

## Injuries in the State of New Hampshire 2001-2009



New Hampshire Department of Health and Human Services  
Division of Public Health Services  
Injury Surveillance Program

November 2012



Injury indicators calculated by referencing the following:  
Thomas KE, Johnson RL. *State injury indicators report: instructions for preparing 2006*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; December 2010.



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## What is an Injury Indicator?

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

### Introduction

Injury surveillance is the building block of injury prevention and control. It determines 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 is also crucial in determining programmatic and prevention priorities as well as evaluating any interventions facilitated.

In 2009, more than 151,000 people died from injuries in the U.S. Among them: 23% died from motor-vehicle crashes; 22% died from suicide; and 8% died from homicide.<sup>1</sup> Unintentional injury was the fifth leading cause of death in the U.S. and the number one cause of death for people ages 1 to 44 years. In 2009, unintentional injury was the fourth leading cause of death in New Hampshire and the number one cause of death for people 1 to 34 years old.<sup>1</sup>

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.<sup>2</sup> The New Hampshire Injury Prevention and Surveillance Programs (IPP) reside in New Hampshire's Division of Public Health Services within the Department of Health and Human Services. The scope of the IPP encompasses injuries involving any mechanism (e.g., firearm, motor vehicle, or burn) and includes both intentional and unintentional injuries. An important part of the IPP is to emphasize that injuries are preventable and to dispel the misconception that injuries are unavoidable. The IPP performs all of its work with colleagues across the State. The Injury Prevention Advisory Council (IPAC) goal is to reduce injury-related morbidity and mortality by providing advice and expertise in the preparation, implementation, and periodic review of the Injury Prevention Program and the New Hampshire Injury Prevention Plan.

The *Consensus Recommendations for Injury Surveillance in Health Departments (Safe States, 2007)* 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. This report was used in the development of injury indicators for the "State Injury Indicators Report: Instructions for Preparing 2006 Data" (December 2010).

Centralized electronic hospital discharge data and centralized electronic vital statistics data are used to calculate the indicators. Inpatient and Emergency Department Acute Care Hospital Discharge data are collected under New Hampshire statute RSA 126:25 that requires all New Hampshire facilities to report discharge data to the NH Department of Health and Human Services. The New Hampshire Division of Vital Records in the Office of the Secretary of State is responsible for collecting information on deaths of New Hampshire residents and deaths

occurring in New Hampshire. Funeral home directors and the Medical Examiner report the information to the Division of Vital Records Administration.

Injuries resulting in or occurring from the following are included: 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. Another example of this overlap is a “struck by or against” injury which may occur as the result of a fall. Thus, the sum of the injuries in this comprehensive report will not equal the total number reported under all injuries.

### **How to Read this Report**

Each injury indicators includes a common template which was provided by the State Injury Indicator Report instructions.<sup>3,4</sup> The headings under each indicator are as follows: ICD codes, Background, Limitations, Healthy People 2020 target, and then tables and charts that were generated using the instructions. Lastly, where applicable, a note on the Prevention Efforts being undertaken by various programs is provided. The ICD codes are the International Classification of Disease Codes used for query data from the database to count each type of injury.

The Background is a brief description of previous data and information about the injury topic. When available, the Background information includes data from both the United States as a whole and New Hampshire in comparison.

The Limitations section states any limitation or deficiencies that may occur in the data set used to review the injury topic. Commonly, the Limitation section states, “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.” This statement refers to the fact that the database allows for a count of the occurrences of types of injury but does not allow for a definition of the severity of the injury. For example, an injury due to a motor vehicle crash can lead to an injury that only requires a few stitches or may require a major operation. When counting the number of motor vehicle crash injuries, the severity of the injury is not taken into account.

The Healthy People 2020 section is related to national goals, developed by the U.S. Department of Health and Human Services, set for health and safety in the Healthy People 2020 report posted online at: <http://www.healthypeople.gov/2020/about/default.aspx>. The Healthy People 2020 goals show injury rates from the baseline year of 2007 compared with the goal rate for year 2020. This is followed by data from New Hampshire of the same year and a goal injury rate that would show a significant difference in the rate by 2010 by noting a rate that would be lower than the lower confidence interval of the 2007 rate. The New Hampshire data for 2020 were developed as part of the New Hampshire Public Health Goal and Objectives Prioritization Plan (GO Plan).

The Prevention Effort sections are unique to this data report. Under this heading are listed New Hampshire efforts to prevent injury, partnerships, and accomplishments.

## **Injury Indicators**

### **All-Injury Indicator 1: Injury Fatalities**

Injury Fatality ICD-10 Codes: V01–Y36, Y85–Y87, Y89, \*U01–\*U03 Injury and poisoning

#### **BACKGROUND**

Injuries are the leading cause of death for people in New Hampshire 1 to 44 years of age and the third leading cause of death overall.<sup>1</sup> Nationally, approximately 174,000 people died from injuries in 2005 and 177,000 in 2009.<sup>1</sup> In New Hampshire, 672 people died from injuries in 2005 and 602 in 2009.

#### **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.<sup>3,4</sup>

#### **HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-1.1 Reduce fatal injuries

Baseline: 59.2 deaths per 100,000 population were caused by injuries in 2007 (age adjusted to the year 2000 standard population)

Target: 53.3 deaths per 100,000 populations

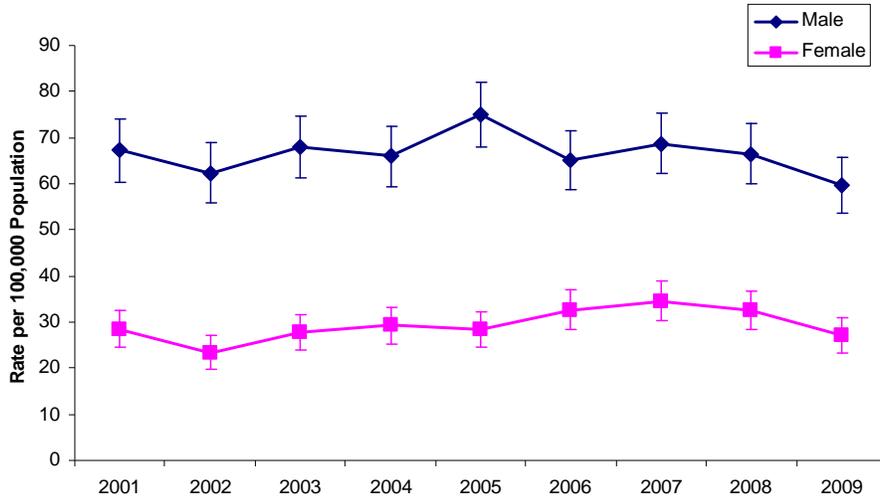
Target-Setting Method: 10 percent improvement

Data Source: National Vital Statistics System–Mortality (NVSS–M), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS)

New Hampshire Prevention Efforts: Throughout New Hampshire, there are many collaborative initiatives, inclusive of public and private entities, dedicated to the prevention of death and disability due to injury. The Injury Prevention Advisory Council (IPAC) was established as an advisory body the New Hampshire Department of Health and Human Services' Injury Prevention Program and to all injury activities occurring within the state. IPAC's goal is to reduce injury-related morbidity and mortality by providing advice and expertise in the preparation, implementation and periodic review of injury prevention efforts and the New Hampshire Strategic Injury Prevention Plan. The IPAC's membership is broad and diverse ranging from the Brain Injury Association of New Hampshire to the State's Chief Medical Examiner's Office (OCME). For more information, please visit <http://www.dhhs.nh.gov/dphs/bchs/mch/injury.htm>.

In New Hampshire, the rate of fatal injuries in 2007 was 50.1 (confidence interval [CI] 47.2-54.8) per 100,000 population, and in 2009 the rate was 43.1 (CI 39.6-46.6) per 100,000 population. This rate is below the Healthy People 2020 Target of 53.3. When reviewing rates by gender in 2009, the male fatal injury rate was 59.7 and the female was 27.1 (Figure 1).

**Figure 1: All Fatal Injuries, NH Residents, by Gender, 2001-2009**

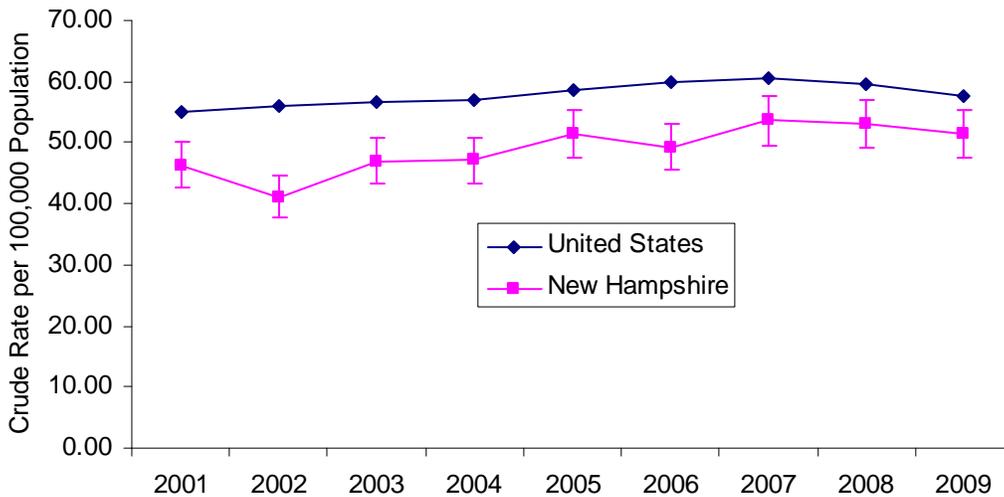


Source: New Hampshire Bureau of Vital Records, Death Certificate Data

There are no statistically significant differences in total death rates due to injury year to year, with gender or age groups. Males are more likely to die from their injuries than females. People of both genders age 75 and older are more likely to die from injuries than those in younger age groups.

New Hampshire's overall injury rate is significantly lower than the United States rate every year from 2001 to 2009 (Figure 2).

**Figure 2: United States versus New Hampshire Age-Adjusted Injury Mortality Rates by Year, 2001-2009**



Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates, [http://www.cdc.gov/injury/wisqars/fatal\\_injury\\_reports.html](http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html).

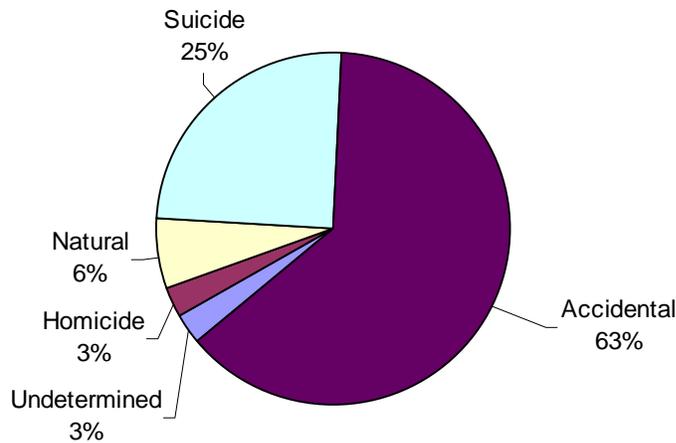
**Figure 3: NH Residents, Fatal Injury Age Specific Rate by Age Group and Year, 2001-2009**

10 yr Age Group	2001	2002	2003	2004	2005	2006	2007	2008	2009
0 to 4	13.2	8.0	6.7	13.3	1.3	2.7	4.1	2.7	5.6
05 to 14	9.9	5.5	3.9	4.5	5.8	4.1	6.0	7.9	4.9
15 to 24	50.8	41.6	48.7	48.8	53.8	39.9	43.7	38.3	34.1
25 to 34	40.8	51.8	47.3	43.6	48.5	51.2	51.6	44.5	41.8
35 to 44	43.8	41.5	51.4	58.0	59.0	55.3	55.3	53.6	41.1
45 to 54	43.9	38.1	55.6	41.6	53.4	53.9	53.9	60.0	52.8
55 to 64	48.1	40.3	40.1	45.7	44.2	37.0	51.0	39.6	48.6
65 to 74	57.4	56.1	48.2	43.5	49.3	46.6	50.8	65.0	49.8
75 to 84	135.6	106.7	125.4	103.6	120.4	135.5	125.9	132.3	130.4
85 Plus	314.0	229.6	304.8	395.0	405.1	397.4	456.7	387.0	285.3

Source: New Hampshire Bureau of Vital Records, Death Certificate Data

Fatal injury is most likely to occur in the older adult population, age 75 and up (Figure 3).

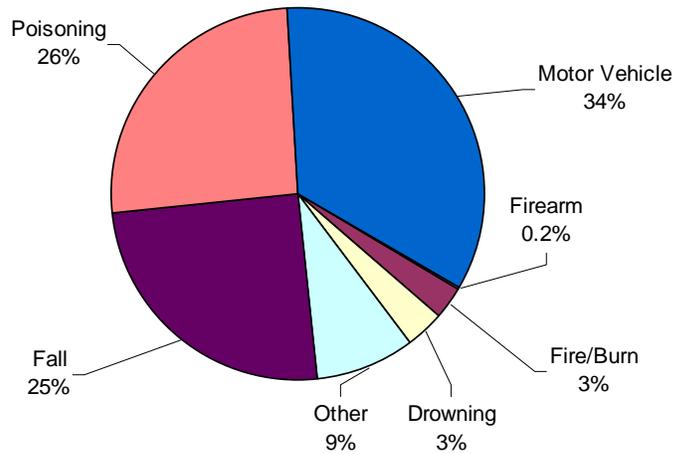
**Figure 4: Fatal Injury by Intent, 2001-2009, NH Residents**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

Unintentional, accidental injuries are the most common manner of injury death in New Hampshire, followed by suicide (Figure 4).

**Figure 5: Fatal Injury by Unintentional Cause, 2001-2009, NH Residents**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

The most common cause of fatal injury in New Hampshire is due to motor vehicle crashes, closely followed by accidental poisoning and falls (Figure 5).

### **All-Injury Indicator 2: Hospitalizations and Emergency Department Visits for All Injuries**

Hospitalizations and Emergency Department Visits 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

#### **BACKGROUND**

During 2009 in the U.S., there were 29 million emergency department (ED) discharges and 2 million inpatient discharges due to injury.<sup>1</sup> In New Hampshire during 2009, there were 155,593 ED discharges and 6,879 inpatient discharges.

#### **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.<sup>3,4</sup>

#### **HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-1.2 Reduce hospitalization for nonfatal injuries

Baseline: 617.6 hospitalizations for nonfatal injuries per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)

Target: 555.8 hospitalizations per 100,000 population

Target-Setting Method: 10 percent improvement

Data Source: National Hospital Discharge Survey (NHDS), CDC, NCHS

IVP-1.3 Reduce emergency department visits for nonfatal injuries

Baseline: 8370.4 emergency department visits for nonfatal injuries per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)  
 Target: 7533.4 emergency department visits per 100,000 population  
 Target-Setting Method: 10 percent improvement  
 Data Source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS

New Hampshire Prevention Efforts: The New Hampshire Injury Prevention Strategic Plan describes the injury burden in the State and provides an overview of the many initiatives and collaborative approaches engaged in injury prevention. Based on an analysis of the data, the Strategic Plan suggests several critical areas of focus. The first goal focuses on building infrastructure and the components of an injury prevention program including surveillance, interventions and evaluation, and policy. Goals two through seven relate to identified priority areas including, motor vehicle safety, falls in older adults, unintentional injuries (other than those motor vehicle related) to young adults and children, suicide, sexual violence, and abusive head trauma. Each objective links with the appropriate evidence-based strategies. Objectives and strategies were carefully thought out to reflect both feasibility and capacity of existing infrastructure. For more information, please visit <http://www.dhhs.nh.gov/dphs/bchs/mch/injury.htm>.

In New Hampshire, the non-fatal rate of inpatient (hospitalization) discharges was 512.8 (CI 500.6-525.0) per 100,000 population, for all injuries in 2007, and 496.4 (CI 484.5-508.4) per 100,000 population in 2009, which are already well below the Healthy People 2020 target. Non-fatal injury emergency department discharges were 12,466 (CI 12,404-12,528) per 100,000 population in 2007, and 12,311 (CI 12,219-12,373) per 100,000 population in 2009. New Hampshire emergency department discharge rates for injury are nearly double the target rate for Healthy People 2020.

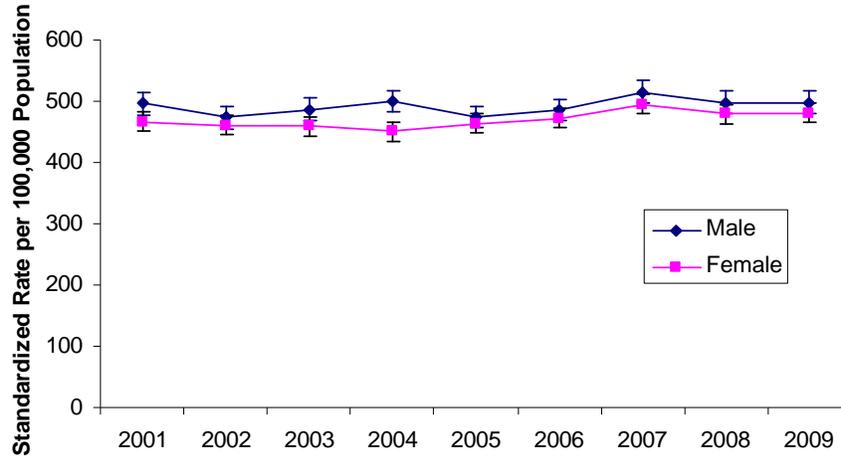
Males are more likely to be treated at the hospital for non-fatal injuries than females. There was a significant decrease in the rate of male visits to the ED between 2001 and 2009, and no change in rates for females. There are no statistically significant differences in inpatient discharge rates from year to year or between genders between 2001 and 2009 (Figures 6 and 7).

**Figure 6: Emergency Department Discharges, Non-Fatal Injury by Gender, NH Residents, 2001-2009**



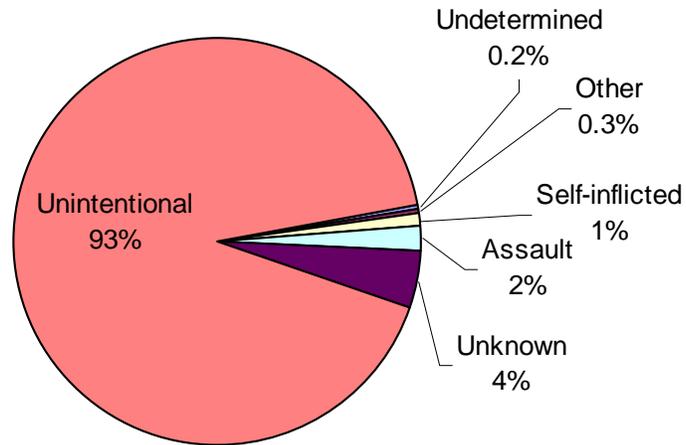
Source: New Hampshire Department of Public Health Services (NH-DPHS) Emergency Department Hospital Discharge Data

**Figure 7: Inpatient Discharges, Non-Fatal Injury by Gender, NH Residents, 2001-2009**



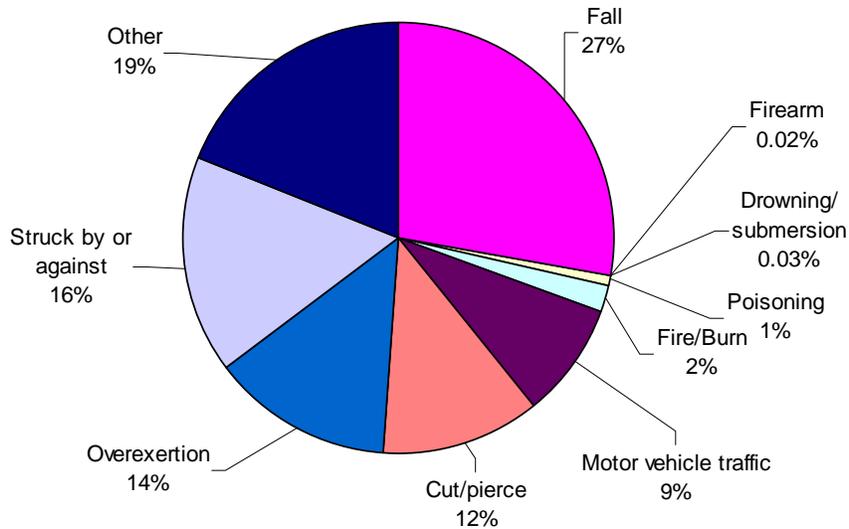
Source: New Hampshire Department of Public Health Services (NH-DPHS) Inpatient Hospital Discharge Data

**Figure 8: Emergency Department Discharges by Injury Intent, NH Residents, 2001-2009**



Source: NH-DPHS Emergency Department Hospital Discharge Data

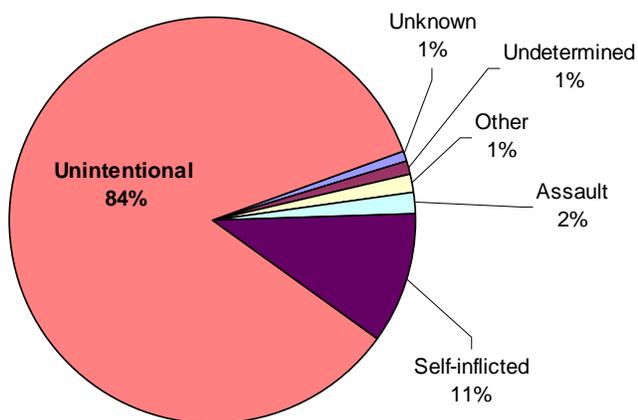
**Figure 9: Emergency Department Discharges Unintentional Injury by Cause, NH Residents, 2001-2009**



Source: NH-DPHS Emergency Department Hospital Discharge Data

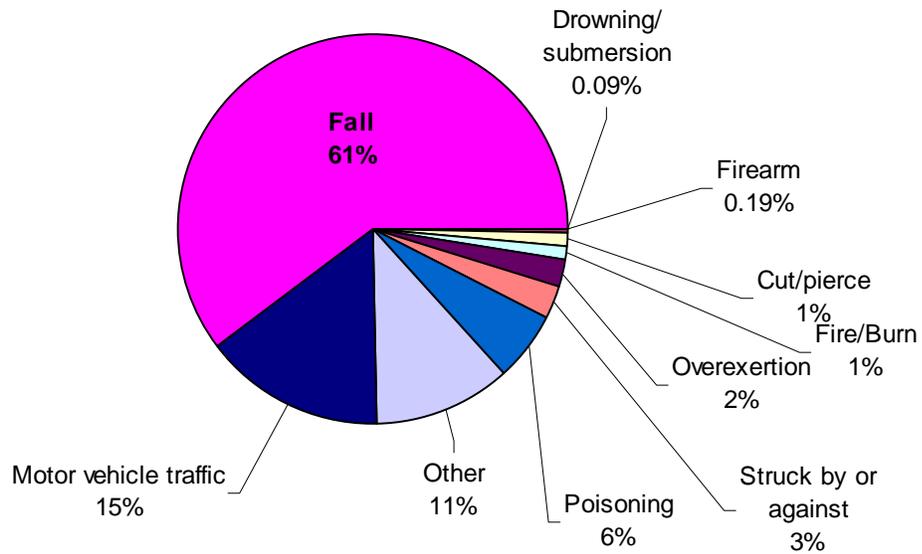
Unintentional injuries make up 93% of all emergency department discharges (Figure 8). Of those discharges, fall-related injuries are the most common reason for seeking emergency treatment, followed by struck by or against, which can be part of a fall type injury (Figure 9).

