State Injury Indicators Report:
Instructions for Preparing 2006 Data

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Injury Response

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FOREWORD AND UPDATES

The Centers for Disease Control and Prevention’s (CDC) National Center for Injury Prevention and Control (NCIPC) is pleased to provide this document to guide you in preparing the 2006 state injury indicators.

Under CDC Program Announcement 05027, 30 states have been funded to collect and submit state injury indicator data; however, all states and U.S. territories are eligible to voluntarily submit data for inclusion in the multistate State Injury Indicators Report. As more states and U.S. territories voluntarily participate in this surveillance effort, a broader picture of the burden of injuries can be presented and priorities for prevention can be targeted. During the 2005 data collection cycle, 33 states participated by submitting data for inclusion in the multistate report. We look forward to continuing our work together to advance and improve injury surveillance.

The methods outlined in this document are consistent with those used in previous cycles of injury indicator data collection. These methods are based on recommendations presented in the “Consensus Recommendations for Using Hospital Discharge Data for Injury Surveillance” and in the National Public Health Surveillance System (NPHSS) indicators developed by the Safe States Alliance, (formerly known as the State and Territorial Injury Prevention Directors Association--STIPDA) and the Council of State and Territorial Epidemiologists (CSTE). With partner feedback, CDC continuously modifies and updates the instructions and methodologies outlined in this document.

Changes for the 2006 data collection cycle include:

- In the previous version of the instructions, one of the drowning indicators was inadvertently misnamed. The “Nonfatal Drowning” indicator should have been called “Drowning-Related Hospitalizations” because all hospitalized drownings should be included, even those resulting in in-patient deaths. This has now been corrected.
- Definition pages were added for the Indicators obtained from additional data sources (e.g., Fatality Analysis Reporting System, Behavioral Risk Factor Surveillance System). Because of this, the “Additional Resources” section was revised and moved before the individual indicator pages.
# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAC</td>
<td>Blood alcohol concentration</td>
</tr>
<tr>
<td>BRFSS</td>
<td>Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CSTE</td>
<td>Council of State and Territorial Epidemiologists</td>
</tr>
<tr>
<td>FARS</td>
<td>Fatality Analysis Reporting System</td>
</tr>
<tr>
<td>HDD</td>
<td>Hospital discharge data</td>
</tr>
<tr>
<td>ICD-10</td>
<td>International Classification of Diseases – Tenth Revision</td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td>International Classification of Diseases – Ninth Revision – Clinical Modification</td>
</tr>
<tr>
<td>MVC</td>
<td>Motor vehicle crash</td>
</tr>
<tr>
<td>SAVIR</td>
<td>Society for Advancement of Violence and Injury Research</td>
</tr>
<tr>
<td>NCCDPHP</td>
<td>National Center for Chronic Disease Prevention and Health Promotion</td>
</tr>
<tr>
<td>NCHS</td>
<td>National Center for Health Statistics</td>
</tr>
<tr>
<td>NCIPC</td>
<td>National Center for Injury Prevention and Control</td>
</tr>
<tr>
<td>NHTSA</td>
<td>National Highway Traffic Safety Administration</td>
</tr>
<tr>
<td>NPHSS</td>
<td>National Public Health Surveillance System</td>
</tr>
<tr>
<td>STIPDA</td>
<td>State and Territorial Injury Prevention Directors Association</td>
</tr>
<tr>
<td>TBI</td>
<td>Traumatic brain injury</td>
</tr>
<tr>
<td>VA</td>
<td>Veterans Affairs</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WISQARS</td>
<td>Web-based Injury Statistics Query and Reporting System</td>
</tr>
<tr>
<td>YRBS</td>
<td>Youth Risk Behavior Survey</td>
</tr>
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What is an Injury Indicator?

An injury indicator describes a health outcome of an injury, such as hospitalization or death, or a factor known to be associated with an injury, such as a risk or protective factor among a specified population.

INTRODUCTION

Injury surveillance is one of the most important and basic elements of injury prevention and control. It helps determine the magnitude of injury morbidity and mortality, the leading causes of injury, and the population groups and behaviors associated with the greatest risk of injury. Surveillance data are also fundamental to determining program and prevention priorities. Furthermore, these data are crucial for evaluating the effectiveness of program activities and for identifying problems that need further investigation.

Injury continues to be the leading cause of death and disability among children and young adults. In 2005, more than 173,000 people died from injuries in the U.S. Among them: 26% died from motor-vehicle crashes; 19% died from suicide; and 10% died from homicide. Additionally, in 2005, more than 29 million people were treated for injuries in U.S. emergency departments. The economic cost of injuries is also significant. The total cost of the 50 million medically treated injuries sustained in 2000 is estimated to be $406 billion in medical expenses and productivity losses.

The mission of public health includes prevention, mitigation, assurance that the injured have access to treatment, and the reduction of injury-related disability and death. The scope of public health encompasses injuries involving any mechanism (e.g., firearm, motor vehicle, or burn) and includes both intentional and unintentional injuries. An important part of the public health mission is to emphasize that injuries are preventable and to dispel the misconception that injuries are unavoidable.

Recognizing the need for more comprehensive injury surveillance data, the State and Territorial Injury Prevention Directors Association (STIPDA) produced Consensus Recommendations for Injury Surveillance in State Health Departments in 1999. These recommendations were developed by a working group representing STIPDA; the Council of State and Territorial Epidemiologists (CSTE); the Centers for Disease Control and Prevention (CDC) and its National Center for Injury Prevention and Control (NCIPC); the Society for Advancement of Violence and Injury Research (SAVIR); and individual state partners.

The State Health Department Consensus Recommendations identifies specific injuries and injury risk factors to be placed under surveillance by all states and data sets to monitor these injuries and risk factors. The goal is to improve state-based injury surveillance to better support injury prevention programs and policies. By enhancing and standardizing injury surveillance at the state level, its integration with overall public health surveillance as part of the National Public Health Surveillance System (NPHSS) will be much easier. In tandem with the State...
Health Department Consensus Recommendations, CSTE and STIPDA developed injury indicators that were formally adopted for inclusion in NPHSS.\(^5,6\) The NPHSS injury indicators add to other indicators developed by CSTE for chronic diseases and other areas.\(^5\)

The Consensus Recommendations for Using Hospital Discharge Data for Injury Surveillance, published in 2003, provides clear and specific recommendations about the evaluation and use of hospital discharge data.\(^7\) It presents important considerations for the evaluation of data quality and outlines the methodology for developing an injury hospitalization data set.

Collection and dissemination of injury indicators is built upon the foundation laid by the publication of these STIPDA and CSTE documents.
BACKGROUND AND PURPOSE

This manual was created to guide states and U.S. territories in collecting, preparing, and submitting their injury surveillance data. All states and U.S. territories are eligible to voluntarily submit data for this report.

Information obtained from participants will be reviewed and assembled for inclusion in the State Injury Indicators Report. This process provides state and U.S. territory injury programs with a standardized method for evaluating injury data and for producing an injury indicator data product that is comparable across states and U.S. territories.

This manual provides straightforward information to encourage participation of all states and U.S. territories regardless of their epidemiologic infrastructure and capabilities. Participation in this report should not be seen as limiting by states of higher capacity, but rather as a place of commonality and a starting point for developing more sophisticated analysis.

