State Injury Indicators Report

Instructions for Preparing 2014 Data

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

CSTE
Council of State and Territorial Epidemiologists

SAFE STATES

State Injury Indicators Report:
Instructions for Preparing 2014 Data

U.S. Department of Health and Human Services

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Analysis, Research and Practice Integration

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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 2014 state injury indicators.

Under Funding Opportunity Announcement CE11-1101, 20 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 products. 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 2012 data collection cycle, 32 states participated by submitting data for inclusion in the multistate products. 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 State and Territorial Injury Prevention Directors Association (STIPDA; now known as the Safe States Alliance) 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 2014 data collection cycle include:

There were no changes to the data collection methods for 2014. This document has been updated to include the appropriate indicators from the additional data sources and more recent background data.

ABBREVIATIONS

BAC	Blood alcohol concentration
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CSTE	Council of State and Territorial Epidemiologists
FARS	Fatality Analysis Reporting System
HDD	Hospital discharge data
ICD-10	International Classification of Diseases– Tenth Revision
ICD-9-CM	International Classification of Diseases– Ninth Revision– Clinical Modification
MVC	Motor vehicle crash
NCHS	National Center for Health Statistics
NCIPC	National Center for Injury Prevention and Control
NHTSA	National Highway Traffic Safety Administration
NPHSS	National Public Health Surveillance System
OSELS	Office of Surveillance, Epidemiology, and Laboratory Services
SAVIR	Society for Advancement of Violence and Injury Research
STIPDA	State and Territorial Injury Prevention Directors Association (currently Safe States Alliance)
TBI	Traumatic brain injury
VA	Veterans Affairs
WHO	World Health Organization
WISQARS	Web-based Injury Statistics Query and Reporting System
YRBS	Youth Risk Behavior Survey

CONTENTS

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.[1] In 2014, almost 200,000 people died from injuries in the U.S. Among them: 21% died from suicide; 17% died from motor-vehicle crashes; 21% died from unintentional poisonings; and 8% died from homicide.[1] In 2014, almost 31 million people were treated for injuries in U.S. emergency departments.[1] The total lifetime medical and work loss costs of injuries and violence in the United States was $671 billion in 2013.[2,3]

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.[4] The scope of public health encompasses injuries involving any mechanism (e.g., firearm, motor vehicle, or burn) and includes both violence 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.[5] 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. While these recommendations were updated in 2007,[6] they remain a foundational building block for injury surveillance.

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.[7] In tandem with the *State Health Department Consensus Recommendations*, CSTE and STIPDA developed injury indicators that were formally adopted for inclusion in NPHSS.[8,9] The NPHSS injury indicators add to other indicators developed by CSTE for chronic diseases and other areas.[8]

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.[10] It presents important considerations for the evaluation of data quality and outlines the methodology for developing an injury hospitalization data set. Specific recommendations for the use of emergency department data for injury surveillance were included in the 2007 version of the *Consensus recommendations for injury surveillance in state health departments*.[6]

Collection and dissemination of injury indicators is built upon the foundation laid by the publication of these Safe States Alliance (formerly known as STIPDA) and CSTE documents.

BACKGROUND AND PURPOSE

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

Information obtained from participants will be reviewed and assembled for inclusion in in various State Injury Indicators products. 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 analyses.

The process of preparing indicators is simplified in that it doesn't include the merging and unduplicating of cases found in multiple 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-of-injury coding found within individual state and U.S. territory data sets.

Statewide, centralized electronic vital statistics, hospital discharge, and emergency department 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 SETS

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.[11] 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).[12]

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. Include all records with a date of death between January 1, 2014 and December 31, 2014. 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, first limit the dataset to only deaths with an injury underlying cause of death (V01–Y36, Y85–Y87, Y89, *U01–*U03), and then search *all fields* in the multiple cause of death file. Specific code ranges are identified in the individual indicator pages (see pages 13–50). Deaths should be age-adjusted to the 2000 standard using the NCHS population distribution (Table 1, page 52).

Background on State Hospital Discharge Data

At least 90% of all states maintain statewide, centralized, electronic databases of hospital discharge records for nonfederal, acute care hospitals located within their borders.[13] The information collected varies from state to state. Many states use the standard uniform billing form (UB-04) as the basis for their hospital discharge database. Others use only a subset of variables from the UB-04 for their databases, and a few collect additional variables.

The UB-04, developed by the National Uniform Billing Committee, includes the following data elements:[14]

- patient's age,
- sex,
- zip code,
- admission date,
- length of stay,
- total charges,
- principal diagnosis, and
- up to seventeen additional diagnoses.

