

**Midcourse  
Review**



**Injury and  
Violence Prevention**

**15**

**Lead Agency:**

Centers for Disease Control and Prevention

**Contents**

Goal . . . . . 15-3

    Introduction . . . . . 15-3

    Modifications to Objectives and Subobjectives . . . . . 15-4

    Progress Toward Healthy People 2010 Targets . . . . . 15-4

    Progress Toward Elimination of Health Disparities . . . . . 15-9

    Emerging Issues . . . . . 15-11

Progress Quotient Chart . . . . . 15-12

Disparities Table . . . . . 15-15

Objectives and Subobjectives . . . . . 15-17

References . . . . . 15-35

Related Objectives From Other Focus Areas . . . . . 15-40



## **Goal: Reduce injuries, disabilities, and deaths due to unintentional injuries and violence.**

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### **Introduction\***

Unintentional and violence-related injuries are leading causes of death and disability among Americans. Injuries are the number one cause of death in children and young adults in the United States and the leading cause of years of potential life lost before age 65 years.<sup>1</sup> More than 5 million people in the United States report suffering from chronic, injury-related disabilities, and the lives of millions of others have been affected by injuries to themselves or to someone they love.<sup>2</sup> The injury and violence prevention objectives aim to reduce such injuries, disabilities, and deaths, thereby increasing the quality and years of healthy life. Contributing to the elimination of health disparities, they also emphasize interventions that focus on populations most at risk for unintentional injury and violence.

Of the measurable objectives and subobjectives for the Injury and Violence Prevention focus area, 20 moved toward their targets, including objectives related to nonfatal motor vehicle injuries, residential fire deaths, hip fractures, dog bites, physical assault (for example, sexual assault and physical fighting among students), nonfatal firearm-related injuries, and weapon-carrying on school property. Two objectives—reducing physical assault by current or former intimate partners and rape—met or exceeded their targets.

Despite these gains, 13 injury and violence objectives and subobjectives moved away from their targets, including those related to nonfatal head injury hospitalizations, firearm-related deaths, nonfatal poisonings, deaths from poisoning or from suffocation, and injury-related emergency department visits.

Positive change occurred in specific areas related to the elimination of health disparities. For example, the disparity in physical assault between the American Indian or Alaska Native population and the best group declined by more than 100 percentage points. The disparity in firearm-related injuries between the Hispanic population and the best group also declined by more than 100 percentage points, as did the disparity in residential fire deaths between the black non-Hispanic population and the best group.

Notwithstanding this progress, health disparities in injury and violence prevention continue and are increasing in some cases. For example, the disparity in firearm-related deaths between the black non-Hispanic population and the best group increased by more than 100 percentage points since the beginning of the decade.

Many objectives have progressed toward their targets since the beginning of the decade. However, continuing efforts are needed to achieve the injury and violence prevention objectives and eliminate disparities.

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\* Unless otherwise noted, data referenced in this focus area come from Healthy People 2010 and can be located at <http://wonder.cdc.gov/data2010>. See the section on DATA2010 in the Technical Appendix for more information.

## Modifications to Objectives and Subobjectives

The following discussion highlights the modifications, including changes, additions, and deletions, to this focus area's objectives and subobjectives as a result of the midcourse review.

Four objectives became measurable. Child fatality review (15-6) became measurable, and the target was set at 100 percent review of deaths due to external causes. The objective was also reworded to include children aged 17 years and under and to incorporate all 50 States and the District of Columbia.

Emergency department visits for nonfatal unintentional injuries (15-14) and bicycle helmet use (15-23) became measurable with the identification of new data sources. Nonfatal unintentional injuries (15-14) was reworded from "reduce nonfatal unintentional injuries" to "reduce emergency department visits for nonfatal unintentional injuries" to reflect the language used in the data source: the U.S. Consumer Product Safety Commission's National Electronic Injury Surveillance System—All Injury Program (NEISS–AIP). Injury protection in school sports (15-31) became measurable, and subobjectives were added to track physical education (15-31a), interscholastic sports (15-31b), and intramural activities or physical activity clubs (15-31c).

## Progress Toward Healthy People 2010 Targets

The following discussion highlights objectives that met or exceeded their 2010 targets; moved toward the targets, demonstrated no change, or moved away from the targets; and those that lacked data to assess progress. Progress is illustrated in the Progress Quotient bar chart (see Figure 15-1), which displays the percent of targeted change achieved for objectives and subobjectives with sufficient data to assess progress.

**Objectives that met or exceeded their targets.** Physical assaults by intimate partners of persons aged 12 years and older (15-34) decreased from the baseline, exceeding the target. This decrease occurred in the context of declining rates for intimate partner physical assaults over the past two decades. The improvement during the first half of the decade may be attributable to some of the same reasons identified over the past 20 years, including increased economic opportunities for women, which give women greater freedom to exit abusive relationships,<sup>3</sup> and age at first marriage (younger women are more at risk for intimate partner violence than older women).<sup>4</sup> In addition, the availability of domestic violence services has increased as a result of the efforts of many State, local, and private entities.<sup>5</sup> All of these initiatives have been linked to a decrease in intimate partner homicides and may also be linked to the reduction in physical assaults by intimate partners.

Reduction of rape or attempted rape of persons aged 12 years and older (15-35) also met its target. Despite the reduction in the rate, rape and attempted rape remain significant public health problems. In 2001, an estimated 146,000 people were victims of rape or attempted rape.<sup>6</sup> Given individuals' reluctance to disclose sexual violence victimization and the limitations of available data, it is likely that the true rates of rape and attempted rape are likely higher than what the data indicate.

**Objectives that moved toward their targets.** The objectives and subobjectives in the focus area’s three topical sections—injury prevention, unintentional injury prevention, and violence and abuse prevention—demonstrated progress.

Two injury prevention objectives moved toward their targets: nonfatal spinal cord injuries (15-2) and nonfatal firearm-related injuries (15-5).

Nine unintentional injury prevention objectives made progress toward their targets. Emergency department visits for nonfatal unintentional injuries (15-14) achieved 55 percent of the targeted change. The rate decreased from a baseline of 9,764 injuries per 100,000 population in 2000 to 9,343 injuries per 100,000 population in 2003. This decline may be related to the progress that many of the topic-specific unintentional injury objectives were making.<sup>1</sup> For example, the rate for nonfatal motor vehicle injuries (15-17) achieved 47 percent of the targeted change. The decreased rate for this objective was related to increased use of occupant restraints.<sup>7</sup> One way the Centers for Disease Control and Prevention (CDC) worked to reduce this rate was implementing and evaluating a community-based intervention project designed to increase booster seat use in children aged 4 to 8 years.<sup>8,9</sup>

The pedestrian death rate (15-16) achieved 22 percent of its targeted change, declining from 1.9 deaths per 100,000 population in 1998 to 1.7 deaths per 100,000 persons in 2001. The target is 1.0 pedestrian death per 100,000 population.

Use of safety belts (15-19) achieved 26 percent of the targeted change. Safety belt use increased from 69 percent in 1998 to 75 percent in 2002, moving toward its target of 92 percent. Contributing to this positive movement were projects such as the National Highway Traffic Safety Administration’s “Click It or Ticket” campaign.<sup>10,11</sup> Primary enforcement safety belt laws, which allow a police officer to stop a motorist solely for not wearing a safety belt, and enhanced enforcement, which includes increased police presence, safety belt citations, and safety belt checkpoints, can contribute to increased safety belt use and decreased injuries and fatalities.<sup>11,12,13</sup> However, it may be difficult to affect groups like teens and truck drivers, who, despite State and local efforts, continue to lag behind the rest of the Nation in their use of safety belts.<sup>7,10,14</sup> Another safety belt initiative is an enhanced enforcement campaign to increase use of safety belts in rural areas.<sup>15</sup>

Use of child restraints (15-20) moved toward the target of 100 percent, increasing from 92 percent in 1998 to 95 percent in 2002, achieving 38 percent of the targeted change. This progress can be linked to increased enforcement, public education, child safety seat distribution programs, and laws mandating the use of child safety seats. The first child passenger protection law was enacted in Tennessee in 1977. Since then, all 50 States have enacted child passenger protection laws, many of which have subsequently been strengthened. Initiatives in this area range from a systematic review of literature about community efforts to increase the use of child safety seats and identification of the most effective interventions<sup>16</sup> to the implementation and evaluation of a booster seat promotion program combining education with booster seat distribution and incentives.<sup>13</sup>