The process of preparing indicators is simplified in that it doesn’t include the merging and unduplicating of cases found in both hospital discharge and vital statistics data sets. It is important to keep in mind that the quality of the injury indicators is dependent on the completeness and accuracy of external cause coding found on individual state and U.S. territory data sets.

Centralized electronic hospital discharge data and centralized electronic vital statistics data are used to calculate the indicators prepared and submitted by states and U.S. territories. Injuries resulting in or occurring from the following are currently included in the State Injury Indicators: all injury, drowning, fall-related injury, fire-related injury, firearm-related injury, homicide/assault, motor vehicle-related injury, poisoning, suicide/suicide attempt, and traumatic brain injury (TBI). Overlap exists among these indicators. For example, a firearm-related homicide would be included in both the firearm-related death indicator and the homicide indicator.
PREPARING THE DATA SET

Background on State Vital Records

Death registration is the responsibility of individual states. The funeral director and the physician who certify the cause of death are usually responsible for the personal and medical information recorded on the death certificate. The cause-of-death section on the certificate is generally the same in all states and is organized according to World Health Organization (WHO) guidelines and coded with ICD-10. Local registrars assure that deaths in their jurisdictions are registered and that required information is on death certificates before submitting to the state registrar. State registrars number and file the death certificates; certificates of nonresidents are sent to their states of residence. All states send death certificate data to the National Vital Statistics System, managed by CDC’s National Center for Health Statistics (NCHS).

Data are limited to information reported on death certificates. The degree of detail in reporting varies among jurisdictions. In general, death certificate data provide limited information about circumstances of injury incidents or contributing factors. The number and type of cause-of-death fields to which states have access also vary, and deaths associated with some injuries, especially suicide, may be underreported. States without access to multiple contributing cause-of-death fields cannot calculate fatality rates for TBI because the diagnostic codes that make up that case definition reside in the contributing cause-of-death fields.

Instructions for Using Vital Statistics Data

Vital statistics data do not require specific preparation for analysis. With the exception of the fatal TBI indicator, all fatal indicators should be calculated by searching the underlying-cause-of-death field only. For the fatal TBI indicator, search all fields in the multiple cause of death file. Specific code ranges are identified in the individual indicator specification sheets (see pages 11–42).

Background on State Hospital Discharge Data

At least 90% of all states maintain electronic databases of hospital discharge records for nonfederal, acute care hospitals located within their borders. The information collected varies from state to state. Many states use the standard uniform billing form (UB-92) as the basis for their hospital discharge database. Others use only a subset of variables from the UB-92 for their databases, and a few collect additional variables.

The UB-92, developed by the National Uniform Billing Committee, includes the following data elements:

- patient’s age,
- sex,
- zip code,
- admission date,
- length of stay,
- total charges,
- principal diagnosis, and
- up to eight additional diagnoses.
For diagnoses resulting from injuries, an external cause of injury (E-code) is also coded. E-codes, listed in ICD-9-CM, describe several aspects of an injury: intentionality; mechanism; and, for unintentional causes of injury, location of occurrence. Completeness of e-coding varies by state.

**Instructions for Creating and Using the Injury Hospitalizations Subset of a State Hospital Discharge Data Set**

To calculate Injury Hospitalization Indicators, first you need to create an injury subset of hospital discharge records. Create this subset using the following specifications:

- Include only nonfederal, acute care, or inpatient facilities in your hospital discharge data (HDD) injury subset. This excludes Veterans Affairs (VA) and other federal hospitals, rehabilitation centers, and psychiatric hospitals.
- Include readmissions, transfers, and deaths occurring in the hospital.
- Include hospitalizations of state residents only.
- If the data are available, out-of-state hospitalizations of state residents should be included.
- Based on the principal diagnosis field, the subset you create will be injury hospitalizations, defined as follows:
  - Select injury cases by searching only the principal diagnostic code field for the included diagnosis codes. Exclude all other records from the injury hospitalization subset, as shown in the chart below:

<table>
<thead>
<tr>
<th>INCLUDE</th>
<th>EXCLUDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>800–909.2,</td>
<td>&lt; 800</td>
</tr>
<tr>
<td>909.4, 909.9</td>
<td>909.3, 909.5</td>
</tr>
<tr>
<td>910–994.9</td>
<td>995.0–995.4</td>
</tr>
<tr>
<td>995.5–995.59</td>
<td>995.6–995.7</td>
</tr>
<tr>
<td>995.80–995.85</td>
<td>995.86, 995.89</td>
</tr>
<tr>
<td></td>
<td>995.90–995.94</td>
</tr>
<tr>
<td></td>
<td>996–999</td>
</tr>
</tbody>
</table>

Once the injury hospitalization subset has been created, calculate the injury indicators case counts as defined on the individual indicator pages. Search for E-codes in the following manner:

- Search all diagnosis fields.
- If a designated E-code field is in your data set, start with the designated E-code field.
- Count the first-listed valid E-code, unless it is E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional E-code fields and all diagnostic fields and use the next listed valid E-code. If a case has multiple valid E-codes, then only the first one should be used in the analysis.
Hospitalizations (except for hip fracture hospitalizations in persons aged 65 years and older) should be age-adjusted to the 2000 standard using the NCHS population distribution (Table 1, page 44).

**Assess the completeness and quality measures of the HDD for the following components:**

- Percentage of HDD injury records with external cause coding (Figure 1, below).
- Completeness of hospitals participating in the HDD system.
- Inclusion of readmissions and transfers within the data set used for analysis.
- A subjective assessment by health department staff if a substantial proportion of state residents injured in-state are actually hospitalized in a neighboring state.

**FIGURE 1.**

\[
\text{Percentage of HDD Injury Hospitalizations with External Cause Coding} = \frac{\text{Number of hospital discharge records identified using the criteria in the previous table that have a valid E-code other than E849, E967, E869.4, E870-E879, or E930-E949}}{\text{Number of hospital discharge records identified using the criteria in the previous chart}} \times 100
\]
ADDITIONAL RESOURCES

Other Recommended Data Systems

Indicators based on the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Survey (YRBS), and the Fatality Analysis Reporting System (FARS) will be calculated at CDC. The data available from YRBS and BRFSS will be examined annually to determine which survey questions should be included.

Behavioral Risk Factor Surveillance System (BRFSS)

CDC’s National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) manages the BRFSS. This is a broad ongoing survey. It is also a state-based, random-digit-dialed telephone survey of the noninstitutionalized U.S. population over age 17. BRFSS monitors risk behaviors associated with the leading causes of disease, injury, and death. Because BRFSS is telephone-based, population subgroups less likely to have telephones, such as persons of low socioeconomic status, may be underrepresented. In addition, data are self-reported and may be biased. For risk-reduction factors such as self-reported use or testing of smoke alarms, these data may not uniformly represent safe and effective use.

Additionally, not all BRFSS questions are asked every year. Questions asked during the year for which a current Injury Indicator Report is being prepared will be reviewed and appropriate questions included in the report. Results will be reported as a percentage of respondents. For 2006, there are four injury-related BRFSS questions that will be reported.