For diagnoses resulting from injuries, an external cause of injury is also coded. External-cause-of-injury codes, listed in ICD-9-CM, describe several aspects of an injury: intentionality; mechanism; location of occurrence; external cause status (e.g., civilian activity done for pay, military activity); and activity.[15] Completeness of external-cause-of-injury 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.
- Include records that have a date of discharge between January 1, 2014 and December 31, 2014.
- Based on the principal diagnosis field, create the injury hospitalization subset 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:[10]

INCLUDE	EXCLUDE
800–909.2,	< 800
909.4, 909.9	909.3, 909.5
910–994.9	995.0–995.4
995.5–995.59	995.6–995.7
995.80–995.85	995.86, 995.89
	995.90–995.94
	996–999

Once the injury hospitalization subset has been created, calculate the injury indicators case counts as defined on the individual indicator pages (see pages 13–50). Search for external-cause-of-injury codes in the following manner:

- Search all diagnosis fields.
- If a designated external-cause-of-injury field is in the data set, start with that field.
- Count the first-listed external-cause-of-injury code, unless it is E000-E030, E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional external-cause-of-injury fields and all diagnostic fields

and use the next listed valid external-cause-of-injury code. If a case has multiple valid external-cause-of-injury codes, then only the first one should be used in the analysis. If no other external-cause-of-injury code is present, report E967 or E869.4 (because these codes provide some information to classify the record to specific Injury Indicator categories) but not E000-E030, E849, 870-E879, or E930-E949.

- 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 52).

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

- Percentage of HDD injury records with external-cause-of-injury 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.

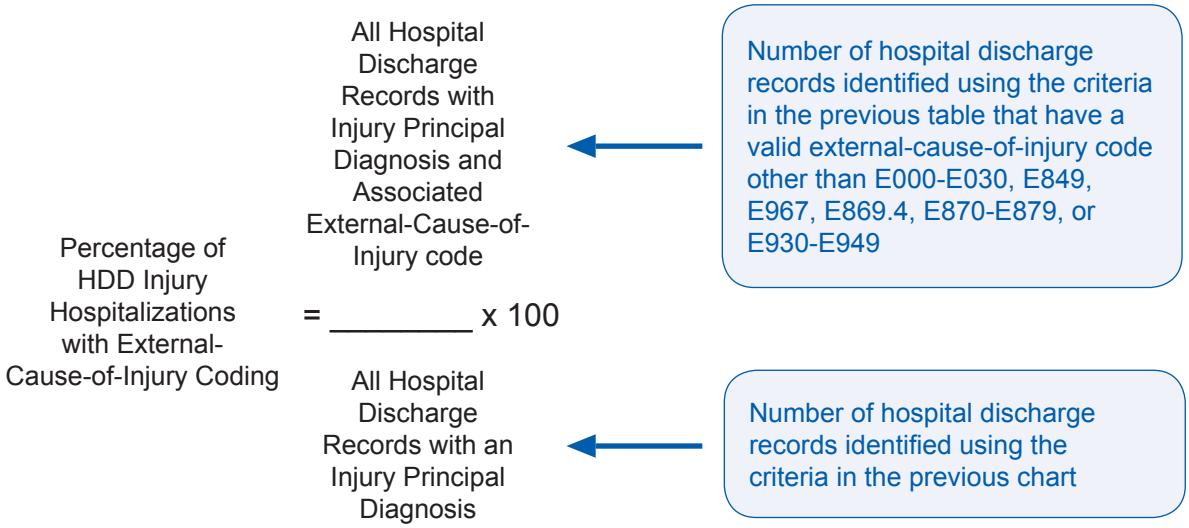

FIGURE 1

Background on State Emergency Department Data

The availability of statewide, centralized, electronic department (ED) datasets is increasing. In 2013 about two-thirds of states reported having access to ED data.[16] Many of these datasets are standardized around administrative or billing data. Since many injuries are seen only in the emergency department this is a dataset of emerging importance for injury surveillance.

The Injury Surveillance Workgroup 5 convened by STIPDA recommended that the ICD-9-CM code-based definition to be used with administrative ED data to identify an injury visit be broadened from the definition that is used to identify cases from HDD. For ED data, the injury subset should include any initial visit where the first-listed diagnosis reflects an injury based on the Barell matrix definition of an injury,[17] regardless of any mention

of an external-cause-of-injury code, **or** any initial visit with a valid external-cause-of-injury code based on the recommended framework for external causes of injury.[18] Similar to the current HDD methodology, complications of care and adverse effects should be excluded from both the diagnosis and external-cause-of-injury codes. For the rationale behind this recommendation, please refer to pages 23–4 of the ISW5 Report.[6]

Instructions for Creating and Using the Injury Subset of a State Emergency Department Data Set

