At its national convention, the National Council of Negro Women (NCNW) passed a resolution supporting the *Buckle Up America* and Impaired Driving Prevention campaigns. The resolution asked all NCNW sections and chapters of its national affiliates to become involved in safety belt and child safety seat activities in their local communities. After attending the Buckle Up workshop during the convention, representatives from California, New Jersey, Mississippi, and other affiliates expressed interest in working with NHTSA to improve safety belt and child safety seat use within the African American community.

BUA at the Local Level

The Alpha Kappa Alpha Sorority (AKA) received a $50,000 grant to continue the promotion of safety belt use in the African American community. The sorority will use most of the grant monies to provide $200 mini-grants to its 200 chapters. The purpose of the mini-grants is to generate enthusiasm and creativity in customizing BUA campaign materials and activities for local community outreach programs.

Strap It On!

Black Entertainment Television (BET) and Jack & Jill of America (JJA), with support from NHTSA, conducted a series of high school and college traffic safety forums across the country. The forums were aired live on BET's *Teen Summit* program before an estimated 6 million teen viewers. BET's celebrity talk show hosts, along with youth leaders, facilitated the forums, which included special panels of experts from the fields of law enforcement and emergency medicine. The forums were taped and an educational video, titled *Strap It On*, was developed.

Community Coalitions for BUA

The National Conference of Black Mayors (NCBM), with support from NHTSA, launched a new initiative—the Community Involvement Project to Increase Safety Belt Use in High-Risk Populations. The purpose of the initiative is to develop community coalitions that will reach high-risk populations with effective measures to increase safety belt use. The initiative was implemented through the provision of mini-grants to local organizations in selected cities.

More Support for CPS

The National Black Child Development Institute (NBCDI) became a new BUA partner in 2002. To support its emphasis on young children, it implemented a community-based Child Passenger Safety Training Initiative. The initiative provided training and awareness activities on occupant protection to daycare providers, elementary school educators, physicians, and parents in 23 States, as part of November's *Buckle Up America* mobilization.

A Habit for Life

Jack & Jill of America (JJA) unveiled its new national safety belt campaign, *A Habit For Life*, to help increase child seat and safety belt use rates among African American families. To promote the campaign, JJA provided mini-grants to 237 chapters in 37 States. Chapter members promoted BUA messages at daycare centers, beauty salons, car washes, and other non-traditional venues frequented by African American families with small children and teens. These activities took place during the November ABC mobilization.

Outreach to Rural Populations

The National Rural Health Association continued its support for BUA through its "Partners for Rural Traffic Safety" initiative. The association also published an article and photo from one of its occupant protection project activities in the May issue of the Minnesota Rural Health Association's newsletter.

Funds Supporting The *Buckle Up America* Campaign

The Transportation Equity Act for the 21st Century (TEA-21) (Public Law 105-178) was signed into law on June 9, 1998. In addition to providing funding for improving America's roadways, bridges, and transit systems, this comprehensive legislation provides funding for increasing safety belt and child safety seat use.

SECTION 402: Section 402 of TEA-21 provides funds to States and communities to reduce traffic crashes and resulting deaths, injuries, and property damage. A State may use these grant funds only for highway safety purposes; at least 40 percent of these funds must be used to address local traffic safety problems, including restraint use.

A State is eligible for Section 402 grants by submitting a Performance Plan, which establishes goals and performance measures to improve highway safety in the State, and a Highway Safety Plan, which describes activities to achieve those goals. Section 402 grants are calculated by using the following formula:

1. Seventy-five percent of the grant amount is based on the ratio of the State's population in the latest Federal census to the total population in all States.
2. Twenty-five percent of the grant amount is based on the ratio of the public road miles in the State to the total public road miles in all States.

SECTION 403: Section 403 under 23 U.S.C. funds demonstration grants (in addition to other programs) to develop new approaches and strategies to reduce motor-vehicle-related deaths and injuries (see Table 5).

Under Section 403 during FY 2002, NHTSA provided continued funding for a variety of ongoing, previously-awarded grant programs to reach high-risk groups who continue to ride unbuckled, including young drivers, rural residents, sport utility vehicle (SUV) drivers, pickup truck drivers, and ethnically diverse populations. Section 403 funds were also used to target occupant protection messages and activities to teens, rural populations, diverse populations, children, parents, and caregivers.

SECTION 405: Section 405 of TEA-21 created a new incentive grant program to increase the use of safety belts and child safety seats by encouraging States to adopt more effective laws, stronger penalties, and highly visible enforcement and education programs. To qualify for a Section 405 occupant protection incentive grant, a State must demonstrate that it has implemented at least four of the following six criteria:

1. A safety belt law that applies to:
   a. All front-seat passengers in all passenger motor vehicles (including cars, pickups, vans, minivans, and SUVs) in FYs 1999 and 2000.
   b. All passengers in all passenger motor vehicles beginning in FY 2001.
2. A standard safety belt law, which allows police to stop vehicles and issue citations based solely on noncompliance with the State's safety belt use law.
3. A minimum fine of $25 or one or more penalty points on the driver's license of an individual for a violation of the State's safety belt use and child passenger protection laws.
4. A Selective Traffic Enforcement Program (sTEP) that covers at least 70 percent of the State's population and combines intensified enforcement, public education, and publicity efforts to increase safety belt and child safety seat use.
5. A comprehensive statewide child passenger protection education program that includes:
   a. Public information efforts about seating children correctly in airbag-equipped vehicles, the importance of restraint use, and instruction on how to reduce the improper use of child restraint systems. These efforts must reach at least 70 percent of the State's population.

b. Child passenger safety training and retraining for key personnel.

c. Child safety seat clinics covering at least 70 percent of the State's target population.

6. A child restraint law that covers all children younger than 16 years of age in all seating positions in all passenger motor vehicles.

SECTION 157: Section 157 of TEA-21 created a program to encourage States to increase their safety belt use rates in recognition that increased safety belt use decreases crash injuries and the financial burden these preventable injuries place on Federal programs. Funds are allocated to eligible States based on estimated savings in medical costs to the Federal Government due to improved safety belt use. A State is eligible for allocated funds in a fiscal year if either of the following conditions is met:

1. Its safety belt use rate for the past two calendar years exceeds the national average safety belt use rate (national average).

2. Its safety belt use rate in the previous calendar year exceeds the highest safety belt use rate the State has achieved for any earlier calendar year beginning in 1996 (its base rate).

A State may not receive allocations under both conditions in a single year. A State may receive an allocation under the base condition only if it fails to meet the national average condition. States must submit safety belt survey information for each calendar year covered by the program to NHTSA for evaluation. The survey information must measure safety belt use rates according to uniform criteria established by NHTSA to ensure accurate and representative measurements. (The national average safety belt use rate will be calculated by NHTSA each year.)

The Act also provides that Section 157 funds not allocated in incentive grants in a fiscal year be allocated to the States to carry out innovative projects to promote increased safety belt use rates. NHTSA established criteria for the selection of State plans to receive allocations, ensuring, to the maximum extent practicable, demographic and geographic diversity and a diversity of safety belt use rates among the States selected for allocations. Subject to the availability of funds, TEA-21 provides that the minimum grant amount for each State plan is $100,000.

SECTION 2003(b): Section 2003(b) of TEA-21 authorizes funds to implement a new child passenger protection program that is designed to prevent deaths and injuries to children, educate the public concerning the proper installation of child restraints, and train child passenger safety personnel concerning child restraint use. A State may use these grant funds only to carry out child passenger protection education and training programs.

TEA-21 funding provided to States and Territories during FY 2002 is presented in Table 5.

Congress Directs Funding of Community Grants to Increase Safety Belt Use

In FY 2002, Congress directed NHTSA to allocate funds for a second year for the implementation of innovative community demonstration programs to reach high-risk groups, such as youth, ages 15 to 24, males, pickup truck drivers, rural populations, minorities, and drivers who speed and/or drink while driving.

To be considered for a grant award, a community had to demonstrate that it had a significant high-risk population and stipulate that it was willing to conduct high-visibility enforcement programs to increase safety belt use. NHTSA awarded grants of up to $50,000 to municipal, county, and other local government entities in September 2002 for programs to be developed and implemented during the 12 months following the award. Communities receiving grants and grant amounts are shown in Table 6.

Table 5 — TEA-21 Highway Safety Funding, FY 2002

State	Section 402 Formula	Section 157 Seat Belt Use Incentive	Section 157 Seat Belt Use Innovative	Section 2003b Child OP Education	Section 405 Occupant Protection	TOTAL FY 2002
Alabama	2,585,517	1,346,400	752,147	129,120	363,821	5,177,005
Alaska	760,000	6,000	365,250	37,954	104,725	1,273,929
Arizona	2,490,055	402,300	534,178	124,353	0	3,550,886
Arkansas	1,930,364	0	488,522	96,402	0	2,515,288
California	14,634,213	14,835,900	3,918,588	730,829	2,017,390	36,156,920
Colorado	2,447,411	0	566,137	122,223	0	3,135,771
Connecticut	1,507,648	616,200	410,906	75,292	224,982	2,835,028
Delaware	760,000	42,500	365,250	37,954	0	1,205,704
D.C.	760,000	182,000	365,250	37,954	104,723	1,449,927
Florida	7,248,495	1,255,600	2,832,544	361,988	928,064	12,626,691
Georgia	4,218,235	344,200	986,175	210,658	534,203	6,293,471
Hawaii	760,000	257,800	365,250	37,954	104,723	1,525,727
Idaho	927,137	24,200	365,250	46,301	0	1,362,888
Illinois	6,071,318	2,023,700	1,713,403	303,200	867,072	10,978,693
Indiana	3,210,260	58,300	1,550,509	160,320	454,036	5,433,425
Iowa	2,173,149	571,600	570,703	108,527	312,266	3,736,245
Kansas	2,276,174	0	588,966	113,672	0	2,978,812
Kentucky	2,290,596	174,500	584,400	114,392	316,317	3,480,205
Louisiana	2,286,059	238,400	611,794	114,165	332,124	3,582,542
Maine	760,000	0	0	37,954	104,723	902,677
Maryland	2,327,082	2,754,400	602,662	116,214	327,080	6,127,438
Massachusetts	2,778,109	0	748,762	138,738	403,116	4,068,725
Michigan	4,961,927	5,205,900	1,514,900	247,798	712,627	12,643,152
Minnesota	3,116,900	113,600	794,419	155,657	0	4,180,576
Mississippi	1,774,969	0	456,562	88,642	0	2,320,173
Missouri	3,293,322	1,320,700	858,337	164,468	0	5,636,827
Montana	988,214	89,400	365,250	49,351	137,405	1,629,620
Nebraska	1,514,189	205,800	392,644	75,618	214,263	2,402,514
Nevada	1,120,667	440,800	630,250	55,966	0	2,247,683
New Hampshire	760,000	0	365,250	37,954	0	1,163,204
New Jersey	3,582,701	4,237,200	940,519	178,919	512,985	9,452,324
New Mexico	1,253,867	977,900	365,250	62,618	170,119	2,829,754
New York	8,369,932	2,929,800	2,259,984	417,993	1,231,333	15,209,042
North Carolina	4,027,888	3,198,600	967,912	201,152	524,760	8,920,312
North Dakota	1,044,422	0	365,250	52,158	0	1,461,830
Ohio	5,462,510	256,100	1,629,262	272,797	0	7,620,669

Table 5 — TEA-21 Highway Safety Funding, FY 2002 (continued)

State	Section 402 Formula	Section 157 Seat Belt Use Incentive	Section 157 Seat Belt Use Innovative	Section 2003b Child OP Education	Section 405 Occupant Protection	TOTAL FY 2002
Oklahoma	2,368,944	792,300	611,794	118,305	0	3,891,343
Oregon	1,937,206	1,042,500	474,825	96,744	279,386	3,830,661
Pennsylvania	5,845,703	371,400	1,597,969	291,933	0	8,107,005
Rhode Island	760,000	0	365,250	37,954	104,723	1,267,927
South Carolina	2,147,215	1,028,500	538,744	107,231	0	3,821,690
South Dakota	1,059,101	0	365,250	0	0	1,424,351
Tennessee	3,002,179	0	744,197	149,928	0	3,896,304
Texas	10,825,339	4,112,100	3,870,709	540,615	1,406,378	20,755,141
Utah	1,247,749	590,300	365,250	62,312	156,740	2,422,351
Vermont	760,000	0	565,250	37,954	104,723	1,467,927
Virginia	3,382,498	0	853,772	168,921	462,636	4,867,827
Washington	3,015,077	2,208,900	980,500	150,572	396,346	6,751,395
West Virginia	1,041,505	0	615,250	52,013	0	1,708,768
Wisconsin	3,105,680	60,400	803,550	155,097	0	4,124,727
Wyoming	760,000	133,900	0	0	0	893,900
Puerto Rico	1,608,474	605,800	424,603	80,327	231,487	2,950,691
BIA	1,140,000	0	0	56,931	0	1,196,931
Am. Samoa	380,000	0	0	18,977	0	398,977
Guam	380,000	0	0	18,977	0	398,977
N. Marianas	380,000	0	0	18,977	52,362	451,339
Virgin Islands	380,000	0	0	18,977	52,362	451,339
TOTAL	**152,000,000**	**55,075,900**	**44,369,348**	**7,500,000**	**14,250,000**	**273,195,248**

Category	Expenditure
Program Development and Demonstration Grants	$6,315,165
Public Information and Education	$4,094,530
Child Passenger Safety	$2,543,305
Total	**$12,953,000***

*Amount for FY 2002 includes $1 million in funds directed by Congress for implementation of community demonstration programs to reach high-risk groups (such as minorities, younger drivers and the occasional safety belt user), and $1 million to increase local efforts to boost safety belt usage rates in their jurisdictions.