Youth Risk Behavior Survey (YRBS)

YRBS, a component of the Youth Risk Behavior Surveillance System, is managed by NCCDPHP at CDC. The YRBS monitors risk behaviors associated with the leading causes of injury and death among teenagers. State and local departments of education and health conduct the survey biennially in many locations throughout the country. The school-based survey is administered to 9th through 12th graders and the data is analyzed by CDC. YRBS data apply only to youth who attend school. The extent of underreporting or overreporting of behaviors cannot be determined, although the survey questions demonstrate good test–retest reliability. Interstate comparisons must be interpreted cautiously because the methods used to collect YRBS data may vary.

Among the 30 funded states, 23 conducted a YRBS in 2005 with overall participation rates of at least 60%. CDC requires a minimum overall participation rate of 60% to generalize the results to the state’s population. States with YRBS data meeting this criterion will be included. Results will be reported as a percentage of respondents. No age adjustment will be applied. The YRBS was not administered in 2006.
Fatality Analysis Reporting System (FARS)

FARS, coordinated by the National Highway Traffic Safety Administration (NHTSA), contains data on all fatal traffic crashes that occur in the 50 states, the District of Columbia, and Puerto Rico. For inclusion in FARS, a crash must involve a motor vehicle traveling on a public roadway and result in the death of a person (either a vehicle occupant or a non-motorist) within 30 days of the crash. The FARS file contains a description of each fatal crash reported. More than 100 coded data elements characterize each crash, the vehicles, and the people involved.\textsuperscript{15}

FARS does not include non-traffic crashes such as those occurring on driveways and other private property. It also does not include deaths occurring more than 30 days after the motor vehicle crash.\textsuperscript{15}
INJURY INDICATORS

The following pages contain specific case definitions for each of the individual injury indicators. These case definitions should be applied when determining case counts. Once the case counts are determined, they should be entered into the provided spreadsheets for rate calculation and submission to CDC.
# ALL-INJURY INDICATOR 1:

## Injury Fatalities

<table>
<thead>
<tr>
<th>Demographic Group</th>
<th>All residents.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
<td>Deaths with any of the following ICD-10 codes as an underlying cause of death.</td>
</tr>
<tr>
<td><strong>Injury Fatality ICD-10 Codes</strong></td>
<td>V01–Y36, Y85–Y87, Y89, *U01–*U03 Injury and poisoning</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006—RESIDENT” (see instructions on page 39).</td>
</tr>
<tr>
<td><strong>Measures of Frequency</strong></td>
<td>Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.</td>
</tr>
<tr>
<td><strong>Data Resources</strong></td>
<td>Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).</td>
</tr>
<tr>
<td><strong>Period for Case Definition</strong></td>
<td>Calendar year.</td>
</tr>
<tr>
<td><strong>Background</strong></td>
<td>Injuries are the leading cause of death for people 1 to 44 years of age and the third leading cause of death overall. Almost 174,000 people died from injuries in 2005.</td>
</tr>
<tr>
<td><strong>Limitations of Indicator</strong></td>
<td>Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.</td>
</tr>
<tr>
<td><strong>Limitations of Data Resources</strong></td>
<td>The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding. The overall completeness of external cause coding on death data is uniformly high. Coding criteria specify that all cases of injury death must contain an injury code in the underlying-cause-of-death field.</td>
</tr>
</tbody>
</table>
| **Healthy People Objectives** | 15-13: Reduce deaths caused by unintentional injuries  
15-32: Reduce homicides |
ALL-INJURY INDICATOR 2:
Hospitalizations for All Injuries

DEMOGRAPHIC GROUP
All residents.

NUMERATOR
Hospitalizations with any of the following ICD-9-CM diagnostic codes. These should be identified by searching for diagnosis codes only in the principal diagnostic field of the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset). The case count for injury hospitalizations should equal the number of records in your injury hospitalization subset.

Hospitalizations for All Injuries ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Diagnosis codes</th>
<th>Injury and poisoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>800–909.2, 909.4, 909.9–994.9, 995.5–995.59, 995.80–995.85</td>
<td></td>
</tr>
</tbody>
</table>

DENOMINATOR
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY
Annual number of persons hospitalized. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES
State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION
Calendar year.

BACKGROUND
Injury is the leading cause of death and disability among children and young adults in the United States.1

LIMITATIONS OF INDICATOR
Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

LIMITATIONS OF DATA RESOURCES
The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding.

HEALTHY PEOPLE OBJECTIVES
15-12: Reduce hospital emergency department visits caused by injuries
15-14: (Developmental) Reduce nonfatal unintentional injuries
DROWNING INDICATOR 1:
Unintentional Drowning Fatalities

DEMOGRAPHIC GROUP  All residents.

NUMERATOR  Deaths with any of the following ICD-10 codes as an underlying cause of death.

<table>
<thead>
<tr>
<th>Unintentional Drowning Fatality ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>W65–W74  Accidental drowning and submersion</td>
</tr>
<tr>
<td>V90  Accident to watercraft causing drowning and submersion</td>
</tr>
<tr>
<td>V92  Water-transport-related drowning and submersion without accident to watercraft</td>
</tr>
</tbody>
</table>

DENOMINATOR  Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY  Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES  Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION  Calendar year.

BACKGROUND  Drowning is one of the 10 leading causes of injury death for persons under age 55 years. In the United States, drowning rates are highest among children under five years of age.1

LIMITATIONS OF INDICATOR  Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.

LIMITATIONS OF DATA RESOURCES  The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding. The overall completeness of external cause coding on death data is uniformly high. Coding criteria specify that all cases of injury death must contain an injury code in the underlying-cause-of-death field.

HEALTHY PEOPLE OBJECTIVES  15-29: Reduce drownings.
DROWNING INDICATOR 2: Drowning-Related Hospitalizations

DEMOGRAPHIC GROUP All residents.

NUMERATOR Hospitalizations with any of the following ICD-9-CM diagnostic or E-codes identified from the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset). These should be identified by searching for diagnosis codes in all diagnostic fields and by searching for E-codes in the following manner: Search all diagnosis fields. If a designated E-code field is in your data set, start with the designated E-code field. Count the first-listed valid E-code, unless it is E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional E-code and diagnostic fields and use the next listed valid E-code.

Drowning-Related Hospitalization ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Diagnosis codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>994.1</td>
<td>Drowning and nonfatal submersion and/or E-codes</td>
</tr>
<tr>
<td>E830</td>
<td>Accident to watercraft causing submersion</td>
</tr>
<tr>
<td>E932</td>
<td>Other accidental submersion or drowning in water transport accident</td>
</tr>
<tr>
<td>E910</td>
<td>Accidental drowning or submersion</td>
</tr>
<tr>
<td>E954</td>
<td>Suicide and self-inflicted injury by submersion (drowning)</td>
</tr>
<tr>
<td>E964</td>
<td>Assault by submersion (drowning)</td>
</tr>
<tr>
<td>E984</td>
<td>Submersion (drowning), undetermined whether accidentally or purposefully inflicted</td>
</tr>
</tbody>
</table>

DENOMINATOR Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population table titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY Annual number of persons hospitalized. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES State hospital discharge data (numerator) and population estimates from the U.S.Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION Calendar year.

BACKGROUND Drowning-related hospitalizations can result in lifelong disability. Among adolescents and adults, risk factors for drowning include drinking alcohol, swimming alone, and not wearing a personal flotation device while engaged in water sports or recreation. For children under age 5, unexpected access to water or brief lapses in adult supervision are implicated in most drowning incidents.