Residential fire death rates (15-25) achieved 10 percent of its targeted change, declining from 1.2 deaths per 100,000 population in 1999 to 1.1 per 100,000 population in 2002. The use of smoke alarms has been shown to be an effective,<sup>17</sup> reliable, and inexpensive method of providing early warning in residential fires. If a fire occurs in a home with a smoke alarm, the risk of death is decreased by 40 percent to 50 percent.<sup>18</sup> Since 1998, the U.S. Department of Health and Human Services (HHS) has worked through CDC to promote smoke alarm installation and fire safety education programs in high-risk communities,

including communities with fire death rates higher than State and national averages and median household incomes below the poverty level.<sup>19</sup> In addition to these programs, progress toward reaching the target may be the result of fire prevention partnerships and collaborations between Federal and nongovernmental organizations, including HHS and the U.S. Department of Homeland Security, the National Fire Protection Association, and the public-private Fire Safety Council, a partnership of public agencies and private-sector organizations.<sup>20</sup>

Hip fracture rates for men and women aged 65 years and older (15-28a and b), drownings (15-29), and rates for emergency department visits for nonfatal dog bites (15-30) also demonstrated progress toward their targets. Initiatives in the area of hip fracture prevention include the development and dissemination of the Tool Kit to Prevent Senior Falls.<sup>21</sup> The kit contains fact sheets and health education materials designed to help reduce falls and related injuries among older adults. The decreasing trend in hip fracture rates among females suggests that osteoporosis screening, combined with pharmaceutical treatment, is an effective approach to reducing this serious fall injury.<sup>22</sup> A major obstacle to preventing hip fractures is the efficacy, acceptability, and use of hip protectors among community-dwelling persons over 65 years of age. The majority of older adults will not use hip protectors, citing discomfort, cost, appearance, and denial of risk, while industry barriers include lack of product specifications and cost reimbursement policies. However, partially due to decreasing mortality from chronic conditions (such as heart disease and stroke), a growing number of people are living past age 65 years. This trend illustrates the challenge of meeting this fall and hip fracture objective in an active and aging population.<sup>23</sup>

In HHS's efforts to reduce the rate for drownings, CDC collaborates in research and programs to disseminate messages about drowning risks and effective prevention strategies, including supervision of children, fencing around pools, development of swimming skills, and utilization of lifeguards.<sup>24</sup> Also, CDC has published a report of the evidence for the effectiveness of strategies to prevent drowning, including personal flotation devices, environmental restrictions to unsafe swim areas, behavioral approaches such as improved parental supervision, awareness and safety education, pool fence requirements, alcohol limits while boating, and drowning prevention campaigns.<sup>25</sup> However, the added expense of safety devices, such as pool covers and fences, may serve as a deterrent to implementing some of these strategies.

Emergency department visits for nonfatal dog bites (15-30) decreased from 152 visits per 100,000 population in 1997 to 116 visits per 100,000 population in 2002, achieving 94 percent of the targeted change toward the target of 114 visits per 100,000 population. An important strategy to reduce emergency department visits for nonfatal dog bites is to educate the public about how to interact safely with dogs.<sup>26, 27</sup> This prevention education should include how to interact appropriately with all dogs and how to select, train, socialize, and care for a dog.<sup>28</sup> Since there is no accurate way to determine which breeds are more likely to bite or kill, policies and programs to prevent dog bites should include all dogs, regardless of breed.

Four objectives related to violence and abuse prevention progressed toward their targets. Sexual assault other than rape in persons aged 12 years and older (15-36) achieved 50 percent of its targeted change, physical assault on persons aged 12 years and older (15-37) achieved 53 percent of the targeted change, physical fighting by students in grades 9 through 12 (15-38) achieved 75 percent of the targeted change, and weapon carrying by students in grades 9 through 12 on school property (15-39) achieved 40 percent of the targeted change.

**Objectives that demonstrated mixed movement toward or away from their targets.** Two objectives showed mixed movement toward their targets: motor vehicle crash death rates (15-15) and maltreatment and maltreatment fatalities of children (15-33).

The rate for deaths from motor vehicle crashes per 100,000 population (15-15a) increased from 14.7 deaths in 1999 per 100,000 population to 15.2 deaths per 100,000 population in 2002, moving away from the target of 8 deaths per 100,000 population. The increase in the number of motor vehicle crash deaths per 100,000 population is related to the changing demographics of drivers in the United States.<sup>14</sup> The number of older drivers is increasing, and although they drive less, they are more likely to crash and to die in a crash.<sup>29,30</sup> In addition, changes in the culture of driving, changes in the vehicle mix on the road, and new sources of driver distraction (for example, cell phone use) may be reducing the impact of safety gains in other areas, including increased restraint use and reductions in alcohol-impaired driving.<sup>31</sup>

In contrast, motor vehicle crash deaths per 100 million miles traveled (15-15b) moved toward the target of 0.8 deaths per million miles traveled. The rate decreased from 1.6 deaths per 100 million miles traveled in 1998 to 1.5 deaths per 100 million miles traveled in 2001, achieving 13 percent of the targeted change.

Despite increased exposure to risk and motorization, vehicle deaths per million miles traveled are declining. This progress can be attributed to the reduced rates for alcohol-impaired driving and increased use of driver and passenger restraints.<sup>14</sup> HHS initiatives in this area include the Task Force on Community Preventive Services publication of systematic literature reviews for five community-based interventions to reduce alcohol-impaired driving. The reviews revealed strong evidence of effectiveness for 0.08 percent blood alcohol concentration (BAC) laws, minimum legal drinking age laws, and sobriety checkpoints.<sup>32</sup> The systematic review of the effectiveness of 0.08 percent BAC laws for drivers was helpful in establishing a 0.08 percent standard nationwide.<sup>33</sup>

Although a reduction occurred in the overall rate for maltreatment of children under 18 years of age (15-33a), an increase was noted in maltreatment fatalities (15-33b). This increase may be related to how maltreatment is determined as the cause of death. Child death review teams (CDRTs) have played a large part in this determination. States and localities now review many child fatalities that were not reviewed in the past. They are discovering that some deaths labeled as “undetermined” or labeled with a specific cause of death actually appear to be the result of caregiver maltreatment.<sup>34</sup> Increases in reported child maltreatment deaths are based on State child maltreatment mortality surveillance. These CDRTs are also initiating public awareness campaigns and other prevention programs to prevent child deaths.<sup>35,36</sup> One such prevention program, called the Positive Parenting Program (Triple P), provides parent training to reduce the risk of child mistreatment. It reaches out to more than 25,000 parents and works with about 500 practitioners in a variety of fields, including counselors, therapists, parent educators, social workers, and nurses.<sup>37</sup>

**Objectives that moved away from their targets.** Eleven objectives moved away from their targets.

Six injury prevention objectives moved away from their targets: nonfatal head injuries (15-1), firearm-related deaths (15-3), nonfatal poisonings (15-7), poisoning deaths (15-8), deaths from suffocation (15-9), and injury-related emergency department visits (15-12).

Poisoning deaths (15-8) increased from 7.1 deaths per 100,000 population in 1999 to 9.2 deaths per 100,000 population in 2002, moving away from the target of 1.5 deaths per 100,000 population. This increase is primarily attributable to increasing numbers of prescription painkiller overdoses.<sup>38</sup> Challenges include a lack of recognition of the extent of the problem and difficulty in preventing abusers from acquiring readily available drugs. Research is being done in this area to document the problem and identify solutions.<sup>38</sup>

Injury-related emergency department visits (15-12) increased from 131 visits per 1,000 population in 1997 to 139 visits per 1,000 population in 2002, moving away from the target of 126 visits per 1,000 population. This movement away from the target may be a reflection of improved surveillance, medical services, trauma systems, and care rather than a true change in the rate. For example, through CDC, HHS has implemented traumatic brain injury surveillance in 30 States. The increased use of emergency departments as sources of primary care for some populations may be contributing to this movement away from the target. Minor injuries once relegated to a general practitioner's office are being seen by emergency physicians, increasing the overall numbers of persons under surveillance via emergency department visits nationwide.<sup>39</sup>

Four unintentional injury objectives moved away from their targets. Unintentional injury deaths (15-13) climbed from 35.3 deaths per 100,000 population in 1999 to 36.9 deaths per 100,000 population in 2002, moving away from the target of 17.1 deaths per 100,000 population. The rates for nonfatal pedestrian injuries (15-18), motorcycle helmet use (15-21), and deaths from falls (15-27) also moved away from their targets. Nonfatal pedestrian injuries on public roads (15-18) increased from 26 injuries per 100,000 population in 1998 to 28 injuries per 100,000 population in 2001, moving away from the target of 19 injuries per 100,000 population. An increasingly hazardous urban environment<sup>40</sup> and alcohol use by pedestrians and drivers<sup>41</sup> contribute toward this rising rate. Research suggests the design of new communities in the Sunbelt States, which approximately include the States in the southern third of the Nation, contributes to the increased injury risk to pedestrians.<sup>42</sup> Also, there are more larger vehicles on the road, and, due to their size, they are associated with greater risk of injury to pedestrians.<sup>43</sup>