To calculate State Emergency Department Indicators, first you need to create an injury subset of emergency department records. The creation of this subset varies from the creation of the HD subset in that ED injury cases may be identified not only by an injury primary diagnosis code but also by the presence of a valid external-cause-of-injury code. Create the ED subset using the following specifications:

- Include only data from nonfederal, acute care-affiliated facilities in your ED injury subset. This excludes Veterans Affairs (VA) and other federal hospitals, rehabilitation centers, and psychiatric hospitals.
- Include ED visits for state residents only.
- If the data are available, out-of-state ED visits of state residents should be included.
- Include records that have a date of visit between January 1, 2014 and December 31, 2014.
- If necessary, exclude records of patients that are seen in the ED and then admitted to the hospital. For most states, these records are not included in their ED data.
- Create the ED injury subset by searching the principal diagnosis field for injury diagnostic codes and all fields for valid external-cause-of-injury codes.
    - Select injury cases by searching the principal diagnosis field for the included ICD-9-CM diagnosis codes.

INCLUDE	EXCLUDE
800–909.2, 909.4, 909.9 910–994.9 995.5–995.59 995.80–995.85	< 800 909.3, 909.5 995.0–995.4 995.6–995.7 995.86, 995.89 995.90–995.94 996–999

    - Select additional cases by searching all fields for the included external-cause-of-injury codes.

SEARCH FOR THESE E-CODES	DO NOT SEARCH FOR THESE E-CODES
E800–E848, E850–E869	E849
E880–E929	E870–E879
E950–E999	E930–E949

- Exclude all other records from the injury ED subset.

Once the injury ED subset has been created, calculate the injury indicators case counts as defined on the individual indicator pages (see pages 13–50). Search for external-cause-of-injury codes in the following manner:

- Search all diagnosis fields.
- If a designated external-cause-of-injury field is in the data set, start with that field.
- Count the first-listed external-cause-of-injury code, unless it is E000–E030, E849, E967, E869.4, E870–E879, or E930–E949; in which case, search additional external-cause-of-injury fields and all diagnostic fields and use the next listed valid external-cause-of-injury code. If a case has multiple valid external-cause-of-injury codes, then only the first one should be used in the analysis. If no other external-cause-of-injury code is present, report E967 or E869.4 (because these codes provide some information to classify the record to specific Injury Indicator categories) but not E000–E030, E849, 870–E879, or E930–E949.
- ED visits (except for hip fracture ED visits in persons aged 65 years and older) should be age-adjusted to the 2000 standard using the NCHS population distribution (Table 1, page 52).

Assess the completeness and quality measures of the ED data for the following components:

- Percentage of ED injury records with external-cause-of-injury coding (Figure 2, below).
- Completeness of hospitals participating in the ED system.
- Inclusion of follow up visits and transfers from other EDs
- A subjective assessment by health department staff if a substantial proportion of state residents injured in-state are actually treated in EDs in a neighboring state.

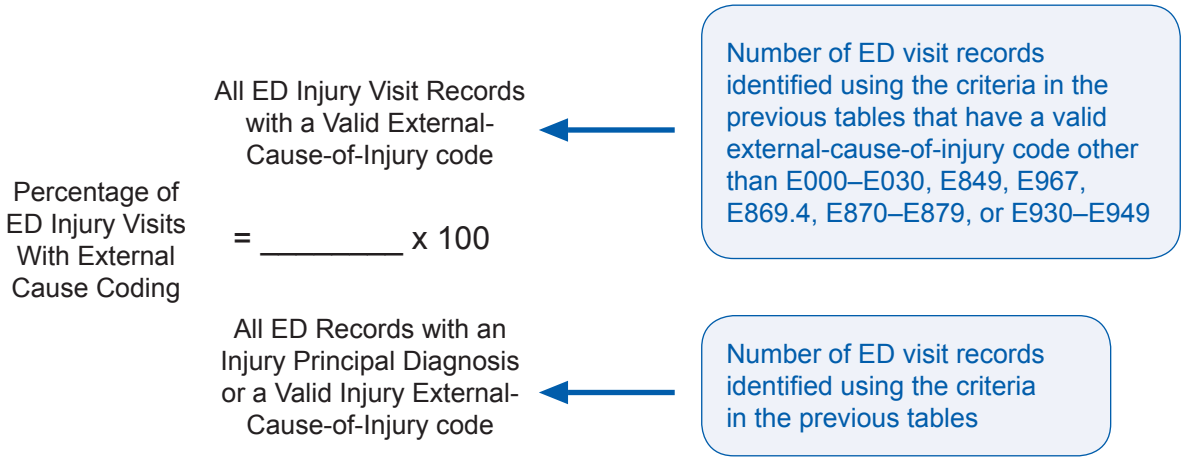

FIGURE 2

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 currently manages the BRFSS. This is a broad ongoing survey that is 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.[19]

Because BRFSS is telephone-based, population subgroups less likely to have telephones, such as persons of low socioeconomic status, may be underrepresented. However, beginning in 2011, BRFSS began to include data from cell phone users to better represent the U.S. population.[20] Additionally, 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.[19]

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 2014, there are four injury-related BRFSS questions that will be reported.