Table 7 — FY 2000 Section 403 Occupant Protection Budget

Site Location by NHTSA Region	Award Amounts	Site Location by NHTSA Region	Award Amounts
Region 1 Rutland, VT	$50,000	Region 6 Lake Charles, LA	$50,000
Region 2 Atlantic, NJ	$50,000	Region 7 Overland Park, KS	$50,000
Region 3 Allentown, PA	$50,000	Region 8 Pueblo, CO Greeley, CO Minot, ND Aberdeen, SD	$49,666 $25,000 (continuation) $49,932 $50,000
Region 4 Albany, GA	$50,000	Region 9 Wailuki, HI Hilo, HI	$50,000 $50,000
Region 5 Chicago Heights, IL Bellwood, IL Moorhead, MN	$50,000 $50,000 $50,000	Region 10 Twin Falls, ID	$50,000

Future Plans And Activities

Under NHTSA's leadership, a majority of the 50 States conducted Statewide observational surveys of safety belt use in June 2002 to capture the impact of their contributions to the May 2002 *Operation ABC* and *Click It or Ticket* Mobilizations. Results from the Mobilizations indicate that the targeted States made impressive gains in safety belt use and that there is positive momentum across the country due to these campaigns. Impact data from these campaigns will be more thoroughly reviewed in the *Buckle Up America Seventh Report to Congress and Fifth Report to the President*, which will cover campaign activities from January 1, 2003, through December 31, 2003.

Program Coordination

Where feasible, NHTSA will plan and conduct nationwide observances, educational efforts and high-visibility law enforcement activities that support the objectives of both the occupant protection program and NHTSA's impaired driving prevention efforts. By pairing complementary efforts, NHTSA and its partners in both program areas will maximize limited resources, boost overall program coordination and avoid unnecessary overlap and duplication of effort. In addition, this team approach should prove beneficial to the impaired driving effort, which saw an increase of less than one percentage point in alcohol-related fatalities in 2002.

Legislation

Because of restrictions that were established under TEA-21, NHTSA is not permitted to urge State or local legislators to favor or oppose specific pending State or local legislation, including safety belt use legislation. However, NHTSA will continue to provide technical support as needed, such as by developing and making available legislative fact sheets and tracking ongoing legislative activities in States regarding occupant protection laws. NHTSA also will continue to provide expert testimony on the benefits of primary occupant protection legislation when it receives a proper request to do so.

NHTSA will also continue to track States' efforts to strengthen their child restraint laws, through the elimination of gaps in those laws and by increasing coverage for older child passengers. In keeping with the agency's updated best practice recommendation for booster seat use (issued in June 2002), NHTSA will closely monitor State legislative developments requiring the use of booster seats by children less than 8-years-old or 4 feet 9 inches tall.

Law Enforcement Activities

NHTSA will continue to strongly support the bi-annual *Operation ABC* Mobilizations. As in 2002, NHTSA will again dedicate much of the FY 2003 Section 157 innovative grant funding to the nationwide implementation of the successful *Click It or Ticket* model during the May 2003 and November 2003 mobilizations. These funds will be used by the States to purchase advertising in key media markets to support high-visibility enforcement activities. In addition, for the first time, Congress authorized NHTSA to purchase advertising promoting the *Click It Or Ticket* messaging on prominent national networks to be broadcast nationwide in conjunction with the May 2003 Mobilization.

The agency will dedicate other available funding to further evaluate the effectiveness of the mobilizations. The States will also conduct evaluations of their efforts to gauge the impact of the mobilizations on local safety belt usage rates. NHTSA also will provide technical assistance to the States and will encourage them to purchase broadcast time and print space (using funds from other sources) to enhance their media campaigns during the mobilizations.

Outreach and Partnerships

In 2003, NHTSA funded innovative community demonstration programs to increase safety belt and child restraint use among diverse populations and those with historically lower than average safety belt use rates and higher fatality rates – such as African Americans, Hispanics, Native Americans

residents of rural communities, youth and residents of States with secondary enforcement safety belt laws. The agency also continued to work with a number of prominent not-for-profit organizations to organize and conduct community-based public information and education programs that support law enforcement initiatives.

NHTSA began its implementation of the five-year strategic booster seat education plan during FY 2003, a key component of which was the awarding of a three-year community demonstration program to determine effective ways to increase booster seat use at the local level. Innovative public education and public awareness efforts, including the agency's longstanding occupant protection contract with the Advertising Council, was also be developed.

NHTSA plans to work during 2003 with the Governors Highway Safety Association to create an organized Occupant Protection for Children Assessment Program. The program, which will be designed for implementation by the States, will be an invaluable tool to strategically plan and manage the human and material resources necessary to ensure an effective statewide child passenger safety program addressing the needs of all children.

NHTSA will continue to refine the NHTSA Standardized Child Passenger Safety Training Program, managed jointly by NHTSA and the American Automobile Association. This 32-hour program, through which more than 30,000 people have been trained since its creation in the late 1990s, ensures that currently-certified, trained instructors and technicians are available in communities nationwide to help parents and caregivers with correct child safety seat installation. These individuals also disseminate accurate and consistent information about child passenger safety to the general public.

NHTSA will also oversee the development and distribution of targeted, shorter-term, non-certification child passenger safety curricula. These alternative programs are designed to stimulate increased participation of key constituency groups in the child passenger safety arena, including child care providers, nursing professionals and the law enforcement community. The curricula will be developed in conjunction with key organizations serving these groups, including, respectively, the American Academy of Pediatrics, the Emergency Nurses Association (ENA), and the International Association of Chiefs of Police.

In 2003, NHTSA expanded its five-year occupant protection partnership with the National Automobile Dealers Association (NADA), formally established in June 2002, to other key traffic safety areas. The initial focus of the partnership is on increasing the use of booster seats among older child passengers. NADA is making resources available to its member dealerships to sponsor and support local child passenger safety activities at the dealership level.

Public Information and Education

In 2003 NHTSA continued to develop public information and education materials and to provide outreach and technical assistance to the States and agency partners. The agency currently plans to:

- Acknowledge the sustained and effective leadership provided by leading African American organizations and institutions that has led to steady and demonstrable increases in safety belt use in the African American community.
- Develop innovative media and educational strategies and partnerships to increase safety belt use by teens, rural residents, and part-time safety belt users.
- Support efforts to train and certify more Child Passenger Safety Technicians in diverse and at-risk communities.
- Stimulate the establishment of additional child safety seat fitting and inspection stations around the country.
- Organize news events promoting child safety seat and safety belt use (including culturally appropriate events and materials for diverse populations) during Child Passenger Safety Week in February 2003, the *Operation ABC* Mobilizations in May and November, and at other peak travel times.
- Ensure public awareness and understanding of the agency's rating system for child safety seats, as mandated in the TREAD Act.

- More widely promote NHTSA's *4 Steps For Kids* approach, which seeks to educate consumers about the milestones for when it is safe to transition child passengers to each of the four stages of occupant restraint (rear-facing infant seat, forward-facing toddler seat, booster seat, and adult safety belts).

REUTERS
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U.S. Would Reward States for Tough Seat-Belt Laws

Tue Apr 5, 2005 05:18 PM ET

By John Crawley

WASHINGTON (Reuters) - The Bush administration pressed Congress on Tuesday to approve $600 million in incentives to entice states to adopt tough laws on seat-belt use or otherwise get more motorists to buckle up.

The proposed incentives are a shift from the more-common policy of denying a share of federal highway aid to states that fail to embrace auto-safety initiatives, but some safety advocates question whether they would work and say financial sanctions may be more effective.

"The single most-important safety measure Congress could pass this decade is the proposal to provide incentive grants for states to pass primary belt laws," Jeffrey Runge, the nation's top auto safety regulator, told Senate lawmakers at a Commerce Committee hearing.

Under the administration proposal, a state that adopts a so-called "primary" belt law allowing police to stop and ticket motorists simply for not wearing a seat belt, or one that achieves a belt-use rate of 90 percent for two years in a row, will receive a cash incentive.

The amount would be five times what a state received in federal aid for highway safety in 2003, and total incentive spending could top $600 million over six years. States that already have the tougher laws would also be eligible.

A minority of 21 states, the District of Columbia and Puerto Rico already have such primary seat-belt laws. Elsewhere, with the exception of New Hampshire, which has no mandatory seat-belt law for adults, ticketing for nonuse of seat belts is allowed only if a driver has been stopped for another reason.

Nearly 2,700 lives would be saved in the United States each year by increasing the rate of seat-belt use from a record-high 80 percent in 2004 to 90 percent, regulators say. Every 1 percent increase in the national belt use rate equals 2.8 million more people buckling up.

Sen. Ted Stevens, an Alaska Republican and the commerce panel chairman, told Runge that some incentives appear worthwhile. The committee next week will consider the highway-aid bill, which contains the seat-belt initiative.

Some safety groups believe there are already enough financial incentives for states to pass tougher belt laws -- in the form of potential savings on state health and welfare costs from higher belt use.

These advocates also say incentives usually are insufficient and that sanctions -- threats to withhold a percentage of federal highway construction money -- are the only way to push states into adopting some safety standards.

"Sanctions have worked very well in the past to get uniformity in the states around an issue, primarily on drunk driving," said Judith Stone, president of the pressure group Advocates for Highway and Auto Safety. "You're talking about a lot of money. It's a great motivator."

More than 42,600 people were killed in road crashes in 2003. Preliminary figures for 2004 are due out this spring.

Runge's agency, the National Highway Traffic Safety Administration, found that more than half of all those killed in traffic crashes were not wearing seat belts.

"Although we are seeing improvements in vehicle crash worthiness and crash avoidance technologies, the numbers of fatalities and injuries on our highways remain staggering," Runge, a former emergency room physician, told the committee.

NSC News Center

For Immediate Release, November 17, 2003
Contact: John Chambers at 202.338.8700 or 202.285.0448 (cell)

AS NATIONWIDE SEAT BELT CRACKDOWN BEGINS, NEW DATA UNDERSCORES DEADLY IMPACT OF FAILURE TO ADOPT PRIMARY SEAT BELT LAWS

More than 12,000 Deaths Since 1995 Because States Have Failed To Enact Primary Enforcement Seat Belt Laws Proven To Increase Belt Use

Washington, D.C. - As more than 12,000 law enforcement agencies begin a nationwide crackdown to enforce seat belt and child passenger safety laws this Thanksgiving holiday, a new study shows that more than 12,000 people have needlessly died due to the failure of states to follow a 1995 National Transportation Safety Board recommendation to enact primary enforcement seat belt use laws. Today, the NTSB reissued that call to states.

"A primary seat belt law is likely to save more lives than possibly any single piece of legislation a state will consider," said NTSB Chairman Ellen G. Engleman. "It is why the Safety Board recommended states adopt these laws in 1995, and why we continue to urge enactment of these laws as a safety priority. It is tragic that 30 states have failed to act to implement this safety countermeasure that costs nothing, but could save so many."

Also see:

- Lost Lives by States' (pdf; 182kb)
- Participating Law Enforcement Agencies (MS Word; 135kb)

Primary seat belt laws enable law enforcement officers to ticket motorists based solely on an observed seat belt violation, just as they do any other motor vehicle law. Primary laws cover 60 percent of the U.S. population. Currently, 29 states have secondary laws (New Hampshire does not have an adult seat belt law), which means officers can only enforce the seat belt law if the motorist is first stopped for some other violation such as speeding.

According to the study released today by the National Safety Council, states that have enacted primary laws since 1995 on average experienced a 15-percentage point increase in belt use. Seat belts are proven to reduce the risk of serious injury or death in a crash by 45 percent, and the study shows 12,177 lives have been lost since 1995 because 30 states have failed to enact the stronger laws.

"We have a vaccine for the leading cause of death for Americans from ages two through 33 - safety belts. Primary safety belt laws are our most effective public policy tool," said Jeffrey W. Runge, M.D., Administrator for the National Highway Traffic Safety Administration. "If all states moved right now to enact them, 1,400 more lives could be saved next year alone in preventable traffic injury."