**Figure 10: Inpatient Discharges by Injury Intent, NH Residents, 2001-2009**



Source: NH-DPHS Inpatient Hospital Discharge Data

**Figure 11: Inpatient Discharges Unintentional Injury by Cause, NH Residents, 2001-2009**



Source: NH-DPHS Inpatient Hospital Discharge Data

Unintentional injuries make up 84% of all inpatient discharges (Figure 10). Of those discharges, fall-related injuries are the most common reason for requiring inpatient treatment followed by injuries sustained in motor vehicle crashes (Figure 11).

## **Drowning Indicator 1: Unintentional Drowning Fatalities**

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

### **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.<sup>1</sup>

### **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.<sup>3,4</sup>

### **HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-25 Reduce drowning deaths

Baseline: 1.2 Drownings per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)

Target: 1.1 Drownings per 100,000 population

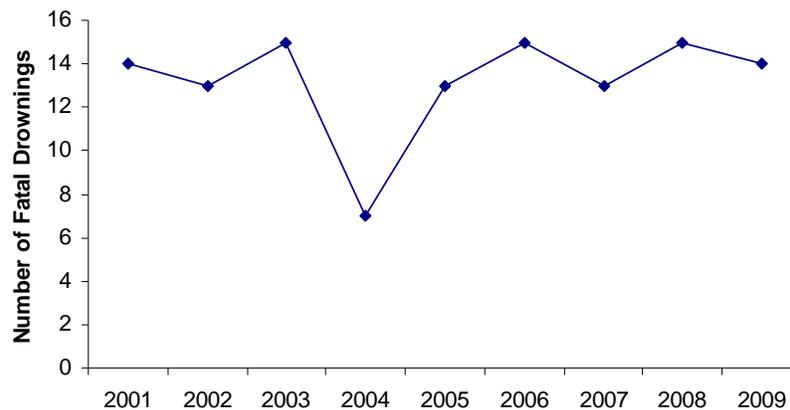
Target-Setting Method: 10 percent improvement

Data Source: National Vital Statistics System–Mortality (NVSS–M), CDC, NCHS

New Hampshire Prevention Efforts: Safe Kids New Hampshire serves as a hub for communication and collaboration for people and organizations in the State who are interested in preventing unintentional childhood injuries, including those in the water. Safe Kids New Hampshire provides educational materials to the public as well as barriers to preventing drowning. For example, there are lifejacket loaner stations at various places in the State, which provides lifejackets free of charge for boaters who may have forgotten or do not own one. For information about Safe Kids New Hampshire, visit [http://chad.dartmouth-hitchcock.org/injury\\_prevention/injury\\_center\\_programs\\_childhood\\_safekids.html](http://chad.dartmouth-hitchcock.org/injury_prevention/injury_center_programs_childhood_safekids.html).

New Hampshire's fatal drowning rate in 2007 was 1.0 (CI 0.5-1.7) per 100,000 population in 2007 and 1.1 (CI 0.6-1.8) per 100,000 population in 2009. New Hampshire is on track with the Healthy People 2020 target rate of 1.1 per 100,000. The number of drowning fatalities in New Hampshire is, on average, less than 14 cases per year. Counts below 20 events do not generate statistically significant differences. For fatal drowning, simply the count of events is shown in the graph below (Figure 12). Any difference in the counts from year to year is due to chance.

**Figure 12: Number of Fatal Drownings, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

### **Drowning Indicator 2: Drowning-Related Hospitalizations plus Emergency Department Visits**

#### **Drowning-Related Hospitalization ICD-9-CM Codes**

Diagnosis codes 994.1 Drowning and nonfatal submersion and/or

E-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.

#### **BACKGROUND**

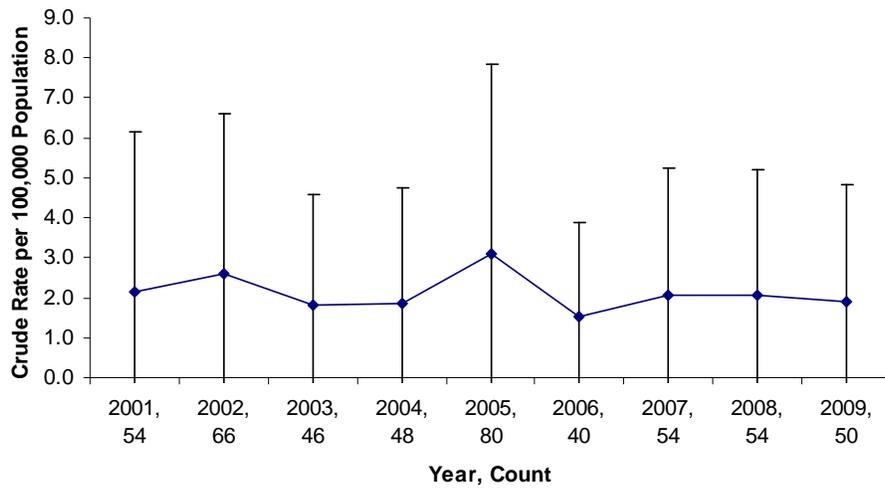
Drowning-related hospitalizations can result in lifelong disability. Hypoxia, lack of oxygen to the brain, can adversely affect brain function. This condition is irreversible and occurs within 4 to 6 minutes without oxygen.<sup>5</sup> Among adolescents and adults, risk factors for drowning include drinking 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.<sup>6</sup>

#### **LIMITATIONS OF INDICATOR**

Injuries that result in a hospital admission or emergency department visit 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.<sup>3,4</sup>

There are no statistically significant differences from year to year for emergency department and inpatient discharges for drowning-related injuries between years 2001-2009. In 2007, the rate of emergency department discharges for drowning was 1.8 (CI 1.1-2.6) per 100,000 populations and 1.7 (CI 1.0-2.6) in 2009. Inpatient discharge rate for drowning in 2007 was 0.3 (CI 0.1-0.7) per 100,000 population and 0.4 (CI 0.1-0.9) per 100,000 population in 2009. Counts are too small to show differences by gender or age group, so the total crude rate is shown in the graph below (Figure 13).

**Figure 13: Emergency Department plus Inpatient Discharge Rate, NH Resident Drowning, 2001-2009**



Source: NH DPHS Emergency Department and Inpatient Hospital Discharge Data

**Additional Information about Boating Accidents**

Below is New Hampshire boating accident data from the United States Coast Guard. Between 2009 and 2011, there were 146 boating accidents resulting in 12 fatalities and 87 injuries (Figure 14).

**FIGURE 14: Boating Accidents in New Hampshire 2009-2011**

Year	# of Accidents	# of Fatalities	# Injured
2009	60	7	39
2010	46	3	27
2011	36	2	21

## **Fall Indicator 1: Unintentional Fall-Related Fatalities**

Unintentional Fall-Related Fatality ICD-10 Codes: W00–W19 Falls

### **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.<sup>1</sup> In 2005, there were 19,656 unintentional fall-related deaths. In 2009 there were 24,793 fall deaths nationally.<sup>1</sup>

### **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.<sup>3,4</sup>

### **HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-23.1 Prevent an increase in the rate of fall-related deaths in all ages

Baseline: 7.0 deaths per 100,000 population were caused by falls in 2007 (age adjusted to the year 2000 standard population)

Target: 7.0 deaths per 100,000 population

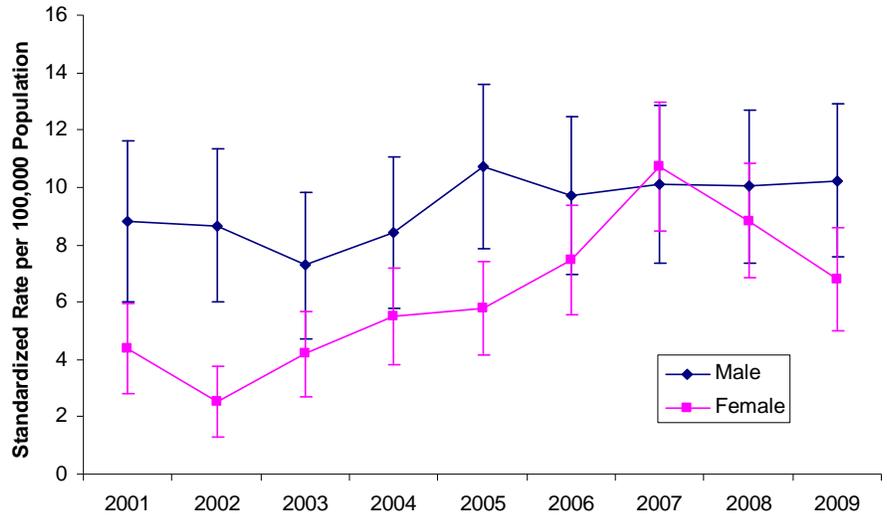
Target-Setting Method: Maintain the baseline rate

Data Source: National Vital Statistics System–Mortality (NVSS–M), CDC, NCHS

New Hampshire Prevention Efforts: The State’s Injury Prevention Program co-facilitates the New Hampshire Falls Risk Reduction Task Force (Task Force), the Injury Prevention Center at Dartmouth. This group is made up of a variety of disciplines, all working with seniors and all sharing a commitment to reducing the risk and number of falls among New Hampshire’s older adult population. For more information on the Task Force, please contact Rhonda Siegel at [rsiegel@dhhs.state.nh.us](mailto:rsiegel@dhhs.state.nh.us) or visit [www.nhfalls.org](http://www.nhfalls.org).

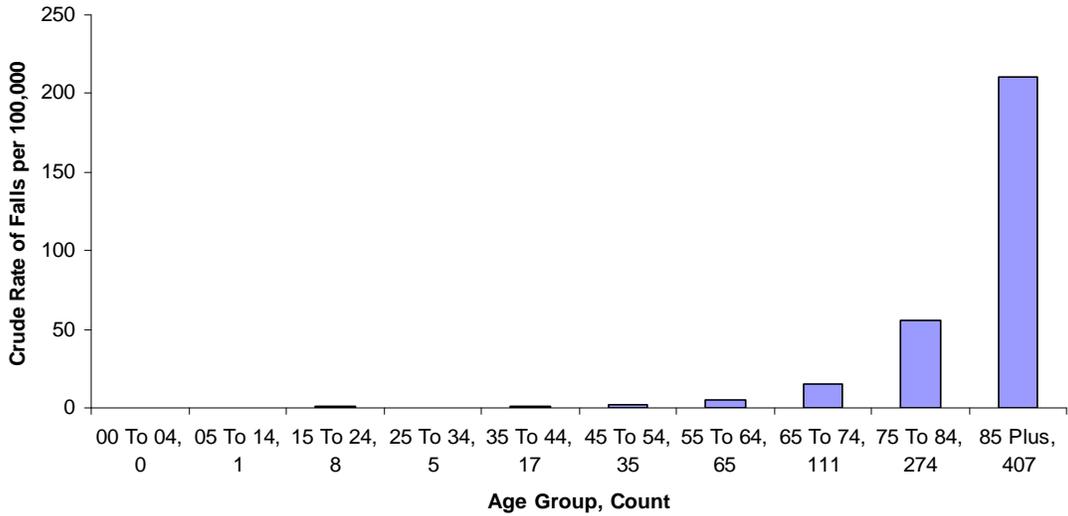
The fatality rate for fall-related injuries in New Hampshire in 2007 was 10.5 (CI 8.8-12.2) per 100,000 population. In 2009 the fatality rate for falls was 8.3 (CI 6.8-9.8) per 100,000 population. While the New Hampshire rate is higher than the national target of 7.0, the New Hampshire confidence interval overlaps this rate, so it is not statistically significantly different.

**Figure 15: Fatal Fall Injuries, NH Residents, by Gender, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

**Figure 16: Fatal Fall Injuries, NH Residents, by Age Group, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

Except in 2002, there are no statistically significant differences in fatal fall rates between males and females, or across years (Figure 15). New Hampshire residents age 65 and older do have a significantly higher fatality rate due to falls than other age groups (Figure 16).

## **Fall Indicator 2: Unintentional Fall-Related Hospitalizations and Emergency Department Visits**

Unintentional Fall-Related Hospitalization

ICD-9-CM Codes: E880–E886, E888 Accidental falls

### **BACKGROUND**

More than one third of adults 65 and older fall each year.<sup>7,8</sup> 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.<sup>9</sup> The total direct cost of nonfatal fall injuries for people 65 and older in 2000 was \$19 billion.<sup>10</sup> Nationally, in 2009, there were 8.7 million ED discharges for fall-related injuries and 876,000 inpatient discharges. Numbers in New Hampshire for 2009 are 41,824 ED and 3,573 inpatient discharges.

### **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.<sup>3,4</sup>

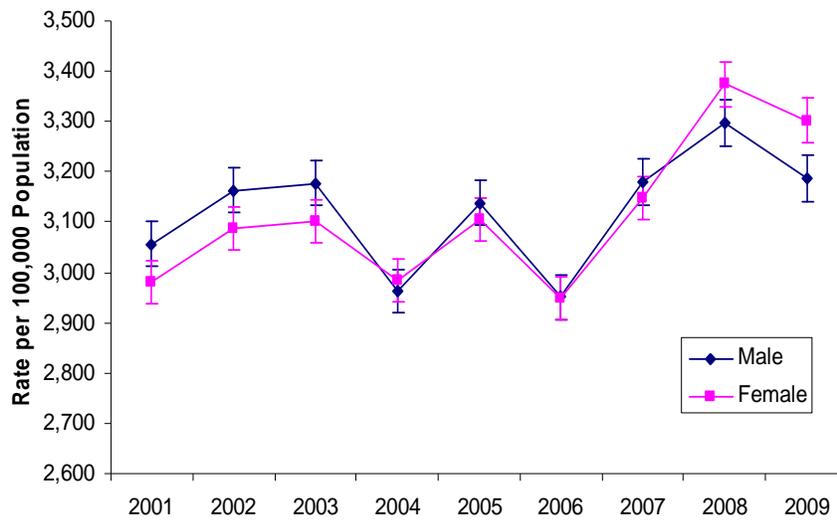
### **HEALTHY PEOPLE 2020 OBJECTIVES**

No objective.

New Hampshire Prevention Efforts: Safe Kids New Hampshire is a non-profit organization made up of individuals and organizations statewide who are interested in preventing unintentional childhood injuries. Safe Kids New Hampshire meets on a quarterly basis and often hosts professional training on the prevention of injuries, including childhood falls. The Injury Prevention Center at Dartmouth facilitates Safe Kids New Hampshire. For more information, please visit [http://chad.dartmouth-hitchcock.org/injury\\_prevention/injury\\_center\\_programs\\_childhood\\_safekids.html](http://chad.dartmouth-hitchcock.org/injury_prevention/injury_center_programs_childhood_safekids.html).

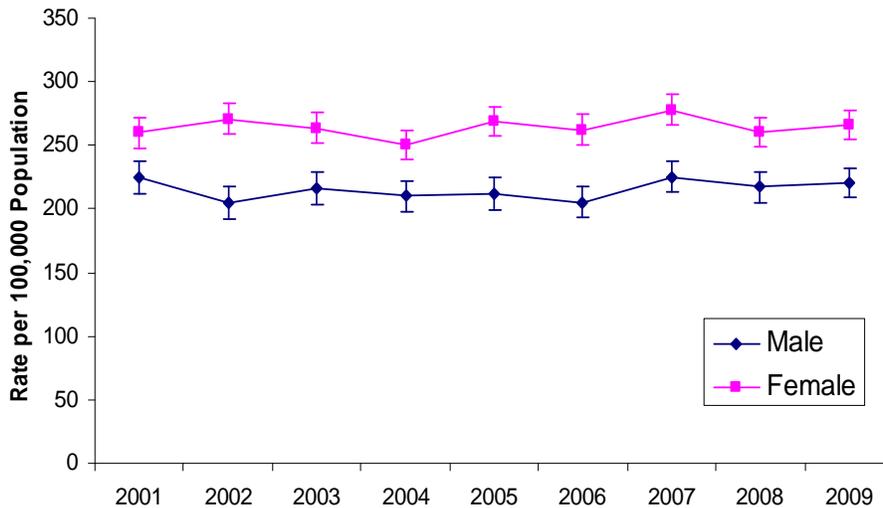
New Hampshire's objective for hospital discharges due to falls is to prevent an increase in the rate of hospital discharges. The ED discharge rate for falls in New Hampshire was 3,181.3 (CI 3,150.1-3,212.6) per 100,000 population in 2007 and 3,261.7 (CI 3,229.9-3,293.5) per 100,000 population in 2009. The inpatient discharge rate for falls in 2007 was 259.0 (CI 250.4-267.5) per 100,000 population, and in 2009 the inpatient rate was 249.6 (CI 241.3-257.9) per 100,000 population.

**Figure 17: Emergency Department Discharge Rate, Fall Injuries, NH Residents, by Gender, 2001-2009**



Source: NH-DPHS Emergency Department Hospital Discharge Data

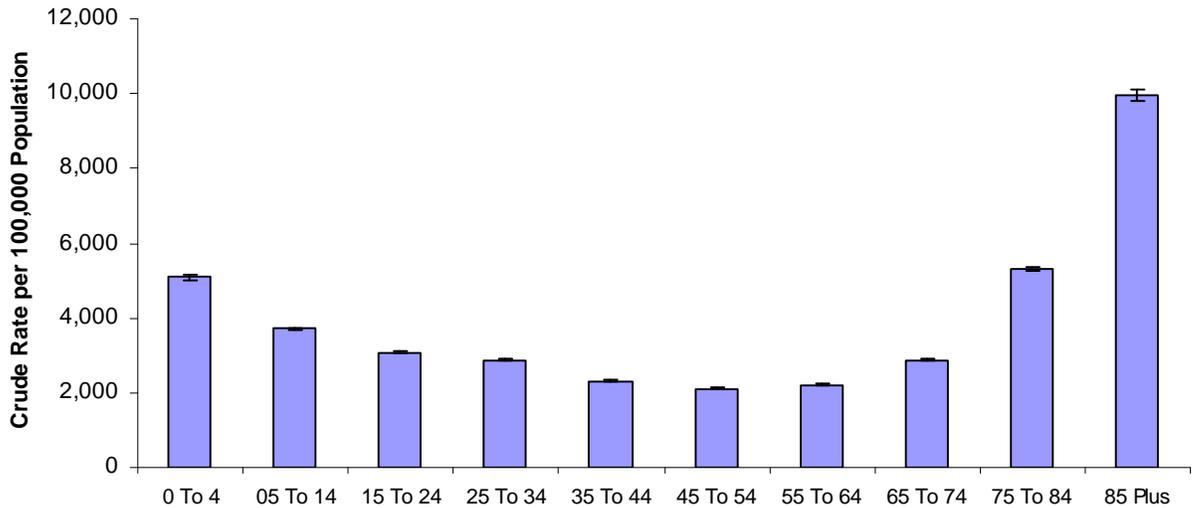
**Figure 18: Inpatient Discharge Rate, Fall Injuries, NH Residents, by Gender, 2001-2009**



Source: NH-DPHS Inpatient Hospital Discharge Data

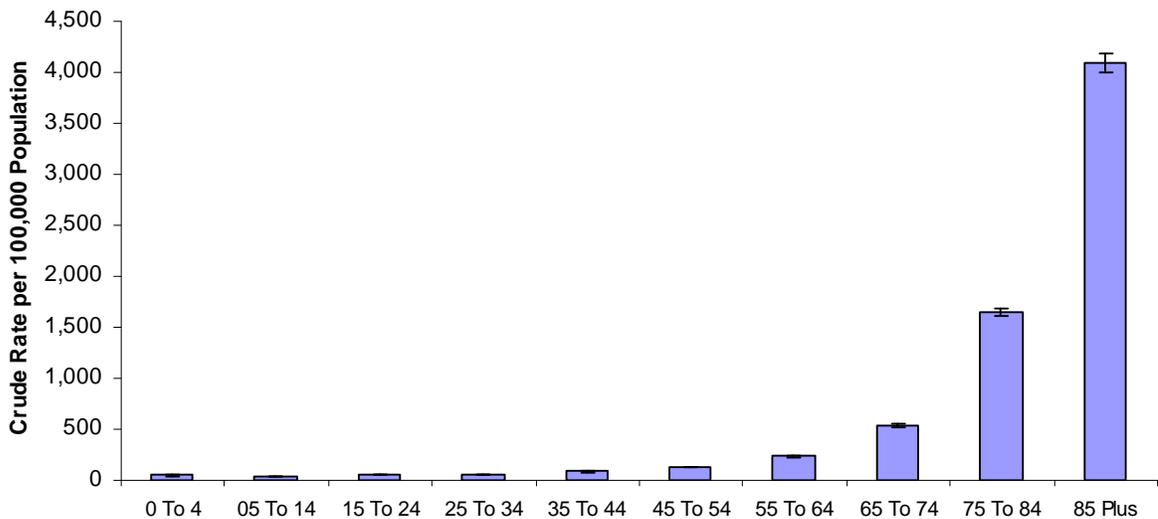
ED discharges in New Hampshire due to falls have significantly increased between 2001 and 2009 (Figure 17). Inpatient discharges rates have remained constant and female inpatient discharge rates are higher than males (Figure 18).

**Figure 19: Emergency Discharge Rate, Fall Injuries, NH Residents, by Age Group, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

**Figure 20: Inpatient Discharge Rate, Fall Injuries, NH Residents, by Age Group, 2001-2009**



Source: NH DPHS Inpatient Hospital Discharge

Age groups most likely to go to the ED due to fall injury are 0 to 14 years and 75 years and older (Figure 19). Ages 65 and older are most likely to need inpatient care after a fall-related injury (Figure 20).