Youth Risk Behavior Survey (YRBS)

The YRBS is managed by the CDC's Division of Adolescent and School Health in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. The YRBS monitors risk behaviors associated with the leading causes of injury and death among teenagers.[21] 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.[21]

In 2013, 42 states conducted YRBS with overall participation rates of at least 60%.[22] 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 2014.

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.[23]

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.[23]

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

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

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

Injury Fatality ICD-10 Codes

V01–Y36, Y85–Y87, Y89, *U01–*U03	Injury and poisoning

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death.

BACKGROUND

Injuries are the leading cause of death for people 1 to 44 years of age and the third leading cause of death overall.[1] Almost 200,000 people died from injuries in 2014.[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 2020 OBJECTIVES

IVP-1.1: Reduce fatal injuries.
IVP-11: Reduce unintentional injury deaths.

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). 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

Diagnosis codes	
800–909.2, 909.4, 909.9–994.9, 995.5–995.59, 995.80–995.85	Injury and poisoning

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] 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 based on date of discharge.

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 2020 OBJECTIVES

IVP-1.2: Reduce hospitalization for nonfatal injuries.
IVP-12: Reduce nonfatal unintentional injuries.

ALL-INJURY INDICATOR 3:
Emergency Department Visits for All Injuries

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

ED visits with any of the following ICD-9-CM diagnostic or external cause of injury codes. These should be identified by searching for diagnosis codes only in the principal diagnostic field of the ED data set or searching all fields for the first valid external cause of injury code (see methods on page 8). The case count for injury ED visits should equal the number of records in your injury ED visit subset.

Emergency Department Visits for All Injuries ICD-9-CM Codes

Diagnosis codes and/or	
800–909.2, 909.4, 909.9–994.9, 995.5–995.59, 995.80–995.85	Injury and poisoning
External-cause-of-injury codes	
E800–E869, E880–E929, E950–E999	Injury and poisoning

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2014, almost 31 million people were treated in U.S. emergency departments for injuries with 3 million of them hospitalized or transferred to another facility.[1]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-1.3: Reduce emergency department visits for nonfatal injuries.
IVP-12: 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.

Unintentional Drowning Fatality ICD-10 Codes

W65–W74	Accidental drowning and submersion
V90	Accident to watercraft causing drowning and submersion
V92	Water-transport-related drowning and submersion without accident to watercraft

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death.

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 2020 OBJECTIVES

IVP-25: Reduce drowning deaths.

DROWNING INDICATOR 2:
Drowning-Related Hospitalizations

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Hospitalizations with any of the following ICD-9-CM diagnostic or external-cause-of-injury codes identified from the injury hospital discharge subset (see methods on page 6). These should be identified by searching for diagnosis codes in all diagnostic fields and by searching the first valid external-cause-of-injury code.

Drowning-Related Hospitalization ICD-9-CM Codes

Diagnosis code and/or	
994.1	Drowning and nonfatal submersion
External-cause-of-injury codes	
E830	Accident to watercraft causing submersion
E832	Other accidental submersion or drowning in water transport accident
E910	Accidental drowning or submersion
E954	Suicide and self-inflicted injury by submersion (drowning)
E964	Assault by submersion (drowning)
E984	Submersion (drowning), undetermined whether accidentally or purposefully inflicted

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] 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 based on date of discharge.

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.[25]

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 external-cause-of-injury is of particular concern and should be reviewed in conjunction with the indicator.

DROWNING INDICATOR 3:
Drowning-Related Emergency Department Visits

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Emergency department visits with any of the following ICD-9-CM diagnostic or external-cause-of-injury codes identified from the injury emergency department visit subset (see methods on page 8). These should be identified by searching for diagnosis codes in all diagnostic fields and by searching the first valid external-cause-of-injury code.

Drowning-Related Emergency Department Visit ICD-9-CM Codes

Diagnosis code and/or	
994.1	Drowning and nonfatal submersion
External-cause-of-injury codes	
E830	Accident to watercraft causing submersion
E832	Other accidental submersion or drowning in water transport accident
E910	Accidental drowning or submersion
E954	Suicide and self-inflicted injury by submersion (drowning)
E964	Assault by submersion (drowning)
E984	Submersion (drowning), undetermined whether accidentally or purposefully inflicted

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2014, there were an estimated 9,600 emergency department visits for unintentional nonfatal drowning-related injuries.[1]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding. The overall completeness of external-cause-of-injury 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

W00–W19	Falls

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death.