LIMITATIONS OF INDICATOR Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

LIMITATIONS OF DATA RESOURCES The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding. The overall completeness of e-coding is of particular concern and should be reviewed in conjunction with the indicator.
FALL INDICATOR 1:  
Unintentional Fall-Related Fatalities

**DEMOGRAPHIC GROUP**  
All residents.

**NUMERATOR**  
Deaths with any of the following ICD-10 codes as an underlying cause of death.

**Unintentional Fall-Related Fatality ICD-10 Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>W00–W19</td>
<td>Falls</td>
</tr>
</tbody>
</table>

**DENOMINATOR**  
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006— RESIDENT” (see instructions on page 39).

**MEASURES OF FREQUENCY**  
Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

**DATA RESOURCES**  
Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

**PERIOD FOR CASE DEFINITION**  
Calendar year.

**BACKGROUND**  
Unintentional falls are the third leading cause of injury death overall and the leading cause of injury death in people 65 years and older. In 2005, there were 19,656 unintentional fall-related deaths.

**LIMITATIONS OF INDICATOR**  
Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.

**LIMITATIONS OF DATA RESOURCES**  
The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding. The overall completeness of external cause coding on death data is uniformly high. Coding criteria specify that all cases of injury death must contain an injury code in the underlying-cause-of-death field.

**HEALTHY PEOPLE OBJECTIVES**  
15-27: Reduce deaths from falls
FALL INDICATOR 2:  
Unintentional Fall-Related Hospitalizations

**DEMOGRAPHIC GROUP**  
All residents.

**NUMERATOR**  
Hospitalizations identified from the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset) by searching for E-codes in the following manner: Search all diagnosis fields. If a designated E-code field is in your data set, start with the designated E-code field. Count the first-listed valid E-code, unless it is E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional E-code and diagnostic fields and use the next listed valid E-code.

Unintentional Fall-Related Hospitalization ICD-9-CM Codes

| E880–E886, E888 | Accidental falls |

**DENOMINATOR**  
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006—RESIDENT” (see instructions on page 39).

**MEASURES OF FREQUENCY**  
Annual number of persons hospitalized. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

**DATA RESOURCES**  
State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

**PERIOD FOR CASE DEFINITION**  
Calendar year.

**BACKGROUND**  
More than one third of adults 65 and older fall each year. Of those who fall, 20% to 30% suffer moderate to severe injuries that make it hard to get around or live alone and increase the chance of early death. The total direct cost of nonfatal fall injuries for people 65 and older in 2000 was $19 billion.

**LIMITATIONS OF INDICATOR**  
Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

**LIMITATIONS OF DATA RESOURCES**  
The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding. The overall completeness of e-coding is of particular concern and should be reviewed in conjunction with the indicator.

**HEALTHY PEOPLE OBJECTIVES**  
No objective
FALL INDICATOR 3:  
Hip Fracture Hospitalizations in Persons Aged 65 Years and Older

DEMOGRAPHIC GROUP  Resident persons aged 65 years or older

NUMERATOR  Hospitalizations with the following ICD-9-CM diagnostic code. These should be identified by searching all diagnostic fields of the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset).

<table>
<thead>
<tr>
<th>Diagnosis code</th>
<th>Fracture of neck of femur</th>
</tr>
</thead>
</table>

DENOMINATOR  Midyear population of those 65 years and older for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006—RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY  Annual number of persons hospitalized. Annual incidence—crude. Rates should be calculated for age and sex.

DATA RESOURCES  State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION  Calendar year.

BACKGROUND  In 2004, there were an estimated 289,000 hospital admissions for hip fractures in people 65 years and older.22 Up to 25% of adults who lived independently before their hip fracture have to stay in a nursing home for at least a year after their injury23 and as many as 20% of hip fracture patients die within a year of their injury.24

LIMITATIONS OF INDICATOR  Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

LIMITATIONS OF DATA RESOURCES  The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding.

HEALTHY PEOPLE OBJECTIVES  15-28: Reduce hip fractures among older adults
FALL INDICATOR 4:  
Falls in Adults Aged 45 Years or Older

This indicator will be calculated at CDC.

DEMOGRAPHIC GROUP  
Resident persons aged 45 years or older.

NUMERATOR  
Those respondents who experienced a fall.

DENOMINATOR  
Respondents aged 45 years or older.

MEASURES OF FREQUENCY  
Annual prevalence—crude.

DATA RESOURCES  
Data from the Behavioral Risk Factor Surveillance System (BRFSS).

PERIOD FOR CASE DEFINITION  
Past 3 months.

BACKGROUND  
More than one third of adults aged 65 years or older fall each year in the United States. Many people who fall, even those who are not injured, develop a fear of falling. This fear may cause them to limit their activities, leading to reduced mobility and physical fitness and increasing their actual risk of falling.

LIMITATIONS OF INDICATOR  
Self-reported data only represent a small portion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of all injuries.

LIMITATIONS OF DATA RESOURCES  
As with all self-reported sample surveys, BRFSS data might be subject to systematic error resulting from noncoverage (e.g., lower telephone coverage among populations of low socioeconomic status), nonresponse (e.g., refusal to participate in the survey or to answer specific questions), or measurement (e.g., social desirability or recall bias).

HEALTHY PEOPLE OBJECTIVES  
No objective
### FALL INDICATOR 5:
Falls in Adults Aged 45 Years or Older that Caused an Injury

*This indicator will be calculated at CDC.*

<table>
<thead>
<tr>
<th>DEMOGRAPHIC GROUP</th>
<th>Resident persons aged 45 years or older.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMERATOR</td>
<td>Those respondents who experienced a fall that caused them to limit their regular activities for at least a day or to go see a doctor.</td>
</tr>
<tr>
<td>DENOMINATOR</td>
<td>Respondents aged 45 years or older who experienced a fall.</td>
</tr>
<tr>
<td>MEASURES OF FREQUENCY</td>
<td>Annual prevalence—crude.</td>
</tr>
<tr>
<td>DATA RESOURCES</td>
<td>Data from the Behavioral Risk Factor Surveillance System (BRFSS).¹²</td>
</tr>
<tr>
<td>PERIOD FOR CASE DEFINITION</td>
<td>Past 3 months.</td>
</tr>
</tbody>
</table>

**BACKGROUND**

More than 3.2 million people aged 45 years or older were treated in emergency departments in 2005 for injuries related to unintentional falls.¹ This statistic does not include those people who sought care in other settings such as outpatient clinics or doctor’s offices.

**LIMITATIONS OF INDICATOR**

Self-reported data only represent a small portion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of all injuries.

**LIMITATIONS OF DATA RESOURCES**

As with all self-reported sample surveys, BRFSS data might be subject to systematic error resulting from noncoverage (e.g., lower telephone coverage among populations of low socioeconomic status), nonresponse (e.g., refusal to participate in the survey or to answer specific questions), or measurement (e.g., social desirability or recall bias).

**HEALTHY PEOPLE OBJECTIVES**

No objective
### FIRE-RELATED INDICATOR 1:
Unintentional Fire-Related Fatalities

**DEMOGRAPHIC GROUP**
All residents.

**NUMERATOR**
Deaths with any of the following ICD-10 codes as an underlying cause of death.

**Unintentional Fire-Related Fatality ICD-10 Codes**

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X00–X09</td>
<td>Exposure to smoke, fire, and flames</td>
</tr>
</tbody>
</table>

**DENOMINATOR**
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

**MEASURES OF FREQUENCY**
Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

**DATA RESOURCES**
Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

**PERIOD FOR CASE DEFINITION**
Calendar year.

**BACKGROUND**
The United States mortality rate from fires ranks sixth among the 25 developed countries for which statistics are available. Four out of five deaths in 2005 occurred in homes and approximately half of home fire deaths occurred in homes without fire alarms.