On November 13, 2003, Chairman Engleman on behalf of the NTSB sent a letter to the governors and legislative leadership of the 29 states with secondary laws and New Hampshire, reminding them of the Safety Board's recommendation and encouraging them to step-up their efforts to enact a primary law in their state.

The national Click It or Ticket Mobilization, which runs from November 17 - 30, is based on a public health model proven to increase belt use, and places specific emphasis on teens and young adults who are least likely to buckle up and most likely to die in a traffic crash.

According to NHTSA, nearly 4,530 teens and young adults, ages 16-19, died in traffic crashes last year and thousands more were injured. Of the 32,519 people killed in crashes in 2002, nearly 60 percent were not wearing a safety belt.

If the situation remains the same as in 2002, the study, conducted by Neil K. Chaudhary and David F. Preusser of PRG Research Group, Inc., estimated an additional 1,400 motorists will be killed next year alone. (State-by-state results are available online, at www.nsc.org)

"Law enforcement officers all over this country are doing a great job saving lives through seat belt enforcement, but in 30 states they are doing it with one hand tied behind their back," said Chuck Hurley, Executive Director of the National Safety Council's Air Bag & Seat Belt Safety Campaign. "We would be saving far more lives if state legislators in the states with secondary laws would respond to the overwhelming majority of voters who support primary laws."

A national survey of 800 Americans conducted by Public Opinion Strategies for the Air Bag & Seat Belt Safety Campaign in May, 2003, showed people in states with secondary laws support enactment of primary laws in their states by a 2-to-1 margin.

"It's especially tragic that teens and young adults are suffering the most as a result of this government inaction," added Hurley. This year, Illinois and Delaware became the 19th and 20th states to pass a primary law respectively.

"At the Naval Safety Center, our job is to look out for all our Sailors, Marines, and civilians," said RADM Brooks. "It's our priority to ensure as safe a working environment as possible, to identify the hazards we all face in both our professional and personal lives, to educate everyone in the vital importance of risk management in everything we do, and to improve readiness. Across our force it's up to the leaders of every Navy and Marine Corps command to promote awareness and set the example, for traffic safety truly is a matter of life and death."

During the Mobilization, law enforcement officers will intensify enforcement of seat belt and child passenger safety laws by setting up checkpoints or saturation patrols across the country. Seat belt violators and drivers failing to restrain their child passengers will be ticketed.

Thanksgiving is one of the most dangerous holidays for motorists. The National Safety Council predicts that 544 people will die and 28,300 people will suffer disabling injuries resulting from traffic crashes during the Thanksgiving holiday period.

"Thanksgiving is a joyous holiday for many Americans, but it is also traditionally one of the deadliest on the roadways," said Lynne Goughler, Vice President of Public Policy at Mothers Against Drunk Driving. "Impaired driving and lack of safety belt usage are the leading killers in automobile crashes, especially during the holiday season."

Mobilizations are conducted twice yearly by the Air Bag & Seat Belt Safety Campaign of the National Safety Council in conjunction with law enforcement agencies, state highway safety offices, NHTSA, the National Transportation Safety Board and MADD. Following the Mobilization in May, 2003, national belt use reached a record high of 79 percent, according to NHTSA.

The Air Bag & Seat Belt Safety Campaign, a program of the National Safety Council, is a public/private partnership of automotive manufacturers, insurance companies, child safety seat manufacturers, government agencies, health professionals and child health and safety organizations. The goal of the Campaign is to increase the proper use of safety belts and child safety seats and to inform the public about how to maximize the lifesaving capabilities of air bags while minimizing the risks.

For additional information about the National Safety Council, visit www.nsc.org.

The National Safety Council is a nonprofit, nongovernmental, international public service organization dedicated to protecting life and promoting health. Members of NSC include more than 45,000 businesses, labor organizations, schools, public agencies, private groups and individuals. Founded in 1913, and chartered by the U.S. Congress in 1953, the primary focus of the NSC is preventing injuries in workplaces,

in transportation and in homes and communities.

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National Safety Council
A Membership Organization Dedicated to Protecting Life and Promoting Health
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November 25, 2003

::: ALASKA

Trio of car crashes leaves three men dead

SEAT BELTS: Two could have survived if they were buckled up, authorities say.

By PETER PORCO
Anchorage Daily News

(Published: September 16, 2004)

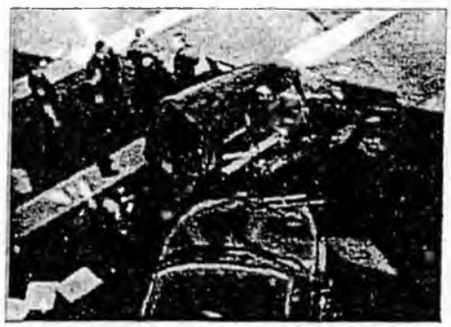
vehicle crashes in Anchorage and Wasilla over a 15-hour period from late Tuesday to Wednesday, and authorities said the use of seat belts probably would have saved two of them.

One wreck was a single-vehicle rollover in Wasilla, another was a head-on on the Hillside and the third was a T-bone collision at a Glenn Highway intersection in Mountain View, according to traffic investigators.

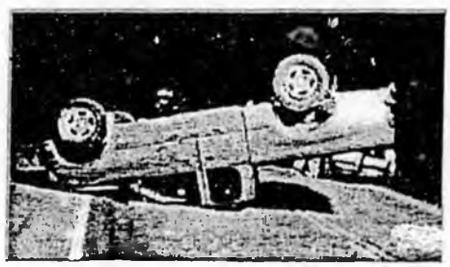
Authorities said the dead were Christian D. Hadley, 33, of Wasilla; Clarence Gerry Banducci, 46, of Anchorage; and Vincent Morrison, 47, also of Anchorage.

A 31-year-old passenger riding with Banducci when the Hillside accident occurred was critically injured, while a mother and two small children in the SUV that Banducci crashed into received minor injuries. No others were hurt.

A dog riding with Morrison was killed



Two vehicles were involved in a fatal accident on the Glenn Highway at Bragaw Street Wednesday afternoon in East Anchorage. *(Photo by Erik Hill / Anchorage Daily News)*



Troopers responded to an accident at Mile 2.5 Pittman Road in Wasilla. An investigation revealed that Christain D. Hadley

a local hospital and treated for non-life-threatening injuries. Reeder credited the belts and an air bag with keeping the injuries to Kroll and her children from being worse.

Police suspect that Banducci and Day had been drinking before the crash, they said.

Police closed O'Malley Road between Our and Elmore roads for four hours after the accident.

The third fatal crash occurred about 12:50 p.m. Wednesday when Morrison, driving a 1988 Jeep Cherokee north on Bragaw Street, drove into the Glenn Highway intersection apparently against the light, Reeder said.

"Witnesses all indicate that the northbound light was red," she said. "For whatever reason -- which we'll never know -- he did not stop."

The Jeep managed to clear the outbound lanes but was struck in the inbound lanes on the passenger side by a large 1999 Dodge pickup.

Morrison was wearing a seat belt, but the collision was too violent for it to help him, Reeder said. The crash crumpled the passenger compartment around the driver, killing him instantly.

"It was such a significant impact, being T-boned by a vehicle doing 55 (mph)," Reeder said.

A German shepherd was thrown from the Jeep and killed, she said.

The driver of the pickup, Brian Devilbiss, 44, of Palmer, was uninjured but "emotionally not fine," Reeder said.

Police closed the inbound lanes of the Glenn between Boniface Parkway and Bragaw for more than four hours.

Daily News reporter Peter Porco can be reached at pporco@adn.com or 257-4582.

The driver of the Kia, in other words, apparently did not stop initially at the intersection as she claimed, the lieutenant said. "Witnesses said she never stopped."

The girl, who was wearing a seat belt, was not injured.

Police did not know if drugs or alcohol were involved, said Reeder.

The intersection where the crash occurred is large and open.

"There are no sight-distance issues at that intersection at all," she said. "It's clear and very clearly lighted. Obviously this collision was caused by reckless behavior."

The police are continuing to investigate the case.

"Certainly it will be looked at and presented to the district attorney's office for a review of (possible) criminal charges," Reeder said.

Daily News reporter Peter Porco can be reached at pporco@adn.com or 257-4582.

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::: ALASKA

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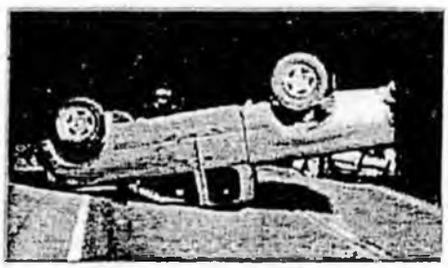
A dog riding with Morrison was killed

Two vehicles were involved in a fatal accident on the Glenn Highway at Bragaw Street Wednesday afternoon in East Anchorage. *(Photo by Erik Hill / Anchorage Daily News)*



Troopers responded to an accident at Mile 2.5 Pittman Road in Wasilla. An investigation revealed that Christain D. Hadley

in the Glenn Highway crash, Anchorage police Lt. Nancy Reeder said.

Hadley and a friend, 24-year-old Michael Melland of Wasilla, had visited a bar early Tuesday evening and then continued drinking at the house of one of the men, according to Alaska State Troopers.

About 10:10 p.m , Hadley was driving a 2002 silver Toyota Tundra north on Pittman Road when he lost control about Mile 2.5, troopers said.

of Wasilla was traveling north in a pickup when he lost control of the vehicle, causing it to roll over. Emergency medical personnel pronounced Hadley dead at the scene. Alcohol is suspected of being a factor in the accident. Hadley was not wearing a seat belt. *(Courtesy of Alaska State Troopers)*

Click on photo to enlarge

"He went on to the shoulder, overcorrected and flipped," troopers spokesman Greg Wilkinson said.

The number of times the pickup flipped was unclear, but the truck, which ended up on its roof, was not badly damaged, Wilkinson said.

Melland was wearing a seat belt and came away without injury, he said. But Hadley was not belted in and was partially ejected and crushed by the pickup, according to the troopers.

"If this guy had a seat belt on, he'd have walked away," Wilkinson said.

Melland had been wanted on a warrant for failing to appear in court on an original charge of driving with a suspended license, and troopers arrested him at the scene, they said.

The Hillside crash occurred shortly after 7 a.m. Wednesday on O'Malley Road, just west of Our Road, according to Anchorage police.

Banducci was driving a 1977 Chevrolet pickup in the westbound lane when he crossed the center line into the path of a 2002 Chevrolet Suburban driven by Elaine Kroll, 36, of Anchorage.

There were no clues that either driver tried to brake, and the two vehicles met head-on, according to police.

Neither Banducci nor his passenger, Rebecca Ann Day, was wearing a seat belt, police said. Banducci struck the steering column with enormous force, said Reeder, chief of the department's traffic unit.

Banducci and Day were taken to Providence Alaska Medical Center, where he died soon after, police said.

Day suffered a "very significant head injury, a torn aorta and a lacerated liver," Reeder said.

Kroll was belted in, and her children, Louis, 5, and John, 2, were strapped into child seats, according to Reeder. They all were taken to

a local hospital and treated for non-life-threatening injuries. Reeder credited the belts and an air bag with keeping the injuries to Kroll and her children from being worse.

Police suspect that Banducci and Day had been drinking before the crash, they said.

Police closed O'Malley Road between Our and Elmore roads for four hours after the accident.

The third fatal crash occurred about 12:50 p.m. Wednesday when Morrison, driving a 1988 Jeep Cherokee north on Bragaw Street, drove into the Glenn Highway intersection apparently against the light, Reeder said.

"Witnesses all indicate that the northbound light was red," she said. "For whatever reason -- which we'll never know -- he did not stop."

The Jeep managed to clear the outbound lanes but was struck in the inbound lanes on the passenger side by a large 1999 Dodge pickup.

Morrison was wearing a seat belt, but the collision was too violent for it to help him, Reeder said. The crash crumpled the passenger compartment around the driver, killing him instantly.

"It was such a significant impact, being T-boned by a vehicle doing 55 (mph)," Reeder said.

A German shepherd was thrown from the Jeep and killed, she said.

The driver of the pickup, Brian Devilbiss, 44, of Palmer, was uninjured but "emotionally not fine," Reeder said.

Police closed the inbound lanes of the Glenn between Boniface Parkway and Bragaw for more than four hours.

Daily News reporter Peter Porco can be reached at pporco@adn.com or 257-4582.

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Anchorage Daily News

Two-vehicle accident kills one, injures two

UNDERAGE: 15-year-old ran a red light, police say.