### **Fall Indicator 3: Hip Fracture Hospitalizations in Persons Aged 65 Years and Older**

Hip Fracture Hospitalization ICD-9-CM Code: Diagnosis code 820 Fracture of neck of femur

#### **BACKGROUND**

In 2004, there were an estimated 289,000 hospital admissions for hip fractures in people 65 years and older.<sup>11</sup> 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<sup>12</sup> and as many as 20% of hip fracture patients die within a year of their injury.<sup>13</sup>

#### **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.<sup>3,4</sup>

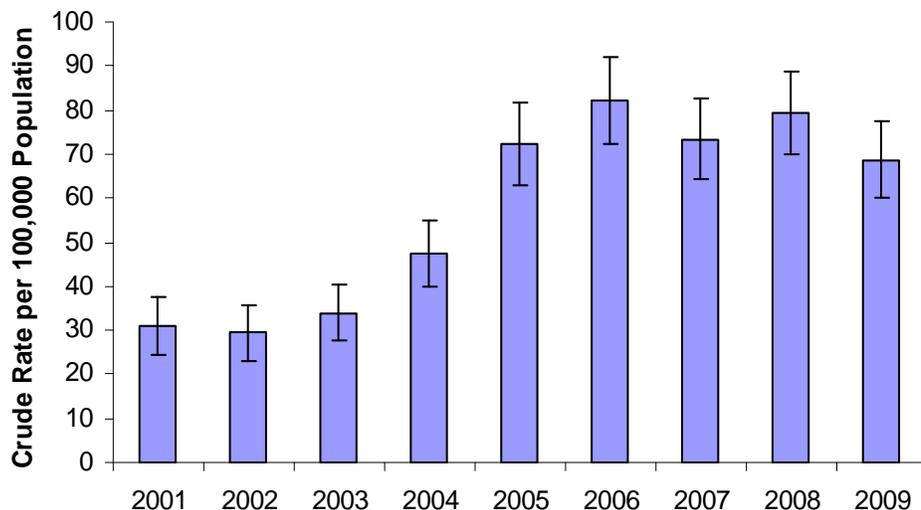
#### **HEALTHY PEOPLE 2020 OBJECTIVES**

No objective.

New Hampshire Prevention Efforts: Falls are not an inevitable consequence of aging; neither are hip fractures. The New Hampshire Falls Risk Reduction Task Force (Task Force) has led efforts to help older adults in the State learn that they do have ways to reduce their risk of falling. Entitled, “You CAN Reduce Your Risk of Falling,” the campaign encourages older adults to review their list of medications at least once a year, have an exercise routine that incorporates balance and strength training, and getting routine eye exams. For more information on the Task Force, please contact Rhonda Siegel, Co-Chair, at [rsiegel@dhhs.state.nh.us](mailto:rsiegel@dhhs.state.nh.us) or visit <http://www.nhfalls.org/>.

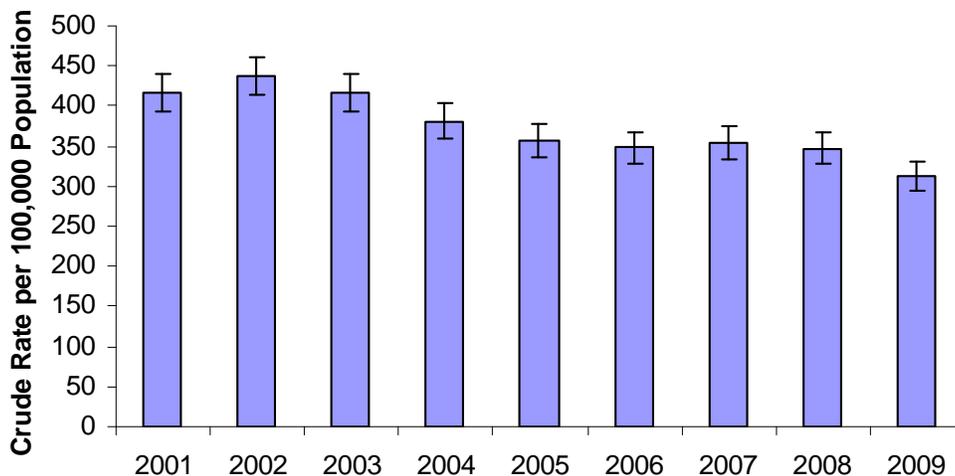
New Hampshire’s objective for hospital discharges for hip fractures due to fall, in residents age 65 and older, is to prevent an increase in the rate of hospital discharges. The total ED discharge rate for New Hampshire in 2007 was 73.4 (CI 64.2-82.6) per 100,000 population and in 2009 it was 68.7 (CI 60.0-77.4) per 100,000 population. In 2007, the inpatient rate for hip fracture was 353.5 (CI 333.3-368.2) per 100,000 population, and in 2009, the rate was 313.3 (CI 294.8-331.8) per 100,000 population.

**Figure 21: Emergency Department Discharge Rate, Hip Fractures, NH Residents, Age 65 and Older, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

**Figure 22: Inpatient Discharge Rate, Hip Fractures, NH Residents, by Age 65 and Older, 2001-2009**



Source: NH-DPHS Inpatient Hospital Discharge

Emergency department discharges for hip fracture in older adults significantly increased in 2005 and has remained constant through 2009 (Figure 21). Inpatient discharges have decreased between years 2002 and 2009 (Figure 22). This may be a sign that there has been a reduction in the severity of hip injuries due to falls as a result of fall risk prevention efforts.

**Fall Indicator 4: Falls in Adults Aged 65 Years or Older and  
Fall Indicator 5: Falls in Adults Aged 65 Years or Older That Caused Injury**

NUMERATOR: Those respondents who experienced a fall.

DENOMINATOR: Respondents aged 45 years or older.

DATA RESOURCES: Data from the Behavioral Risk Factor Surveillance System (BRFSS).<sup>14</sup>

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.<sup>15, 16</sup> 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.<sup>17</sup>

**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.<sup>3, 4</sup>

**HEALTHY PEOPLE 2020 OBJECTIVES**

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

Baseline: 5,235.1 emergency department visits per 100,000 due to falls occurred among older adults in 2007 (age adjusted to year 2000 standard population)

Target: 4,711.6 emergency department visits per 100,000 due to falls among older adults

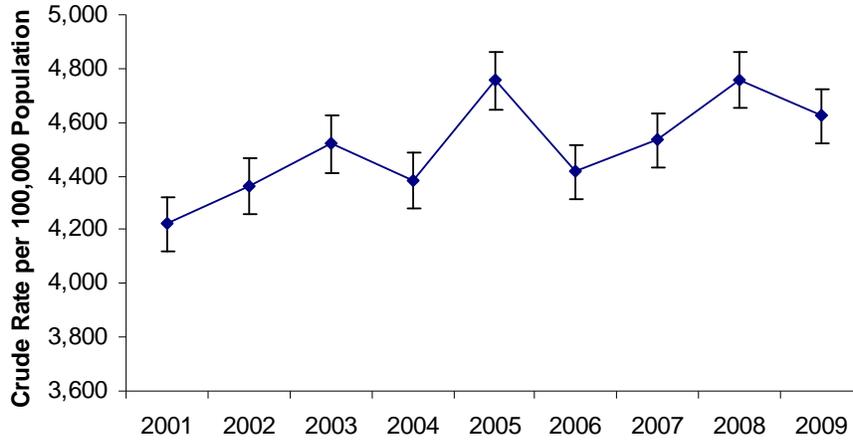
Target-Setting Method: 10 percent improvement

Data Source: National Hospital Ambulatory Medical Care Survey, CDC, NCHS

New Hampshire Prevention Efforts: There are several efforts in the State including the New Hampshire Falls Risk Reduction Task Force (Task Force) that have at its mission the education and training of medical professionals, including older adult falls. One of these programs is the Partnership for Patient Safety (the Partnership) out of the Foundation for Healthy Communities. The Partnership is a Federal program designed to help hospitals reduce preventable readmissions, injuries, and complications from healthcare acquired conditions, including older adult falls. For more information, contact Anne Diefendorf at [adiefendorf@healthynh.com](mailto:adiefendorf@healthynh.com). The Northern New England Geriatric Education Center (NNEGEC) helps to improve the health and quality of life for older adults in New Hampshire and Vermont by expanding the capacity of the healthcare workforce to provide high-quality, safe, and interdisciplinary care to older adults. One of the focus areas is improving outcomes through targeted implementation of an evidence based falls risk reduction program in rural settings. For more information, please visit [http://med.dartmouth-hitchcock.org/nne\\_geriatric\\_education\\_center.html](http://med.dartmouth-hitchcock.org/nne_geriatric_education_center.html).

The ED discharge rate for fall-related injuries in New Hampshire residents age 65 and older in 2007 was 4,532.3 (CI 4,432.0-4,632.5) per 100,000 population, and in 2009 it was 4,622.8 (CI 4,524.8-4,720.7) per 100,000 population (Figure 23). While the New Hampshire rate is lower than the national target rate of 4,711.6, the New Hampshire confidence interval overlaps this rate, and is not statistically significantly different..

**Figure 23: ED Discharges for falls, NH Residents, Age 65 and Older, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

**Figure 24: NH Residents, Age 65 and Older, Who Fell within the Last Three Months**

Survey Year	Estimated Age 65+ Adults with One or More Falls	Percent Reporting One or More Falls	Confidence Limits (95%)	Fell and was Injured	Percent Fell and was Injured	Confidence Limits (95%)
2006	26,200	16.5	14.2-18.7	8,680	33.1	25.8-40.5
2008	32,291	19.2	17.1-21.2	8,686	26.9	21.8-32.1
2010	26,456	15.0	13.2-16.9	8,663	32.7	26.7-38.8

Source: New Hampshire Behavioral Risk Surveillance System (NH BRFSS)

The New Hampshire Behavioral Risk Surveillance System Survey shows an estimated 26,456 New Hampshire residents over age 65 fell one or more times in 2010. Of those, 32.7% reported being injured due to falls (Figure 24).

**Falls and Nursing Homes**

Nursing home falls data is collected as part of Health Facility Administration Certification. Data is tracked on a Minimum Data Set (MDS). Each resident has at least 4 MDS done per resident per year including:

- 1 at admission
- 1 annually
- 3 quarterly
- And at Significant Change (when resident status changes).

Between October 1, 2011 and August 1, 2012, a total of 2,855 admission assessments were complete for male patients and 5,166 assessments on female patients. (Note: this is the number of assessments, not the number of patients.) Of the 2,855 assessments on males, 1,133 (40%) had

fallen prior to admission to the nursing home. Of the 5,166 assessments for females, 2,106 (41%) had fallen prior to admission.

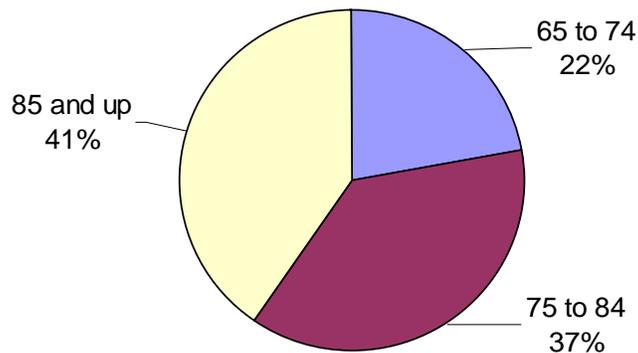
### Ambulance Runs to Assist with Fall-Related Injuries

New Hampshire Emergency Medical Services has a statewide electronic patient care record system called TEMSIS (Trauma and EMS Information System). This system is a secure, web-based, mandatory electronic reporting system that is provided free of charge to every licensed EMS service in New Hampshire. All data are stored and accessed centrally through a secure web server. The TEMSIS system was created under RSA 153-A:20-IV and RSA 21-P:12-b II (g) and is required of all New Hampshire licensed EMS services under Administrative Rules Saf-C 5902.08-09. Use of the data for analysis of emergency medical and trauma systems to identify modifications to the system based on gaps and shortfalls in delivery of EMS is defined under RSA 21-P:12-b II (g) and use for research and evaluation purposes is defined under RSA 126:24-a-f. For more information about TEMSIS, please see the following website:

[http://www.nh.gov/safety/divisions/fstems/ems/research/temsis\\_overview.html](http://www.nh.gov/safety/divisions/fstems/ems/research/temsis_overview.html)

Forty-one percent of ambulance runs for falls in the older population are for patients age 85 and older (Figure 25).

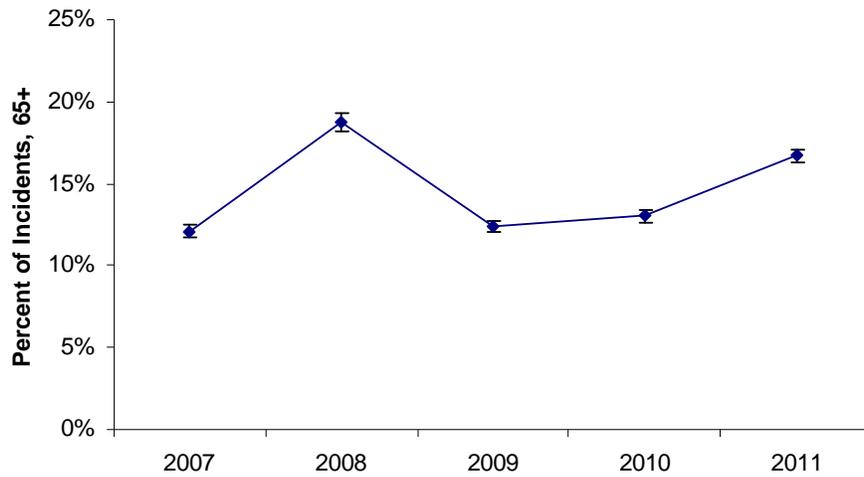
**Figure 25: Ambulance Runs in NH of Fall-Related Injuries, Percent of Patient's Age 65 and up, by Age Group, 2007-2011**



Source: New Hampshire Trauma Emergency Medical Services Information System (TEMSIS)

The number of incidents where ambulances were called for fall-related injuries in adults 65 and over rose between 2007 and 2011 because more cities were added to the TEMSIS data base. The percentage of ambulance runs for patients over 65 years of age with fall-related injuries changes significantly year to year with a slightly increasing trend. The increase may be due to the increase in the older adult population (Figure 26).

**Figure 26: Percentage of Ambulance Runs in NH for Fall-Related Injuries, Patients Age 65 and up, by Year**



Source: NH TEMSIS

Of the 20,905 ambulance runs for older adult falls between 2007 and 2011, 80.6% of patients were treated then transported to the hospital, 10.4% refused either treatment or transport, and 2.1% required no treatment (Figure 27).

**Figure 27: Number and Percentage of Ambulance Runs in NH for Fall-Related Injuries, Patients Age 65 and up, by Treatment, 2007-2011**

Treatment	Total	Percent
Dead at Scene	30	0.1%
Treated and Released	217	1.0%
No Treatment Required	445	2.1%
No Information or Not Applicable	1,194	5.7%
Refused Treatment and/or Transport	2,167	10.4%
Treated and Transported	16,852	80.6%
Grand Total	20,905	

Source: NH TEMSIS

## **Fire-Related Indicator 1: Unintentional Fire-Related Fatalities**

Unintentional Fire-Related Fatality ICD-10 Codes: X00–X09 Exposure to smoke, fire, and flames.

### **BACKGROUND**

The United States mortality rate from fires ranks sixth among the 25 developed countries for which statistics are available.<sup>18</sup> Four out of five deaths in 2005 occurred in homes<sup>19</sup> and approximately half of home fire deaths occurred in homes without fire alarms.<sup>20</sup>

### **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.<sup>3,4</sup>

### **HEALTHY PEOPLE 2020 OBJECTIVES**

Baseline: 0.95 deaths per 100,000 population were caused by residential fires in 2007 (age adjusted to the year 2000 standard population)

Target: 0.86 deaths per 100,000 population

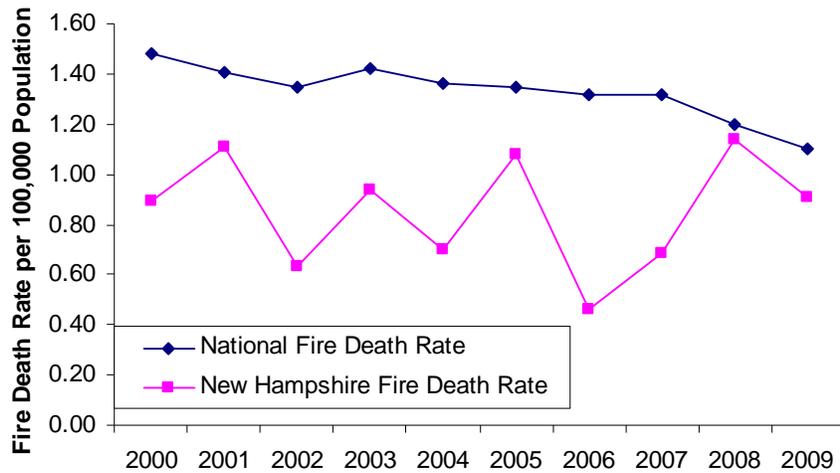
Target-Setting Method: 10 percent improvement

Data Source: National Vital Statistics System–Mortality (NVSS–M), CDC, NCHS

New Hampshire Prevention Efforts: The New Hampshire Division of Fire Safety, Office of the State Fire Marshal's mission is to prevent deaths, injury, and property loss by promoting a safe fire, building, and hazardous materials environment for the citizens and visitors of New Hampshire through education, engineering, investigation, and enforcement. To help do so, there are two public educators available for prevention programming. For more information, please contact Mary MacCaffrie at [mary.maccaffrie@dos.nh.gov](mailto:mary.maccaffrie@dos.nh.gov) or visit [http://www.nh.gov/safety/divisions/firesafety/pub\\_ed/index.htm](http://www.nh.gov/safety/divisions/firesafety/pub_ed/index.htm).

Data from the National Fire Incident Reporting website, <http://nfirs.fema.gov>, shows the U.S. rate for fire-related fatalities at 1.10 per 100,000 and the New Hampshire rate at 0.91 per 100,000 in 2009. According to 2009 NH Vital Statistics Death Certificate Data, the fatality rate due to fire was 0.76 (CI 0.36-1.40) per 100,000 population. The confidence interval envelopes both the 2007 national rate and the 2020 target rate. In New Hampshire, there are fewer than 11 deaths per year due to fire, which causes the annual rates to be statistically unstable (Figure 28).

**Figure 28: National and New Hampshire Fire-Related Fatality Rates, 2000-2009**



Sources:

1) National Center for Health Statistics. 2000-2009 Mortality Data File, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

2) U.S. Census Bureau, Population Division. July 1, 2009 population estimates from Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2009 (NST-EST2009-01).

Note: The fire death rates are based on all deaths in which exposure to fire, fire products, or explosion was the underlying cause of death or was a contributing factor in the chain of events leading to death (specifically, ICD 10 Codes: F63.1, W39-W40, X00-X09, X75-X76, X96-X97, Y25-Y26, and Y35.1).

**Fire-Related Indicator 2: Unintentional Fire-Related Hospitalizations plus Emergency Department Discharges**

Unintentional Fire-related Hospitalization ICD-9-CM Codes: E890–E899 Accident caused by fire and flames.

**BACKGROUND**

In 2011, New Hampshire fire departments responded to 1,264 home fires that claimed the lives of seven civilians and injuring another forty-one civilians and 18 fire service personnel. "In a fire, seconds count. Smoke alarms can give you time to get out. According to the National Fire Protection Association (NFPA), a smoke alarm, available at any hardware store can reduce your risk of dying in a home fire. Studies show that roughly one-fifth of the tens of millions of smoke alarms installed in homes are not in proper working condition. Evidence compiled over the past several decades shows that a working smoke alarm can reduce the chances of dying in a fire by 50%" Source: Mary MacCaffrie at the New Hampshire Fire Marshal's Office, mary.maccaffrie@dos.nh.gov

**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.<sup>3,4</sup>

## HEALTHY PEOPLE 2020 OBJECTIVES

No objective.

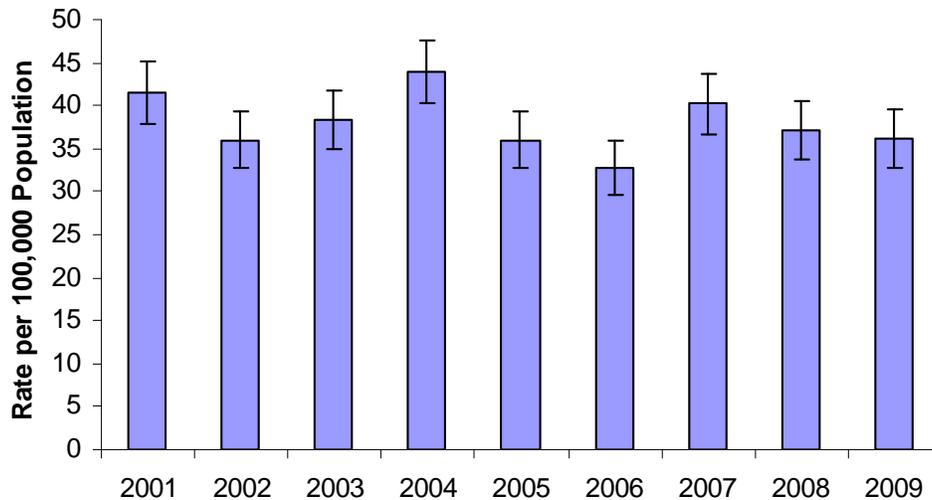
New Hampshire Prevention Efforts: Most fire-related injuries happen in the home. The New Hampshire Healthy Homes Program encourages prevention efforts to take a holistic and comprehensive approach to helping people in their homes. The New Hampshire Healthy Homes Program also provides the training and tools to housing, safety, and health professionals necessary to address the broad range of housing deficiencies and hazards, such as the lack of a smoke alarm, associated with unhealthy and unsafe homes. For more information, please visit <http://www.dhhs.nh.gov/dphs/bchs/clpp/index.htm>.

In 2007, the rate of emergency department discharges for fire-related injuries was 36.8 (CI 33.4-40.2) per 100,000 population. In 2009, the ED discharge rate was 32.7 (CI 29.5-36.0). There was no statistically significant change between 2007 and 2009 ED discharge rates for fire-related injuries.

In 2007, the rate of inpatient discharges for fire-related injuries was 3.4 (CI 2.5-4.5) per 100,000 population. In 2009, the inpatient discharge rate was 3.4 (CI 2.5-4.5). There was no statistically significant change between 2007 and 2009 inpatient discharge rates for fire-related injuries.