**LIMITATIONS OF INDICATOR**
Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.

**LIMITATIONS OF DATA RESOURCES**
The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding. The overall completeness of external cause coding on death data is uniformly high. Coding criteria specify that cases of injury death must contain an injury code in the underlying-cause-of-death field.

**HEALTHY PEOPLE OBJECTIVES**
15-25: Reduce residential fire deaths
FIRE-RELATED INDICATOR 2:  
Unintentional Fire-Related Hospitalizations

DEMOGRAPHIC GROUP
All residents.

NUMERATOR
Hospitalizations identified from the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset) by searching for E-codes in the following manner: Search all diagnosis fields. If a designated E-code field is in your data set, start with the designated E-code field. Count the first-listed valid E-code, unless it is E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional E-code and diagnostic fields and use the next listed valid E-code.

Unintentional Fire-Related Hospitalization ICD-9-CM Codes

| E890–E899   | Accident caused by fire and flames |

DENOMINATOR
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY
Annual number of persons hospitalized. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES
State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION
Calendar year.

BACKGROUND
In 2005, fire departments responded to 396,000 home fires in the U.S., which claimed the lives of 3,030 people (not including firefighters) and injured another 13,825 (not including firefighters). Residential fires disproportionately affect young children, older adults, African Americans, and Native Americans. Working smoke alarms reduce the chance of dying in a house fire by 40% to 50%; however, about 25% of U.S. households lack working smoke alarms.

LIMITATIONS OF INDICATOR
Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

LIMITATIONS OF DATA RESOURCES
The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding. The overall completeness of e-coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE OBJECTIVES
No objective
FIREARM-RELATED INDICATOR 1: Firearm-Related Fatalities

DEMOGRAPHIC GROUP  All residents.

NUMERATOR  Deaths with any of the following ICD-10 codes as an underlying cause of death.

Firearm-Related Fatality ICD-10 Codes

- W32–W34  Exposure to inanimate mechanical forces—firearm discharge
- X72–X74  Intentional self-harm by firearm discharge
- X93–X95  Assault by firearm discharge
- Y22–Y24  Firearm discharge of undetermined intent
- Y35.0  Legal intervention involving firearm discharge
- *U01.4  Terrorism involving firearms

DENOMINATOR  Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY  Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES  Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION  Calendar year.

BACKGROUND  Firearm-related injuries were the second leading cause of injury-related death in the United States, accounting for about 30,700 deaths in 2005. Nationally, the firearm-related death rate for males is almost seven times higher than that of females.

LIMITATIONS OF INDICATOR  Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.

LIMITATIONS OF DATA RESOURCES  The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding. The overall completeness of external cause coding on death data is uniformly high. Coding criteria specify that all cases of injury death must contain an injury code in the underlying-cause-of-death field.

HEALTHY PEOPLE OBJECTIVES  15-3: Reduce firearm-related deaths
FIREARM-RELATED INDICATOR 2:
Firearm-Related Hospitalizations

DEMOGRAPHIC GROUP  All residents.

NUMERATOR  Hospitalizations identified from the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset) by searching for E-codes in the following manner: Search all diagnosis fields. If a designated E-code field is in your data set, start with the designated E-code field. Count the first-listed valid E-code, unless it is E849, E967, E869.4, E870–E879, or E930–E949, in which case, search additional E-code and diagnostic fields and use the next listed valid E-code.

Firearm-Related Hospitalization ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E922.0–E922.3, E922.8, E922.9</td>
<td>Accident caused by firearm missile</td>
</tr>
<tr>
<td>E955.0–E955.4</td>
<td>Suicide and self-inflicted injury by firearms</td>
</tr>
<tr>
<td>E965.0–E965.4</td>
<td>Assault by firearms</td>
</tr>
<tr>
<td>E985.0–E985.4</td>
<td>Injury by firearms, undetermined whether accidentally, or purposely inflicted</td>
</tr>
<tr>
<td>E970</td>
<td>Injury due to legal intervention by firearms</td>
</tr>
<tr>
<td>E979.4</td>
<td>Terrorism involving firearms</td>
</tr>
</tbody>
</table>

DENOMINATOR  Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006–RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY  Annual number of persons hospitalized. Annual incidence rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES  State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION  Calendar year.

BACKGROUND  Nonfatal firearm-related injury rates are highest among persons ages 15 to 24 years. About one fifth of nonfatal firearm-related injuries treated in U.S. hospital emergency departments are unintentional.

LIMITATIONS OF INDICATOR  Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

LIMITATIONS OF DATA RESOURCES  The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding. The overall completeness of e-coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE OBJECTIVES  15-5: Reduce nonfatal firearm-related injuries
HOMICIDE/ASSAULT INDICATOR 1: Homicides

**DEMOGRAPHIC GROUP**
All residents.

**NUMERATOR**
Deaths with any of the following ICD-10 codes as an underlying cause of death.

**Homicide ICD-10 Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X85–Y09</td>
<td>Assault</td>
</tr>
<tr>
<td>Y87.1</td>
<td>Sequelae of assault</td>
</tr>
<tr>
<td>*U01</td>
<td>Terrorism-assault</td>
</tr>
<tr>
<td>*U02</td>
<td>Sequelae of terrorism-assault</td>
</tr>
</tbody>
</table>

**DENOMINATOR**
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

**MEASURES OF FREQUENCY**
Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

**DATA RESOURCES**
Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

**PERIOD FOR CASE DEFINITION**
Calendar year.

**BACKGROUND**
Homicide is the fifteenth leading cause of death in the United States; it is the second most common cause of death among persons ages 15 to 24 years.¹

**LIMITATIONS OF INDICATOR**
Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.

**LIMITATIONS OF DATA RESOURCES**
The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding. The overall completeness of external cause coding on death data is uniformly high. Coding criteria specify that all cases of injury death must contain an injury code in the underlying-cause-of-death field.

**HEALTHY PEOPLE OBJECTIVES**
15-32: Reduce homicides
HOMICIDE/ASSAULT INDICATOR 2: 
Assault-Related Hospitalizations

DEMOGRAPHIC GROUP All residents.

NUMERATOR Hospitalizations identified from the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset) by searching for E-codes in the following manner: Search all diagnosis fields. If a designated E-code field is in your data set, start with the designated E-code field. Count the first-listed valid E-code, unless it is E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional E-code and diagnostic fields and use the next listed valid E-code.

Assault-Related Hospitalization ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E960–E969</td>
<td>Injury purposely inflicted by other persons</td>
</tr>
<tr>
<td>E979</td>
<td>Terrorism</td>
</tr>
<tr>
<td>E999.1</td>
<td>Late effect of injury due to terrorism</td>
</tr>
</tbody>
</table>

DENOMINATOR Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006—RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY Annual number of persons hospitalized. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION Calendar year.

BACKGROUND In 2005, over 1.6 million people were treated in U.S. emergency departments for assault-related injuries with 114,000 of them hospitalized or transferred for a higher level of care.