By PETER PORCO
Anchorage Daily News

(Published: August 7, 2004)

A 23-year-old Anchorage man was killed and two other people were injured early Friday in a two-vehicle collision near Dimond Center after a 15-year-old girl ran a red light, police said.

The teenager was driving alone, against the laws governing her limited learner's license, said Anchorage Lt. Nancy Reeder.

Christopher Mack died in the hospital several hours after the crash, according to the police. He had been driving a 1999 Ford pickup that rolled several times after being struck by a 2002 Kia sedan driven by the girl.

Mack was not wearing a seat belt and was ejected, police said.

Mack's two passengers -- 23-year-old Jennifer Jansen and 22-year-old Ryan William Toney, both of Anchorage -- received relatively minor injuries, Reeder said. Both of them were wearing seat belts, she said.

The Anchorage girl had taken her grandmother's car without the woman's permission, said Reeder. She has an instruction permit, which requires that she be accompanied by a licensed driver age 21 or older, according to the police.

The girl was driving west on Dimond Boulevard about 1:10 a.m. approaching the Old Seward Highway while Mack was heading south on Old Seward and coming up to Dimond, police investigators determined.

The light was red for the Kia and green for the Ford, according to several people who saw the crash.

"The witnesses were all consistent about the colors of the lights," Reeder said.

The girl told police she had first stopped for the light, then continued into the intersection, said Reeder. "She said the light was red, and 'I saw it was clear and thought it was OK to go.'"

The effect of the collision, however, "doesn't sync with her statement," Reeder said.

The Kia T-boned the Ford "with significant enough force to roll that truck -- not once but several times," Reeder said. "Sometimes you can do (that) without a lot of speed, but in this particular collision, speed was involved."

The driver of the Kia, in other words, apparently did not stop initially at the intersection as she claimed, the lieutenant said. "Witnesses said she never stopped."

The girl, who was wearing a seat belt, was not injured.

Police did not know if drugs or alcohol were involved, said Reeder.

The intersection where the crash occurred is large and open.

"There are no sight-distance issues at that intersection at all," she said. "It's clear and very clearly lighted. Obviously this collision was caused by reckless behavior."

The police are continuing to investigate the case.

"Certainly it will be looked at and presented to the district attorney's office for a review of (possible) criminal charges," Reeder said.

Daily News reporter Peter Porco can be reached at pporco@adn.com or 257-4582.

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Minnesota man killed in crash by Knik bridge

ROLLOVER: A teenager, who is unhurt, caused the accident, troopers said.

By ZAZ HOLLANDER
Anchorage Daily News
(Published: August 26, 2004)

PALMER -- A 17-year-old Willow girl changing lanes to make an illegal U-turn apparently caused a fatal rollover on the Glenn Highway, Alaska State Troopers said.

A Minnesota man, 46-year-old Ronald Melbostad, was killed, troopers said.

Bobbi Spain was southbound, driving slower than 65 mph in the right lane, when she moved into the fast lane to get over to an emergency-vehicles-only turn lane, troopers said.

Melbostad's black 1999 GMC pickup was passing Spain in the fast lane, they said.

"She clipped the right rear of the truck, causing it to slide sideways and then roll," trooper Lt. Rick Roberts said.

Alaska State Troopers investigate the scene of a fatal accident Wednesday in the southbound lanes of the Glenn Highway along the Palmer Hay Flats. The white truck at top left clipped the rear end of the black truck, causing it to roll. One person died in the accident. *(Photo by Stephen Nowers / Anchorage Daily News)*

Click on photo to enlarge

Melbostad and another passenger were not wearing seat belts and were thrown from the pickup when the truck rolled, troopers said. Then the pickup caught on fire.

Melbostad sustained massive trauma during the collision and died at the scene, troopers said.

The driver, Melbostad's 22-year-old nephew, Wasilla resident Jeffrey M. Melbostad, was transported to Valley Hospital for treatment of his injuries. Another passenger, 20-year-old Christine Hansen of Wasilla, was also taken to Valley Hospital. Neither was admitted, a nursing supervisor said.

Spain sat with friends in the dry grass along the highway Wednesday afternoon, about 30 minutes after the accident, which occurred at 12:50 p.m. at Mile 33.5 near the Knik River access.

Asked what happened, Spain said, "I was switching lanes and they tried to get in front of me."

She said she wasn't hurt.

A trooper approached and asked her to accompany him to his car.

After the accident, Spain's white 1996 Chevrolet pickup remained in the fast lane, crumpled on the

front driver side.

Ronald Melbostad's body, plainly visible to passing drivers, rested beneath two bath towels at the side of the road. The dark pickup he had been driving rested in the ditch of the median, a charred strip leading from the road.

Mike Crews, driving a water truck under contract to a state construction project, said he helped extinguish the fire that started beneath the pickup. Mat-Su fire crews and volunteers also responded.

The accident snarled traffic for more than a mile, up the Glenn to the new Glenn-Parks Interchange and up the Parks Highway toward Wasilla.

Crews said he sees people driving dangerously on that stretch of the Glenn all the time.

Daily News reporter Zaz Hollander can be reached at 1-907-352-6711 or zhollander@adn.com.

Print Page Close Window

Man dies in crash; girls critically hurt

2003 Juneau-Douglas High School graduate killed in one-car rollover at Mile 32 of Glacier Highway

JUNEAU EMPIRE

Juneau resident Brant Cooper, 19, died Sunday afternoon after the vehicle he was driving collided with a rock wall and rolled upside down near Mile 32 of Glacier Highway.

Cooper was ejected and died at the scene, police said.

Two female passengers, both 17, were medivaced in critical condition to a Seattle hospital. One was ejected from the vehicle, and another was partially ejected. Police would not release their names.

The accident is still under investigation.

"We're investigating the factors at this point, and speed is one of the things we're looking at," Sgt. Kris Sell said.

Reached at their home, Coopers' parents did not wish to comment.

Passing motorists found the wrecked vehicle at about 2:10 p.m. and called police. Four Juneau police cars responded, along with an emergency team from Capital City Fire and Rescue.

BRANT COOPER

Cooper was driving outbound toward the end of the road, police said. Mile 32 is just north of Tee Harbor and about eight miles from the end of the road. At the accident scene, a guardrail is on the water side of the road and the rock wall on the other.

Cooper played trumpet with the Juneau-Douglas High School musicians who traveled to Chicago in March to play at the Heritage Music Festival of Gold.

"He just had a great disposition," JDHS band teacher Ken Guiher said. "If anyone was feeling down or something, he was always trying to cheer them up. He was a neat kid to be around. He was always real positive, and he just worked real hard."

...

Accident occured 10/31/04
Juneau Empire - 11/1/04

Driver wasn't dr.. king before fatal accident

JUNEAU EMPIRE

The 19-year-old driver killed Oct. 30 in a vehicle collision with a rock wall on Glacier Highway wasn't drinking before the accident, police reported Wednesday.

Brant Cooper had no "drugs of abuse" in his system, according to a report from the Alaska State Crime Laboratory, Lt. Jerry Nankervis said.

The autopsy that produced negative tests for alcohol and other drugs also found that Cooper died of "blunt-force trauma."

Two 17-ye.r-old girls riding in the car, Erin Scheidecker and Patricia Brown, were flown to Harborview Medical Center in Seattle after the accident. Their conditions were unavailable.

Cooper reportedly was driving outbound toward the end of the road about 30 miles from downtown when the accident occurred. Police reported the day of the accident that he was ejected from the vehicle. One or both of the pas.ngers also was ejected from the vehicle.

Nankervis said the vehicle was moving sideways when it hit the wall, forcing it to roll upside down.

"Seat belts probably would have helped," he said, noting that injuries were related to being thrown from the vehicle.

He also said speed appeared to be a fact.r, but did not have an estimate as to how fast the vehicle was going.

Nov 25, 2004

adn.com
Anchorage Daily News

Print Page Close Window

Man dies in rollover on Glenn

Daily News staff

(Published: November 25, 2004)

An 88-year-old man died when he and his wife were thrown from their vehicle in an accident Wednesday afternoon on the Glenn Highway near Eureka Summit, Alaska State Troopers said.

Norman Cosgrove was pronounced dead at the scene, troopers said. His wife, Lois Cosgrove, 91, was flown to Alaska Native Medical Center in Anchorage in serious condition. Neither was wearing their seat belts at the time of the wreck, troopers said.

The accident occurred just before 1 p.m. near Mile 134.5 of the highway. Troopers said the couple was in a 2004 GMC pickup when Norman Cosgrove lost control of the truck, careened into the oncoming lane and into a ditch. The pickup rolled twice before coming to rest on its tires.

Print Page Close Window

Home Health a...
Reka Drive, Anchorage ...

Arrangements are with E... ergreen's Eagle River Funeral Home.

ANCHORAGE

Kenneth W. Lane, 46

Lifelong Alaska resident Kenneth W. Lane, 46, died Aug. 16, 2004, at mile 109.5 of the Richardson Highway in Copper Center from injuries sustained in an auto accident.

A service will be at 3 p.m. today at Witzleben's Bragaw Chapel, 1707 S. Bragaw St. Burial will be afterward in Anchorage Memorial Park.

Mr. Lane was born July ... 1958, in Anchorage. He worked as a construction laborer.

His hobbies included visiting with family and friends. His most enjoyable hobby was cutting firewood.

"Kenny adored his mother and tried to visit her as often as he could," his family wrote. "He liked to work on cars, doing body work, carpentry and roofing. He always had a smile on his face and helped out family and friends. He will be greatly missed by all who knew him."

He is survived by his mother, Virginia Kobuk; uncle and aunt, Frank and Leslie Jordan; cousins, Darryl, Robert and Diane Jordan and Donna Acuna; great-uncle, Frank Stickwan; great-aunts, Ina Lincoln and Emma Bell; aunts, Virginia Pete, Delia Renard, Dorothy Locke, Catherine DeWitt, Gloria Stickwan and Mable Murphy; uncles, Phillip, John, Jack and Ewan Sabon; and many cousins and special friends.

Mr. Lane was preceded in death by his grandparents, Edna and Pete Jordan, and great-aunts, Elsie Stickwan and May Jackson Stickwan.

ANCHORAGE

Laasaga Laasaga, 56

...age resident the Re... Laasaga, 56, di... Aug. 5...

My name is Brenda Arney. Until August 25th 2003 I lived in Wasilla with my husband, Robert A. Arney, Sr. I still live in Wasilla, but now I live alone.

Bob and I lived in Wasilla for 17 years. After 23 years with the Municipality of Anchorage, I took early retirement to join Bob, who had previously retired. Bob took a part time job as a janitor at Gottschalks in Wasilla to build up a vacation funds so we could travel, visiting the children, grandchildren and doing Bob's ancestry research. This was our dream.

In mid-summer 2003, Bob was diagnosed with a tumor in his lung. He had surgery at a local hospital in Anchorage on August 19th and we were all relieved to find out they got all of the tumor and his chance for a full recovery was really quite good. I stayed at the hospital all that day, night and the next day, Aug 20th, until late in the evening. Bob was doing very well. I was back the next morning, again staying until late in the evening. I stayed so Bob would feel more at ease and so I could speak with his doctors and nurses as often as possible. We had received good news that day. Pathologist reports showed there was no spread of the cancer. The surgeon was not only elated with this news, but was so impressed with Bob's progress, he advised us Bob would be able to get out of bed the next morning and start exercising on a stationary bicycle. Everything was going well and it looked like Bob would be coming home on his scheduled release date, the 25th.

The next morning at 6:25 a.m. I was contacted by the Anchorage Police Department saying they had Bob. I thought it was a mistake, but it wasn't. A Monitoring Technician and nurses at the hospital who were responsible for taking care of Bob did not do their jobs. They turned the volume down on the monitors and left the floor for a smoke or bathroom break. *Alone and heavily medicated on powerful pain medication,* Bob pulled out his chest tubes, catheters and EKGs and left the hospital, *unseen*, in a hospital gown, opened in back, and barefoot. He was approx. 1 block from the hospital when he knocked on the door of a trailer and asked for help. He was disoriented and cold. In retracing the route, from statements made, I figure Bob most likely traveled 2-3 blocks to get to that trailer.

Three days later Bob died. *His death was caused by the negligence of the hospital and health care providers.* The hospital said they were sorry. They said they have made changes in some policies. They said they would waive some of the hospital bills. But, they cannot bring Bob back.

I would like a jury to know these facts and judge my loss. *Not* the legislature, *not* the hospital and his doctors and *not* an insurance company. Because Bob was retired, his economic damage loss in a medical malpractice lawsuit would be quite small. *My* pain and suffering since my loss of Bob *really* cannot be valued by anyone but me. Bob's *agony* before his death was horrendous. I trust the judgment of a jury of mine and Bob's peers more than the legislature, insurance companies and doctors valuing his life at $250,000. Bob was my *best friend, my soul mate; he was priceless to me.* Having my non-economic damages limited to *$250,000 is a slap in the face.* The distress I have experienced since losing Bob, especially in such a senseless and completely avoidable way is something that never leaves me.