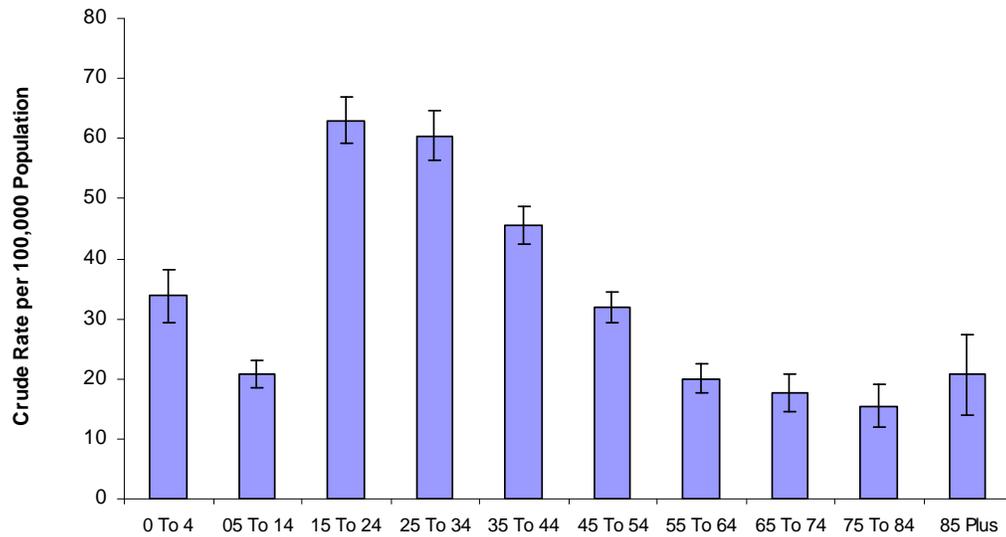
Since the inpatient discharge counts were so small, they have been added to the emergency department discharge data for the following graphs.

**Figure 29: Emergency Department plus Inpatient Discharge Rates, Fire-Related Injuries, NH Residents, 2001-2009**



Source: NH DPHS Emergency Department plus Inpatient Hospital Discharge Data

**Figure 30: Emergency Department plus Inpatient Discharge Rates, Fire-Related Injuries, NH Residents, by Age Group, 2001-2009**



Source: NH DPHS Emergency Department plus Inpatient Hospital Discharge Data

There are no statistically significant differences in ED discharges from year to year for fire-related injuries (Figure 29). The age group most likely to suffer fire related injury is people between 15 and 34 years old (Figure 30).

## **Firearm-Related Indicator 1: Firearm-Related Fatalities**

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

### **BACKGROUND**

Firearm-related injuries were the second leading cause of injury-related death in the United States, accounting for about 30,700 deaths in 2005.<sup>1</sup> Nationally, the firearm-related death rate for males is almost seven times higher than that of females.<sup>21</sup>

### **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.<sup>3,4</sup>

### **HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-30 Reduce firearm-related deaths

Baseline: 10.2 firearm-related deaths per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)

Target: 9.2 deaths per 100,000 population

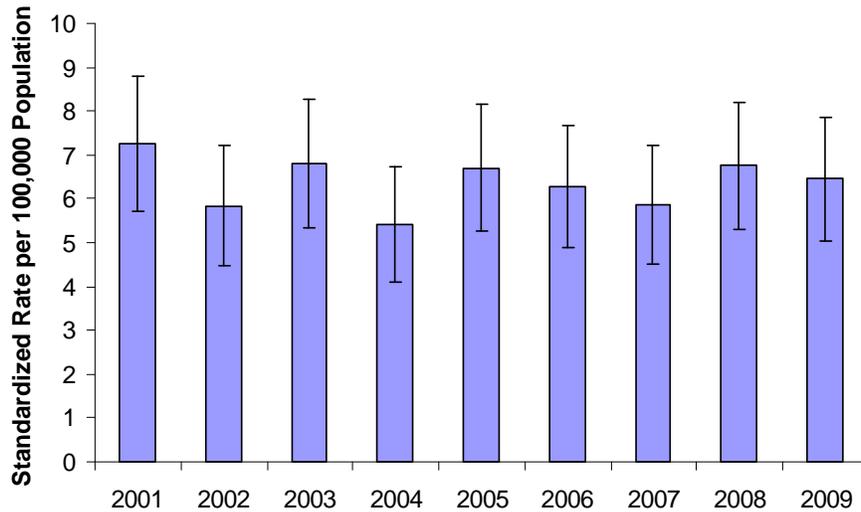
Target-Setting Method: 10 percent improvement

Data Source: National Vital Statistics System–Mortality (NVSS–M), CDC, NCHS

New Hampshire Prevention Efforts: The Youth Suicide Prevention Assembly (YSPA) is dedicated to reducing the occurrence of suicide and suicidal behaviors among New Hampshire's youth and young adults between 10 and 24 years of age. This is accomplished through a coordinated approach of providing service providers and communities with current information regarding best practices in suicide prevention and postvention strategies and by promoting youth and young adult safety in our communities and organizations. For more information, please visit <http://www.theconnectprogram.org/assembly-youth-and-teen-suicide-prevention>.

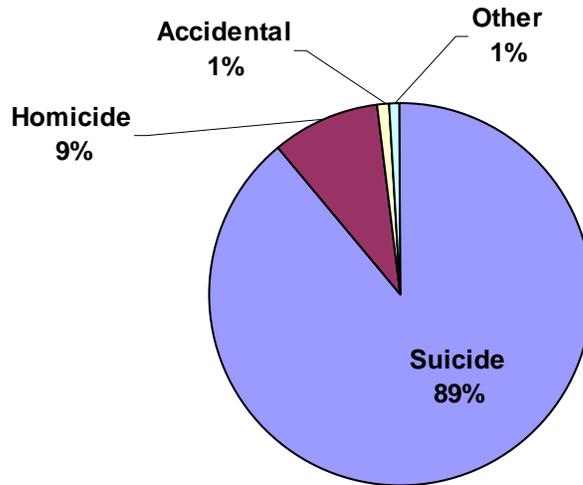
On average in New Hampshire, there are 82 firearm-related fatalities per year. Between the years 2001-2009 the rate of firearm fatalities has remained constant. The most common intent in firearm deaths is suicide (89%) followed by homicide (9%). The firearm fatality rate in 2007 was 5.9 per 100,000 population. In 2007, the firearm-related fatality rate was 5.9 (CI 4.6-7.3) per 100,000 population. There are no statistically significant changes in the firearm fatality rate from year to year (Figure 31). In 2009, the State rate was 6.5 (CI 5.2-8.0) per 100,000 population. New Hampshire's firearm fatality rate is currently below the national target rate of 9.2 per 100,000 population.

**Figure 31: Fatal Firearm Injury Rates, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

**Figure 32: Fatal Fire Arm Injury Rates, by Intent, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

**Firearm-Related Indicator 2: Firearm-Related Hospitalizations plus Emergency Department Visits**

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

## BACKGROUND

Nonfatal firearm-related injury rates are highest among persons ages 15 to 24 years. About one fifth of nonfatal firearm-related injuries treated in U.S. hospital emergency departments are unintentional.<sup>21</sup>

## 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.<sup>3,4</sup>

## HEALTHY PEOPLE 2020 OBJECTIVES

IVP-31 Reduce nonfatal firearm-related injuries

Baseline: 20.7 emergency department discharges for nonfatal firearm-related injuries per 100,000 population occurred in 2007

Target: 18.6 injuries per 100,000 population

Target-Setting Method: 10 percent improvement

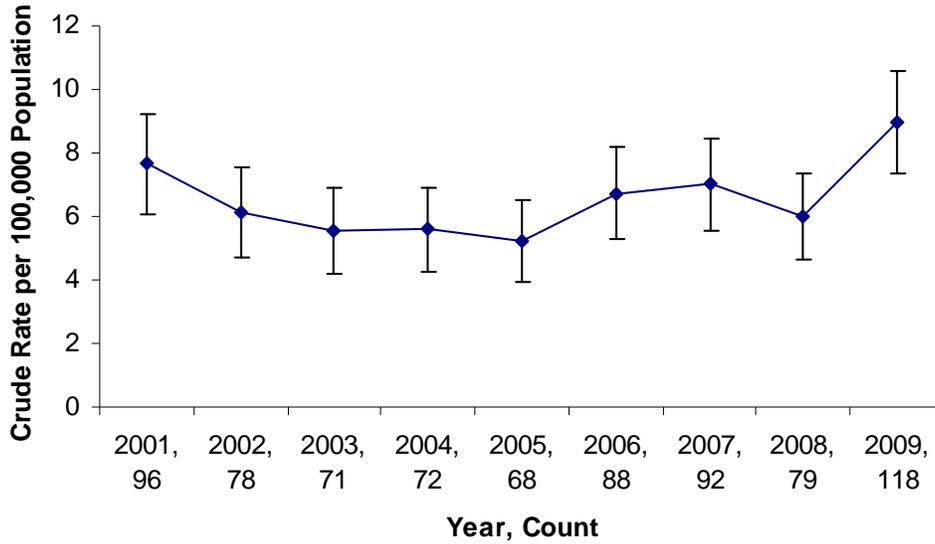
Data Source: National Electronic Injury Surveillance System (NEISS), US Consumer Product Safety Commission (CPSC)

New Hampshire Prevention Effort: The New Hampshire Firearm Safety Coalition brings together individuals and organizations with a broad range of views on gun ownership who share a concern with safety and with preventing suicide. The group includes: gun shops and firing ranges, legislators, injury prevention and mental health advocates, researchers, and committed volunteers. Since the Coalition first formed in 1994, it has produced public education materials geared towards young people: a brochure and other printed materials, Firearm Safety Display Kits available for use at health fairs and educational programs, and two videos entitled “Staying Safe Around Guns - What You DON’T Know Can Hurt You” – one geared toward middle school students and the other toward high school students. Since then, more than 4,500 copies of these have been distributed throughout New Hampshire, the U.S. and abroad. In 2009, the Coalition began the Gun Shop Project – a collaborative effort to engage gun shop and firing range owners, their employees, and their customers in preventing suicide, the number one type of firearm death in the U.S. For more information, visit <http://www.theconnectprogram.org/firearms-safety-coalitions-role-nh-suicide-prevention>.

In 2007, the rate of ED discharges for firearm-related injuries was 7.0 (CI 5.7-8.6) per 100,000 population, and in 2009 it was 9.0 (CI 7.3-10.6) per 100,000 population. In 2007, the rate of inpatient discharges for firearm-related injuries was 2.5 (CI 1.7-3.5) per 100,000 population and 2.9 (CI 2.0-3.9) per 100,000 population in 2009. New Hampshire’s rates are well below the national target of 18.6 per 100,000 population.

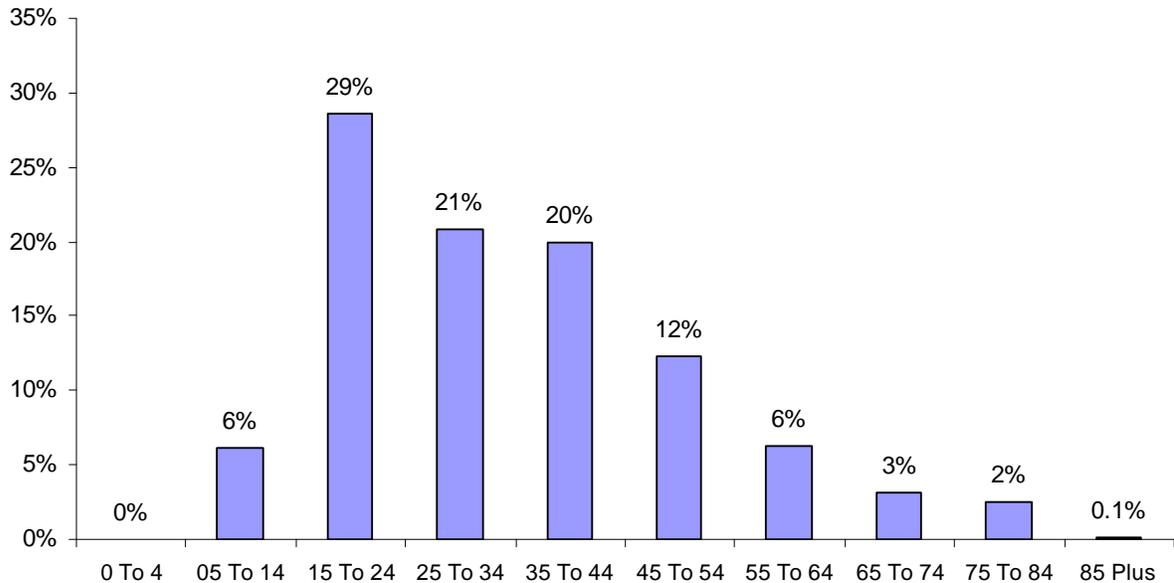
Since the inpatient discharge counts were so small, they have been added to the emergency department discharge data for the following graphs.

**Figure 33: Emergency Department plus Inpatient Discharge Rates, Fire Arm Injury, NH Residents, 2001-2009**



Source: NH DPHS Emergency Department plus Inpatient Hospital Discharge Data

**Figure 34: Emergency Department plus Inpatient Discharge, Fire Arm Injury, Percent by Age Group, NH Residents, 2001-2009**



Source: NH DPHS Emergency Department plus Inpatient Hospital Discharge Data

The rate of firearm injuries in New Hampshire requiring hospital attention remained constant between 2001 and 2009 (Figure 33). The most common group to suffer firearm injuries is 15 to 24 years old (Figure 34). Males make up 86% of all ED discharges for gun shot wounds.

## **Homicide/Assault Indicator 1: Homicides**

Homicide ICD-10 Codes:

X85–Y09 Assault

Y87.1 Sequelae of assault

U01 Terrorism-assault

U02 Sequelae of terrorism-assault

### **BACKGROUND**

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

### **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.<sup>3,4</sup>

### **HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-29 Reduce homicides

Baseline: 6.1 homicides per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)

Target: 5.5 homicides per 100,000 population

Target-Setting Method: 10 percent improvement

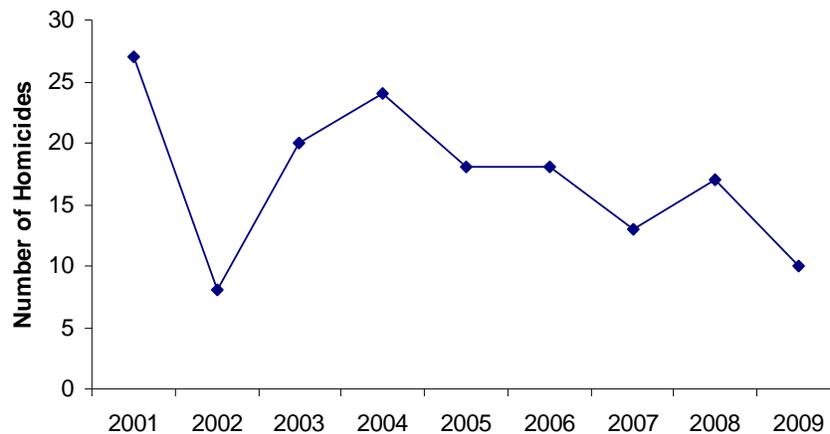
Data Source: National Vital Statistics System–Mortality (NVSS–M), CDC, NCHS

New Hampshire Prevention Efforts: The Child Fatality Review Committee’s (CFRC) mission is to reduce preventable child fatalities through systemic multidisciplinary review of child fatalities in New Hampshire; through multidisciplinary training and community-based prevention education; and through data-driven recommendations for legislation and public policy. After each review, the CFRC identifies risk factors related to the death and makes recommendations aimed at improving systematic responses in an effort to prevent similar deaths in the future. The CFRC provides the recommendations to the participating agencies and asks them to take actions consistent with their own mandates. It also publishes the recommendation and the agency responses to those recommendations in an annual report. For more information, please visit <http://doj.nh.gov/criminal/victim-assistance/child-fatality-review-committee.htm>.

In New Hampshire, on average, there are fewer than 20 homicides per year, which causes the annual rates to be statistically unstable. In 2007, the homicide rate was 1.0 (CI 0.5-1.7) per 100,000 population. In 2009, the homicide rate was 0.8 (CI 0.4-1.4) per 100,000 population. The State rate is well below the national target rate of 5.5 per 100,000.

The count of homicides per year is shown in the graph below. Any differences in the counts from year to year are statistically due to chance (Figure 35).

**Figure 35: Number of Homicides, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

### **Homicide/Assault Indicator 2: Assault-Related Hospitalizations and Emergency Department Visits**

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

#### **BACKGROUND**

In 2005, over 1.6 million people were treated in U.S. emergency departments for assault-related injuries with 114,000 of them hospitalized or transferred for a higher level of care.<sup>1</sup>

#### **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.<sup>3, 4</sup>

#### **HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-32 Reduce nonfatal physical assault injuries

Baseline: 514.1 emergency department visits for nonfatal physical assault injuries per 100,000 population occurred in 2008 (age adjusted to the year 2000 standard population)

Target: 462.7 injuries per 100,000 population

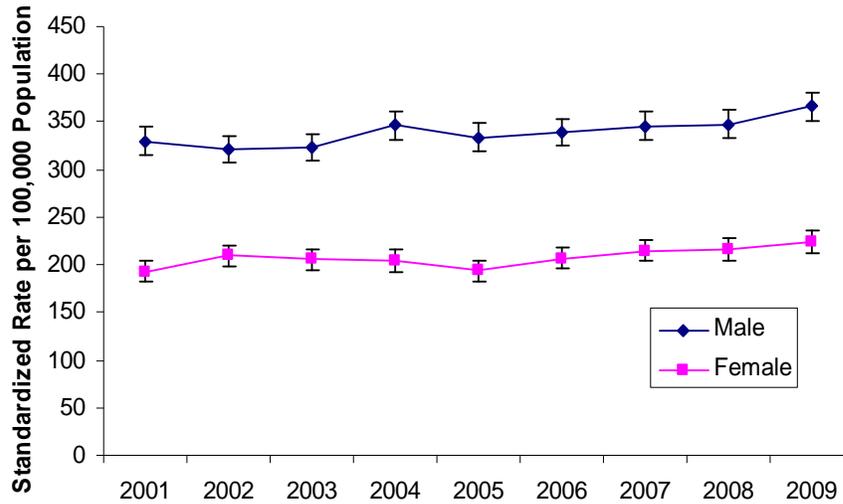
Target-Setting Method: 10 percent improvement

Data Source: National Electronic Injury Surveillance System—All Injury Program (NEISS-AIP), CDC, NCIPC, US Consumer Product Safety Commission (CPSC)

New Hampshire Prevention Efforts: New Hampshire’s Injury Prevention Program funds sexual violence prevention efforts of the 13 member programs of the New Hampshire Coalition Against Domestic and Sexual Violence (NHCADSV). The member programs (usually referred to as crisis centers) are located throughout the State. Staff provide prevention education in community-based locations such as schools. For more information, please visit [www.nhcadsv.org](http://www.nhcadsv.org).

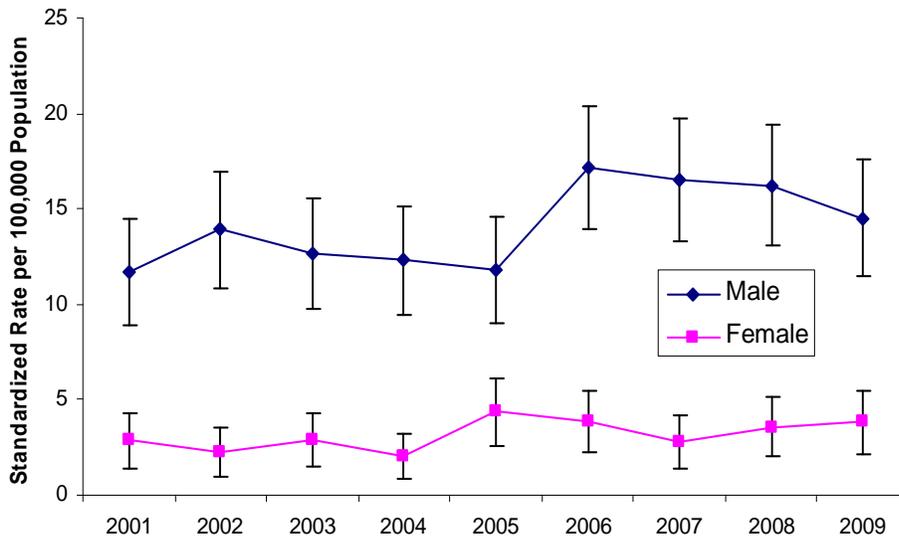
New Hampshire's ED discharge rates in 2007 due to assault were 281.1 (CI 271.7-290.5) per 100,000 population. In 2009, the State rate was 295.6 (CI 285.8-305.3). The national target rate for assault injuries is 462.7 per 100,000 population. New Hampshire is well below the national target rate.

**Figure 36: Emergency Department Discharge Rates for Assault, NH Residents, by Gender, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

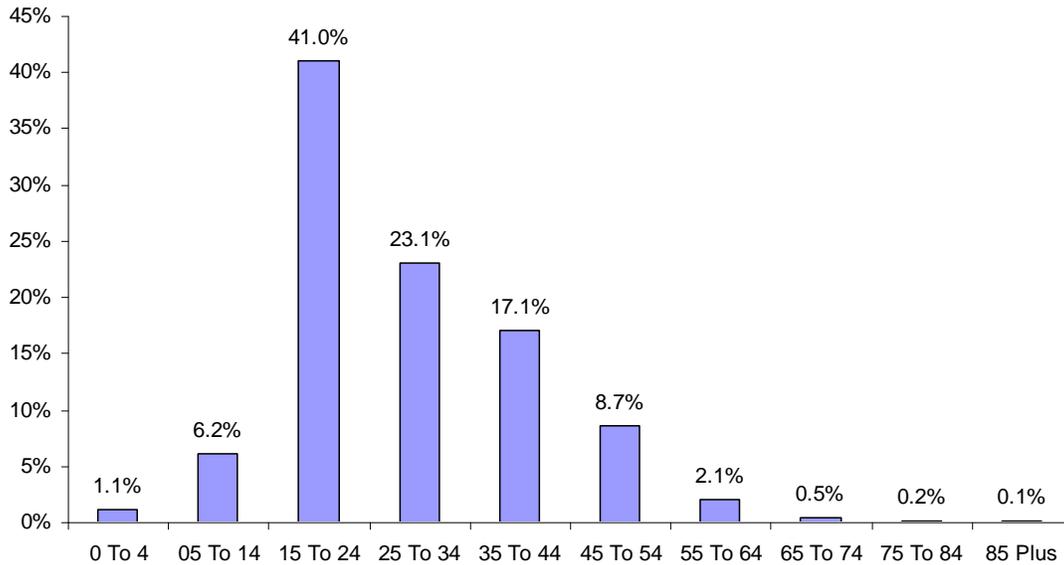
**Figure 37: Inpatient Discharge Rates for Assault, NH Residents, by Gender, 2001-2009**



Source: NH DPHS Inpatient Hospital Discharge

For both ED and inpatient data, the discharge rates for assault remain constant. Males are more likely to need hospital care for assault injuries than females (Figures 36 and 37).

**Figure 38: Emergency Department plus Inpatient Discharge, Assault Injury, Percentage by Age Group, NH Residents, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

Young adults are the most likely age group to need hospital care for assault injuries (age 15-24, 41%, age 25-24, 23%) (Figure 38).

**Additional Information on Sexual Violence**

- Sexual Violence Hospitalization ICD-9-CM Codes:
- 995.53 Rape of Child
  - 995.83 Rape of Adult
  - V71.5 Alleged Rape, Examination and Observation
  - E960.1 Cause of Injury, Rape

The rate of hospitalizations (emergency department and inpatient) is greatest in people 24 years of age and younger. This is consistent with other additional sources of information about rape, including victims served in NHCADSV member programs as well as sexual assault nurse exams (exams done for forensic evidence, usually in a hospital) and crime reports.