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.[1] In 2014, there were 31,959 unintentional fall-related deaths.[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 2020 OBJECTIVES

IVP-23: Prevent an increase in the rate of fall-related deaths.

FALL INDICATOR 2:
Unintentional Fall-Related Hospitalizations

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Hospitalizations identified from the injury hospital discharge subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 6).

Unintentional Fall-Related Hospitalization ICD-9-CM Codes

E880–E886, E888	Accidental falls

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] 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 based on date of discharge.

BACKGROUND

More than one third of adults 65 and older fall each year.[26, 27] 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.[28] In 2013, direct medical costs for falls—what patients and insurance companies pay—totaled $34 billion.[29]

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 external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

No objective.

FALL INDICATOR 3:
Unintentional Fall-Related Emergency Department Visits

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Emergency department visits identified from the injury emergency department visit subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 8).

Unintentional Fall-Related Emergency Department Visit ICD-9-CM Codes

E880–E886, E888	Accidental falls

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2014, there were over 9.1 million emergency department visits for unintentional fall-related injuries, with over 1.2 million resulting in hospitalization or transfer for additional care.[1]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding. The overall completeness of external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

No objective.

FALL INDICATOR 4:
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).

Hip Fracture Hospitalization ICD-9-CM Code

Diagnosis code	
820	Fracture of neck of femur

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. 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 based on date of discharge.

BACKGROUND

In 2004, there were an estimated 289,000 hospital admissions for hip fractures in people 65 years and older.[30] 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 injury[31] and as many as 20% of hip fracture patients die within a year of their injury.[32]

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 2020 OBJECTIVES

No objective.

FALL INDICATOR 5:
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older

DEMOGRAPHIC GROUP

Resident persons aged 65 years or older

NUMERATOR

Emergency department visits with the following ICD-9-CM diagnostic code. These should be identified by searching all diagnostic fields of the injury emergency department visit subset (see methods on page 8).

Hip Fracture Emergency Department VIsit ICD-9-CM Code

Diagnosis code	
820	Fracture of neck of femur

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude. Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2004, there were an estimated 289,000 hospital admissions for hip fractures in people 65 years and older.[30] 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 injury[31] and as many as 20% of hip fracture patients die within a year of their injury.[32]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding.

HEALTHY PEOPLE 2020 OBJECTIVES

OA-11: Reduce the rate of emergency department visits due to falls among older adults.

FALL INDICATOR 6:
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).[19]
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.[26, 27] 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.[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 2020 OBJECTIVES	No objective

FALL INDICATOR 7:
Falls in Adults Aged 45 years or Older That Caused an Injury

This indicator will be calculated at CDC.

DEMOGRAPHIC GROUP	Resident persons aged 45 years or older.
NUMERATOR	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.
DENOMINATOR	Respondents aged 45 years or older who experienced a fall.
MEASURES OF FREQUENCY	Annual prevalence—crude.
DATA RESOURCES	Data from the Behavioral Risk Factor Surveillance System (BRFSS).[19]
PERIOD FOR CASE DEFINITION	Past 3 months.
BACKGROUND	More than 4.7 million people aged 45 years or older were treated in emergency departments in 2014 for injuries related to unintentional falls.[1]
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 2020 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

X00–X09	Exposure to smoke, fire, and flames

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death

BACKGROUND

The United States mortality rate from fires ranks sixth among the 25 developed countries for which statistics are available.[34] Four out of five deaths in 2005 occurred in homes[35] and approximately half of home fire deaths occurred in homes without fire alarms.[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

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 2020 OBJECTIVES

IVP-28: 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 with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 6).

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 (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] 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 based on date of discharge.

BACKGROUND

Residential fires disproportionately affect young children, older adults, African Americans, and Native Americans.[37] 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.[38, 39]

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 external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

No objective.

FIRE-RELATED INDICATOR 3:
Unintentional Fire-Related Emergency Department Visits

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Emergency department visits identified from the injury emergency department visit subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 8).

Unintentional Fire-Related Emergency Department Visit ICD-9-CM Codes

E890–E899	Accident caused by fire and flames

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2014, there were over 390,000 emergency department visits for unintentional fire-related injuries, with over 28,000 resulting in hospitalization or transfer for additional care.[1]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding. The overall completeness of external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 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 (see instructions on page 51).