Thank you for your time.

Senate Bill #67

Short Title: Claims Against Health Care Providers

I am apposed to this type of legislation.

This Bill wants to limit damages for non-economic loss (pain and suffering), in medical malpractice lawsuits, to $250,000.00. Limiting damages for non-economic loss will penalize those whose damages for lost wages would be low, such as low income earners, retired people and those who never had an income.

The health care providers are saying that it is high jury awards that are driving malpractice insurance companies out of Alaska. Health care providers say that if the limit is lowered on non-economic loss that it will attract more malpractice insurance companies to Alaska which in turn will attract more doctors to Alaska. There is no proof that putting a $250,000 cap on non-economic damages will attract insurers to the Alaska market place. It is the ***economic*** damages that drive awards up, not ***non-economic*** awards.

Do not let doctors and insurance companies decide what the value of a life is. Let a jury of our peers be the judge. ***Not*** the legislature, insurance companies and health care providers.

Please *DO NOT* support Senate Bill 67

I would like these articles submitted as part of my testimony to be ~~reviewed~~ viewed by the available for your review.

A BOWL FOR THE TRAIL

The hunt for halibut began Sunday, just in time for you to make a fine fish chowder to warm your belly Saturday while cheering on the mushers tackling the Iditarod Trail. **Wednesday in Life & Taste**

PATIENT POWER

Illustration by LANCE LEKANDER

By ANN POTEMPA
Anchorage Daily News

National groups and Alaska watchdogs encourage consumers to question health care providers

NEXT TIME YOU PAY A VISIT TO YOUR DOCTOR, ask questions.

Here's one to start with: "Did you wash your hands?"

Patients may take it for granted that doctors and nurses head to the sink before each exam, but local hospitals admit some of their employees don't. At one, a study showed that about a third of the staff wasn't washing up.

This new approach is a healthy self-defense for patients. It's a shift away from automatically trusting that the folks in scrubs and stethoscopes always do the right thing. This year, a national hospital accreditation agency gave consumers some muscle by creating seven National Patient Safety Goals that hospitals must meet (see list at left).

Too often, patients think: "Gosh, they're a *hospital*. They know what they're doing," said Dr. Norman Wilder, one of the founding members of Alaska's Patient Safety Collaborative, a group of patient safety advocates from medical facilities around the state.

But medical professionals make mistakes. Intentional or not, they can be deadly. An Institute of Medicine report in 1999 concluded that mistakes made in hospitals cause more deaths nationwide than do car accidents, breast cancer or AIDS. The report, "To Err Is Human: Building a Safer Health System," drew from studies of Utah, Colorado and New York hospitals. Alaska was not a focus of the study, but the error rates from participating states were extrapolated over total U.S. hospital admissions in 1997. The institute estimated that errors killed 44,000 to 98,000 people every year.

National agencies and Alaska's own advocates are coming up with new ways to help lower those numbers. Alaska's group is giving patients stickers that tell them to question their doctors. They're asking doctors to wear stickers that say they welcome inquiries.

Members of the collaborative talked about a recent

See Page D-2, **POWER**

NATIONAL PATIENT SAFETY GOALS

Since Jan. 1, the Joint Commission on Accreditation of Healthcare Organizations has required hospitals add a step that marks the surgical location and involve the patient in this step.

■ **Make sure infusion pumps are safe.**

Hospitals use pumps to feed patients or add fluids and medication to their bloodstream. Now these pumps must shut off if they malfunction.

■ **Test and maintain alarm systems used on medical devices.**

Many hospital devices use alarms to signal a change in vital statistics or a problem that needs to be fixed. Hospitals must ensure that these alarms are audible and distinguishable. The alarms also must be tested regularly.

■ **Prevent infections from being acquired in health care facilities.**

One way to do this is to require workers to wash their hands before and after seeing each patient.

Rondy event brings together dozens of Anchorage cultures

■ **BRIDGE BUILDERS:** Meet the World spotlights ethnicities of city residents.

dashed table to table. Adults thoughtfully browsed the crafts, artwork and costumes of about 35 cultures.

Mostly, people chatted, which was

Youths' sports injuries multiply at alarming rate

■ **OVERUSE:** Kids are playing too hard at too early an age, doctors warn.

By NICK SORTAL
South Florida Sun-Sentinel

POWER: *Health care agencies encourage patients to question doctors*

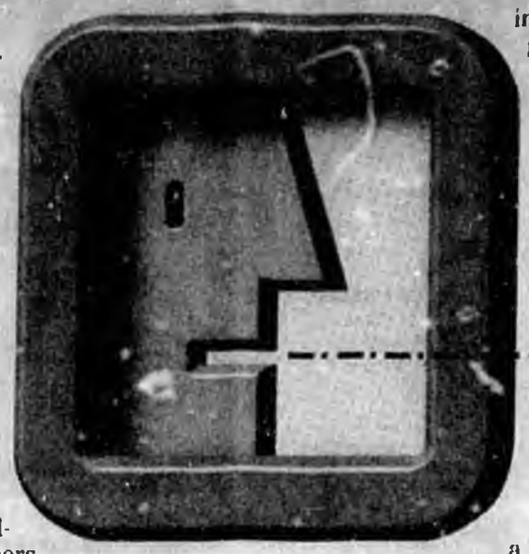
Continued from D-1

serious error on the East Coast. Last year, a teen girl died after a medical team at Duke University Hospital performed a heart-lung transplant on her using an organ donor with the wrong blood type.

Alaska's collaborative didn't just point fingers Outside. Medical staff here admitted to giving the wrong drugs to patients. From now on, staff have to find two ways to correctly identify each patient before giving medications or taking blood. It's no longer acceptable to allow patients to simply nod "yes" when a doctor asks if they go by a certain name; patients might be stressed or tired and nod in approval without really thinking, the committee members said.

"It has happened at every one of our facilities," said Denise Smith, patient safety coordinator at Providence Alaska Medical Center. "We have given the wrong medication to a patient because we misidentified the patient."

In one example, medical workers went into hospital rooms to give pills to one patient, only to hear the other patient sharing the room say those pills look like the ones he normally takes. It turned out the patients had switched beds, Smith said, resulting in the medication mix-up.



GIVING PATIENTS POWER

The collaborative's members know their request for patients to take charge represents a sharp shift in the doctor-patient culture most of us are used to. It asks the patient to question authority, to challenge someone who has completed medical school, years of fellowships and residencies, and board examinations. To some, that will be intimidating.

Lori Chiara, patient safety manager for Alaska's Veterans Affairs, tried to assure patients that today's medical environment makes patient input essential. The health care system has become highly complex, she said, with countless new drugs on the market and new technologies too.

"It's hard for one person to know all this," she said.

Adding the patient to the mix means more people are watching out for patient care.

"They've just got to be the leader of their health care team," said Wilder, vice president of medical affairs for Alaska Regional Hospital.

This new culture means a twist in tradition for doctors too. When Wilder entered medical school in the 1960s, patients revered him.

"I was like a god on a pedestal," he said. "No one questioned what I said."

Dr. Bruce Chandler, Anchorage's medical officer and a longtime pediatrician, said doctors can get used to patients questioning their behavior.

"I think a few questions from a few patients certainly can stimulate a change in behavior, all for the better," he said.

"The first few times, you might be a little offended," he said. "But I think you'd quickly adapt."

These new efforts are coming to hospitals through a group that began about two years ago in Anchorage. Patient safety coordinators from Providence, Alaska Regional, the Alaska Native Medical Center, the 3rd Medical Group at Elmendorf Air Force Base and the Alaska Veterans Affairs Healthcare System voluntarily started meeting monthly. Since then, the Alaska Psychiatric Institute, Fairbanks Memorial Hospital, Valley Hospital, the Yukon-Kuskokwim Health Corp. in Bethel and Qualis Health, a private organization paid by the federal government to improve health care, joined, and the group started representing medical facilities statewide.

Many of these hospitals shared staff, particularly doctors who can practice at multiple facilities. They also shared common safety problems. Instead of asking everyone to come up with individual answers to common problems, they decided to stop competition on patient safety issues and join forces.

They began openly discussing problems and sharing programs that worked for them.

"We're sharing numbers that may be embarrassing," Wilder said.

Sometimes those numbers show a hospital's infection rate. Other times, they're an admission that doctors and nurses aren't washing their hands enough.

Smith explained how Valley Hospital helped Providence solve a safety problem from an unlikely source: balloons meant to cheer up patients. The latex in balloons, gloves and other products used in hospitals can be dangerous for patients with a sensitivity to that product. Vulnerable patients could be exposed by a delivery person arriving with balloons. In a worst-case scenario, a patient's respiratory system could shut down.

Smith followed Valley Hospital's lead in removing latex from Providence and putting up signs telling people not to bring latex products inside the hospital. Smith also contacted balloon vendors and asked them not to deliver latex balloons to Providence.

ROOM FOR IMPROVEMENT

Safety problems like this must be addressed under a new set of accreditation requirements effective in 2003 and 2004. The National Patient Safety Goals are being implemented by a nonprofit, independent organization called the Joint Commission on Accreditation of Healthcare Organizations.

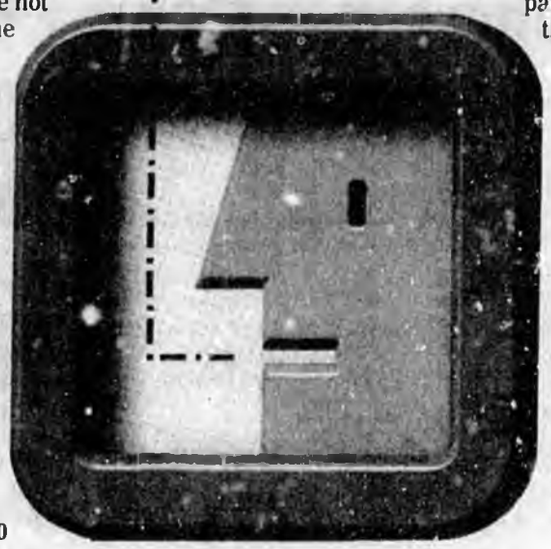
The commission sets out to improve patient safety and care by accrediting more than 16,000 health care facilities throughout the United States. The group accredits all of Alaska's major hospitals as well as village clinics and specialty health programs for substance abuse, diabetes, nutrition and physical therapy. To maintain accreditation, the commission must conduct on-site reviews at least once every three years.

The National Patient Safety Goals address seven main issues. Accredited hospitals must improve how they identify patients to ensure people are having the right procedures done and receiving the right medications. They must improve communication between doctors and patients and between doctors and nurses. They also have to make sure staff members are washing their hands to prevent the spread of infections inside medical facilities.

Local hospitals have added technology to remove human error. Alaska Regional Hospital is bar-coding patients and medications. Alaska Native Medical Center fills prescriptions with robot technology. Providence has mechanized its laboratory, sending vials down a line that tests and transports blood samples.

Alaska's collaborative said hospitals here are still struggling to address the accreditation requirements that involve human actions.

"We're trying to get our staff to wash their hands," Smith said. "It sounds so simple, but it's a challenge."



To track hand-washing, Smith has sat in nursing units to observe the employees' habits. While doing paperwork, she has watched nurses, doctors and technicians to see if they wash their hands. She discovered that about 68 percent of Providence's staff members wash their hands regularly.

Hospitals like Alaska Regional have sent letters to employees reminding them of the importance of keeping their hands clean. They've placed alcohol-based, waterless hand cleaners outside patient rooms, said Rosemary Craig, Alaska Regional's director of quality management. Providence's infection control team has been attending staff meetings to promote hand-washing, Smith said.

To prevent confusion in prescriptions, the hospitals are deciding which medical abbreviations will be allowed and which won't. Wilder said doctors have been using Latin abbreviations that can be mixed up, potentially causing harm to patients. For example, the abbreviation "qd" means daily, but the abbreviation "qid" means four times a day. If the abbreviations are written illegibly, someone might interpret them wrong and order the wrong dosage. Wilder said hospitals are now requiring staff to write "daily" or "everyday," instead of abbreviating the words.

The new accreditation requirements also call for "timeouts," Wilder said. Before starting a procedure, the team of doctors and nurses should pause and talk about what they're there to do and whom they will do it do. They can start their work when they agree they have the right patient and procedure, Wilder said.

He said hospitals are adding communication plans that change how nurses and doctors talk to each other: When sharing medical orders or test results, the person receiving the information is required to verify its accuracy by repeating it back to the person giving the orders. That means if a nurse tells a doctor a test result, the doctor must say it back to check its accuracy.

■ Daily News reporter Ann Potempa can be reached at 257-4581 or apotempa@adn.com.