Deaths from falls among adults aged 65 years and older (15-27) moved away from the target of 3.3 deaths from falls per 100,000 people, with the rate increasing from 4.8 deaths per 100,000 population in 1999 to 5.6 deaths per 100,000 population in 2002. A number of factors may explain the increase in the rate for older adult fall deaths. Death rates from cardiovascular and other chronic diseases have decreased, and the average life expectancy has increased—from 76.7 years in 1999 to 77.3 years in 2002.<sup>44</sup> Although the fatality rates were adjusted for age, additional age-related factors may explain the increasing rate. Advancing age is associated with physiologic changes, including decreased muscle strength and endurance, delayed reaction times, slowed reflexes, and loss of visual acuity. These changes may interact with use of psychoactive medications and chronic conditions, such as osteoporosis, arthritis, and diabetes, which put older adults at high risk of sustaining fatal fall injuries.<sup>45, 46</sup> Efforts are under way to decrease deaths from falls among older adults. For example, within HHS, CDC is collaborating with the States to provide custom exercise classes designed to improve strength, balance, and mobility; education about how to reduce fall risk factors; assistance to improve the home environment; and medical referrals as appropriate. The program is being implemented in senior centers, senior housing, and a community hospital.

One violence and abuse prevention objective appeared to have moved away from its target. Between 1999 and 2002, the homicide rate (15-32) increased from 6.0 deaths per 100,000 population to 6.1 deaths



per 100,000 population, moving away from the target of 2.8 deaths per 100,000 population. This change may not be statistically significant, but efforts to understand these trends in homicide rates are under way.

The National Violent Death Reporting System (NVDRS)<sup>47</sup> seeks to provide a more detailed description of the circumstances around homicides through enhanced data collection so that prevention programs can be targeted appropriately. NVDRS operates in 17 States by gathering, sharing, and linking State-level data about violent deaths.<sup>47</sup> These data will then inform violence prevention efforts and provide a better understanding of what strategies are effective at saving lives.

**Objectives that could not be assessed.** Nine objectives did not have data to assess progress toward the targets: proper firearm storage in homes (15-4), child fatality review (15-6), emergency department and hospital discharge surveillance systems (15-10 and 15-11), graduated driver licensing (15-22), bicycle helmet use (15-23), bicycle helmet laws (15-24), functioning smoke alarms in residences (15-26), and injury protection in school sports (15-31). Trend data are anticipated for these nine objectives by the end of the decade.

## Progress Toward Elimination of Health Disparities

The following discussion highlights progress toward the elimination of health disparities. The disparities are illustrated in the Disparities Table (see Figure 15-2), which displays information about disparities among select populations for which data were available for assessment.

While every person is at risk for injury, some populations are at increased risk for certain injuries. In general, the white non-Hispanic population, females, and persons with at least some college education had the best group rates within the respective race and ethnicity, gender, and education characteristics for the majority of the objectives. Females had better rates than men for all but one of the objectives with measurable gender disparity. Persons with at least some college had the best rates for almost all of the objectives with education data. Overall, disparities from the best group rates tended to be large—50 percent or greater for most of the objectives with disparity data.

Firearm-related deaths (15-3) demonstrated increases in disparity, while firearm-related injuries (15-5) demonstrated decreases in disparities. The Asian or Pacific Islander population had the best rate for firearm-related deaths. The death rate of the black non-Hispanic population was more than six times as high, and this disparity increased by more than 100 percentage points between 1999 and 2002. Rates for all other racial and ethnic populations were about three times the rate of the Asian or Pacific Islander population. The male firearm death rate was six times the rate for females; the disparity between males and females increased by 10 to 49 percentage points between 1999 and 2002.

The white non-Hispanic population had the best rate for nonfatal firearm-related injuries (15-5), compared with the black non-Hispanic and the Hispanic populations. The nonfatal firearm-related injury rate for the black non-Hispanic population was almost 10 times the rate of the best group. The rate for the Hispanic population decreased sharply between 1997 and 2001, from 39.4 injuries per 100,000 population to 21.8 injuries per 100,000 population. As a result, the disparity between the Hispanic and white non-Hispanic populations declined by more than 100 percentage points. Although the disparity between male and female firearm-related injuries declined by 50 to 99 percentage points, males continued to experience firearm injuries at a rate more than seven times that for females.

The Asian or Pacific Islander population had the lowest rate for poisoning deaths (15-8), while rates for the other racial and ethnic populations were at least three times as high. Between 1999 and 2002, the disparity between the white non-Hispanic population and the Asian or Pacific Islander population increased by more than 100 percentage points, largely due to an increase in poisoning deaths among the white non-Hispanic population. Despite a decline in the gender disparity between 1999 and 2002, males were almost twice as likely as females to die from poisoning. Similarly, persons with a high school education or less were more than twice as likely as individuals with some college to die from poisoning.

Disparities were also observed in unintentional injury deaths (15-13). The Asian or Pacific Islander population had the best rate, while the rate for the American Indian or Alaska Native population was three times as high, and the rates for the white non-Hispanic and black non-Hispanic populations were twice as high. Males were more than twice as likely to die from unintentional injuries than were females. Persons with a high school education or less were more than twice as likely to die from unintentional injuries as persons with at least some college.

Motor vehicle deaths per 100,000 population (15-15a) demonstrated disparities of race and ethnicity, gender, and education level. The Asian or Pacific Islander population had the best group rate for motor vehicle deaths (15-15a). The American Indian or Alaska Native population had the highest motor vehicle death rate, three times the rate for the Asian or Pacific Islander population. The black non-Hispanic and white non-Hispanic populations both had rates 50 percent to 99 percent higher than the Asian or Pacific Islander population. Part of this inequality is likely related to differences in safety belt use and rates for alcohol-impaired driving.<sup>48</sup> Motor vehicle deaths were more than twice as high in males as in females. By education level, persons with at least some college had the best rate, while persons with a high school education or less had rates at least twice as high. Furthermore, the disparity between these groups increased by at least 10 percentage points between 1999 and 2002.

Residential fire deaths (15-25) showed improvement in disparities by race and ethnicity. The Hispanic population had the best rate for this objective. The rate for the black non-Hispanic population declined by almost 20 percent between 1999 and 2002, resulting in a decrease in disparity of more than 100 percentage points between this group and the Hispanic population. Despite this change, the black non-Hispanic population continued to have the highest rate for residential fire deaths, more than three times that of the Hispanic population.

Violence is another important area of health disparity among populations. The homicide rate (15-32) for the black non-Hispanic population was especially high—more than seven times that of the white non-Hispanic population in 2002. The American Indian or Alaska Native and Hispanic populations had rates that were three times the rate for the white non-Hispanic population. Between 1999 and 2002, the disparity between the black non-Hispanic and white non-Hispanic populations increased by over 50 percentage points. By gender, the disparity between males and females increased by more than 10 percentage points, with males more than three times as likely to be the victim of a homicide. The homicide rates for persons with a high school education or less were more than four times the rate experienced by persons with at least some college.

Physical assaults (15-37) also showed considerable variability among different racial and ethnic populations, with the Asian or Pacific Islander population having the best rate. Other races and ethnicities had rates for physical assault that were at least twice the rates of the Asian or Pacific Islander population. Furthermore, between 1998 and 2001 the Hispanic population had a 100 percentage point or more increase in disparity from the best group rate. The rate for the American Indian or Alaska Native

population declined from 99.4 assaults per 1,000 population in 1998 to 39.2 assaults per 1,000 population in 2001, resulting in a more than 100 percentage point decrease in the disparity between this group and the Asian or Pacific Islander population.