**FIGURE 39: Emergency Department plus Inpatient Discharge Rate for Rape, 2003-2007 by Age Group**

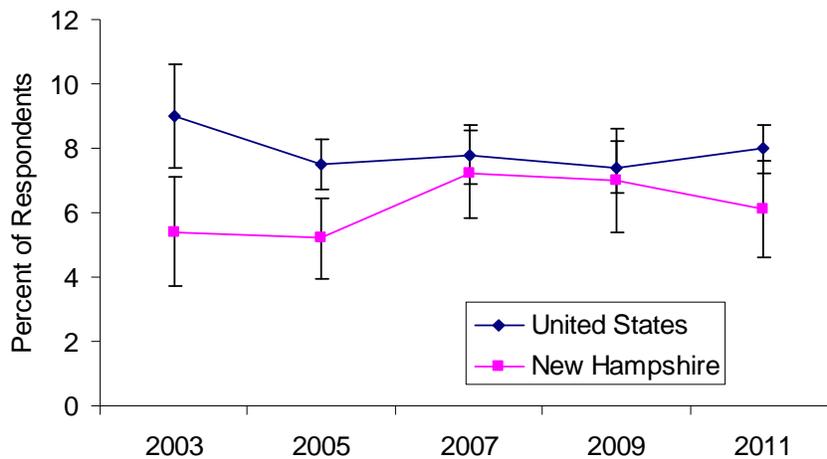
Age Group	Count	Age Specific Rate / 100,000	Lower 95% CI	Upper 95% CI
0 to 4	158	42.7	36.0	49.3
05 to 14	286	33.2	29.3	37.0
15 to 24	880	96.3	90.0	102.7
25 to 34	243	32.3	28.2	36.4
35 to 44	134	12.7	10.5	14.8
45 to 54	73	6.9	5.4	8.7
55 to 64	18	2.5	1.5	3.9
65 to 74	3	0.7	0.1	2.1
75 to 84	1	0.4	0.0	2.0
85 Plus	4	3.6	1.0	9.2

Source: NH DPHS Emergency Department plus Inpatient Hospital Discharge Data

The age group with the higher rate of ED and inpatient hospital discharges for rape and alleged rape is ages 15 to 24 (Figure 39).

The Youth Risk Behavior Survey (YBRS) asked students if they have ever been force to have sexual intercourse with they did not want to. The percentage of respondents in New Hampshire is lower than the percentage of respondents nationwide, but not statistically significantly difference in recent years (Figure 40).

**FIGURE 40: Have you ever been physically forced to have sexual intercourse when you did not want to?**



Source: Youth Risk Behavior Survey (YBRS) <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx>

## Motor Vehicle Indicator 1: Motor Vehicle Traffic Fatalities

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

### BACKGROUND

Motor vehicle crashes are the leading cause of injury death in the United States. They are also the leading injury cause for years of potential life lost.<sup>1</sup>

### 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.<sup>3,4</sup>

### HEALTHY PEOPLE 2020 OBJECTIVES

IVP-13.1 Deaths per 100,000 population

Baseline: 13.8 deaths per 100,000 population were caused by motor vehicle crashes in 2007 (age adjusted to the year 2000 standard population)

Target: 12.4 deaths per 100,000 population

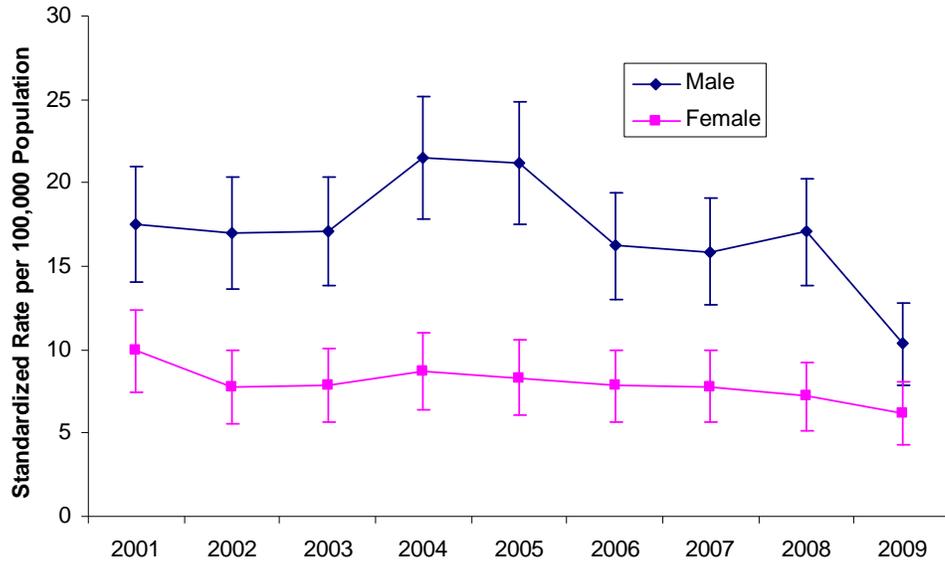
Target-Setting Method: 10 percent improvement

Data Source: National Vital Statistics System–Mortality (NVSS–M), CDC, NCHS

New Hampshire Prevention Efforts: The New Hampshire Driving Toward Zero Coalition (NHDTZ), spearheaded by the State’s Department of Transportation, is a collaborative effort of both public and private entities whose mission is to create a culture of safety on New Hampshire roadways. The vision of the Coalition is to reduce the number of fatal and severe injury crashes on New Hampshire roadways to zero through the implementation of education, enforcement, engineering, and emergency management solutions. For more information, please visit the NHDTZ website at <http://www.nhdtz.com>.

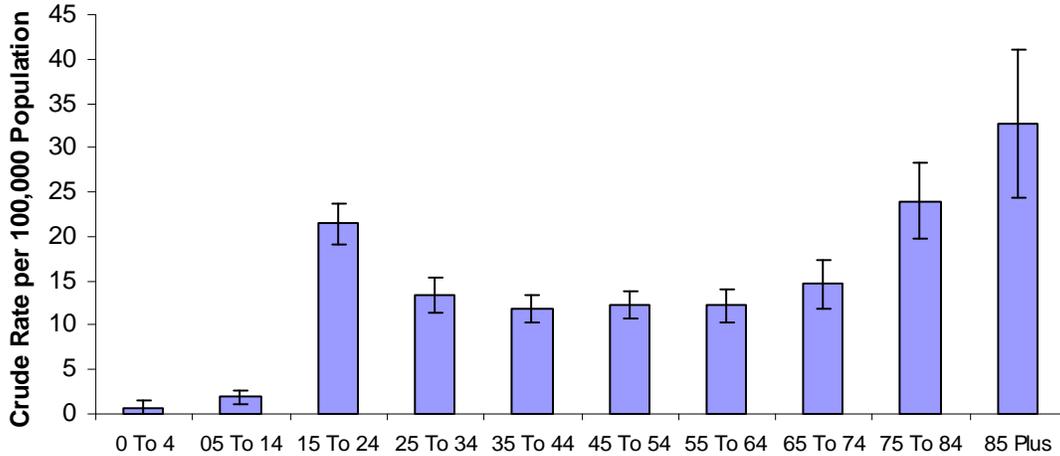
The New Hampshire motor vehicle fatality rate in 2007 was 11.6 (CI 9.8-13.5) per 100,000 population, and 8.3 (CI 6.8-9.8) per 100,000 population in 2009. The confidence intervals are close; since they actually overlap there has been no statistically significant change between 2007 and 2009. The State rate is well below the national target rate of 12.4 per 100,000 population.

**Figure 41: Fatal Motor Vehicle Crash Injuries, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

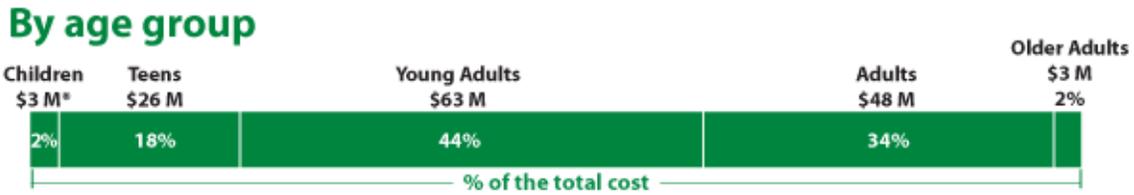
**Figure 42: Fatal Motor Vehicle Crash Injuries, by Age Group, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

Between 2001 and 2009, motor vehicle fatality rates have decreased in males, who remained at a higher rate than females until 2009 where there is no statistically significant difference (Figure 41). The age groups most likely to perish in an automobile crash are ages 15 to 24 years and 75 years and older (Figure 42).

**Figure 43: Percentage of Cost of Fatal Motor Vehicle Crashes by Age Group**



Children: 0-14, Teens: 15-19, Young Adults: 20-34, Adults: 35-64, Older Adults: 65+  
 \* Cost is based on fewer than 20 deaths and may be unstable.

Source: <http://www.cdc.gov/Motorvehiclesafety/statecosts/nh.html>

**Motor Vehicle Indicator 2: Motor Vehicle Traffic Hospitalizations and Emergency Department Visits**

Motor Vehicle Traffic Hospitalization ICD-9-CM Codes:  
 E810–E819 Motor vehicle traffic accidents

**BACKGROUND**

In 2005, motor vehicle crashes were the cause of more than 4.3 million emergency department visits in the United States.<sup>1</sup> It is estimated that front seat occupants who use lap/shoulder belts reduce their risk for fatal injury by about 45% and for moderate to critical injury by 45% to 50%.<sup>22</sup>

**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.<sup>3, 4</sup>

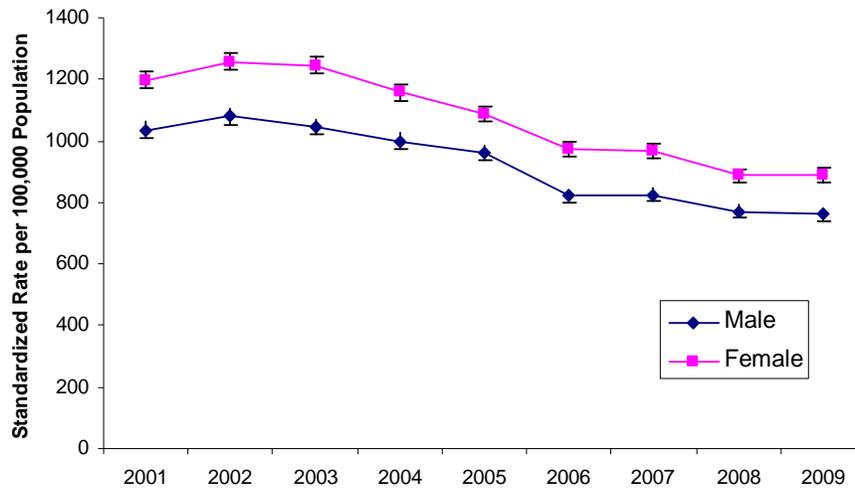
**HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-14 Reduce nonfatal motor vehicle crash-related injuries  
 Baseline: 771.5 nonfatal injuries per 100,000 population were caused by motor vehicle crashes in 2008  
 Target: 694.4 nonfatal injuries per 100,000 population  
 Target-Setting Method: 10 percent improvement  
 Data Source: General Estimates System (GES), DOT, NHTSA

New Hampshire Prevention Efforts: The New Hampshire Child Passenger Safety (NH CPS) Program provides technical assistance regarding child passenger safety to professionals and the public. Consultation is available for transporting children with special medical needs. Short-term loans of special needs seats and vests are also available. The NH CPS facilitates two child passenger safety technician trainings per year. After successfully passing this course, an individual is certified as a child passenger safety technician. The NH CPS also coordinates permanent inspection stations located around the State. For more information, please visit [http://chad.dartmouth-hitchcock.org/injury\\_prevention/injury\\_center\\_programs\\_traffic\\_passenger.html](http://chad.dartmouth-hitchcock.org/injury_prevention/injury_center_programs_traffic_passenger.html).

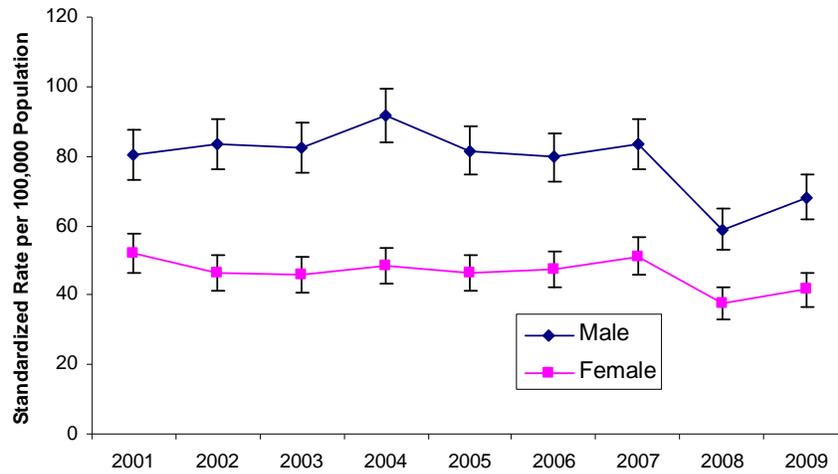
Since the data source for the national target does not provide state-level data, no direct comparison can be made between the U.S. and New Hampshire for this objective. Within New Hampshire, in 2007 the rate of ED discharges was 895.9 (CI 879.4-912.5) per 100,000 population, and in 2009 it was 824.6 (CI 808.6-840.5) per 100,000 population. This shows a statistically significant decrease between years 2007 and 2009. Within New Hampshire, in 2007 the rate of inpatient discharges was 66.9 (CI 62.4-71.3) per 100,000 population and 55.0 (CI 50.9-59.0) per 100,000 population in 2009. This also shows a statistically significant decrease between 2007 and 2009.

**Figure 44: Emergency Department Discharge Rates for Motor Vehicle Crash Injuries, NH Residents, by Gender, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

**Figure 45: Inpatient Discharge Rates for Motor Vehicle Crash Injuries, NH Residents, by Gender, 2001-2009**

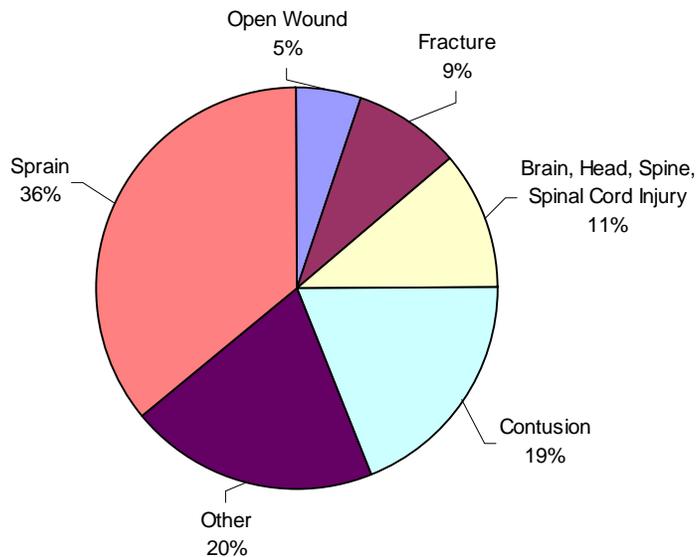


Source: NH DPHS Inpatient Hospital Discharge

ED and inpatient discharge rates between 2001 and 2009 have significantly decreased. Females are more likely than males to need ED treatment after a crash (Figure 44). Males are more likely than females to require inpatient care after a crash (Figure 45).

**Figure 46: Percentage of Nonfatal Motor Vehicle ED and Inpatient Discharges, 2007, by Injury Outcome**

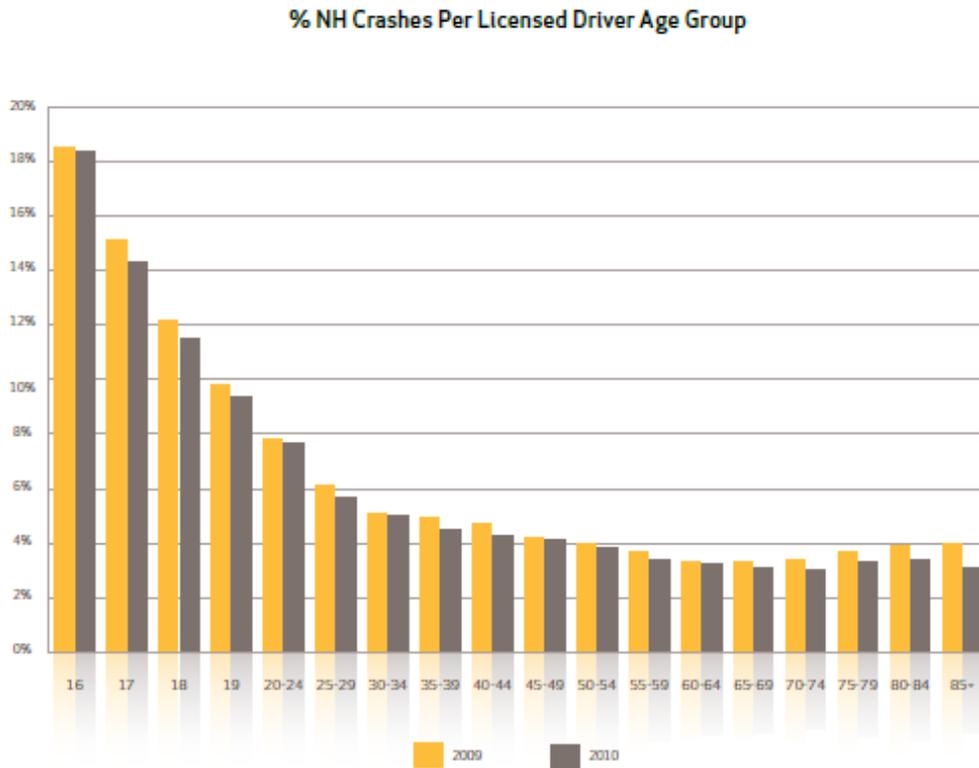
Percent of Nonfatal Motor Vehicle ED and Inpt Discharges by Principle Diagnosis, 2007  
(n =16,041 include NH Residents and Non-Residents)



Source: NH DPHS Emergency Department plus Inpatient Hospital Discharge Data

In 2007, there were 16,041 emergency department and inpatient hospital discharges for nonfatal motor vehicle crash injuries, which is the second leading cause of injury after falls. In the chart above, most injuries are sprains and bruising. Injuries to the brain and spine make up 11% of all the injuries (Figure 46).

**Figure 47: Percentage of NH Crashes per Licensed Driver by Age Group, 2009 and 2010**



*New drivers, aged 16-19, represent the highest number of crashes among the different age groups of licensed drivers in NH. Many reasons account for this, but distracted driving (texting and cell phone use), in addition to driver inexperience, are the two most important prevalent.*

Source: Driving Toward Zero: <http://www.nhdrivingtowardzero.com/resources/detail/18>

More than 18% of licensed teen drivers, 16 years of age, will be the driver during a car crash (Figure 47).

**Motor Vehicle Indicator 3: Seat Belt Use**

**DATA RESOURCES**

Data from the Behavioral Risk Factor Surveillance System (BRFSS).<sup>12</sup>

**BACKGROUND**

Safety belts are 45% to 60% effective in reducing deaths and 50% to 65% effective in reducing moderate-to-critical injuries.<sup>23</sup>

## 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.<sup>3,4</sup>

## HEALTHY PEOPLE 2020 OBJECTIVES

IVP-15 Increase use of safety belts

Baseline: 84.0 percent of motor vehicle drivers and right-front seat passengers used safety belts in 2009

Target: 92.4 percent

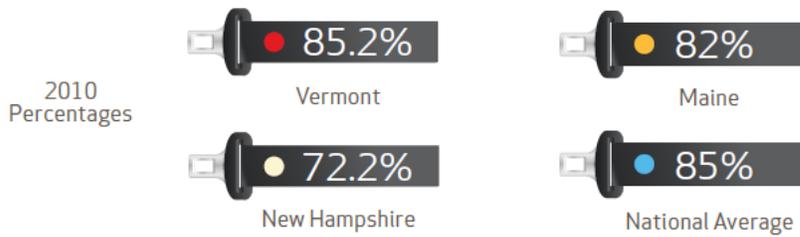
Target-Setting Method: 10 percent improvement

Data Source: National Occupant Protection Use Survey (NOPUS), DOT, NHTSA

New Hampshire Prevention Efforts: The Buckle Up NH Coalition (Buckle UP) is a group of highway safety advocates who are committed to promoting seat belt use through education. Efforts of Buckle Up include an annual traffic safety conference and the promotion of Buckle Up Week in May. Specific targeted efforts have been made to adolescents and pick-up truck drivers, both of whom consistently have a lower than average belt use. For additional information, please visit <http://buckleupnh.org.ipage.com/2201.html>.

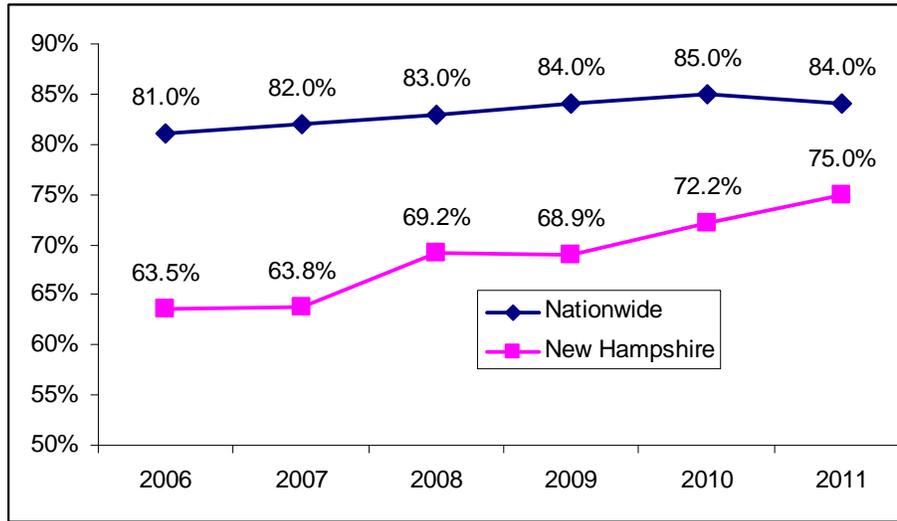
While the national data (NOPUS) and the State data (BRFSS) are from different sources, the outcomes are similar enough for comparison. Seatbelt use has been slowly increasing year by year across all New England States. In 2010, New Hampshire (72.2%) was still below the national average (85%) and has a long way to go to meet the Healthy People 2020 Objective of 92.4% (Figure 48).