Daily News Letters

...ncome tax would not exceed ...heck amounts. Now the real ...he guarantee the amount of ...at Alaskans receive will con... ...ially since the amounts have ...ast few years. The answer is,

...ary, mankind doesn't ...n as an excuse to kill

...History shows that religion con... ...ession, hatred" (Feb. 26), Matt... ...ed us to check our history then ...gion in general and Christianity in... ...en and continues to be the ringle... ...r bloodshed, oppression, bigot... ...the earliest days of man."

Mr. Nelson's views of history are myopic, focusing on ... on that of the Anglo-Saxon for the last 2,000 years.

Instead of blaming God for the evils of man, consider the nature of man himself. Mankind does not need religion for an excuse to hate and kill. Together, Einstein and Freud considered the ...

My congrats to Rep. Jim Holm. Let's put it out to the people to decide!

— Terry Luther
Anchorage

Why discard our right to receive medical negligence awards?

Sources from the medical profession confirm that 40 percent of Americans and one-third of doctors say that they or their family members have been victims of a preventable medical error. Ten percent of doctors say that a family member died as a consequence of medical negligence. As many as 98,000 Americans die in hospitals because of medical negligence each year. Why do those promoting House Bill 472 want to take away your rights to have your damages evaluated by a jury of your peers? If the aviation industry killed jumbo jets full of people each week, America would do something about it. Planes would be grounded, investigations would be launched and the problem would be solved. But that is not the approach in Alaska, where members of your Legislature want to immunize the medical profession from accountability for errors.

By my count, in the history of Alaska, there have been only about 15 jury verdicts in favor of plaintiffs in medical negligence cases. That's all. This is apparently the "crisis" that motivates certain members of your Legislature to strip Alaskans of their right to place their claims before a jury for its evaluation of their damages. This legislation is terrible public policy. People should discourage their senators and representatives from supporting it.

— Michael J. Schneider
Anchorage

Public schools teach social skills, life lessons that Mommy cannot

either.

Police are there to protect all from harm — both animal and human. If police feel only humans in danger deserve their protection maybe they need to find other work. Police should be serving all victims, human and animal, equally.

For those of you who disagree with me and feel that human life has more value, three words: You are wrong.

— SR Phoenix
Girdwood

IN BRIEF

UNITED STATES

Bear meat called leading cause of trichinosis

Scientists at the Centers for Disease Control and Prevention say improperly cooked wild game — mostly black bear meat — has become the leading cause of human trichinosis in the United States.

And with more bears and bear hunters in the woods, the risk may grow.

Trichinosis — long associated with pork — is caused by the consumption of raw or undercooked meat injected with larvae of a round worm called Trichinella.

Victims suffer fever, facial swelling, weakness, pain and swelling in the muscles. Cardiac and neurological problems or death can follow the most severe infections. To kill the larvae, the CDC says meat should be heated to a temperature of 170 degrees Fahrenheit.

NEW JERSEY

Fish and Game authorities OK bear hunt

UPPER FREEHOLD — New Jersey's Fish and Game Council gave final approval Tuesday to plans for a bear hunt, drawing immediate opposition from the state environmental commissioner, who said he would instruct wildlife officials not to issue the hunting permits.

The council, which sets the game code and determines the dates of the hunting seasons, voted in support of a December hunt, one year after New Jersey's first bear hunt in more than three decades. The hunts are intended to decrease New Jersey's growing black bear population, estimated last year at 3,200.

State wildlife officials say 328 bears were killed in last year's hunt and that about 500 cubs were expected to be born this year.

D.C.

NASA, environmental funds targeted by House

WASHINGTON — A House subcommittee voted Tuesday to cut NASA's budget by 7 percent next year, including steep reductions in President Bush's proposal for manned missions to the moon and Mars.

The Republican-run panel also approved cuts in environment, science and housing in a wide-ranging $92.9 billion measure. That freed up enough money for lawmakers to boost veterans' healthcare by $2 billion, to $30.3 billion, evidence of Congress' desire to make such money a wartime priority, especially in an election year.

The Senate has yet to write its version of the bill.

D.C.

Hospital accrediting group faulted in report

WASHINGTON — The private organization that clears hospitals to receive Medicare payments missed most problems later identified by state inspectors, potentially compromising patient safety, congressional investigators said Tuesday.

The Joint Commission on Accreditation of Healthcare Organizations, made up mainly of health professionals, failed to find 167 of 241 "serious deficiencies" in a survey of 500 hospitals that were reviewed between 2000 and 2002, the Government Accountability Office said. The agency, Congress' investigative arm, was formerly called the General Accounting Office.

MICHAEL SCHUMACHER / Amarillo (Texas) Globe-News

Larry Spatola tries to stay dry as muddy water rises around his vehicle after heavy rain on Tuesday afternoon in Amarillo, Texas. Spatola waited long enough for the flood water to recede, then walked away saying, "It wasn't that deep when I drove in."

KENTUCKY

Animal-rights group films abuse at KFC supplier

LOUISVILLE — An investigator for an animal-rights group captured video of chickens being kicked, stomped and thrown against a wall by workers at a supplier for Kentucky Fried Chicken.

The footage, released online Tuesday, was secretly taken at the Pilgrim's Pride plant in Moorefield, W.Va., by an investigator for People for the Ethical Treatment of Animals who worked there from October to May.

PETA said its investigator also obtained eyewitness testimony about employees "ripping birds' beaks off, spray-painting their faces, twisting their heads off, spitting tobacco into their mouths and eyes, and breaking them in half — all while the birds are still alive."

Pilgrim's Pride spokesman Ray Atkinson said the company has reopened a previous investigation into complaints of chicken mistreatment and will fire any employees who have violated company policies on animal welfare.

KFC spokeswoman Bonnie Warschauer said in a statement that KFC told Pilgrim's Pride it will buy no more chickens from its Moorefield plant unless the supplier provides assurances that the abuses are no longer taking place.

— Daily News wire reports

FAA issues rules for piloting light sport aircraft

■ **FLYING:** Training time and expense are cut by new regulations.

By RICARDO ALONSO-ZALDIVAR
Los Angeles Times

WASHINGTON — With a valid driver's license and 20 hours of flight training, people who dream of being pilots but are discouraged by the red tape and high costs will be able to solo in a new class of light aircraft created Tuesday by the government.

The "sport pilot/light sport aircraft" regulations issued by the Federal Aviation Administration acknowledge the growing sophistication of low-powered personal aircraft weighing between 254 and 1,320 pounds and aim to encourage thousands of new pilots to take to the skies for recreation.

"Getting wings just got considerably less expensive with one stroke of the pen," said FAA administrator Marion Blakey. "The typical private pilot's license costs approximately $9,000 and generally takes months to achieve. With the new sport pilot certificate, it can be $2,600."

Currently, the standard qualifications for private pilots are 40 hours of training and a medical certificate issued by an FAA-approved doctor. The sport pilot rules, which take effect Sept. 1, cut the training time in half and, in most cases, eliminate the medical certification.

Holders of a sport certificate will be able to fly to altitudes of up to 10,000 feet, during the day and in good visibility, and carry one passenger.

Personal aircraft fly "low and slow" and give their owners a "wind in your face" experience. The government's regulation is an outgrowth of the increasing sophistication and variety of these flying machines.

There are ultralights that look like giant insect wings with a basket for the pilot; powered parachutes that resemble airborne swamp buggies hanging from a sausage; gyroplanes that look like helicopters and small fixed-wing aircraft, such as miniature Cessnas.

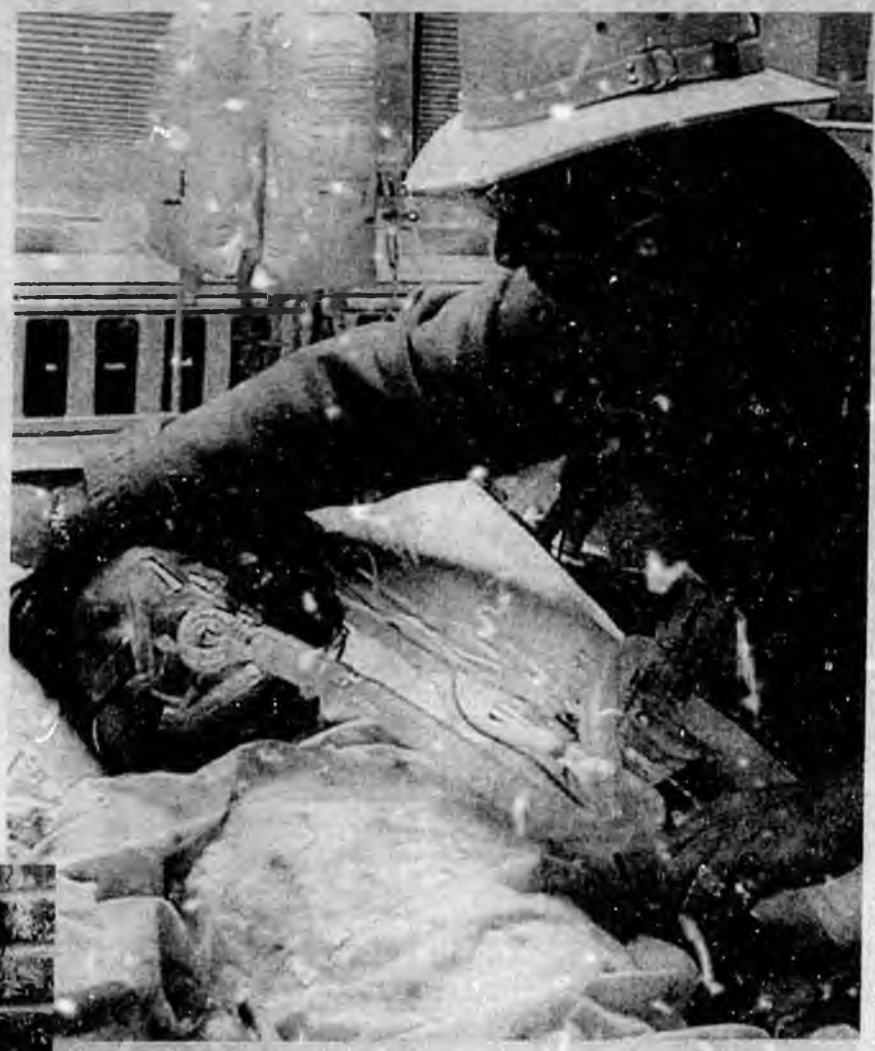
Recreational pilots welcomed the news. "This is going to recognize aircraft (whose names) the FAA hasn't even been able to spell before," said Dale Hooper, executive director of the U.S. Ultralight Association.

Bob Comperini, an ultralight instructor who flies in the desert near Edwards Air Force Base in Southern California, said the new rules would create a niche for personal aircraft in the heavily regulated world of aviation and should promote safer equipment and more appropriate training for pilots.

Almost 100,000 Americans die each year as a result of preventable errors in hospitals.

How You Can Protect Yourself

By Tom Clavin



Jesica Santillán (left, at 15) suffered from a serious ailment that required a heart and lung transplant. After waiting a year, Jesica finally received the organs, but she died due to incompatibility with the donor's blood type. Above, following surgery, Mack Mahoney watches over her in the ICU. Mahoney had founded Jesica's Hope Chest to raise money for her operation. The charity now provides emotional and financial support to families with children in need of medical care.

PHOTOS BY DRAPER/THE RALEIGH NEWS & OBSERVER (JESICA AT 15); JESI. AS HOPE CHEST, INC./WWW.4JHC.ORG (JESICA IN HOSPITAL) AND GETTY IMAGES (DOCTORS AND PRESCRIPTION PILLS; MODELS POSED FOR ILLUSTRATIVE PURPOSES)

IN FEBRUARY OF 2003, JESICA Santillán, 17, died at the Duke University Medical Center in North Carolina after undergoing a heart and lung transplant. Because of an oversight, no one noticed that the organs she was receiving contained type A blood; Jesica was type O. As soon as the operation began, she was essentially doomed.

On Mother's Day last year, 5-year-old Matthew Siravo died at Children's Hospital in Boston, one of the best pediatric facilities in the country. Matthew had undergone an operation to better track his epilepsy. Post-op, the boy had an intense seizure. After 90 minutes of convulsions, Matthew stopped breathing. State officials found that no single doctor had been designated to be in charge of his treatment.

Unfortunately, such hospital foul-ups are not rare. According to a groundbreaking 1999 study by the Institute of Medicine (IOM) of the National Academy of Sciences, as many as 98,000 patients die in the more than 5000 U.S. hospitals each year because of medical errors. Such mistakes are the eighth leading cause of death in America—ahead of car accidents, AIDS and breast cancer—according to the IOM's most conservative estimates.

"It's a major cause of preventable death in the U.S., yet there is a lot of denial about it in the hospital industry," says Arthur Levin of the Center for Medical Consumers, a nonprofit clearinghouse for medical information, who worked on the IOM study. "Most of what happens is not disclosed. In health care, we have the tradition of keeping bad things quiet."