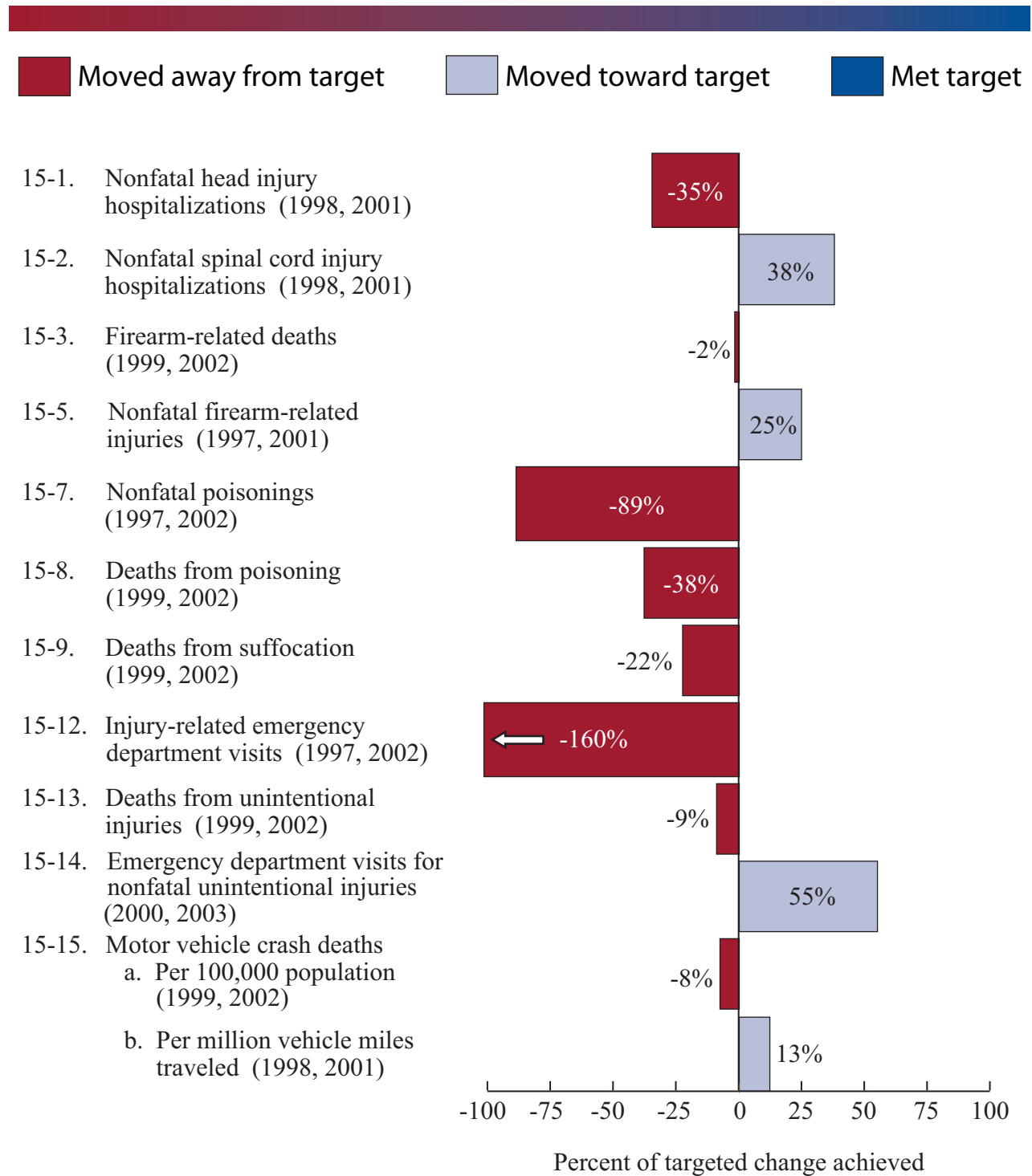
## Emerging Issues

The estimated direct medical cost for the care of acutely injured persons in the United States is \$80 billion per year.<sup>49</sup> Through CDC, HHS released the *CDC Acute Injury Care Research Agenda: Guiding Research for the Future*,<sup>50</sup> which identifies priorities in reducing acute injury. The agenda will help guide research efforts to prevent needless deaths, lessen adverse health effects from injuries, and potentially reduce the cost of medical care to injured persons. Full implementation of the research priorities could help improve outcomes for persons who are injured and reduce the adverse health effects of daily occurring injuries and related medical costs.

Elder abuse is an emerging public health issue that may increase as the population ages. More than 550,000 persons aged 60 years and older experience abuse, neglect, and/or self-neglect in a 1-year period.<sup>51, 52</sup>

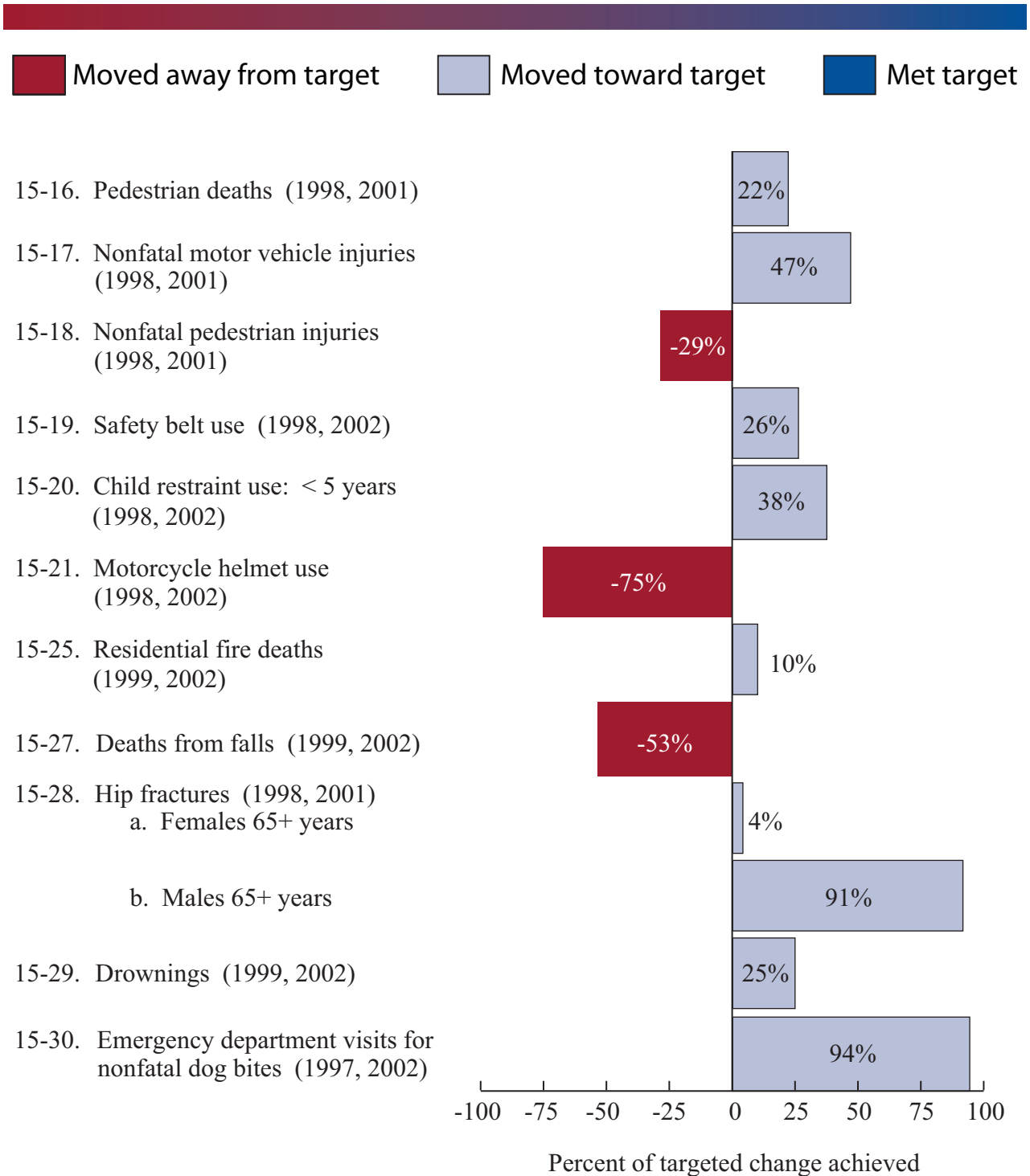
E-codes serve as a critical link in the public health approach to preventing injuries.<sup>53</sup> E-codes are a group of number and letter codes beginning with the letter “E” that categorize injuries by cause and describe their severity. Use of this system, combined with cataloging patient information, can assist in the development of effective prevention strategies and help evaluate the effectiveness of intervention programs. Between 1997 and 2004, improvement occurred in the availability and quality of statewide E-coded hospitalization and emergency department data.<sup>53</sup> The challenge remains to work toward establishing a statewide hospital discharge data system and hospital emergency department data systems to collect uniform, high-quality data on nonfatal injuries in all States.