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).[24] 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 based on date of death.

BACKGROUND

Firearm-related injuries accounted for over 33,000 deaths in 2014. Nationally, the firearm-related death rate for males is six times higher than that of females.[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 2020 OBJECTIVES

IVP-30: Reduce firearm-related deaths.

FIREARM-RELATED INDICATOR 2:
Firearm-Related Hospitalizations

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Hospitalizations identified from the injury hospital discharge subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 6).

Firearm-Related Hospitalization ICD-9-CM Codes

E922.0–E922.3, E922.8, E922.9	Accident caused by firearm missile
E955.0–E955.4	Suicide and self-inflicted injury by firearms
E965.0–E965.4	Assault by firearms
E985.0–E985.4	Injury by firearms, undetermined whether accidentally, or purposely inflicted
E970	Injury due to legal intervention by firearms
E979.4	Terrorism involving firearms

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. Annual incidence rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] 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 based on date of discharge.

BACKGROUND

In 2014, there were over 81,000 emergency department visits for nonfatal firearm-related injuries, with over 46,000 resulting in hospitalization or transfer for additional care.[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 external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-31: Reduce nonfatal firearm-related injuries.

FIREARM-RELATED INDICATOR 3:
Firearm-Related Emergency Department Visits

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Emergency department visits identified from the injury emergency department visit subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 8).

Firearm-Related Emergency Department Visit ICD-9-CM Codes

E922.0–E922.3, E922.8, E922.9	Accident caused by firearm missile
E955.0–E955.4	Suicide and self-inflicted injury by firearms
E965.0–E965.4	Assault by firearms
E985.0–E985.4	Injury by firearms, undetermined whether accidentally, or purposely inflicted
E970	Injury due to legal intervention by firearms
E979.4	Terrorism involving firearms

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence rate—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2014, there were over 81,000 emergency department visits for nonfatal firearm-related injuries. Males comprised 89% of these visits.[1]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding. The overall completeness of external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-31: 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

X85–Y09	Assault
Y87.1	Sequelae of assault
*U01	Terrorism-assault
*U02	Sequelae of terrorism-assault

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death.

BACKGROUND

Homicide is the seventeenth leading cause of death in the United States; it is the third most common cause of death among persons ages 1 to 4 and 15 to 34 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 2020 OBJECTIVES

IVP-29: Reduce homicides.

HOMICIDE/ASSAULT INDICATOR 2:
Assault-Related Hospitalizations

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Hospitalizations identified from the injury hospital discharge subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 6).

Assault-Related Hospitalization ICD-9-CM Codes

E960–E969	Injury purposely inflicted by other persons
E979	Terrorism
E999.1	Late effect of injury due to terrorism

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of discharge.

BACKGROUND

In 2014, over 1.5 million people were treated in U.S. emergency departments for assault-related injuries with over 157,000 of them hospitalized or transferred for additional care.[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 external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-32: Reduce nonfatal physical assault injuries.

HOMICIDE/ASSAULT INDICATOR 3:
Assault-Related Emergency Department Visits

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Emergency department visits identified from the injury emergency department visit subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 8).

Assault-Related Emergency Department VIsit ICD-9-CM Codes

E960–E969	Injury purposely inflicted by other persons
E979	Terrorism
E999.1	Late effect of injury due to terrorism

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2014, over 1.5 million people were treated in U.S. emergency departments for assault-related injuries with over 157,000 of them hospitalized or transferred for additional care.[1]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding. The overall completeness of external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-32: Reduce nonfatal physical assault injuries.

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

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

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death.

BACKGROUND

Motor vehicle crashes are the second leading cause of injury death in the United States. They are also the second leading injury cause for years of potential life lost[1]

LIMITATIONS OF INDICATOR

Injuries severe enough to result in death represent only a small proportion of the overallburden 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 2020 OBJECTIVES

IVP-13: Reduce motor vehicle crash-related deaths.
IVP-18: Reduce pedestrian deaths on public roads.
IVP-20 Reduce pedalcyclist deaths on public roads.

MOTOR VEHICLE INDICATOR 2:
Motor Vehicle Traffic Hospitalizations

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Hospitalizations identified from the injury hospital discharge subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 6).

Motor Vehicle Traffic Hospitalization ICD-9-CM Codes

E810–E819	Motor vehicle traffic accidents

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] 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 based on date of discharge.

BACKGROUND

In 2014, motor vehicle crashes were the cause of over 3.8 million emergency department visits in the United States with over 350,000 people hospitalized or transferred.[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 external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-14: Reduce nonfatal motor vehicle crash-related injuries.
IVP-19: Reduce nonfatal pedestrian injuries on public roads.