Levin adds that the total number of deaths may actually be much greater, since the IOM figure does not include outpatient care. What's more, he notes, "medical mistakes are well known to go unrecognized and undocumented in hospital medical records."

The most common mistakes. By far the most common problem is when patients receive incorrect dosages or types of medication, according to the Agency for Healthcare Research and Quality (AHRQ). Prescriptions are unreadable or vague, the right medication is given to the wrong patient or different medicines have bad interactions. "In the 21st century, no one should get a handwritten prescription, yet that's fairly common," says Dr. Carolyn Clancy, who heads AHRQ, part of the U.S. Department of Health and Human Services.

Other common medical errors:

- a faulty or delayed diagnosis
- the use of outmoded tests
- equipment failure
- surgery on the wrong limb or organ
- tissue samples lost or misread
- an object left inside a patient during surgery
- mistaken patient identities

Why errors occur. Reasons for preventable hospital errors include poor communication among staff, overworked or minimally trained workers and a faulty system of checks and balances. "Starbucks has more procedures in place for catching errors than many hospitals have," contends Dr. Clancy.

Another important factor is the shortage of nurses. According to the American Nurses Association, there will be a shortage of 139,000 registered nurses this year and 275,000 by 2010.

There is a direct relationship between the number of nurses, patient care and hospital errors. One study by Linda Aiken and the University of Pennsylvania School of Nursing showed that the number of patients dying after common surgeries in hospitals jumps when there is more than the average 4:1 patient-nurse ratio. A 7% increase in deaths is tied to a 5:1 ratio, and a 31% increase results from an 8:1 ratio.

Nursing shortages and cost-cutting can add up to errors.

"The system is overwhelmed," says Gail Van Kanegan, author of *How To Survive Your Hospital Stay.* "With the shortage of nurses, lab and X-ray people as well as computer malfunctions, mistakes will happen."

The type of hospital you're in also matters. A study by Prof. Eric Thomas of the University of Texas revealed that patients in for-profit hospitals, government-owned minor teaching hospitals and all government-owned nonteaching hospitals are at least 1.6 times more likely to suffer "preventable adverse events" than those in nonprofit hospitals. This suggests that bottom-line concerns may affect the quality of patient care.

One error's ripple effects. Sometimes a medical error doesn't cause immediate physical injury to a patient but still has serious consequences. Holly Shivers of Long Island, N.Y., claims that an error will affect her for at least a decade.

During a hospital stay in 2002, the 42-year-old mother of two teenage girls had a lump removed from her breast. Shivers recalls the day her doctor called and began, "I'm sorry." She was certain she was about to be told she had breast cancer. Instead, Shivers says she was informed that her tissue sample had been lost, and there was no way of knowing if it was malignant because the lump already had been destroyed. As a result, for the next 10 years—the typical "cancer-free" waiting period—she will worry about what the biopsy would have found.

Shivers goes for checkups every six months. "Each time, it's the longest six months of my life," she says.

Infections also are a concern. Every year, according to the Centers for Disease Control and Prevention, nearly 2 million people contract infections while hospitalized and 100,000 die. "Hospitals are doing a pret-

continued

Take Charge Of Your Care

PARADE Health Editor Dr. Isadore Rosenfeld recommends taking the following precautions if you require hospitalization.

Thousands of people die every year due to medical mistakes. Hospitals are doing what they can by introducing new, foolproof computerized technology and training their personnel. But you can play a key role in ensuring your own safety during treatment. Here's what you can do:

☑ ***Ask about the hospital.*** Hospitalization is often an emergency. You may not have the time or luxury to inquire about the patient-nurse ratio or how many of the procedures that you will undergo have been successful at that particular institution. So plan ahead: Ask your own doctor to which hospital he would send you, research its track record and assess if it's the best one for you.

☑ ***Designate an advocate.*** In many emergency situations, you can't call the shots. You may be unconscious, confused or too sick to know what's going on. Designate a friend or relative to represent you and act on your behalf. Make these arrangements in advance and in writing. Be sure your designee is someone who is willing and able to assume that responsibility.

☑ ***Know your pills.*** Ask for a printed list of all your medications and the dosages, how often you must take them and who prescribed them. Was it your doctor or a hospital resident? If it was the latter, make sure your doctor agrees. Every time you're handed a medication, ask for its name and check it against your prescription list. Don't rely on appearances. Different brands and generics have varying colors and shapes. Make sure the pill you're given is for you and not your roommate. If you had a bad reaction to a medication, tell the nurse and doctor before taking it again.

Carefully examine all medication you receive.

Check the hospital staff's washing habits.

☑ ***Check hand-washing.*** Doctors usually wash their hands after seeing a patient. That's mainly for their own protection. But it's important for doctors to wash their hands *before* examining you for *your* protection. Most hospital rooms now have a washbasin in the entry to each patient's room. When health-care providers enter your room, pay attention to whether they wash their hands—and comment if necessary.

☑ ***Explore all your options.*** Learn as much as you can about your own health status and, if you're sick, what all your treatment options are. If there's any question about a proposed therapy, get a second opinion—especially if you've been told you need nonemergency surgery.

☑ ***Mark it.*** Before undergoing surgery, make sure the right organ or area to be operated on has been tagged. Also check the name tag on your wrist.

☑ ***Prepare for tests and procedures.*** If you need an X-ray or other diagnostic procedure that requires an injection, ask what it is. Tell the technician or radiologist if you're allergic (especially if the injection contains iodine). If you develop any problems during a procedure (even one as simple as a urinary catheterization), let the doctor or technician know. Don't hesitate to yell, "Ouch!" If you've been given an intravenous drip, check your arm for swelling or discoloration (especially if you feel pain). The needle may have slipped out of the vein and into the surrounding tissues, which can cause problems.

Dr. Rosenfeld is the author of "Power to the Patient: The Treatments To Insist on When You're Sick" (Warner Books).

Holly Shivers, 42, of Long Island, N.Y., says she will never know the results of a biopsy from her breast.

There are simple steps hospitals can take to improve patient care.

ty good job of preventing many types of infection, but they are failing to control the most dangerous one: the antibiotic-resistant infection," says Dr. Barry Farr, head of infection control at the University of Virginia Medical Center. Causes of infection include staffers who don't change gloves after every patient and doctors who don't wash their hands often enough. Staff also may fail to identify and sufficiently isolate contagious patients.

What's being done. Some states are taking a proactive approach. The Massachusetts Coalition for the Prevention of Medical Errors, the first public-private partnership of its kind in the U.S., was founded in 1998 to improve patient safety and minimize medical errors. Such organizations now exist in about a dozen states.

Some hospitals also are taking steps. Last year, the Cincinnati Children's Hospital Medical Center implemented a computer-based system in which all patient orders—including medications, special diets, lab and other test results—are documented electronically.

"Studies have demonstrated that as much as 40 minutes per shift can be gained by using electronic charting," says Terri Price, a nurse in the hospital's department of patient services. "That's 40 minutes more that a nurse can spend with patients." And more nursing care can lead to fewer errors.

There are efforts on the national level too. In 2001, U.S. Health and Human Services Secretary Tommy Thompson announced the formation of a Patient Safety Task Force to coordinate research among his department's various agencies. Since July 2001, U.S. hospitals have been required by the Joint Commission on Accreditation of Healthcare Organizations to disclose errors that harm patients. Since then, according to one study, 70% of hospitals have increased the number of medical error disclosures. (There isn't enough data yet on how this impacts the hospitals' record in patient care.)

Last year, the Patient Safety and Quality Improvement Act was approved by the House of Representatives. A supporter of the bill, Rep. Carolyn McCarthy (D., N.Y.), a former nurse, believes the measure will allow hospitals to share information without assigning blame for mistakes. The Senate has yet to pass the act. Critics say it may conflict with patient privacy rules and may not be as strong as laws already enacted by some states.

But is it enough? "To be fair, there are providers and practitioners who are working hard to make the system better," says Arthur Levin. "There is, however, a systemic lack of urgency about getting this job done quickly. In part, that's because no one wants to admit that in every year since the IOM report was issued, we've had a large number of people dying unnecessarily. There isn't enough attention being paid to the fact that, as we speak, people are dying or being injured because we're not doing enough." ■

You can find more resources on hospital safety at *www.parade.com* on the Web.

PHOTO OF SHIVERS BY STEPHEN MALLON FOR PARADE

H SECTION

FIGHTING WORKAHOLISM

She quit her job as a high-pressure Manhattan chief executive when she just couldn't take it any more. She's still charging hard, but on her own terms. 'Women have to give themselves permission to rest,' she says.

Monday's Money section.

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SUNDAY, MARCH 20, 2005

ANCHORAGE DA

CHICAGO LAWYER SYMBOLIZES WH[illegible]OUSE TARGET

Malpractice money

Administration seeks to curb suits but doesn't address medical errors

By STEVE LOHR
The New York Times

CHICAGO — Todd A. Smith is one of the nation's leading medical malpractice lawyers, renowned and feared in the courtroom, having extracted a lengthy string of multimillion-dollar settlements and verdicts from doctors, hospitals and insurers over the years. Though wealthy even by the standards of his profession, Smith, 55, seems to have lost none of the intensity and passion that fuel his 12- to 14-hour workdays and make him a persuasive trial lawyer.

Seated in his law firm's conference room with an Olympian view high above Lake Michigan, Smith recited the details of his first courtroom victory in the summer of 1977, when he was a $12,000-a-year assistant public defender in the Cook County criminal courts. The defendant, he recalled, was an American Indian who was accused of armed robbery in a case that was based mainly on his race. The man was identified as the robber, for example, in a lineup that included him and a collection of off-duty, white police officers. "It was terribly unfair," Smith said.

What drives Smith now, he says, is what drove him then: a desire to seek justice for people who need it, whether they are criminal defendants too poor to hire lawyers or victims of medical lapses whose lives have been ruined and face huge bills for care. "You can make a significant contribution to someone's life, someone who might be in desperate straits," he explained. "That's as rewarding as it gets for me. It's not really, or mostly, about money."

TORT REPORT

- Medical errors are estimated to be responsible for 45,000-98,000 deaths a year – more than those caused by breast cancer, AIDS or motor vehicle accidents.
- Nationally, defendants prevail in nearly 80 percent of the medical malpractice cases that go to trial.
- In a 2002 survey by the Association of Trial Lawyers of America, only 11 percent of its 60,000 members said medical malpractice was their primary area of practice.
- In 1975 California passed the Medical Injury Compensation Reform Act, which included a cap of $250,000 for damages like pain and suffering in malpractice cases.

The Bush administration wants to make Smith's profession far less financially rewarding. Medical malpractice lawyers are cast as the marquee villains in the administration's war against what it regards as a litigious culture run amok. If there were a face in the bull's-eye in this political battle, it would be Smith's. He is not only a big-name medical malpractice lawyer, but he is also serving this year as the president of the Association of Trial Lawyers of America, the principal advocacy and lobbying group for trial lawyers. And within conservative circles and inside the White House, the term "trial lawyer" is an epithet.

PETER THOMPSON / The New York Times

Attorney Todd A. Smith, one of the leading medical malpractice lawyers in the country, said the Bush administration's battle against medical malpractice lawyers is simple to explain. "It's about politics and money; it's not really about health care," he said. "If you want to address the medical malpractice crisis in this country, do something about the medical errors. That's the real problem."

In February, the administration won the first round in its fight to curb litigation, as Congress passed legislation to sharply restrict class-action lawsuits against companies. Next up is medical malpractice. In his re-election campaign, Bush repeatedly decried "junk lawsuits" as the bane of the nation's doctors. The issue was deftly framed, and the subtext was clear: Greedy lawyers were attacking the Marcus Welbys of America, good doctors doing their best.

In a January speech in Illinois, Bush again called for strict limits on medical malpractice suits, including "a hard cap of $250,000" on what patients could recover for noneconomic damages like physical and emotional pain and suffering. Returning to his election-year themes, Bush said doctors "should be focused on fighting illnesses, not fighting lawsuits."

"We need to fix a broken medical liability system," he said, and he called on Congress to act this year. This month, a medical litigation overhaul bill, mirroring the administration's proposals, was introduced in the Senate by two Republican senators, John Ensign of Nevada and Judd Gregg of New Hampshire.

THE MODEL OF CALIFORNIA

The medical liability system, health care analysts agree, is deeply flawed. But they also generally agree that the solution offered by the administration and the Republican Congress — putting a ceiling on damages — addresses only one aspect of the problem.

Medical liability policy, said Dr. William Sage, a physician and a law professor at Columbia University, should seek three goals: restraining overall costs, compensating the victims of medical mistakes and providing incentives for doctors and hospitals to reduce medical errors.