**Figure 48: Percentage of Seatbelt Use, All Ages, by State, 2010**



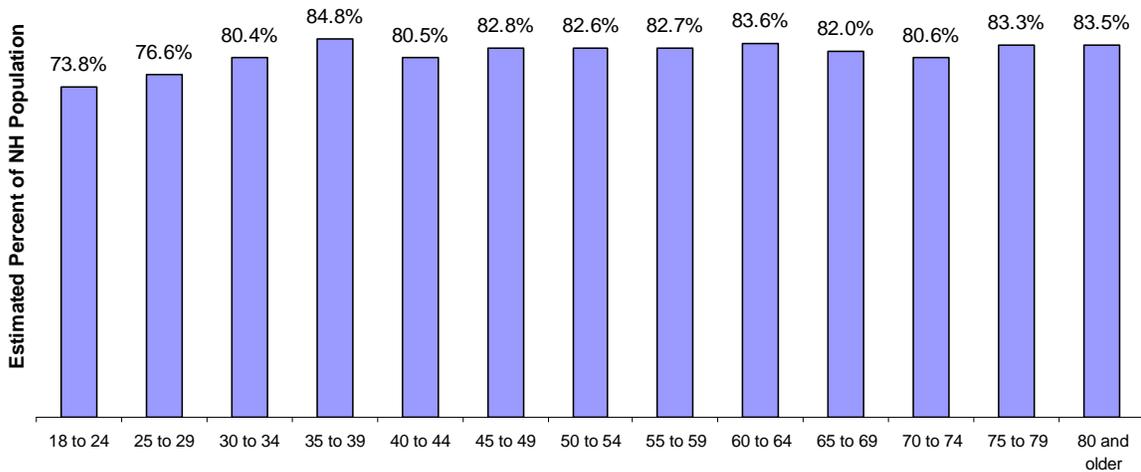
Source: Driving Toward Zero: <http://www.nhdrivingtowardzero.com/resources/detail/18>

**FIGURE 49: National Occupant Protection Use Survey, Seatbelt Use in New Hampshire and the United States, 2006-2011**



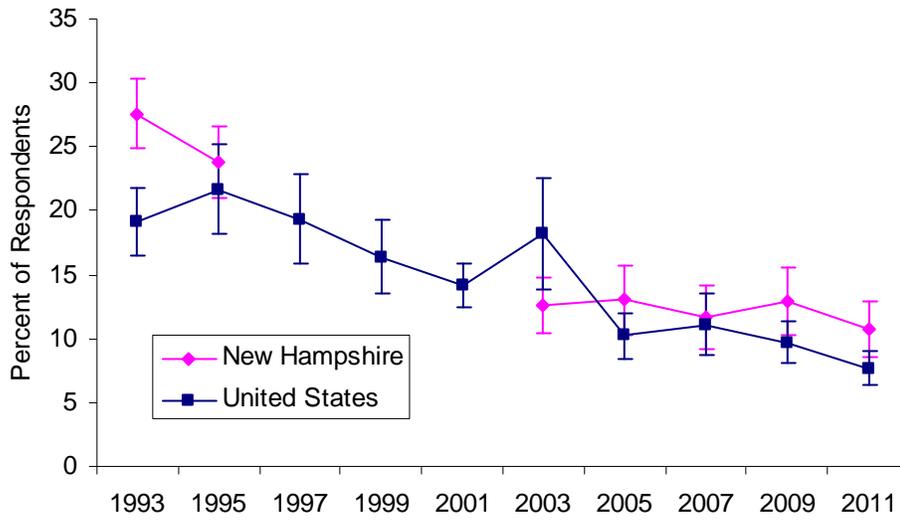
Source: <http://www-nrd.nhtsa.dot.gov/Pubs/811651.pdf>

**Figure 50: NH Residents, Age 18 and older, Reporting They Always Wear Seatbelt, by Age Group, 2006, 2008, 2010**



Source: NH Behavioral Risk Factor Surveillance System Survey (BRFSS)

**FIGURE 51: Teens Who Rarely or Never Wore a Seatbelt**



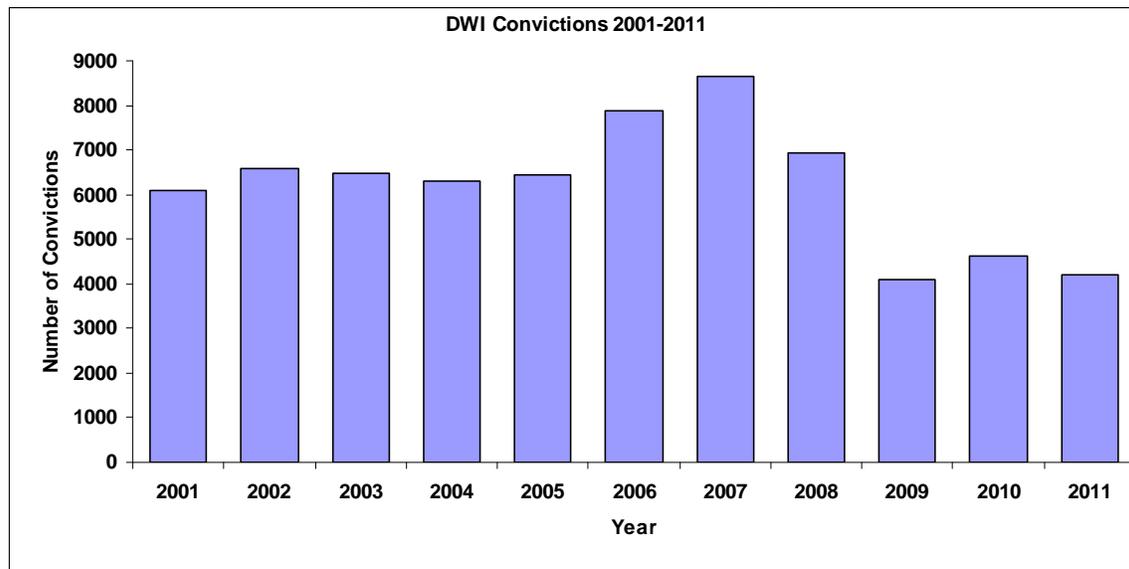
Source: Youth Risk Behavior Survey (YRBS) <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx>

## Motor Vehicle Indicator 4: Drinking and Driving

### BACKGROUND

In 2005, nearly 1.4 million drivers were arrested for driving under the influence of alcohol or narcotics.<sup>24</sup> This statistic is less than 1% of the 159 million self-reported episodes of alcohol-impaired driving among U.S. adults each year.<sup>25</sup>

**Figure 52: Number of Driving While Intoxicated Convictions per Year 2001-2011**



Source: New Hampshire Department of Safety, Office of Information Technology

The number of driving-while-intoxicated (DWI) convictions has declined from 8,656 in 2007 to 4,186 in 2011 (Figure 52). Less than 1% of licensed drivers are convicted of DWI each year in New Hampshire.

## Motor Vehicle Indicator 5: Alcohol-Related Crash Deaths

### 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 non-occupant (e.g., pedestrian or bicyclist) had a blood alcohol concentration (BAC) greater than or equal to 0.01 g/dL.<sup>26</sup>

### 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)<sup>26</sup> and population estimates from the U.S. Census Bureau or suitable alternative (denominator).

## PERIOD FOR CASE DEFINITION

Calendar year.

## BACKGROUND

In 2006, 13,470 people died in alcohol-impaired driving crashes, accounting for nearly one third (32%) of all traffic-related deaths in the United States. Half of the 306 child passengers aged 14 years and younger who died in alcohol-related crashes in 2006 were riding with drivers who had a BAC level of 0.08 g/dL or higher.<sup>27</sup>

## 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.<sup>3,4</sup>

## HEALTHY PEOPLE 2020 OBJECTIVES

SA-17 Decrease the rate of alcohol-impaired driving (.08+ blood alcohol content [BAC]) fatalities

Baseline: 0.40 deaths per 100 million vehicle miles traveled involved a driver or motorcycle rider with a BAC of .08 or greater in 2008

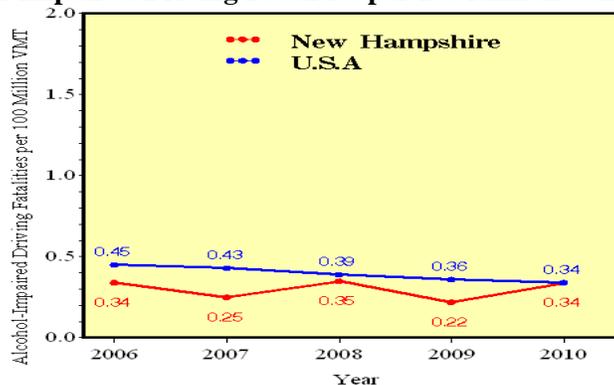
Target: 0.38 deaths per 100 million vehicle miles traveled

Target-Setting Method: 5 percent improvement

Data Source: Fatality Analysis Reporting System (FARS), U.S. Department of Transportation (DOT)

New Hampshire Prevention Efforts: DrugfreeNH.org is a collaborative effort of the New Hampshire Department of Health and Human Services' Bureau of Drug and Alcohol Services, the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment, and the Partnership for a Drug-Free New Hampshire. This last collaborative coordinates media efforts around issues such as alcohol-impaired driving. For more information, visit [www.drugfreenh.org](http://www.drugfreenh.org).

**FIGURE 53: Alcohol-Impaired Driving Fatalities per 100 Million Vehicle Miles Traveled**



Source: FARS, [http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/33\\_NH/2010/33\\_NH\\_2010.htm#TAB2B](http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/33_NH/2010/33_NH_2010.htm#TAB2B)

**Figure 54: During the past month, have you driven at least once after having too much to drink?**

	Yes	No
United States	1.8	98.2
New Hampshire NH CI	1.3 (0.9-1.8)	98.7 (98.2-99.1)

Source: 2010 BRFSS Data: <http://apps.nccd.cdc.gov/BRFSS/>

**Figure 55: Persons Killed in New Hampshire and Highest Driver Blood Alcohol Concentration (BAC) in Crash**

Year	Highest Driver Blood Alcohol Concentration in Crash								Total Killed	
	BAC = .00		BAC = .01-.07		BAC = .08+		BAC=.01+		Number	Percent
	Number	Percent	Number	Percent	Number	Percent	Number	Percent		
2001	76	54	14	10	51	36	66	46	142	100
2002	79	62	5	4	43	34	48	38	127	100
2003	80	63	10	8	36	29	46	36	127	100
2004	114	67	6	3	51	30	57	33	171	100
2005	106	64	5	3	54	33	59	36	166	100
2006	79	62	3	2	46	36	48	38	127	100
2007	85	66	10	8	34	26	44	34	129	100
2008	85	62	8	6	45	33	53	38	138	100
2009	73	66	7	6	30	27	36	33	110	100

Source: FARS data: <http://www-fars.nhtsa.dot.gov/States/StatesAlcohol.aspx>

Between 33% and 46% of drivers killed in and automobile crash had a blood alcohol level of .01 or higher (Figure 55).

## Poisoning Indicator 1: Poisoning Fatalities

### 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

### BACKGROUND

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

### 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.<sup>3,4</sup>

### HEALTHY PEOPLE 2020 OBJECTIVES

IVP-9 Prevent an increase in the rate of poisoning deaths

Baseline: 13.1 deaths per 100,000 population were caused by poisonings in 2007 (age adjusted to the year 2000 standard population)

Target: 13.1 deaths per 100,000 population

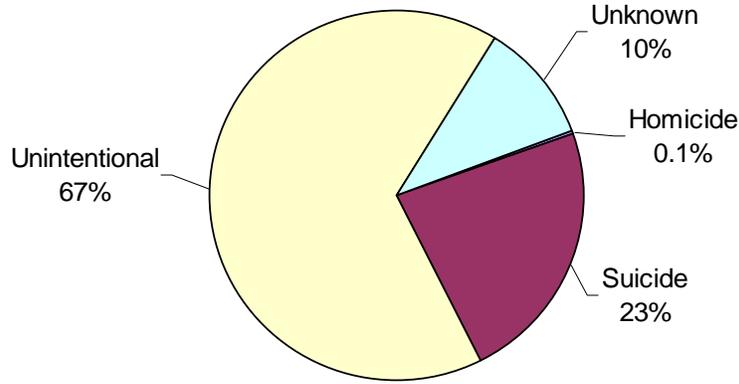
Target-Setting Method: Maintain the baseline rate (why instead of a decrease like all the others, this needs an explanation.)

Data Source: National Vital Statistics System–Mortality (NVSS–M), CDC, NCHS

New Hampshire Prevention Efforts: The New Hampshire Carbon Monoxide Work Group is an interagency task force dedicated to keeping the public informed of the many safety and health issues related to carbon monoxide. The group includes representatives from the State's departments of Environmental Services, Health and Human Services, and Safety (the Fire Marshal's Office) and the Federal Consumer Product Safety Commission. For more information, go to [www.nh.gov/co](http://www.nh.gov/co).

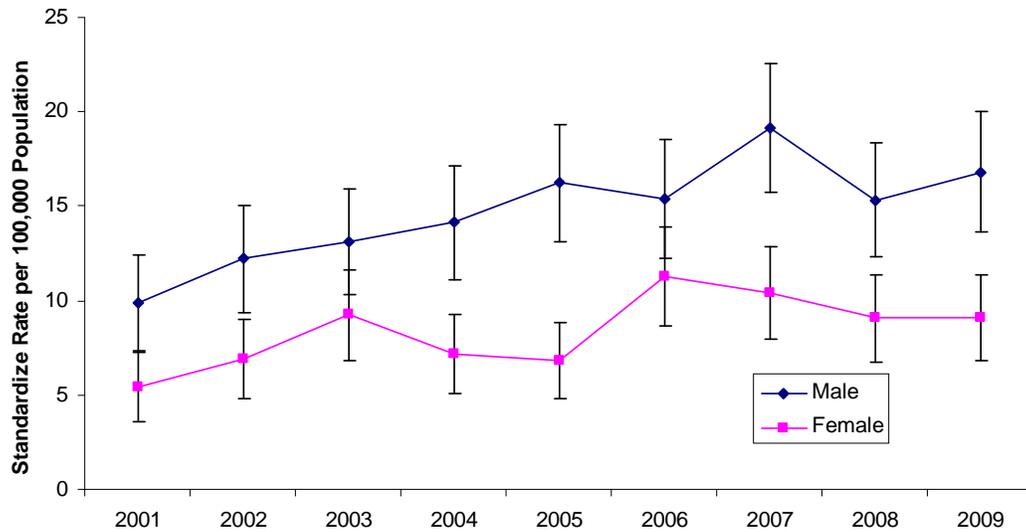
In 2007, the fatality rate for poisoning in New Hampshire was 14.8 (CI 12.7-16.9) per 100,000 population. This decreased, though not significantly, to 12.9 (11.0-14.9) per 100,000 population in 2009. Since the confidence interval for the 2009 data overlaps the rate for 2007 and the national target rate of 13.1, there are no statistically significant differences in these rates. New Hampshire rates meet the Healthy People 2020 target.

**FIGURE 56: NH Resident Poisoning Death by Intent 2001-2009, n=1377**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

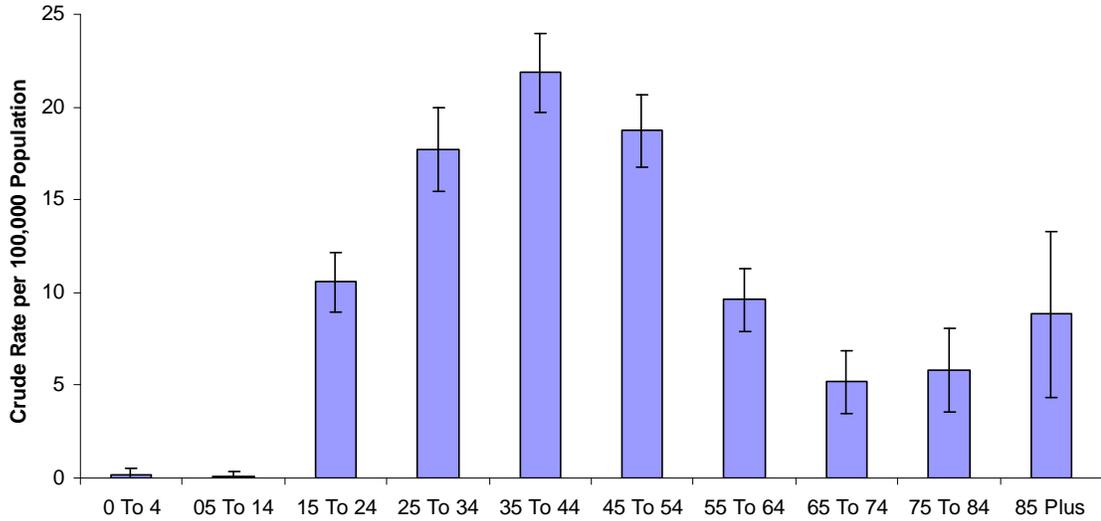
**Figure 57: Fatal Poisoning Rates, by Gender, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

Males are more likely to suffer a fatal poisoning than females. There are no statistically significant changes in fatal poisoning rates between 2001 and 2009 (Figure 57). The age group most likely to die from poisoning is between 25 and 54 years old with 35 to 44 at 21.9 deaths per 100,000 population (Figure 58).

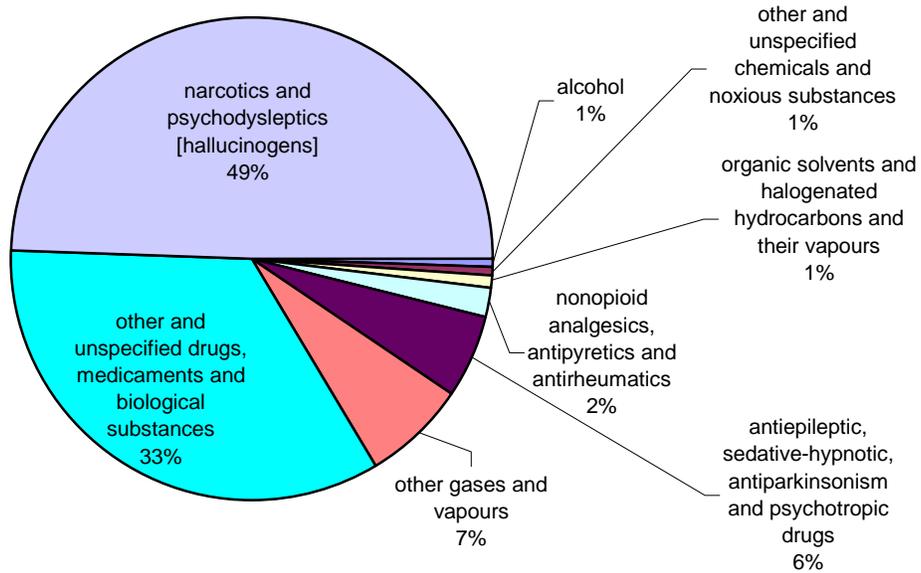
**Figure 58: Fatal Poisoning Rates, by Age Group, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

Forty-nine percent of fatal poisoning deaths in 2007 were due to narcotics (Figure 59).

**Figure 59: Substances That Caused Fatal Poisonings, 2007**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

## Poisoning Indicator 2: Poisoning Hospitalizations and Emergency Department Discharges

### 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

### BACKGROUND

In 1999, 21 states reported that hospitalization rates were 4 to 15 times higher than death rates for poisoning-related injuries.<sup>28</sup>

### 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.<sup>3,4</sup>

### HEALTHY PEOPLE 2020 OBJECTIVES

IVP-10 Prevent an increase in the rate of nonfatal poisonings

Baseline: 304.4 nonfatal poisonings per 100,000 population occurred in 2008 (age adjusted to the year 2000 standard population)

Target: 304.4 nonfatal poisonings per 100,000 population

Target-Setting Method: Maintain the baseline rate

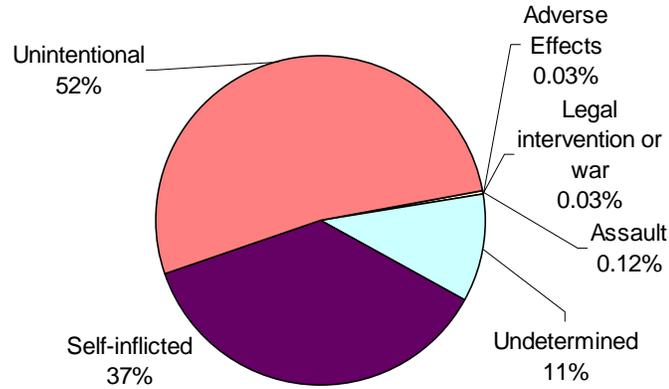
Data Source: National Electronic Injury Surveillance System—All Injury Program (NEISS-AIP), CDC, NCIPC, US Consumer Product Safety Commission (CPSC)

New Hampshire Prevention Efforts: The Northern New England Poison Center (NNEPC) is New Hampshire's resource for all things poison. The NNEPC operates a 24/7 hotline for anyone who thinks he or she has been poisoned or who has questions. The hotline's number is 1-800-222-1222. The NNEPC also provides outreach education and has an educator specific to New Hampshire. The goals of the education program are to 1) prevent poisonings, 2) increase awareness of poison center services, 3) increase the use of the NNEPC, 4) help health care providers with diagnosis, monitoring and management, and 5) improve patient outcomes while reducing costs. For more information, please visit [www.nnepc.org](http://www.nnepc.org).

New Hampshire's data for non-fatal poisoning comes from hospital discharges, which is a different source than the data used for the national target. In 2007, the ED discharge rate for poisonings was 195.0 (CI 197.1-202.8) per 100,000 population. In 2009, the ED discharge rate for poisoning was also 195.0 (CI 197.1-202.8). The inpatient discharge rate in 2007 was 88.4 (CI 83.2-93.5) per 100,000 population, and in 2009 it was 91.2 (CI 85.9-96.4) per 100,000 population. There are no significant differences in overall ED or inpatient discharges from year to year.

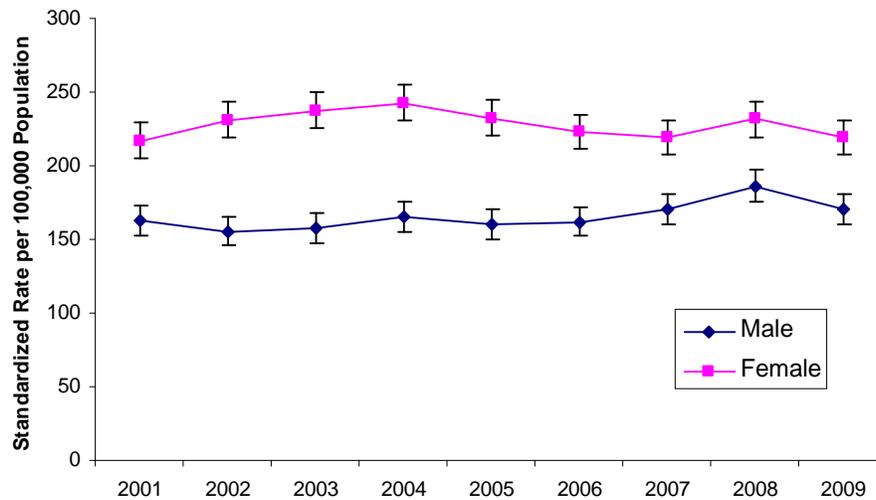
More females than males are seen at the hospital for non-fatal poisoning (Figures 61 and 63). New Hampshire residents ages 0 to 4 and ages 15 to 24 have the highest rates for emergency department discharges for poisoning (Figure 64). The age groups for inpatient discharges for poisoning mirrors that for fatal poisonings: between 25 and 54 years old with 35 to 44 at 21.9 deaths per 100,000 population (Figures 65).