**Figure 15-1. Progress Quotient Chart for Focus Area 15: Injury and Violence Prevention**



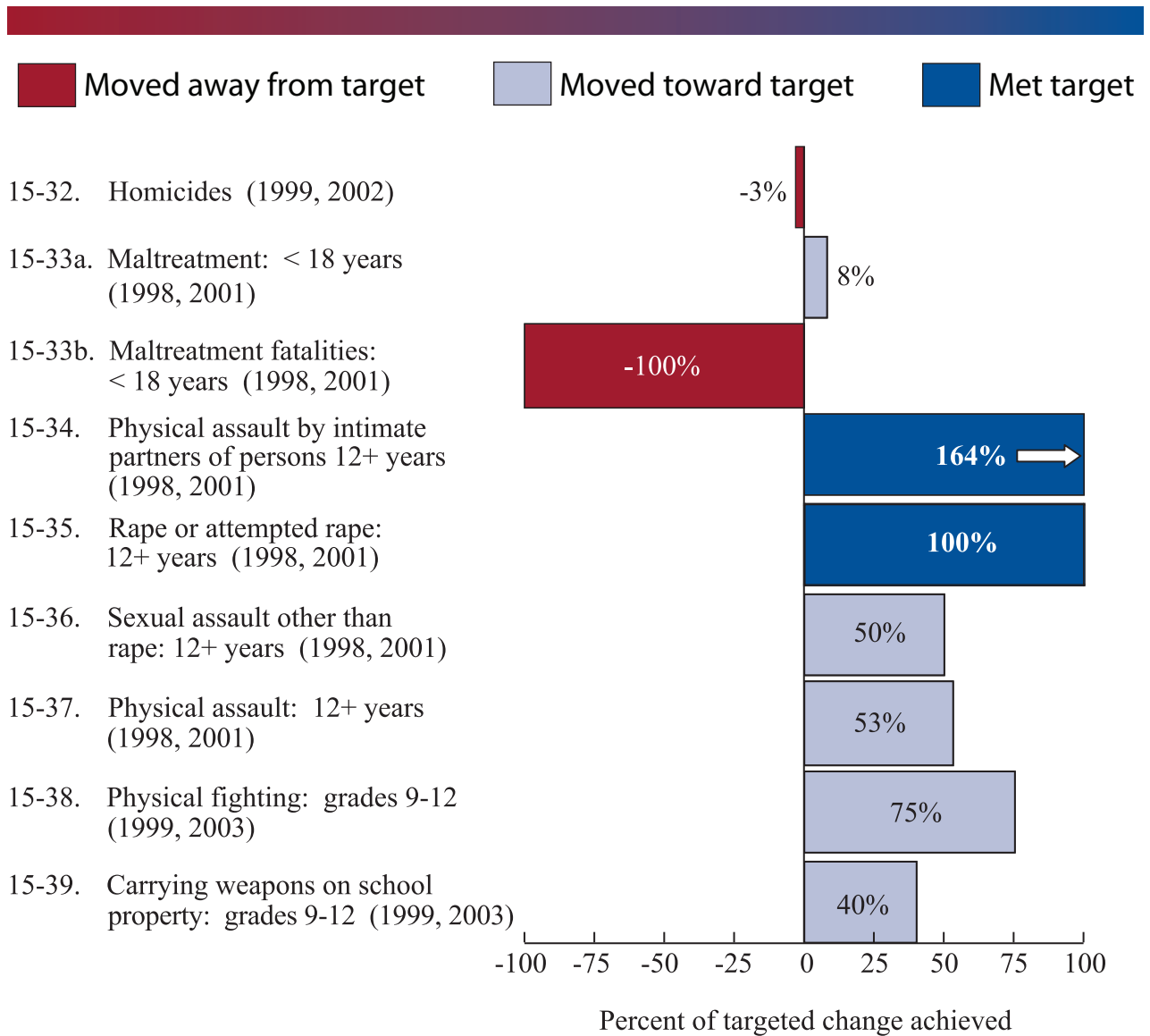
See notes at end of chart. (continued)

Figure 15-1. (continued)



See notes at end of chart. (continued)

**Figure 15-1.** (continued)



**Notes:** Tracking data for objectives 15-4, 15-6, 15-10, 15-11, 15-22, 15-23a and b, 15-24, 15-26a and b, and 15-31a, b, and c are unavailable.

Years in parentheses represent the baseline data year and the most recent data year used to compute the percent of the Healthy People 2010 target achieved.

$$\text{Percent of targeted change achieved} = \left( \frac{\text{Most recent value} - \text{baseline value}}{\text{Year 2010 target} - \text{baseline value}} \right) \times 100$$

**Figure 15-2. Disparities Table for Focus Area 15: Injury and Violence Prevention**

Disparities from the best group rate for each characteristic at the most recent data point and changes in disparity from the baseline to the most recent data point.

Population-based objectives		Characteristics															
		Race and ethnicity							Gender		Education			Location			
		American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	Summary index	Female	Male	Less than high school	High school graduate	At least some college	Summary index	Urban or metropolitan	Rural or nonmetropolitan
15-1.	Nonfatal head injury hospitalizations (1998, 2001) *						I	B <sup>1</sup>		B							
15-2.	Nonfatal spinal cord injury hospitalizations (1998, 2001) *							I									
15-3.	Firearm-related deaths (1999, 2002) *		B <sup>2</sup>				↑↑	↑		B	↑		↑	B			
15-4.	Improper firearm storage in homes (1998) *		2			b		B		B			B				
15-5.	Nonfatal firearm-related injuries (1997, 2001) †					↓↓	↓↓	B	↓↓	B	↓↓						
15-7.	Nonfatal poisonings (1997, 2002) *							I	B <sup>1</sup>								
15-8.	Deaths from poisoning (1999, 2002) *		B <sup>2</sup>					↑↑		B	↓		↑	B			
15-9.	Deaths from suffocation (1999, 2002) *		2			B		↑		B				B			
15-12.	Injury-related emergency department visits (1997, 2002) *		b <sup>2</sup>				I	B <sup>1</sup>		B							
15-13.	Deaths from unintentional injuries (1999, 2002) *		B <sup>2</sup>				↓			B		↑	↑	B	↑		
15-14.	Emergency department visits for nonfatal unintentional injuries (2000, 2003) *									B							
15-15a.	Motor vehicle crash deaths (1999, 2002) *		B <sup>2</sup>							B		↑	↑	B	↑		
15-16.	Pedestrian deaths (1998, 2001) †									B							
15-18.	Nonfatal pedestrian injuries (1998, 2001) †									B							
15-25.	Residential fire deaths (1999, 2002) *		b <sup>2</sup>			B	↓↓	↓		B			↑↑	B			
15-26a.	Persons in residences with smoke alarms (1998) *							B		B				B			
15-27.	Deaths from falls (1999, 2002) *		↑ <sup>2</sup>					B	↑	B	↓			B			
15-28a.	Hip fractures: females 65+ years (1998, 2001) *							I	I								
15-28b.	Hip fractures: males 65+ years (1998, 2001) *								I								
15-29.	Drownings (1999, 2002) *		B <sup>2</sup>			B		B		B				B		B <sup>3</sup>	3
15-30.	Emergency department visits for nonfatal dog bites (1997, 2002) *							I									

(continued)

Figure 15-2. (continued)

	Characteristics															
	Race and ethnicity							Gender		Education level			Location			
	American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	Summary index	Female	Male	Less than high school	High school graduate	At least some college	Summary index	Urban or metropolitan	Rural or nonmetropolitan
<b>Population-based objectives</b>																
15-32. Homicides (1999, 2002) *		2				↑↑	B		B	↑			B			
15-34. Physical assault by intimate partners of persons 12+ years (1998, 2001) †					B				↓	B						
15-35. Rape or attempted rape: 12+ years (1998, 2001) †																
15-36. Sexual assault other than rape: 12+ years (1998, 2001) †																
15-37. Physical assault: 12+ years (1998, 2001) †	↓	B <sup>2</sup>			↑↑				B	↓						
15-38. Physical fighting: grades 9-12 (1999, 2003) *							B		B							
15-39. Carrying weapons on school property: grades 9-12 (1999, 2003) *					B		b									

Notes: Data for objectives 15-6, 15-10, 15-11, 15-15b, 15-17, 15-19 through 15-22, 15-23a and b, 15-24, 15-26b, 15-31a, b, and c, and 15-33a and b are unavailable or not applicable.

Years in parentheses represent the baseline data year and the most recent data year (if available).

Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic (for example, race and ethnicity). The summary index is the average of these percent differences for a characteristic. Change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point. Change in the summary index is estimated by subtracting the summary index at baseline from the summary index at the most recent data point. See Technical Appendix for more information.

The best group rate at the most recent data point.	B	The group with the best rate for specified characteristic.	b	Most favorable group rate for specified characteristic, but reliability criterion not met.		Best group rate reliability criterion not met.
<b>Percent difference from the best group rate</b>						
Disparity from the best group rate at the most recent data point.		Less than 10 percent or not statistically significant		10-49 percent		50-99 percent
						100 percent or more
<b>Changes in disparity over time are shown when the change is greater than or equal to 10 percentage points and statistically significant, or when the change is greater than or equal to 10 percentage points and estimates of variability were not available.</b>						
<b>Increase in disparity (percentage points)</b>						
		↑ 10-49		↑↑ 50-99		↑↑ 100 or more
<b>Decrease in disparity (percentage points)</b>						
		↓ 10-49		↓↓ 50-99		↓↓ 100 or more
Availability of data.		Data not available.				Characteristic not selected for this objective.