"There is a strong consensus among people who have really studied the issue that caps on damages would tend to keep costs down and make liability insurance more affordable for doctors," Sage said. "And there is a universal consensus that caps would do absolutely nothing to reduce medical errors or to compensate injured patients. If anything, caps on damages would make those problems worse."

Medical malpractice laws vary from state to state. But California offers a glimpse of a future preferred by the administration and many Republicans in Congress. In 1975 California passed the Medical Injury Compensation Reform Act, which includ-

See Page H-4, **MALPRACTICE**

MALPRACTICE: *For their job's sake, lawyers must weed out 'frivolous' suits*

Continued from H-1

ed a cap of $250,000 for damages like pain and suffering in malpractice cases. It did not limit economic damages for things like the cost of continuing care for a person disabled or wages lost because of medical errors. The law also curbed attorneys' fees on a sliding scale that prohibited them from collecting more than 15 percent on award amounts over $600,000, with higher percentages for the amounts below that sum. In states without limits on fees, contingency payments to malpractice lawyers are typically about one-third of awards.

Research varies on the likely impact of curbs on awards and fees, but a RAND Corp. study last year concluded that the California law had reduced the net recoveries for plaintiffs by 15 percent and had cut attorneys' fees by far more, an estimated 60 percent. Defendant liabilities, it calculated, were trimmed 30 percent because of the law.

California malpractice lawyers say the law also discourages them from taking wrongful-death cases if the victims are children or retirees. Those groups have no economic value by the cold logic of the courtroom: They are not earning salaries, so the maximum award would be $250,000. Complex cases, which often require many expert witnesses and years of research, can cost that much to bring to trial.

Linda Fermoyle Rice, a medical malpractice lawyer in Woodland Hills, Calif., said she recently told the family of a 14-year-old boy who died unexpectedly in a hospital — apparently from medical negligence, Rice maintained — that she could not afford to pursue the case. "The law has made it impossible for many victims to get access to the court," she said.

Even plaintiffs who get to court often come away empty-handed. Nationally, defendants prevail in nearly 80 percent of the medical malpractice cases that go to trial. Many malpractice suits, legal analysts say, are filed by personal-injury lawyers, accustomed to handling simpler cases like those involving auto accidents but not as experienced in medical negligence work. In a 2002 survey by the trial lawyers association, only 11 percent of its 60,000 members said medical malpractice was their primary area of practice; 40 percent replied that medical negligence cases were some part of their practice.

GETTING INTO THE PROFESSION

Smith, a partner at Power, Rogers & Smith in Chicago, resides at the top of the medical malpractice mountain. He does some aviation litigation, but medical negligence claims account for 70 percent of his cases; in the last 17 years, he has won more than $300 million in verdicts and settlements for clients. Contingency fees collected by his firm would typically be 20 percent of the total, a limit set by Illinois state law on all awards more than $1 million.

So how much does he earn? "Far less than you might expect," Smith replied. His firm employs 11 lawyers — six working on medical malpractice cases, the remainder focusing on other personal-injury claims. It also employs four nurses as full-time researchers. Complex cases can require reams of expert testimony, years of investigation and hundreds of thousands of dollars to prepare. Medical malpractice lawsuits are custom work, focusing on one victim at a time, as opposed to large class actions against an entire industry, like the $246 billion tobacco settlement that trial lawyers helped 46 states win in 1998.

There are no hourly fees and no well-heeled corporate clients paying for expenses. Trial lawyers are the venture capitalists of the legal system, putting their money on the line and taking up-front risk. The occasional big paydays cover the daily expenses.

For all the costs, there is still plenty left over for Smith. He won't say precisely how much, but he concedes that his yearly income is routinely in the high six figures, and seven figures in good years, which appear to have been plentiful recently. That would put him on a par with partners at leading corporate law firms.

At one time, corporate law would have seemed the natural choice for Smith. In 1973, he was a freshly minted MBA from Northwestern University's graduate school of business, and most of his job offers were from banks in the Chicago area. But he says he balked at what struck him as an anonymous career within the crowded managerial ranks of a big bank. He became intrigued by the law and enrolled at the Loyola University law school; while there, he started working for the public defender's office.

In that office, Smith got his first taste of trial work, and he vividly described the thrill of standing in the huge courtrooms of the Cook County criminal court and the exhilaration of presenting cases. "It was real life, and the outcome really mattered to people's lives," he said.

The most skilled trial lawyers, legal professionals agree, truly savor the theater of the courtroom, the adrenaline rush of verbal combat, the on-the-fly decisions made in cross-examination and the challenge of winning over an audience. "In the end, it all depends on the judgment of 12 people," Smith said.

But medical malpractice work requires more than a deft touch in court. According to colleagues and courtroom adversaries, Smith combines a relentless work ethic — needed to absorb the arcane details of medical science — and an underlying belief that his clients are victims who have suffered grave injustices.

"The best plaintiffs' lawyers in this field, like Todd Smith, almost have a crusader mentality," said Brian Fetzer, a leading malpractice defense lawyer in Chicago, who has represented physicians, hospitals and insurers against Smith in cases for more than 20 years. "They are true believers."

Joseph Balesteri, a lawyer who joined Power, Rogers & Smith in 2000, after five years of working the defense side of medical negligence cases, said of his colleague, "Todd gets into the medicine. He wears his emotions on his sleeve, and listening to him you really see that he believes what he says. It's a credibility that is felt by the jury."

'JUNK' CASES WEEDED OUT

Smith says his success rate is higher than 80 percent — including jury verdicts and settlements — far higher than the national average for medical malpractice plaintiffs' lawyers. Being picky in his selection of cases helps explain the high winning percentage. He says he decides to take fewer than three of every 100 cases that are brought to his firm. "We say to people right off that a bad outcome does not mean you have a medical negligence case," he said.

The plaintiff's lawyer must argue that a doctor or hospital failed to meet the profession's acknowledged standard of care for a certain operation, test or treatment, and, more important, must be able to prove it.

Cases worth pursuing, Smith said, are typically ones in which the victim has suffered a major injury that results in continuing pain, suffering and disability. Brain damage, loss of a limb and facial disfigurement, he noted, are good candidates.

At his firm, potential cases go through rigorous screening that can take months and cost costs tens of thousands of dollars. The victim's medical records are collected after receiving the authorization of the patient or family. Those records are reviewed, and one of the firm's nurse-researchers assesses the care that the patient received.

Next, the case is sent to a consulting specialist — and often more than one. If the case still seems promising, the accumulated information is sent to a physician who determines whether the care was negligent enough to write a certificate of merit, required in Illinois and some other states, to be presented to the court.

"In his speeches, Bush makes it sound as if every lawsuit that is brought is junk or frivolous," Smith said. "But we do everything we can to weed out cases that are without merit. We have to. Our own money is at risk."

POLITICS AND CUTTING COSTS

To Smith, the administration's battle against medical malpractice lawyers is simple to explain. "It's about politics and money; it's not really about health care," he said. "If you want to address the medical malpractice crisis in this country, do something about the medical errors. That's the real problem."

Analysts agree that the quality of medicine across the country is uneven, which represents a huge problem. Medical errors are estimated to be responsible for 45,000-98,000 deaths a year — more than those caused by breast cancer, AIDS or motor vehicle accidents, according to the Institute of Medicine of the National Academy of Sciences.

So Smith has a point. But improving the quality of health care raises a separate set of complex issues about incentives for improvement, investment in information technology and changes in the culture of medicine.

Pointing the finger elsewhere will not get Smith and his fellow lawyers off the political hook. There have been calls to overhaul medical malpractice before. But this time the White House, doctors, insurers and other business interests, who see curbs on malpractice suits as one step in reducing their health care costs, are pushing hard together.

The champions of tort reform are spending heavily. Last year, the Institute for Legal Reform, an affiliate of the Chamber of Commerce, and the American Medical Association, the physicians' advocacy group, spent a total of $33.8 million on lobbying, according to PoliticalMoneyLine, which tracks federal lobbying. The trial lawyers' association spent $2.9 million on federal lobbying, PoliticalMoneyLine reported.

"We're outgunned financially, and we're being targeted because we have supported candidates who support Americans' rights to access to a jury trial," Smith said.

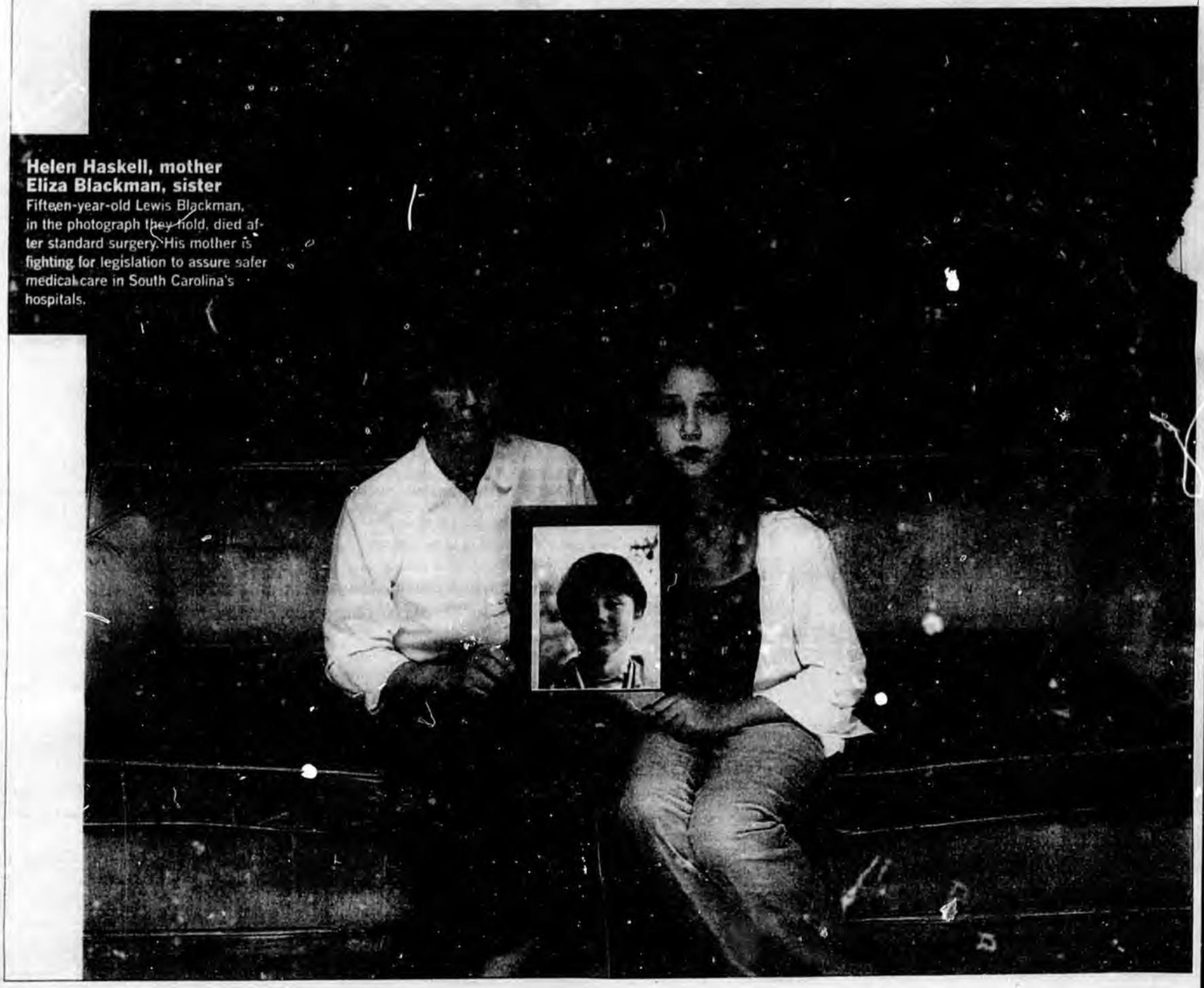
Smith has done his part. In the 2003-04 campaign cycle, he contributed just under $100,000, nearly all of it to Democrats and Democratic political action committees, according to the Center for Responsive Politics, a nonpartisan group.

Yet even if the Bush administration prevails and malpractice awards are curbed, the impact on Smith will probably be limited. It may crimp his style, but it won't change his game. "There will always be plenty of work for people like him, the best litigators on the plaintiffs' side," said Sage, the Columbia law school professor.

Fatal Mistakes

Every year at least 98,000 Americans die—and millions more are injured—as a result of medical errors. Now victims' families are fighting back. But how do you fix a system that's more concerned with innovation than safety?

BY TRUDY LIEBERMAN PHOTOGRAPHS BY KRISTINE LARSEN



Helen Haskell, mother
Eliza Blackman, sister
Fifteen-year-old Lewis Blackman, in the photograph they hold, died after standard surgery. His mother is fighting for legislation to assure safer medical care in South Carolina's hospitals.