**FIGURE 60: Emergency Department Discharges for Poisoning, NH Residents, by Intent, 2001-2009, n=22,054**



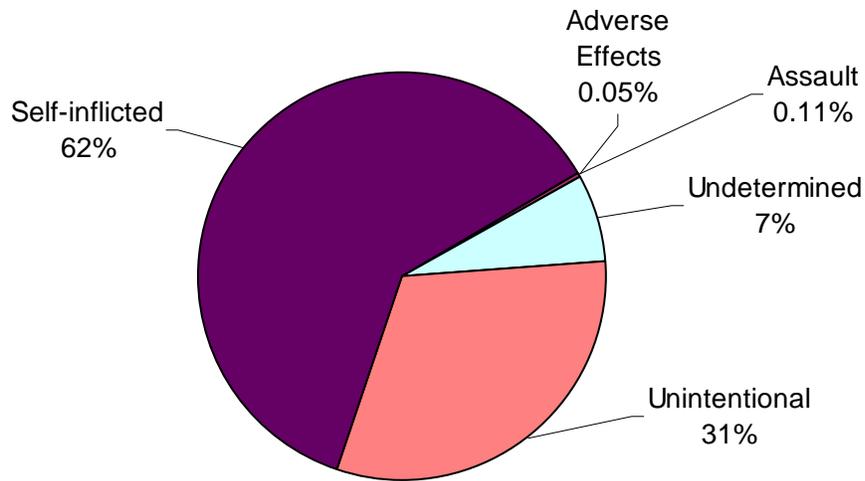
Source: NH DPHS Emergency Department Hospital Discharge Data

**Figure 61: Emergency Department Discharge Rates for Poisoning, NH Residents, by Gender, 2001-2009**



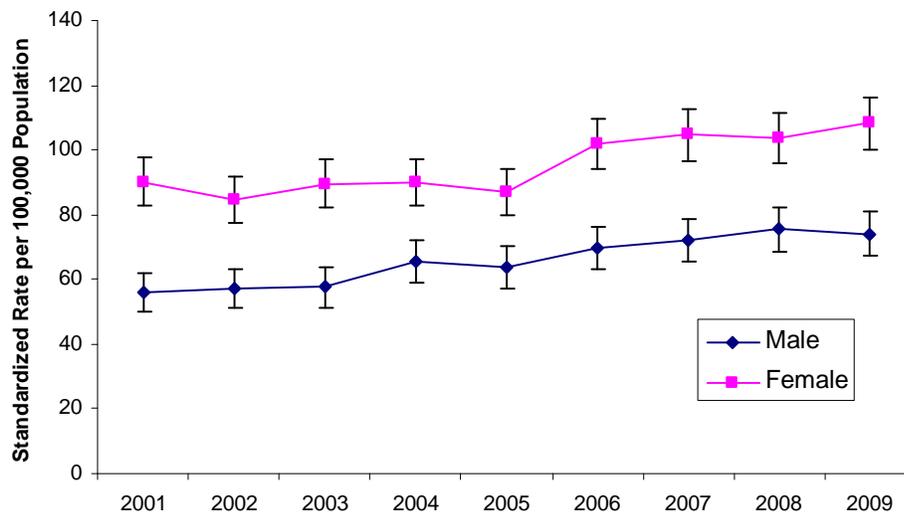
Source: NH DPHS Emergency Department Hospital Discharge Data

**FIGURE 62: Inpatient Discharges for Poisoning, NH Residents, by Intent, 2001-2009, n=9,416**



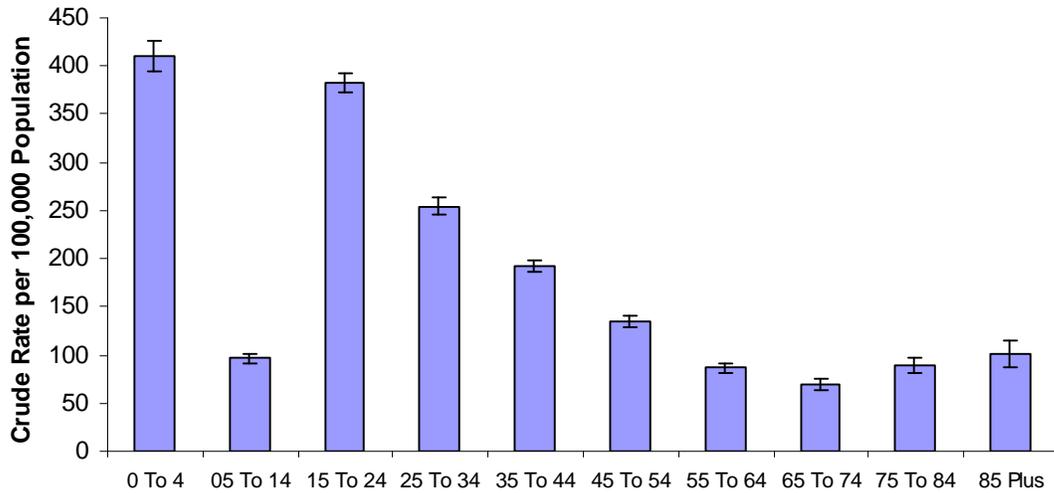
Source: NH DPHS Inpatient Hospital Discharge Data

**Figure 63: Inpatient Discharge Rates for Poisoning, NH Residents, by Gender, 2001-2009**



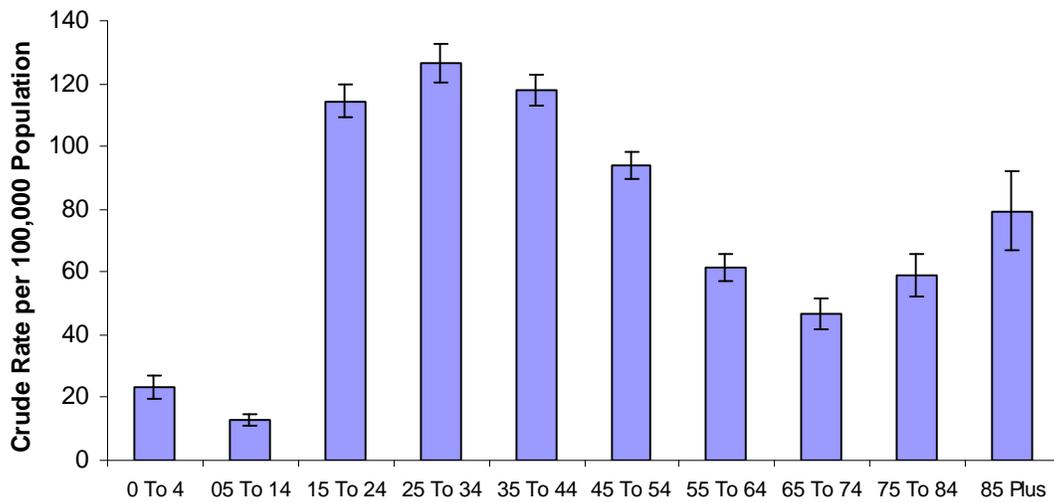
Source: NH DPHS Inpatient Hospital Discharge Data

**Figure 64: Emergency Department Discharge Rates for Poisoning, NH Residents, by Age Group, 2001-2009**



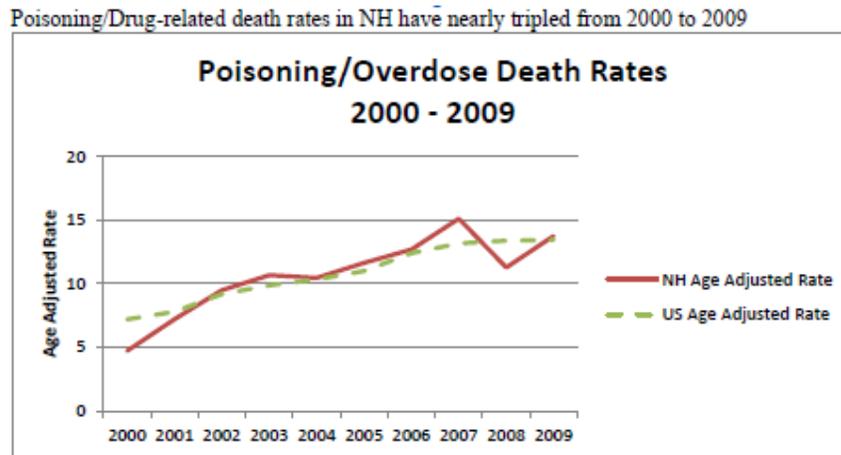
Source: NH DPHS Emergency Department Hospital Discharge Data

**Figure 65: Inpatient Discharge Rates for Poisoning, NH Residents, by Age Group, 2001-2009**



Source: NH DPHS Inpatient Hospital Discharge Data

**Figure 66: Poisoning/Overdose Deaths in NH and US, 2000-2009**



Source: CDC WISQARS

**Additional Note about Lead Poisoning:**

A confirmed venous blood lead level (BLL) that meets or exceeds 10 micrograms per deciliter of blood (mcg/dL) for children six years of age or younger is defined as an elevated BLL. In 2010, 119 New Hampshire children six years of age or younger were newly identified with elevated BLLs, or 0.8% of the 14,793 children screened in the State. For more information about childhood lead poisoning, see the New Hampshire Healthy Homes and Lead Poisoning Prevention Program 2010 *Childhood Blood Lead Surveillance Data*, full report, which can be found at: <http://www.dhhs.nh.gov/dphs/bchs/clpp/documents/2010childlead.pdf>.

**Additional Note about Carbon Monoxide Poisoning:**

Each year in America, more than 150 people die from accidental non-fire related Carbon Monoxide (CO) poisoning associated with consumer products. These products include faulty, improperly used or incorrectly vented fuel-burning appliances such as furnaces, stoves, water heaters, and fireplaces. Source: Consumer Product Safety Commission, <http://www.usfa.fema.gov/citizens/co/index.shtm>.

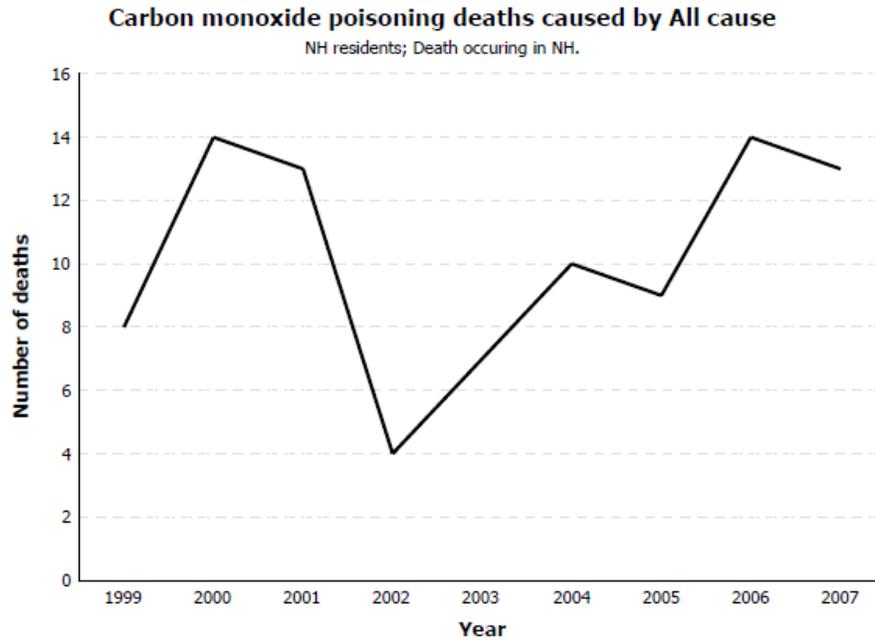
CO is a toxic gas that is invisible and odorless. Breathing high levels of CO can cause severe illness or death in a matter of minutes. All people and animals are at risk for CO poisoning. Certain individuals, such as unborn babies, infants, and people with chronic heart disease, anemia, or respiratory problems, are more susceptible to its effects. Every year thousands of people across the U.S. seek medical care for non-fatal CO poisoning. Survivors of severe poisoning may suffer long-term neurological problems.

Unintentional CO poisoning can almost always be prevented. Furthermore, the New Hampshire Carbon Monoxide Working group reports that several deaths occur in the State every year due to carbon monoxide poisoning caused by malfunctioning or improperly used fuel-burning furnaces, stoves, or appliances.

Breathing CO can cause headache, dizziness, and nausea. If CO levels are high enough, loss of consciousness or sudden death may occur.

More information about CO poisoning can be found on the NH Environmental Public Health Website's EHDIN data analysis tool: [http://www.nh.gov/epht/topics/carbon\\_monoxide.htm](http://www.nh.gov/epht/topics/carbon_monoxide.htm). There are, on average, 128 ED plus inpatient hospital discharges per year and 11 deaths (Figure 67).

**Figure 67: Carbon Monoxide Poisoning Deaths in NH by Year, 1999-2007**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

## **Suicide/Suicide Attempt Indicator 1: Suicides**

Suicide ICD-10 Codes:

X60–X84 Intentional self-harm

Y87.0 Sequelae of intentional self-harm

U03 Terrorism-intentional self-harm

### **BACKGROUND**

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

### **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.<sup>3,4</sup>

### **HEALTHY PEOPLE 2020 OBJECTIVES**

MHMD-1 Reduce the suicide rate

Baseline: 11.3 suicides per 100,000 occurred in 2007

Target: 10.2 suicides per 100,000

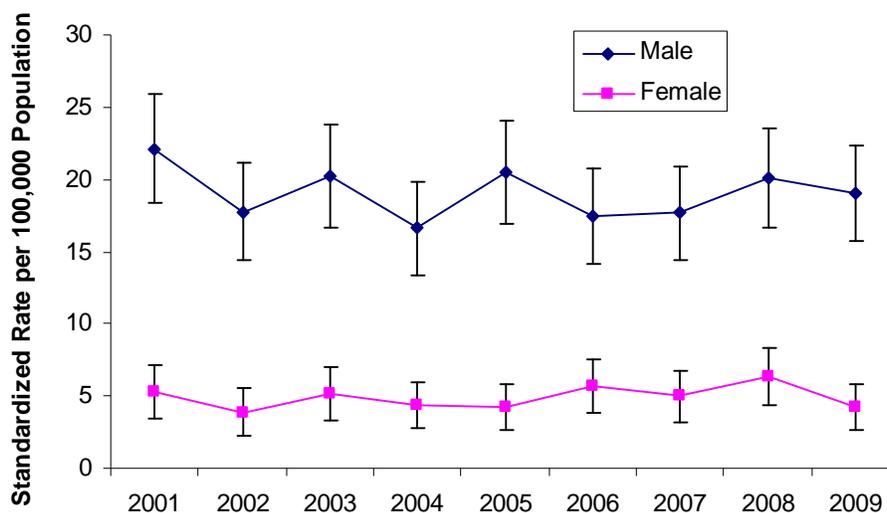
Target-Setting Method: 10 percent improvement

Data Source: National Vital Statistics System (NVSS), CDC, NCHS

New Hampshire Prevention Efforts: The New Hampshire Suicide Prevention Council's (SPC) mission is to reduce the incidence of suicide in the State by accomplishing the following goals of the State Suicide Prevention Plan: 1) raise public and professional awareness of suicide prevention, 2) address the mental health and substance abuse needs of all residents, 3) address the needs of those affected by suicide, and 4) promote policy change. The success and strength of the SPC is a direct result of the collaboration that takes place within its membership and with other agencies/organizations, including public, private, local, state, federal, military, and civilian. Strong leadership and active participation comes from the Council's subcommittees: Communication and Public Education; Data Collection and Analysis; Military and Veterans; Professional Practice and Education; Public Policy; and Suicide Fatality Review. For example, the Military and Veterans Subcommittee provided Applied Suicide Intervention Skills Training (ASIST) workshops to community members working with military personnel on suicide prevention and to multiple VFWs in the State. For additional information on the SPC, go to <http://www.theconnectprogram.org/learn-about-mission-and-meetings-suicide-prevention-council-nh>.

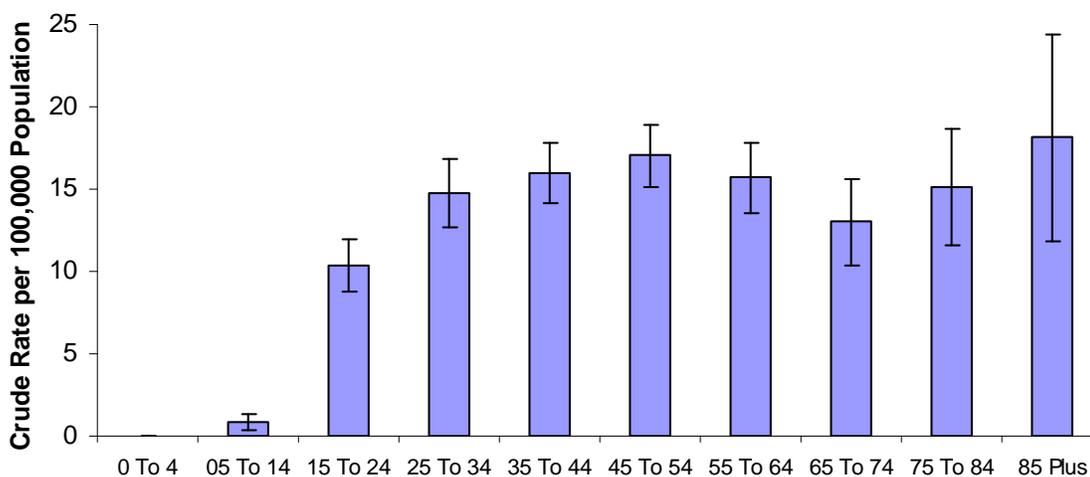
In 2007, the suicide rate in New Hampshire was 11.0 (CI 9.3-12.8) per 100,000 population, and in 2009 the rate was 11.4 (9.6-14.3). Since the confidence interval in 2009 overlaps both the rate for 2007 and the national target of 10.2 per 100,000, there are no statistically significant differences in the rates and no significant changes from year to year.

**Figure 68: Completed Suicides by Gender, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

**Figure 69: Completed Suicides by Age Group, NH Residents, 2001-2009**

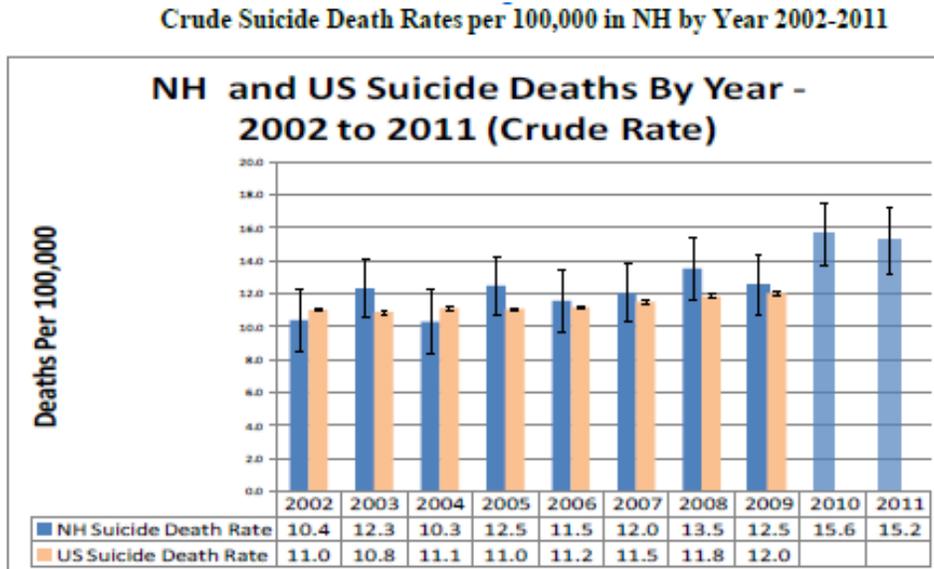


Source: New Hampshire Bureau of Vital Records, Death Certificate Data

Males have a higher rate of completed suicides than females (Figure 68). There are no statistically significant differences among age groups 15 to 85 years old and older (Figure 69).

For more information on suicide and suicide prevention efforts, see the *NH 2011 Suicide Prevention Annual Report* posted on line at: <http://www.theconnectprogram.org/nh-suicide-prevention-data-report>. The following charts and graphs are from that report.