\* The variability of best group rates was assessed, and disparities of ≥ 10% are statistically significant at the 0.05 level. Changes in disparity over time, noted with arrows, are statistically significant at the 0.05 level. See Technical Appendix.

† Measures of variability were not available. Thus, the variability of best group rates was not assessed, and the statistical significance of disparities and changes in disparity over time could not be tested. See Technical Appendix.

<sup>1</sup> Data include persons of Hispanic origin.

<sup>2</sup> Data are for Asians or Pacific Islanders.

<sup>3</sup> Baseline data only.



## Objectives and Subobjectives for Focus Area 15: Injury and Violence Prevention

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**Goal:** Reduce injuries, disabilities, and deaths due to unintentional injuries and violence.

As a result of the Healthy People 2010 Midcourse Review, changes were made to the Healthy People 2010 objectives and subobjectives. These changes are specific to the following situations:

- Changes in the wording of an objective to more accurately describe what is being measured.
- Changes to reflect a different data source or new science.
- Changes resulting from the establishment of a baseline and a target (that is, when a formerly developmental objective or subobjective became measurable).
- Deletion of an objective or subobjective that lacked a data source.
- Correction of errors and omissions in *Healthy People 2010*.

Revised baselines and targets for measurable objectives and subobjectives do not fall into any of the above categories and, thus, are not considered a midcourse review change.<sup>1</sup>

When changes were made to an objective, three sections are displayed:

1. In the Original Objective section, the objective as published in *Healthy People 2010* in 2000 is shown.
2. In the Objective With Revisions section, strikethrough indicates text deleted, and underlining is used to show new text.
3. In the Revised Objective section, the objective appears as revised as a result of the midcourse review.

Details of the objectives and subobjectives in this focus area, including any changes made at the midcourse, appear on the following pages.

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<sup>1</sup> See Technical Appendix for more information on baseline and target revisions.

## Injury Prevention

### NO CHANGE IN OBJECTIVE

#### 15-1. Reduce hospitalization for nonfatal head injuries.

**Target:** 45.0 hospitalizations per 100,000 population.

**Baseline:** 60.6 hospitalizations for nonfatal head injuries per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Hospital Discharge Survey (NHDS), CDC, NCHS.

### NO CHANGE IN OBJECTIVE

#### 15-2. Reduce hospitalization for nonfatal spinal cord injuries.

**Target:** 2.4 hospitalizations per 100,000 population.

**Baseline:** 4.5 hospitalizations for nonfatal spinal cord injuries per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population).

**Target setting method:** 46 percent improvement. (Better than the best will be used when population data are available.)

**Data source:** National Hospital Discharge Survey (NHDS), CDC, NCHS.

### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

#### 15-3. Reduce firearm-related deaths.

**Target:** 3.6<sup>1</sup> deaths per 100,000 population.

**Baseline:** 10.3<sup>2</sup> deaths per 100,000 population were related to firearm injuries in 1999<sup>2</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Vital Statistics System (NVSS), CDC, NCHS.

<sup>1</sup> Target revised from 4.1 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline and baseline year revised from 11.3 and 1998 after November 2000 publication.

### NO CHANGE IN OBJECTIVE

**15-4. Reduce the proportion of persons living in homes with firearms that are loaded and unlocked.**

**Target:** 16 percent.

**Baseline:** 19 percent of the population aged 18 years and older lived in homes with loaded and unlocked firearms in 1998 (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Health Interview Survey (NHIS), CDC, NCHS.

### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

**15-5. Reduce nonfatal firearm-related injuries.**

**Target:** 9.1<sup>1</sup> injuries per 100,000 population.

**Baseline:** 23.5<sup>2</sup> nonfatal firearm-related injuries per 100,000 population occurred in 1997.

**Target setting method:** Better than the best.

**Data source:** National Electronic Injury Surveillance System (NEISS), Consumer Product Safety Commission (CPSC).

<sup>1</sup> Target revised from 8.6 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline revised from 24.0 after November 2000 publication.

### ORIGINAL OBJECTIVE

**15-6. (Developmental) Extend State-level child fatality review of deaths due to external causes for children aged 14 years and under.**

**Potential data source:** Inter-Agency Council on Child Abuse and Neglect (ICAN) National Database, FBI Uniform Crime Report, U.S. Department of Justice.

### OBJECTIVE WITH REVISIONS

**15-6. (Developmental) ~~Extend State-level child fatality review of deaths due to external causes for children aged 14 years and under.~~ Increase the number of States and the District of Columbia where 100 percent of deaths to children aged 17 years and younger under that are due to external causes are reviewed by a child fatality review team.**

### OBJECTIVE WITH REVISIONS *(continued)*

**Target:** All States and the District of Columbia.

**Baseline:** 10 States had 100 percent of deaths to children aged 17 years and under that were due to external causes reviewed by a child fatality team in 2000.

**Target setting method:** Total coverage.

**Potential Data sources:** Inter-Agency Council on Child Abuse and Neglect (ICAN) National Database, FBI Uniform Crime Report, U.S. Department of Justice Michigan Public Health Institute; National Vital Statistics System (NVSS), CDC, NCIPCHS.

### REVISED OBJECTIVE

**15-6. Increase the number of States and the District of Columbia where 100 percent of deaths to children aged 17 years and under that are due to external causes are reviewed by a child fatality review team.**

**Target:** All States and the District of Columbia.

**Baseline:** 10 States had 100 percent of deaths to children aged 17 years and under that were due to external causes reviewed by a child fatality team in 2000.

**Target setting method:** Total coverage.

**Data sources:** Michigan Public Health Institute; National Vital Statistics System (NVSS), CDC, NCIPC.

### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

**15-7. Reduce nonfatal poisonings.**

**Target:** 292.0 nonfatal poisonings per 100,000 population.

**Baseline:** 348.3<sup>1</sup> nonfatal poisonings per 100,000 population occurred in 1997 (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

<sup>1</sup> Baseline revised from 348.4 after November 2000 publication.

**NO CHANGE IN OBJECTIVE  
(Data updated and footnoted)**

**15-8. Reduce deaths caused by poisonings.**

**Target:** 1.5 deaths per 100,000 population.

**Baseline:** 7.1<sup>1</sup> deaths per 100,000 population were caused by poisonings in 1999<sup>1</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Vital Statistics System (NVSS), CDC, NCHS.

<sup>1</sup> Baseline and baseline year revised from 6.8 and 1998 after November 2000 publication.

**NO CHANGE IN OBJECTIVE  
(Data updated and footnoted)**

**15-9. Reduce deaths caused by suffocation.**

**Target:** 3.3<sup>1</sup> deaths per 100,000 population.

**Baseline:** 4.2<sup>2</sup> deaths per 100,000 population were caused by suffocation in 1999<sup>2</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Vital Statistics System (NVSS), CDC, NCHS.

<sup>1</sup> Target revised from 3.0 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline and baseline year revised from 4.1 and 1998 after November 2000 publication.

**NO CHANGE IN OBJECTIVE**

**15-10. Increase the number of States and the District of Columbia with statewide emergency department surveillance systems that collect data on external causes of injury.**

**Target:** All States and the District of Columbia.

**Baseline:** 12 States had statewide ED surveillance systems that collected data on external causes of injury in 1998.

**Target setting method:** Total coverage.

**Data source:** External Cause of Injury Survey, American Public Health Association (APHA).

### NO CHANGE IN OBJECTIVE

**15-11. Increase the number of States and the District of Columbia that collect data on external causes of injury through hospital discharge data systems.**

**Target:** All States and the District of Columbia.

**Baseline:** 23 States collected data on external causes of injury through hospital discharge data systems in 1998.

**Target setting method:** Total coverage.

**Data source:** External Cause of Injury Survey, American Public Health Association (APHA).

### NO CHANGE IN OBJECTIVE

**15-12. Reduce hospital emergency department visits caused by injuries.**

**Target:** 126 hospital emergency department visits per 1,000 population.

**Baseline:** 131 hospital emergency department visits per 1,000 population were caused by injury in 1997 (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

## Unintentional Injury Prevention

### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

**15-13. Reduce deaths caused by unintentional injuries.**

**Target:** 17.1<sup>1</sup> deaths per 100,000 population.

**Baseline:** 35.3<sup>2</sup> deaths per 100,000 population were caused by unintentional injuries in 1999<sup>2</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Vital Statistics System (NVSS), CDC, NCHS.

<sup>1</sup> Target revised from 17.5 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline and baseline year revised from 35.0 and 1998 after November 2000 publication.