LIMITATIONS OF INDICATOR Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

LIMITATIONS OF DATA RESOURCES The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding. The overall completeness of e-coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE OBJECTIVES 15-34: Reduce the rate of physical assault by current or former intimate partners 15-37: Reduce physical assaults 15-38: Reduce physical fighting among adolescents
MOTOR VEHICLE INDICATOR 1:
Motor Vehicle Traffic Fatalities

DEMOGRAPHIC GROUP
All residents.

NUMERATOR
Deaths with any of the following ICD-10 codes as an underlying cause of death.

Motor Vehicle Traffic Fatality ICD-10 Codes

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V02–V04 (.1, .9), V09.2</td>
<td>Pedestrian injured in transport accident</td>
</tr>
<tr>
<td>V12–V14 (.3–.9), V19 (.4–.6)</td>
<td>Pedal cyclist injured in transport accident</td>
</tr>
<tr>
<td>V20–V28 (.3–.9), V29 (.4–.9)</td>
<td>Motorcycle rider injured in transport accident</td>
</tr>
<tr>
<td>V30–V39 (.4–.9)</td>
<td>Occupant of three-wheeled motor vehicle injured in transport accident</td>
</tr>
<tr>
<td>V40–V49 (.4–.9)</td>
<td>Car occupant injured in transport accident</td>
</tr>
<tr>
<td>V50–V59 (.4–.9)</td>
<td>Occupant of pick-up truck or van injured in transport accident</td>
</tr>
<tr>
<td>V60–V69 (.4–.9)</td>
<td>Occupant of heavy transport vehicle injured in transport accident</td>
</tr>
<tr>
<td>V70–V79 (.4–.9)</td>
<td>Bus occupant injured in transport accident</td>
</tr>
<tr>
<td>V80 (.3–.5), V81.1, V82.1, V83–V86 (.0–.3), V87 (.0–.8), V89.2</td>
<td>Other land transport accidents</td>
</tr>
</tbody>
</table>

DENOMINATOR
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population table titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY
Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES
Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION
Calendar year.

BACKGROUND
Motor vehicle crashes are the leading cause of injury death in the United States. They are also the leading injury cause for years of potential life lost. 

LIMITATIONS OF INDICATOR
Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.

LIMITATIONS OF DATA RESOURCES
The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding. The overall completeness of external cause coding on death data is uniformly high. Coding criteria specify that all cases of injury death must contain an injury code in the underlying-cause-of-death field.

HEALTHY PEOPLE OBJECTIVES
15-15: Reduce deaths caused by motor vehicle crashes
15-16: Reduce pedestrian deaths on public roads
26-1: Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes
MOTOR VEHICLE INDICATOR 2:  
Motor Vehicle Traffic Hospitalizations

**DEMOGRAPHIC GROUP**  
All residents.

**NUMERATOR**  
Hospitalizations identified from the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset) by searching for E-codes in the following manner: Search all diagnosis fields. If a designated E-code field is in your data set, start with the designated E-code field. Count the first-listed valid E-code, unless it is E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional E-code and diagnostic fields and use the next listed valid E-code.

### Motor Vehicle Traffic Hospitalization ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E810–E819</td>
<td>Motor vehicle traffic accidents</td>
</tr>
</tbody>
</table>

**DENOMINATOR**  
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

**MEASURES OF FREQUENCY**  
Annual number of persons hospitalized. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

**DATA RESOURCES**  
State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

**PERIOD FOR CASE DEFINITION**  
Calendar year.

**BACKGROUND**  
In 2005, motor vehicle crashes were the cause of more than 4.3 million emergency department visits in the United States. It is estimated that front seat occupants who use lap/shoulder belts reduce their risk for fatal injury by about 45% and for moderate to critical injury by 45% to 50%.

**LIMITATIONS OF INDICATOR**  
Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

**LIMITATIONS OF DATA RESOURCES**  
The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding. The overall completeness of e-coding is of particular concern and should be reviewed in conjunction with the indicator.

**HEALTHY PEOPLE OBJECTIVES**  

15-17: Reduce nonfatal injuries caused by motor vehicle crashes  
15-18: Reduce nonfatal pedestrian injuries on public roads  
26-1: Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes
MOTOR VEHICLE INDICATOR 3:
Seat Belt Use

This indicator will be calculated at CDC.

DEMOGRAPHIC GROUP  Resident persons aged 18 years or older.

NUMERATOR  Those respondents reporting wearing their seatbelt “always” or “almost always” when driving or riding in a car.

DENOMINATOR  Respondents aged 18 years or older.

MEASURES OF FREQUENCY  Annual prevalence—crude.

DATA RESOURCES  Data from the Behavioral Risk Factor Surveillance System (BRFSS).\(^{12}\)

PERIOD FOR CASE DEFINITION  No time frame.

BACKGROUND  Safety belts are 45%–60% effective in reducing deaths and 50%–65% effective in reducing moderate-to-critical injuries.\(^{33}\)

LIMITATIONS OF INDICATOR  Self-reported data only represent a small portion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of all injuries.

LIMITATIONS OF DATA RESOURCES  As with all self-reported sample surveys, BRFSS data might be subject to systematic error resulting from noncoverage (e.g., lower telephone coverage among populations of low socioeconomic status), nonresponse (e.g., refusal to participate in the survey or to answer specific questions), or measurement (e.g., social desirability or recall bias).

HEALTHY PEOPLE OBJECTIVES  15-9: Increase use of safety belts
MOTOR VEHICLE INDICATOR 4:
Drinking and Driving

This indicator will be calculated at CDC.

DEMOGRAPHIC GROUP

Resident persons aged 18 years or older reporting drinking at least one alcoholic beverage in the past 30 days.

NUMERATOR

Those respondents reporting driving one or more times after perhaps having too much to drink in the past 30 days.

DENOMINATOR

Respondents aged 18 years or older reporting having a specific number of drinks on one occasion during the previous month (including unknowns and refusals).

MEASURES OF FREQUENCY

Annual prevalence—crude.

DATA RESOURCES

Data from the Behavioral Risk Factor Surveillance System (BRFSS).12

PERIOD FOR CASE DEFINITION

Previous month.

BACKGROUND

In 2005, nearly 1.4 million drivers were arrested for driving under the influence of alcohol or narcotics.34 This statistic is less than 1% of the 159 million self-reported episodes of alcohol-impaired driving among U.S. adults each year.35

LIMITATIONS OF INDICATOR

Self-reported data only represent a small portion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of all injuries.

LIMITATIONS OF DATA RESOURCES

As with all self-reported sample surveys, BRFSS data might be subject to systematic error resulting from noncoverage (e.g., lower telephone coverage among populations of low socioeconomic status), nonresponse (e.g., refusal to participate in the survey or to answer specific questions), or measurement (e.g., social desirability or recall bias).

HEALTHY PEOPLE OBJECTIVES

26-1: Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes
MOTOR VEHICLE INDICATOR 5:
Alcohol-Related Crash Deaths

This indicator will be calculated at CDC.