MOTOR VEHICLE INDICATOR 3:
Motor Vehicle Traffic Emergency Department Visits

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Emergency department visits identified from the injury emergency department visit subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 8).

Motor Vehicle Traffic Emergency Department Visit ICD-9-CM Codes

E810–E819	Motor vehicle traffic accidents

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2014, motor vehicle crashes were the cause of over 3.8 million emergency department visits in the United States.[1] Seat belts dramatically reduce risk of death and serious injury. Among drivers and front-seat passengers, seat belts reduce the risk of death by 45%, and cut the risk of serious injury by 50%.[40]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding. The overall completeness of external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-14: Reduce nonfatal motor vehicle crash-related injuries.
IVP-19: Reduce nonfatal pedestrian injuries on public roads.

MOTOR VEHICLE INDICATOR 4:
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	Prevalence—crude.
DATA RESOURCES	Data from the Behavioral Risk Factor Surveillance System (BRFSS).[19]
PERIOD FOR CASE DEFINITION	No time frame.
BACKGROUND	Seat belts dramatically reduce risk of death and serious injury. Among drivers and front-seat passengers, seat belts reduce the risk of death by 45%, and cut the risk of serious injury by 50%.[40]
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 2020 OBJECTIVES	IVP-15: Increase use of safety belts.

MOTOR VEHICLE INDICATOR 5:
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).[18]
PERIOD FOR CASE DEFINITION	Previous month.
BACKGROUND	In 2009, approximately 1.4 million drivers were arrested for driving under the influence of alcohol or narcotics.[41] This statistic is only about 1% of the 112 million self-reported episodes of alcohol-impaired driving among U.S. adults each year.[42]
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 2020 OBJECTIVES	No objective

MOTOR VEHICLE INDICATOR 6:
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.[23]
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)[23] and population estimates from the U.S. Census Bureau or suitable alternative (denominator).
PERIOD FOR CASE DEFINITION	Calendar year based on the year of the crash.
BACKGROUND	In 2010, 10,228 people died in alcohol-impaired driving crashes, accounting for nearly one third (31%) of all traffic-related deaths in the United States. Over half (62%) of the 211 child passengers aged 14 years and younger who died in alcohol-related crashes in 2010 were riding with drivers who had a BAC level of 0.08 g/dL or higher.[43]
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 2020 OBJECTIVES	SA-17: Decrease the rate of alcohol-impaired driving (.08+ blood alcohol content [BAC]) fatalities.

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

X40–X49	Accidental poisoning by and exposure to noxious substances
X60–X69	Intentional self-poisoning
X85–X90	Assault by poisoning
Y10–Y19	Poisoning of undetermined intent
Y35.2	Legal intervention involving gas
*U01 (.6–.7)	Terrorism involving biological or chemical weapons

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death.

BACKGROUND

In 2014, almost 52,000 people in the United States died from poisoning.

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 2020 OBJECTIVES

IVP-9: Prevent an increase in the rate of poisoning deaths.
MPS-2.4: (Developmental) Reduce deaths from the use of pain medicines.
SA-12: Reduce drug-induced deaths.

POISONING INDICATOR 2:
Poisoning Hospitalizations

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Hospitalizations identified from the injury hospital discharge subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 6).

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 (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2010 standard U.S. population).[24] 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 based on date of discharge.

BACKGROUND

In 2006, 33 states reported that hospitalization rates were 2.5 to 16 times higher than death rates for poisoning-related injuries.[44]

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 2020 OBJECTIVES

IVP-10: Prevent an increase in the rate of nonfatal poisonings.
MPS-2.3: (Developmental) Reduce serious injuries from the use of pain medicines.

POISONING INDICATOR 3:
Poisoning Emergency Department Visits

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Emergency department visits identified from the injury emergency department visit subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 8).

Poisoning Emergency Department Visit 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 (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2014 there were over 1.4 million poisoning-related emergency department visits, of which over 508,000 resulted in hospitalization or transfer for additional care.[1]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding. The overall completeness of external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-10: Prevent an increase in the rate of nonfatal poisonings.
MPS-2.3: (Developmental) Reduce serious injuries from the use of pain medicines.

POISONING INDICATOR 4:
Drug Overdose Fatalities

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Deaths with any of the following ICD-10 codes as an underlying cause of death.[45]

Drug Overdose Fatality ICD-10 ICD Codes

X40–X44	Accidental poisoning by drugs
X60–X64	Intentional self-poisoning by drugs
X85	Assault by drug poisoning
Y10–Y14	Drug poisoning of undetermined intent

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death.