### ORIGINAL OBJECTIVE

**15-14. (Developmental) Reduce nonfatal unintentional injuries.**

**Potential data source:** National Hospital Ambulatory Medical Care Survey, Emergency Department Component, CDC, NCHS.

### OBJECTIVE WITH REVISIONS

**15-14. (Developmental) Reduce emergency department visits for nonfatal unintentional injuries.**

**Target:** 9,000.0 emergency department visits per 100,000 population.

**Baseline:** 9,767.4 emergency department visits for nonfatal unintentional injuries per 100,000 population occurred in 2000 (age adjusted to the year 2000 standard population).

**Target setting method:** 8 percent improvement.

**Potential dData source:** ~~National Hospital Ambulatory Medical Care Survey, Emergency Department Component, CDC, NCHS~~ National Electronic Injury Surveillance System (NEISS), CDC, NCIPC.

### REVISED OBJECTIVE

**15-14. Reduce emergency department visits for nonfatal unintentional injuries.**

**Target:** 9,000.0 emergency department visits per 100,000 population.

**Baseline:** 9,767.4 emergency department visits for nonfatal unintentional injuries per 100,000 population occurred in 2000 (age adjusted to the year 2000 standard population).

**Target setting method:** 8 percent improvement.

**Data source:** National Electronic Injury Surveillance System (NEISS), CDC, NCIPC.

### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

**15-15. Reduce deaths caused by motor vehicle crashes.**

**Target and baseline:**

Objective	Reduction in Deaths Caused by Motor Vehicle Crashes	1999 Baseline	2010 Target
		<i>Per 100,000 Population</i>	
<b>15-15a.</b>	Deaths per 100,000 population	14.7 <sup>1</sup> (1999)*	8.0 <sup>2</sup>
<b>15-15b.</b>	Deaths per 100 million vehicle miles traveled	1.6	0.8

**NO CHANGE IN OBJECTIVE (continued)  
(Data updated and footnoted)**

\* Age adjusted to the year 2000 standard population.

**Target setting method:** For 15-15a, better than the best; for 15-15b, 50 percent improvement. (Better than the best will be used when data are available.)

**Data sources:** National Vital Statistics System (NVSS), CDC, NCHS; Fatality Analysis Reporting System (FARS), DOT, NHTSA.

<sup>1</sup> Baseline and baseline year revised from 15.6 and 1998 after November 2000 publication.

<sup>2</sup> Target revised from 9.2 because of baseline revision after November 2000 publication.

**NO CHANGE IN OBJECTIVE**

**15-16. Reduce pedestrian deaths on public roads.**

**Target:** 1.0 pedestrian death per 100,000 population.

**Baseline:** 1.9 pedestrian deaths per 100,000 population occurred on public roads in 1998.

**Target setting method:** 50 percent improvement. (Better than the best will be used when data are available.)

**Data source:** Fatality Analysis Reporting System (FARS), DOT, NHTSA.

**NO CHANGE IN OBJECTIVE**

**15-17. Reduce nonfatal injuries caused by motor vehicle crashes.**

**Target:** 933 nonfatal injuries per 100,000 population.

**Baseline:** 1,181 nonfatal injuries per 100,000 population were caused by motor vehicle crashes in 1998.

**Target setting method:** 21 percent improvement. (Better than the best will be used when data are available.)

**Data source:** General Estimates System (GES), DOT, NHTSA.

**NO CHANGE IN OBJECTIVE**

**15-18. Reduce nonfatal pedestrian injuries on public roads.**

**Target:** 19 nonfatal injuries per 100,000 population.



### NO CHANGE IN OBJECTIVE *(continued)*

**Baseline:** 26 nonfatal pedestrian injuries per 100,000 population occurred on public roads in 1998.

**Target setting method:** 28 percent improvement. (Better than the best will be used when data are available.)

**Data source:** General Estimates System (GES), DOT, NHTSA.

### NO CHANGE IN OBJECTIVE

#### 15-19. Increase use of safety belts.

**Target:** 92 percent.

**Baseline:** 69 percent of the total population used safety belts in 1998.

**Target setting method:** 33 percent improvement. (Better than the best will be used when data are available.)

**Data sources:** National Occupant Protection Use Survey (NOPUS), DOT, NHTSA; Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

### NO CHANGE IN OBJECTIVE

#### 15-20. Increase use of child restraints.

**Target:** 100 percent.

**Baseline:** 92 percent of motor vehicle occupants aged 4 years and under used child restraints in 1998.

**Target setting method:** Total coverage.

**Data source:** National Occupant Protection Use Survey (NOPUS), Controlled Intersection Study, DOT, NHTSA.

### NO CHANGE IN OBJECTIVE

#### 15-21. Increase the proportion of motorcyclists using helmets.

**Target:** 79 percent.

**Baseline:** 67 percent of motorcycle operators and passengers used helmets in 1998.

### NO CHANGE IN OBJECTIVE *(continued)*

**Target setting method:** 18 percent improvement. (Better than the best will be used when data are available.)

**Data sources:** National Occupant Protection Use Survey (NOPUS), DOT, NHTSA; Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

### NO CHANGE IN OBJECTIVE

**15-22. Increase the number of States and the District of Columbia that have adopted a graduated driver licensing model law.**

**Target:** All States and the District of Columbia.

**Baseline:** 23 States had a graduated driver licensing model law in 1999.

**Target setting method:** Total coverage.

**Data source:** U.S. Licensing Systems for Young Drivers, Insurance Institute for Highway Safety.

### ORIGINAL OBJECTIVE

**15-23. (Developmental) Increase use of helmets by bicyclists.**

**Potential data sources:** Consumer Product Safety Commission; Behavioral Risk Factor Surveillance System (BRFSS), CDC; World Health Organization Study of Health Behavior in School Children.

### OBJECTIVE WITH REVISIONS

**15-23. (Developmental) Increase the proportion of use of helmets by bicyclists who regularly wear a bicycle helmet.**

**Target and baseline:**

Objective	Increase in the Proportion of Bicyclists Who Regularly Wear a Bicycle Helmet	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>15-23a.</b>	Children aged 1 to 15 years	69	76
<b>15-23b.</b>	Adults aged 16 years and older	38	42

**Target setting method:** 10 percent improvement.

**Potential dData source:** National Bike Helmet Survey, Consumer Product Safety Commission (CPSC).; Behavioral Risk Factor Surveillance System (BRFSS), CDC; World Health Organization Study of Health Behavior in School Children.

## REVISED OBJECTIVE

### 15-23. Increase the proportion of bicyclists who regularly wear a bicycle helmet.

#### Target and baseline:

Objective	Increase in the Proportion of Bicyclists Who Regularly Wear a Bicycle Helmet	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>15-23a.</b>	Children aged 1 to 15 years	69	76
<b>15-23b.</b>	Adults aged 16 years and older	38	42

**Target setting method:** 10 percent improvement.

**Data source:** National Bike Helmet Survey, Consumer Product Safety Commission (CPSC).

## NO CHANGE IN OBJECTIVE

### 15-24. Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders.

**Target:** All States and the District of Columbia.

**Baseline:** 10 States had laws requiring bicycle helmets for bicycle riders under age 15 years in 1999.

**Target setting method:** Total coverage.

**Data source:** Safe Kids Worldwide.

## NO CHANGE IN OBJECTIVE (Data updated and footnoted)

### 15-25. Reduce residential fire deaths.

**Target:** 0.2 deaths per 100,000 population.

**Baseline:** 1.2 deaths per 100,000 population were caused by residential fires in 1999<sup>1</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Vital Statistics System (NVSS), CDC, NCHS.

<sup>1</sup> Baseline year revised from 1998 after November 2000 publication.

## NO CHANGE IN OBJECTIVE

### 15-26. Increase functioning residential smoke alarms.

**Target and baseline:**

Objective	Increase in Functioning Residential Smoke Alarms	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>15-26a.</b>	Total population living in residences with functioning smoke alarm on every floor	88*	100
<b>15-26b.</b>	Residences with a functioning smoke alarm on every floor	87	100

\* Age adjusted to the year 2000 standard population.

**Target setting method:** Total coverage.

**Data source:** National Health Interview Survey (NHIS), CDC, NCHS.

## NO CHANGE IN OBJECTIVE (Data updated and footnoted)

### 15-27. Reduce deaths from falls.

**Target:** 3.3<sup>1</sup> deaths per 100,000 population.

**Baseline:** 4.8<sup>2</sup> deaths per 100,000 population were caused by falls in 1999<sup>2</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Vital Statistics System (NVSS), CDC, NCHS.

<sup>1</sup> Target revised from 3.0 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline and baseline year revised from 4.7 and 1998 after November 2000 publication.