**DEMOGRAPHIC GROUP**
All residents.

**NUMERATOR**
Alcohol-related death of a person involved in crash of a motor vehicle traveling on a public roadway and occurring within 30 days of the crash. Deaths are considered alcohol related if either a driver or nonoccupant (e.g., pedestrian or bicyclist) had a blood alcohol concentration (BAC) greater than or equal to 0.01 g/dL.\(^{15}\)

**DENOMINATOR**
Midyear population for the calendar year under surveillance.

**MEASURES OF FREQUENCY**
Annual number of deaths. Annual mortality rate—crude.

**DATA RESOURCES**
Fatality Analysis Reporting System (FARS) coordinated by the National Highway Traffic Safety Administration (NHTSA) (numerator)\(^{15}\) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

**PERIOD FOR CASE DEFINITION**
Calendar year.

**BACKGROUND**
In 2006, 13,470 people died in alcohol-impaired driving crashes, accounting for nearly one third (32\%) of all traffic-related deaths in the United States. Half of the 306 child passengers aged 14 years and younger who died in alcohol-related crashes in 2006 were riding with drivers who had a BAC level of 0.08 g/dL or higher.\(^{36}\)

**LIMITATIONS OF INDICATOR**
Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less severe injuries.

**LIMITATIONS OF DATA RESOURCES**
FARS does not include nontraffic crashes such as those occurring on driveways and other private property. In addition, it does not include deaths that occur more than 30 days after the motor vehicle crash. Because blood alcohol levels are not available on all fatalities, the estimates are based on a discriminant analysis of information from all cases where BAC data are available.

**HEALTHY PEOPLE OBJECTIVES**
15-15: Reduce deaths caused by motor vehicle crashes
15-16: Reduce pedestrian deaths on public roads
26-1: Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes
POISONING INDICATOR 1: Poisoning Fatalities

DEMOGRAPHIC GROUP  All residents.

NUMERATOR  Deaths with any of the following ICD-10 codes as an underlying cause of death.

Poisoning Fatality ICD-10 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X40–X49</td>
<td>Accidental poisoning by and exposure to noxious substances</td>
</tr>
<tr>
<td>X60–X69</td>
<td>Intentional self-poisoning</td>
</tr>
<tr>
<td>X85–X90</td>
<td>Assault by poisoning</td>
</tr>
<tr>
<td>Y10–Y19</td>
<td>Poisoning of undetermined intent</td>
</tr>
<tr>
<td>Y35.2</td>
<td>Legal intervention involving gas</td>
</tr>
<tr>
<td>*U01 (.6–.7)</td>
<td>Terrorism involving biological or chemical weapons</td>
</tr>
</tbody>
</table>

DENOMINATOR  Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY  Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES  Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION  Calendar year.

BACKGROUND  Poisoning is the result of the damaging effect of exposure to a broad range of chemicals (e.g., gases, pesticides, heavy metals, drugs, and common household substances such as bleach and ammonia). In 2005, 32,691 people in the United States died from poisoning.1

LIMITATIONS OF INDICATOR  Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.

LIMITATIONS OF DATA RESOURCES  The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding. The overall completeness of external cause coding on death data is uniformly high. Coding criteria specify that cases of injury death must contain an injury code in the underlying-cause-of-death field.

HEALTHY PEOPLE OBJECTIVES  15-8: Reduce deaths caused by poisonings
POISONING INDICATOR 2:
Poisoning Hospitalizations

DEMographic GROUP  All residents.

NUMERATOR  Hospitalizations identified from the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset) by searching for E-codes in the following manner: Search all diagnosis fields. If a designated E-code field is in your data set, start with the designated E-code field. Count the first-listed valid E-code, unless it is E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional E-code and diagnostic fields and use the next listed valid E-code.

Poisoning Hospitalization ICD-9-CM Codes

| E850–E858 | Accidental poisoning by drugs, medicinal substances, and biologicals |
| E860–E869 | Accidental poisonings by other solid and liquid substances, gases, and vapors |
| E950–E952 | Suicide and self-inflicted poisoning |
| E962 | Assault by poisoning |
| E972 | Injury due to legal intervention by gas |
| E980–E982 | Poisoning undetermined whether accidentally or purposefully inflicted |
| E979 (.6–.7) | Terrorism involving biological or chemical weapons |

DENOMINATOR  Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY  Annual number of persons hospitalized. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES  State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION  Calendar year.

BACKGROUND  In 1999, 21 states reported that hospitalization rates were 4 to 15 times higher than death rates for poisoning-related injuries.

LIMITATIONS OF INDICATOR  Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

LIMITATIONS OF DATA RESOURCES  The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding. The overall completeness of e-coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE OBJECTIVES  15-7: Reduce nonfatal poisonings
SUICIDE/SUICIDE ATTEMPT INDICATOR 1: Suicides

DEMOGRAPHIC GROUP  All residents.

NUMERATOR  Deaths with any of the following ICD-10 codes as an underlying cause of death.

Suicide ICD-10 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X60–X84</td>
<td>Intentional self-harm</td>
</tr>
<tr>
<td>Y87.0</td>
<td>Sequelae of intentional self-harm</td>
</tr>
<tr>
<td>*U03</td>
<td>Terrorism-intentional self-harm</td>
</tr>
</tbody>
</table>

DENOMINATOR  Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY  Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES  Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION  Calendar year.

BACKGROUND  In 2005, suicide was the second leading cause of death among adults ages 25 to 34 years and the third leading cause of death for adolescents and young adults ages 10 to 24 years.1

LIMITATIONS OF INDICATOR  Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.

LIMITATIONS OF DATA RESOURCES  The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding. The overall completeness of external cause coding on death data is uniformly high. Coding criteria specify that cases of injury death must contain an injury code in the underlying-cause-of-death field.

HEALTHY PEOPLE OBJECTIVES  18-1: Reduce the suicide rate
SUICIDE /SUICIDE ATTEMPT INDICATOR 2: Suicide Attempt Hospitalizations

DEMOGRAPHIC GROUP
All residents.

NUMERATOR
Hospitalizations identified from the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset) by searching for E-codes in the following manner: Search all diagnosis fields. If there is a designated E-code field in your data set, start with the designated E-code field. Count the first-listed valid E-code, unless it is E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional E-code and diagnostic fields and then use the next listed valid E-code.

Suicide Attempt Hospitalization ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E950–E959</td>
<td>Suicide and self-inflicted injury</td>
</tr>
</tbody>
</table>

DENOMINATOR
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY
Annual number of persons hospitalized. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES
State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION
Calendar year.

BACKGROUND
In 2005, there were an estimated 373,000 hospital emergency department visits for suicide attempts in the United States.1

LIMITATIONS OF INDICATOR
Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

LIMITATIONS OF DATA RESOURCES
The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding. The overall completeness of e-coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE OBJECTIVES
18-2: Reduce the rate of suicide attempts by adolescents
TRAUMATIC BRAIN INJURY INDICATOR 1:
Traumatic Brain Injury Fatalities

DEMographic GROUP
All residents.

NUMERATOR
Deaths with any of the following ICD-10 codes in any field of the multiple cause of death file.