BACKGROUND

In 2014, drug overdose deaths (47,055) exceeded the number of deaths from motor vehicle traffic crashes (33,736).[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 2020 OBJECTIVES

IVP-9: Prevent an increase in the rate of poisoning deaths.
MPS-2.4: (Developmental) Reduce deaths from the use of pain medicines.
SA-12: Reduce drug-induced deaths.

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

X60–X84	Intentional self-harm
Y87.0	Sequelae of intentional self-harm
*U03	Terrorism-intentional self-harm

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death.

BACKGROUND

In 2014, suicide was the second leading cause of death among those ages 10 to 34 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 2020 OBJECTIVES

MHMD-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 with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 6).

Suicide Attempt Hospitalization ICD-9-CM Codes

E950–E959	Suicide and self-inflicted injury

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] 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 based on date of discharge.

BACKGROUND

In 2014, there were over 469,000 hospital emergency department visits for suicide attempts in the United States, with over 330,000 hospitalized or transferred.[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 external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-41: Reduce nonfatal intentional self-harm injuries.
MHMD-2: Reduce suicide attempts by adolescents.

SUICIDE/SUICIDE ATTEMPT INDICATOR 3:
Suicide Attempt Emergency Department Visits

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Emergency department visits identified from the injury emergency department visit subset with any of the following ICD-9-CM codes as the first valid external cause of injury code (see methods on page 8).

Suicide Attempt Emergency Department Visit ICD-9-CM Codes

E950–E959	Suicide and self-inflicted injury

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

In 2014, there were over 469,000 hospital emergency department visits for suicide attempts in the United States, with over 330,000 hospitalized or transferred.[1]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding. The overall completeness of external-cause-of-injury coding is of particular concern and should be reviewed in conjunction with the indicator.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-41: Reduce nonfatal intentional self-harm injuries.
MHMD-2: Reduce suicide attempts by adolescents.

TRAUMATIC BRAIN INJURY INDICATOR 1:
Traumatic Brain Injury Fatalities

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

First, limit deaths to those with an injury underlying cause of death (V01–Y36, Y85–Y87, Y89, *U01–*U03). Then select 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

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

* These codes are not considered valid in the U.S.

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

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).[24] 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 based on date of death.

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.[46]

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 2020 OBJECTIVES

IVP-2.1: Reduce fatal traumatic brain injuries.

TRAUMATIC BRAIN INJURY INDICATOR 2:
Traumatic Brain Injury Hospitalizations

DEMOGRAPHIC 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

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

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of hospitalizations. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] 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 based on date of discharge.

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.[47, 48]

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 2020 OBJECTIVES

IVP-2.2: Reduce hospitalization for nonfatal traumatic brain injuries.

TRAUMATIC BRAIN INJURY INDICATOR 3:
Traumatic Brain Injury Emergency Department Visits

DEMOGRAPHIC GROUP

All residents.

NUMERATOR

Emergency department visits with any of the following ICD-9-CM diagnostic codes. These should be identified by searching all diagnostic fields of the injury emergency department visit subset (see methods on page 8 for developing the injury emergency department visit subset).

Traumatic Brain Injury Emergency Department Visit ICD-9-CM Codes

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

DENOMINATOR

Midyear population for the calendar year under surveillance (see instructions on page 51).

MEASURES OF FREQUENCY

Annual number of emergency department visits. Annual incidence—crude and age-adjusted (standardized by the direct method to the year 2000 standard U.S. population).[24] Rates should be calculated for age and sex.

DATA RESOURCES

State emergency department data (numerator) and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

PERIOD FOR CASE DEFINITION

Calendar year based on date of ED visit.

BACKGROUND

Of the 1.365 million emergency department visits for TBI annually, almost half a million (473,947 or 34.7% of all TBI emergency department visits) are by children aged 0 to 14 years.[46]

LIMITATIONS OF INDICATOR

Injuries that result in emergency department visits 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 emergency department data is limited by the completeness and quality of coding.

HEALTHY PEOPLE 2020 OBJECTIVES

IVP-2.3: Reduce emergency department visits for nonfatal traumatic brain injuries.

CALCULATING AND SUBMITTING RATES

Calculation Formula and Instructions

Preformatted rate calculation spreadsheets have been prepared for the hospital discharge, emergency department, 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:
    - http://www.census.gov/popest/data/state/asrh/2014/index.html (preferred)
        - Under "Tables" and "Median Age by Age and Sex"
        - Select "Annual Estimates of the Resident Population by Single Year of Age and Sex: April 1, 2010 to July 1, 2014
        - From the table, you can choose the state and download the data.
    - 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:

Under 1	
1–4	**45–54**
5–14	**55–64**
15–24	**65–74**
25–34	**75–84**
35–44	**85+**

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

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

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