## NO CHANGE IN OBJECTIVE

### 15-28. Reduce hip fractures among older adults.

**Target and baseline:**

Objective	Reduction in Hip Fractures	1998 Baseline	2010 Target
		<i>Rate per 100,000</i>	
<b>15-28a.</b>	Females aged 65 years and older	1,055.8*	416.0
<b>15-28b.</b>	Males aged 65 years and older	592.7*	474.0

\* Age adjusted to the year 2010 standard population.

### NO CHANGE IN OBJECTIVE (*continued*)

**Target setting method:** For 15-28a, better than the best; for 15-28b, 20 percent improvement. (Better than the best will be used when data are available.)

**Data source:** National Hospital Discharge Survey (NHDS), CDC, NCHS.

### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

#### 15-29. Reduce drownings.

**Target:** 0.7<sup>1</sup> drownings per 100,000 population.

**Baseline:** 1.5<sup>2</sup> drownings per 100,000 population occurred in 1999<sup>2</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data sources:** National Vital Statistics System (NVSS), CDC, NCHS; Consumer Product Safety Commission (CPSC).

<sup>1</sup> Target revised from 0.9 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline and baseline year revised from 1.6 and 1998 after November 2000 publication.

### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

#### 15-30. Reduce hospital emergency department visits for nonfatal dog bite injuries.

**Target:** 114.0 hospital emergency department visits per 100,000 population.

**Baseline:** 151.5<sup>1</sup> hospital emergency department visits per 100,000 population were for nonfatal dog bite injuries in 1997 (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data source:** National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

<sup>1</sup> Baseline revised from 151.4 after November 2000 publication.

### ORIGINAL OBJECTIVE

**15-31. (Developmental) Increase the proportion of public and private schools that require use of appropriate head, face, eye, and mouth protection for students participating in school-sponsored physical activities.**

**Potential data source:** School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

### OBJECTIVE WITH REVISIONS

**15-31. (Developmental) Increase the proportion of public and private schools that require students to wear use of appropriate head, face, eye, and mouth protection ve for students participating in gear when engaged in school-sponsored physical activities.**

**Target and baseline:**

Objective	Increase in Public and Private Schools That Require Students To Wear Appropriate Protective Gear When Engaged in School-Sponsored Physical Activities	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>15-31a.</b>	Physical education	77	85
<b>15-31b.</b>	Interscholastic sports	98	100
<b>15-31c.</b>	Intramural activities or physical activity clubs	88	97

**Target setting method:** For 15-31a and 15-31c, 10 percent improvement; for 15-31b, 2 percent improvement.

**Potential dData source:** School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

### REVISED OBJECTIVE

**15-31. Increase the proportion of public and private schools that require students to wear appropriate protective gear when engaged in school-sponsored physical activities.**

**Target and baseline:**

Objective	Increase in Public and Private Schools That Require Students To Wear Appropriate Protective Gear When Engaged in School-Sponsored Physical Activities	1998 Baseline	2010 Target
		<i>Percent</i>	
<b>15-31a.</b>	Physical education	77	85
<b>15-31b.</b>	Interscholastic sports	98	100

## REVISED OBJECTIVE *(continued)*

<b>15-31c.</b>	Intramural activities or physical activity clubs	88	97
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**Target setting method:** For 15-31a and 15-31c, 10 percent improvement; for 15-31b, 2 percent improvement.

**Data source:** School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

### Violence and Abuse Prevention

#### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

##### 15-32. Reduce homicides.

**Target:** 2.8<sup>1</sup> homicides per 100,000 population.

**Baseline:** 6.0<sup>2</sup> homicides per 100,000 population occurred in 1999<sup>2</sup> (age adjusted to the year 2000 standard population).

**Target setting method:** Better than the best.

**Data sources:** National Vital Statistics System (NVSS), CDC, NCHS; FBI Uniform Crime Reports, U.S. Department of Justice.

<sup>1</sup> Target revised from 3.0 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline and baseline year revised from 6.5 and 1998 after November 2000 publication.

#### NO CHANGE IN OBJECTIVE (Data updated and footnoted)

##### 15-33. Reduce maltreatment and maltreatment fatalities of children.

**15-33a.** Reduce maltreatment of children.

**Target:** 10.1<sup>1</sup> per 1,000 children under age 18 years.

**Baseline:** 12.6<sup>2</sup> child victims of maltreatment per 1,000 children under age 18 years were reported in 1998.

**Target setting method:** 20 percent improvement. (Better than the best will be used when data are available.)

**NO CHANGE IN OBJECTIVE (continued)  
(Data updated and footnoted)**

**Data source:** National Child Abuse and Neglect Data System (NCANDS), Administration for Children and Families (ACF), Administration on Children, Youth, and Families, Children's Bureau.

<sup>1</sup> Target revised from 10.3 because of baseline revision after November 2000 publication.

<sup>2</sup> Baseline revised from 12.9 after November 2000 publication.

**15-33b.** Reduce child maltreatment fatalities.

**Target:** 1.4 per 100,000 children under age 18 years.

**Baseline:** 1.6 child maltreatment fatalities per 100,000 children under age 18 years occurred in 1998.

**Target setting method:** 12 percent improvement. (Better than the best will be used when data are available.)

**Data source:** National Child Abuse and Neglect Data System (NCANDS), Administration for Children and Families (ACF), Administration on Children, Youth, and Families, Children's Bureau.

**NO CHANGE IN OBJECTIVE**

**15-34.** Reduce the rate of physical assault by current or former intimate partners.

**Target:** 3.3 physical assaults per 1,000 persons aged 12 years and older.

**Baseline:** 4.4 physical assaults per 1,000 persons aged 12 years and older by current or former intimate partners occurred in 1998.

**Target setting method:** Better than the best.

**Data source:** National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics.

**NO CHANGE IN OBJECTIVE**

**15-35.** Reduce the annual rate of rape or attempted rape.

**Target:** 0.7 rapes or attempted rapes per 1,000 persons.

**Baseline:** 0.8 rapes or attempted rapes per 1,000 persons aged 12 years and older occurred in 1998.



**NO CHANGE IN OBJECTIVE (continued)**

**Target setting method:** Better than the best.

**Data source:** National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics.

**NO CHANGE IN OBJECTIVE**

**15-36. Reduce sexual assault other than rape.**

**Target:** 0.4 sexual assaults other than rape per 1,000 persons aged 12 years and older.

**Baseline:** 0.6 sexual assaults other than rape per 1,000 persons aged 12 years and older occurred in 1998.

**Target setting method:** Better than the best.

**Data source:** National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Labor Statistics.

**NO CHANGE IN OBJECTIVE**

**15-37. Reduce physical assaults.**

**Target:** 13.6 physical assaults per 1,000 persons aged 12 years and older.

**Baseline:** 31.1 physical assaults per 1,000 persons aged 12 years and older occurred in 1998.

**Target setting method:** Better than the best.

**Data source:** National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics.

**NO CHANGE IN OBJECTIVE**

**15-38. Reduce physical fighting among adolescents.**

**Target:** 32 percent.

**Baseline:** 36 percent of adolescents in grades 9 through 12 engaged in physical fighting in the previous 12 months in 1999.

**NO CHANGE IN OBJECTIVE (continued)**

**Target setting method:** Better than the best.

**Data source:** Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

**NO CHANGE IN OBJECTIVE**

**15-39. Reduce weapon carrying by adolescents on school property.**

**Target:** 4.9 percent.

**Baseline:** 6.9 percent of students in grades 9 through 12 carried weapons on school property during the past 30 days in 1999.

**Target setting method:** Better than the best.

**Data source:** Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

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## Related Objectives From Other Focus Areas

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### 1. Access to Quality Health Services

- 1-3. Counseling about health behaviors
- 1-11. Rapid prehospital emergency care
- 1-12. Single toll-free number for poison control centers

### 7. Educational and Community-Based Programs

- 7-3. Health-risk behavior information for college and university students

### 8. Environmental Health

- 8-13. Pesticide exposures
- 8-24. Exposure to pesticides
- 8-25. Exposure to heavy metals and other toxic chemicals

### 18. Mental Health and Mental Disorders

- 18-1. Suicide
- 18-2. Adolescent suicide attempts

### 20. Occupational Safety and Health

- 20-1. Work-related injury deaths
- 20-2. Work-related injuries
- 20-5. Work-related homicides
- 20-6. Work-related assaults

### 26. Substance Abuse

- 26-1. Motor vehicle crash deaths
- 26-5. Alcohol-related hospital emergency department visits
- 26-6. Adolescents riding with a driver who has been drinking
- 26-7. Alcohol- and drug-related violence
- 26-24. Administrative license revocation laws
- 26-25. Blood alcohol concentration (BAC) levels for motor vehicle drivers