Traumatic Brain Injury Fatality ICD-10 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S01.0–S01.9</td>
<td>Open wound of head</td>
</tr>
<tr>
<td>S02.0, S02.1, S02.3, S02.7–S02.9</td>
<td>Fracture of skull and facial bones</td>
</tr>
<tr>
<td>S04.0</td>
<td>Injury of optic nerve and pathways</td>
</tr>
<tr>
<td>S06.0–S06.9</td>
<td>Intracranial injury</td>
</tr>
<tr>
<td>S07.0, S07.1, S07.8, S07.9</td>
<td>Crushing injury of head</td>
</tr>
<tr>
<td>S09.7–S09.9</td>
<td>Other and unspecified injuries of head</td>
</tr>
<tr>
<td>T01.0*</td>
<td>Open wounds involving head with neck</td>
</tr>
<tr>
<td>T02.0*</td>
<td>Fractures involving head with neck</td>
</tr>
<tr>
<td>T04.0*</td>
<td>Crushing injuries involving head with neck</td>
</tr>
<tr>
<td>T06.0*</td>
<td>Injuries of brain and cranial nerves with injuries of nerves and spinal cord at neck level</td>
</tr>
<tr>
<td>T90.1, T90.2, T90.4, T90.5, T90.8, T90.9</td>
<td>Sequelae of injuries of head</td>
</tr>
</tbody>
</table>

* These codes are not considered valid in the US

DENOMINATOR
Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY
Annual number of deaths. Annual mortality rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).

DATA RESOURCES
Death certificate data from vital statistics agencies (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION
Calendar year.

BACKGROUND
Of the approximately 1.7 million people who sustained a TBI in the United States each year, an estimated 52,000 died; 275,000 were hospitalized; and 1.365 million were treated and released from an emergency department.

LIMITATIONS OF INDICATOR
Injuries severe enough to result in death represent only a small proportion of the overall burden of injury. An evaluation of only these injuries may not present an accurate picture of the causes of less-severe injuries.

LIMITATIONS OF DATA RESOURCES
The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of coding.

HEALTHY PEOPLE OBJECTIVES
No objective
TRAUMATIC BRAIN INJURY INDICATOR 2:
Traumatic Brain Injury Hospitalizations

DEMEOGRAPHIC GROUP All residents.

NUMERATOR Hospitalizations with any of the following ICD-9-CM diagnostic codes. These should be identified by searching all diagnostic fields of the injury hospital discharge subset (see methods on page 6 for developing the injury hospital discharge subset).

Traumatic Brain Injury Hospitalization ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Diagnosis codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>800.00–801.99</td>
<td>Fracture of the vault or base of the skull</td>
</tr>
<tr>
<td>803.00–804.99</td>
<td>Other and unqualified or multiple fractures of the skull</td>
</tr>
<tr>
<td>850.0–850.9</td>
<td>Concussion</td>
</tr>
<tr>
<td>851.00–854.19</td>
<td>Intracranial injury, including contusion, laceration, and hemorrhage</td>
</tr>
<tr>
<td>950.1–950.3</td>
<td>Injury to the optic chiasm, optic pathways, or visual cortex</td>
</tr>
<tr>
<td>959.01</td>
<td>Head injury, unspecified</td>
</tr>
<tr>
<td>995.55</td>
<td>Shaken infant syndrome</td>
</tr>
</tbody>
</table>

DENOMINATOR Midyear population for the calendar year under surveillance. To obtain population estimates by age and sex for your state, use U.S. Census Bureau population tables titled “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT” (see instructions on page 39).

MEASURES OF FREQUENCY Annual number of persons hospitalized. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population). Rates should be calculated for age and sex.

DATA RESOURCES State hospital discharge data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION Calendar year.

BACKGROUND An estimated 5.3 million Americans live with a TBI-related disability. According to one study, about 40% of those hospitalized with a TBI had at least one unmet need for services one year after their injury. Injuries that result in a hospital admission represent only a portion of the overall burden of injury. Evaluations of these injuries should be considered in the context of both less- and more-severe injuries.

LIMITATIONS OF INDICATOR The accuracy of indicators based on codes found in hospital discharge data is limited by the completeness and quality of coding.

LIMITATIONS OF DATA RESOURCES

HEALTHY PEOPLE OBJECTIVES 15-1: Reduce hospitalization for nonfatal head injuries
CALCULATING AND SUBMITTING RATES

Calculation Formula and Instructions

Preformatted rate calculation spreadsheets have been prepared for both the hospital discharge and vital records-based indicators. These spreadsheets can be obtained from Karen Thomas at KEThomas@cdc.gov. Completion of the spreadsheet requires:

- Answering a few data background questions;
- Inserting state population data;
- Entering case counts for individual indicators; and
- Renaming the spreadsheets to reflect state and submission number.

Rate calculations include several types of rates (i.e., age-specific crude rates and age-adjusted rates). The following rate calculation specifications have been preprogrammed into the spreadsheet. If you are preparing these data independent of the spreadsheet, please be sure to follow the same specifications.

- Use the estimated population for the year of the data. This information may be obtained from several sources:
  - www.census.gov/popest/datasets.html (preferred)
    - Scroll to “State population datasets”
    - Continue scrolling to “State Estimates by Demographic Characteristics– Age, Sex, Race, and Hispanic Origin”
    - Continue scrolling to “State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2006 – RESIDENT”
    - Download File layout
    - Download CSV File
  - your state’s demographic center
- Compute rates per 100,000 population.
- For each indicator, except hip fracture hospitalizations, report age-adjusted rates stratified by sex (female and male), and report the overall age-adjusted rate for the state.
- Report age-specific rates for each indicator in the following age categories:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td>45–54</td>
</tr>
<tr>
<td>1–4</td>
<td>55–64</td>
</tr>
<tr>
<td>5–14</td>
<td>65–74</td>
</tr>
<tr>
<td>15–24</td>
<td>75–84</td>
</tr>
<tr>
<td>25–34</td>
<td>85+</td>
</tr>
<tr>
<td>35–44</td>
<td></td>
</tr>
</tbody>
</table>
It is possible to obtain the anomalous looking overall age-adjusted rate which does not fall between the two gender-specific age-adjusted rates. Such outcomes are mathematically possible and should be included.

Calculate age-adjusted rates using the age-specific U.S. standard population weights from Table 1.

**TABLE 1. AGE ADJUSTMENT TABLE: ALL AGES–ELEVEN AGE GROUPS**

<table>
<thead>
<tr>
<th>Age</th>
<th>U.S. 2000 Standard Population (1,000’s)</th>
<th>Adjustment Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>274,634</td>
<td>1.000000</td>
</tr>
<tr>
<td>Under 1</td>
<td>3,795</td>
<td>0.013818</td>
</tr>
<tr>
<td>1–4</td>
<td>15,192</td>
<td>0.055317</td>
</tr>
<tr>
<td>5–14</td>
<td>39,977</td>
<td>0.145565</td>
</tr>
<tr>
<td>15–24</td>
<td>38,077</td>
<td>0.138646</td>
</tr>
<tr>
<td>25–34</td>
<td>37,233</td>
<td>0.135573</td>
</tr>
<tr>
<td>35–44</td>
<td>44,659</td>
<td>0.162613</td>
</tr>
<tr>
<td>45–54</td>
<td>37,030</td>
<td>0.134834</td>
</tr>
<tr>
<td>55–64</td>
<td>23,961</td>
<td>0.087247</td>
</tr>
<tr>
<td>65–74</td>
<td>18,136</td>
<td>0.066037</td>
</tr>
<tr>
<td>75–84</td>
<td>12,315</td>
<td>0.044842</td>
</tr>
<tr>
<td>85+</td>
<td>4,259</td>
<td>0.015508</td>
</tr>
</tbody>
</table>
REFERENCES