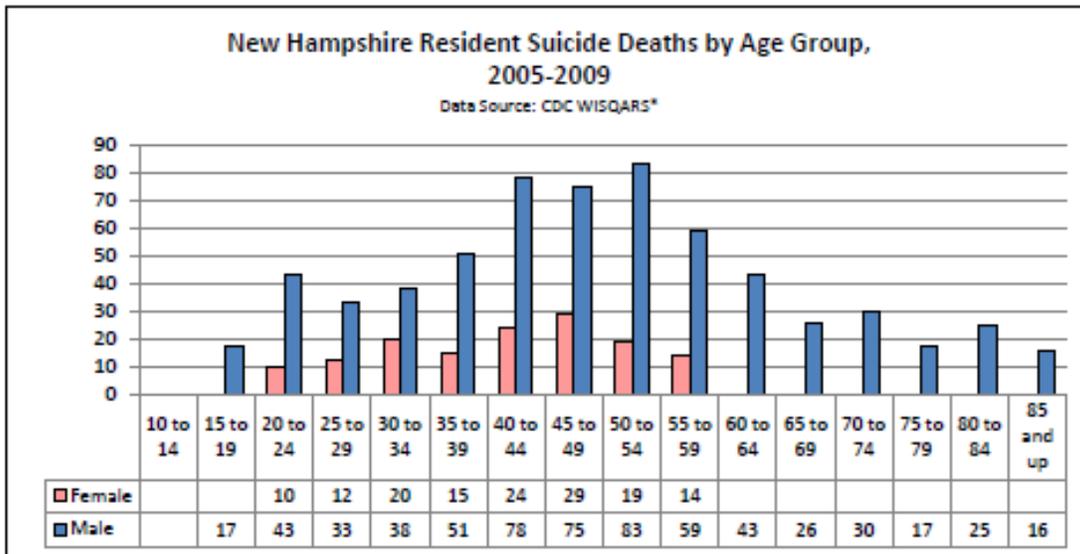
Figure 70: Suicide Death Rate in NH by Year, 2002-2011



Source: 2002-2009 – CDC Data; 2008-2011 – NH OCME Data

Figure 71: Suicide Death Rate in NH by Age Group and Gender, 2002-2009

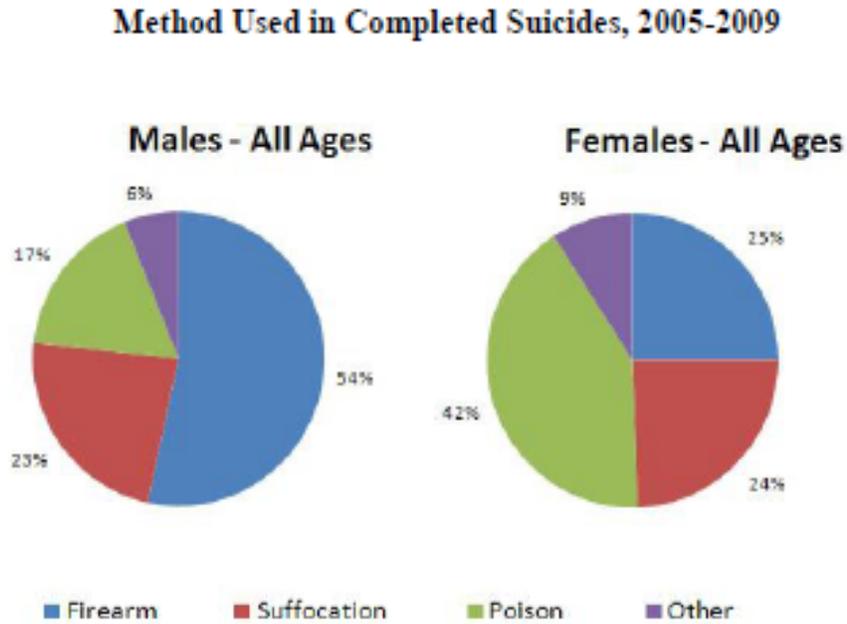
The highest numbers of suicides are seen in males and females in the 40 and 50 year-old age groups.



\*Note: Beginning with 2008 data, the CDC has suppressed state-level counts/rates for categories with fewer than ten deaths

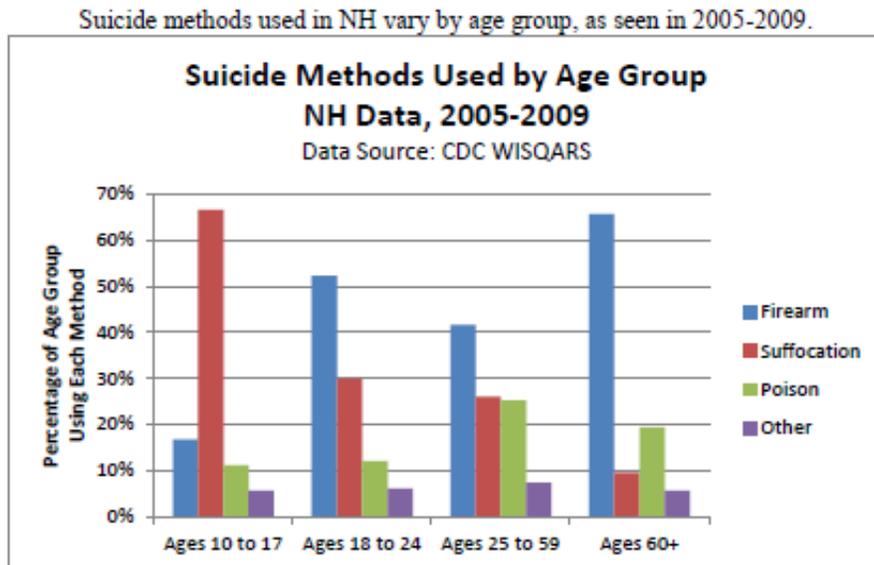
Males are more likely than females to use firearms as a lethal means of suicide (Figure 72).

**Figure 72: Suicide Death Rate in NH by Gender and Method, 2002-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

**Figure 73: Suicide Death Rate in NH by Age Group and Method, 2002-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

## **Suicide /Suicide Attempt Indicator 2: Suicide Attempt Hospitalizations and Emergency Department Visits**

Suicide Attempt Hospitalization ICD-9-CM Codes:  
E950–E959 Suicide and self-inflicted injury

### **BACKGROUND**

In 2009, there were an estimated 394,000 hospital emergency department visits for suicide attempts in the United States.<sup>1</sup> Self-inflicted injury is proxy for suicide attempts; some self-inflicted injuries are intentional, but not suicide attempts.

### **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.<sup>3,4</sup>

### **HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-41 Reduce nonfatal intentional self-harm injuries

Baseline: 125.3 emergency department visits for nonfatal intentional self-harm injuries per 100,000 population occurred in 2008 (age adjusted to the year 2000 standard population)

Target: 112.8 injuries per 100,000 population

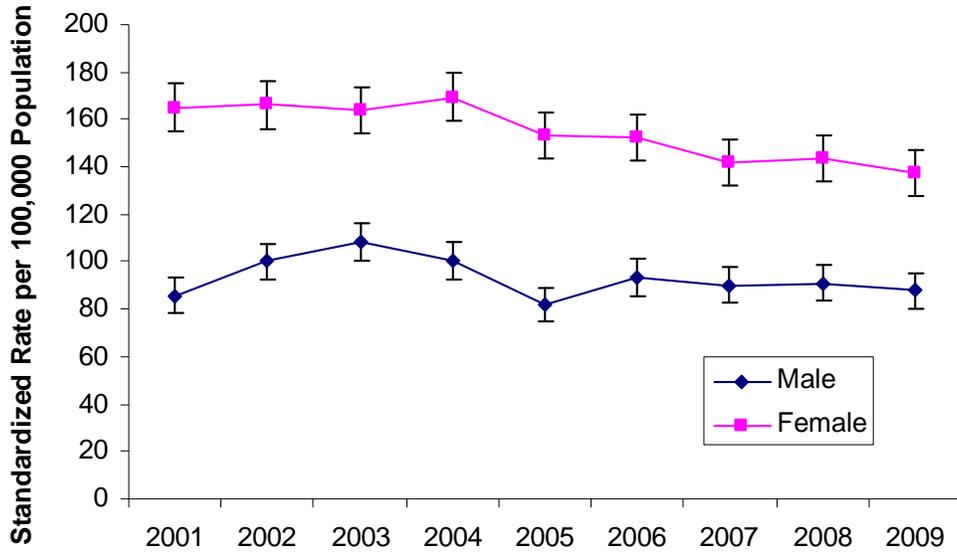
Target-Setting Method: 10 percent improvement

Data Source: National Electronic Injury Surveillance System—All Injury Program (NEISS-AIP), CDC, National Center for Injury Prevention and Control (NCIPC), US Consumer Product Safety Commission (CPSC)

New Hampshire Prevention Efforts: The National Alliance on Mental Illness, New Hampshire (NAMI NH) is a partner in the Suicide Prevention Council. NAMI NH's Connect Suicide Prevention Program is designated as a National Best Practice by the Suicide Prevention Resource Center. Connect's community-based approach focuses on education about early recognition (prevention); skills for responding to attempts, thoughts and threats of suicide (intervention); and reducing risk and promoting healing after a suicide (postvention). For more information, visit the Connect website at [www.theconnectproject.org](http://www.theconnectproject.org).

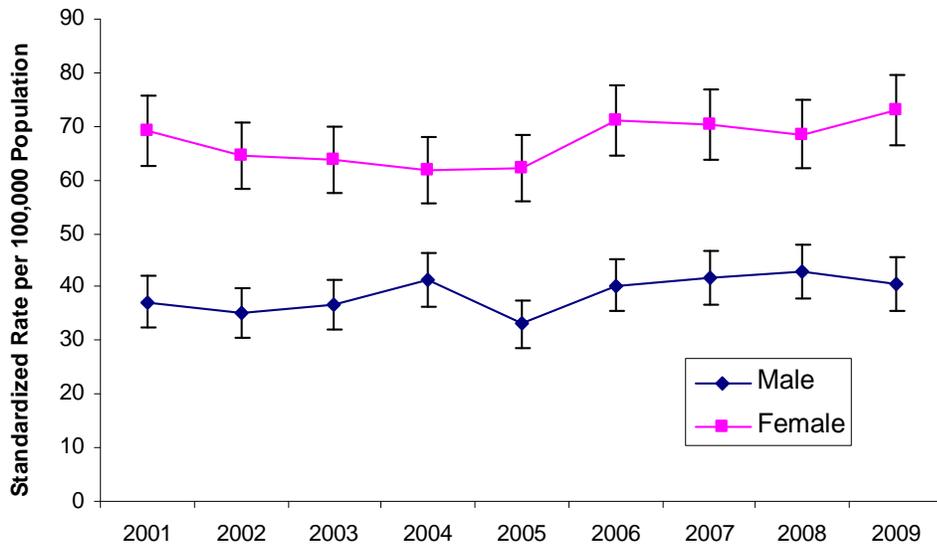
In New Hampshire, during 2007, the ED discharge rate for self-harm (suicide attempts) was 115.8 (CI 109.8-121.8) per 100,000 population. In 2009, the ED discharge rate for self-harm (suicide attempts) was 112.4 (CI 106.5-118.4) per 100,000 population, which is in line with the national target of 112.8 and not statistically significantly different from 2007. Inpatient discharge rates in 2007 were 56.1 (CI 52.0-60.2) per 100,000 population, and in 2009 they were 56.9 (CI 52.7-61.1) per 100,000 population. There was no statistically significant difference in inpatient discharges year to year either.

**Figure 74: Emergency Department Discharge Rates for Suicide Attempts/Self-Harm by Gender, NH Residents, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

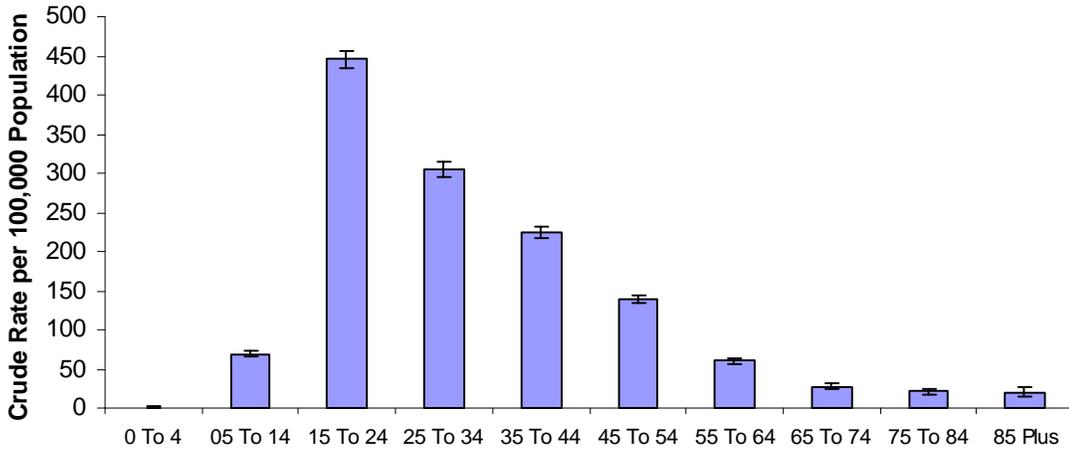
**Figure 75: Inpatient Discharge Rates for Suicide Attempts/Self-Harm by Gender, NH Residents, 2001-2009**



Source: NH-DPHS Inpatient Hospital Discharge Data

Females have a higher rate of hospital discharges than males (Figures 74 and 75). This may be because males are more likely to use firearms as a lethal means of completed suicides.

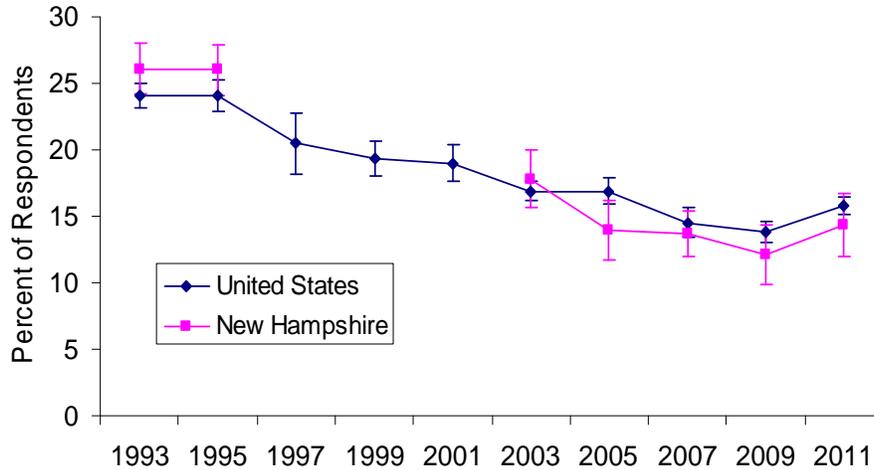
**Figure 76: Emergency Department plus Inpatient Discharge Rates for Suicide Attempts/Self-Harm by Age Group, NH Residents, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

Residents 15 to 24 years of age have the highest rate of hospital discharges for suicide than any other age group (Figure 76).

**FIGURE 77: Teens Who Seriously Considered Suicide within the Last 12 Months**



Source: Youth Risk Behavior Survey (YRBS) <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx>

## **Traumatic Brain Injury Indicator 1: Traumatic Brain Injury Fatalities**

Traumatic Brain Injury (TBI) 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

### **BACKGROUND**

Of the approximately 1.7 million people who sustained a Traumatic Brain Injury (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.<sup>29</sup>

### **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.<sup>3,4</sup>

### **HEALTHY PEOPLE 2020 OBJECTIVES**

IVP-2.1 Reduce fatal traumatic brain injuries

Baseline: 17.3 deaths per 100,000 population were caused by traumatic brain injuries in 2007 (age adjusted to the year 2000 standard population)

Target: 15.6 deaths per 100,000 population

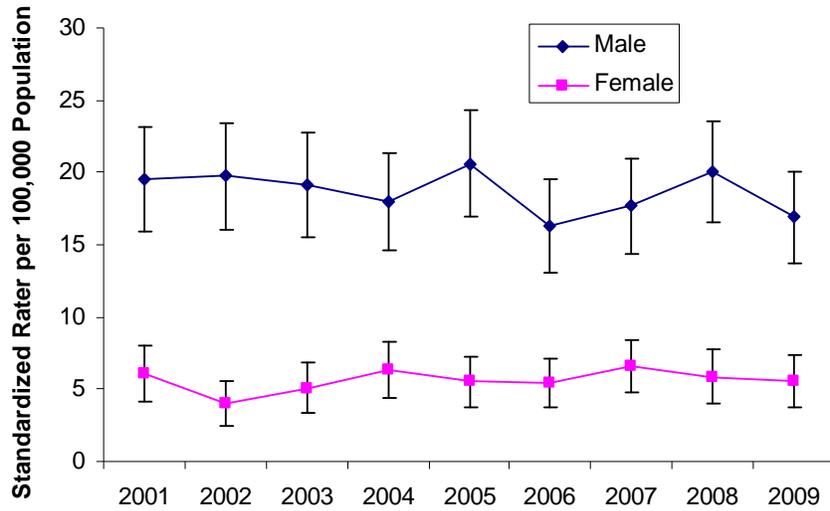
Target-Setting Method: 10 percent improvement

Data Source: National Vital Statistics System–Mortality (NVSS-M), CDC, NCHS

New Hampshire Prevention Efforts: Unintentional falls are the leading cause of traumatic brain injury deaths. The New Hampshire Injury Prevention Program works with the United States Consumer Product Safety Commission (CPSC) to help facilitate recall effectiveness checks. Many products are recalled, such as a particular type of bicycle or infant seat because of a fall hazard. The State and the CPSC work in tandem to help ensure that businesses and the public know about these products and remove those recalled from stores and homes alike. The CPSC is also the agency that releases product safety standards, such as those for window guards and cribs, both helping to decrease the potential of falls. For more information, visit the CPSC website at [www.cpsc.gov](http://www.cpsc.gov).

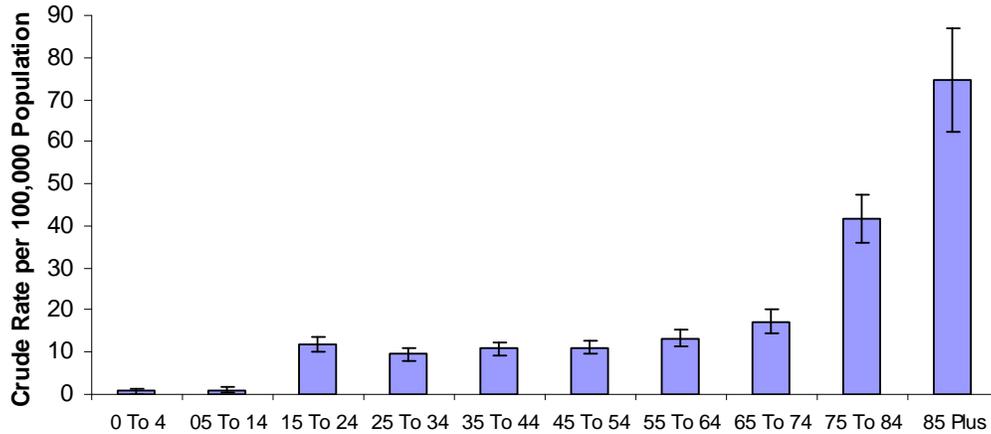
In 2007, the fatality rate for TBI was 11.8 (CI 9.9-13.6) per 100,000 population. In 2009, the rate was 11.0 (9.2-12.7). New Hampshire is well below the national target rate of 15.6 per 100,000 population. There was no statistically significant difference between the death rate for TBI between 2007 and 2009.

**Figure 78: Fatal Traumatic Brain Injury, by Gender, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

**Figure 79: Fatal Traumatic Brain Injury, by Age Group, NH Residents, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

Males have a higher rate of TBI than females (Figure 78). There are no statistically significant differences between years 2001-2009. The older population, age 75 and up, have the highest fatality rate due to TBI (Figure 79).

## Traumatic Brain Injury Indicator 2: Traumatic Brain Injury Hospitalizations

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 (Abusive Head Trauma)

### 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.<sup>30, 31</sup>

### 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.<sup>3, 4</sup>

### HEALTHY PEOPLE 2020 OBJECTIVES

IVP-2.2 Reduce hospitalization for nonfatal traumatic brain injuries

Baseline: 85.6 hospitalizations for nonfatal traumatic brain injuries per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population).

Target: 77.0 hospitalizations per 100,000 population

Target-Setting Method: 10 percent improvement

Data Source: National Hospital Discharge Survey (NHDS), CDC, NCHS

New Hampshire Prevention Efforts: The New Hampshire State Advisory Council on Sport Related Concussions provides guidance to schools, youth league administrators, coaches, parents, and athletes on concussion identification, treatment, and return to play issues. This multi-disciplinary group was an advocate for the passage of SB402, signed into law in August of 2012. This law encourages local school districts to properly identify and manage concussions. More information can be found at the website of the Brain Injury Association of New Hampshire at [www.bianh.org](http://www.bianh.org).

The Inpatient discharge rate for TBI in New Hampshire was 74.2 (CI 69.5-78.9) per 100,000 population in 2007 and 77.6 (CI 72.8-82.3) in 2009. New Hampshire is below the nation baseline rate of 85.6 and within the confidence interval for the national target rate of 77.0.

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

Baseline: 407.2 emergency department visits for nonfatal traumatic brain injuries per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population).

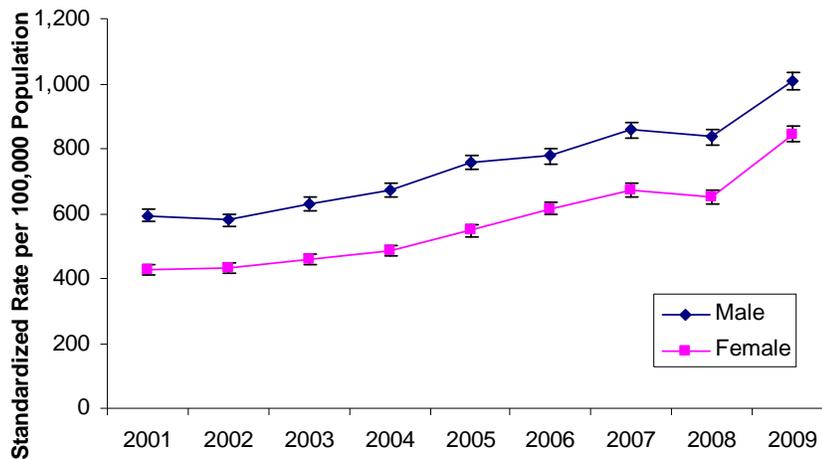
Target: 366.5 emergency department visits per 100,000 population

Target-Setting Method: 10 percent improvement

Data Source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS

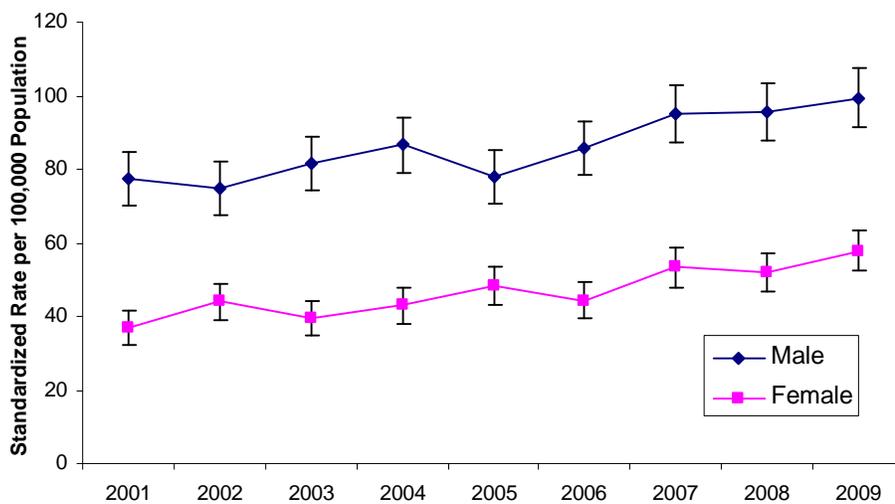
The ED discharge rate for TBI in New Hampshire was 797.9 (CI 752.5-783.3) per 100,000 population in 2007 and 930.2 (CI 913.1-947.4) per 100,000 population in 2009. This increase may be due to increased awareness of the severe potential outcomes of concussion. New Hampshire's ED discharge rate is more than twice the national target rate of 366.5 per 100,000 population.

**Figure 80: Emergency Department Discharge Rates, Traumatic Brain Injury, by Gender, NH Residents, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

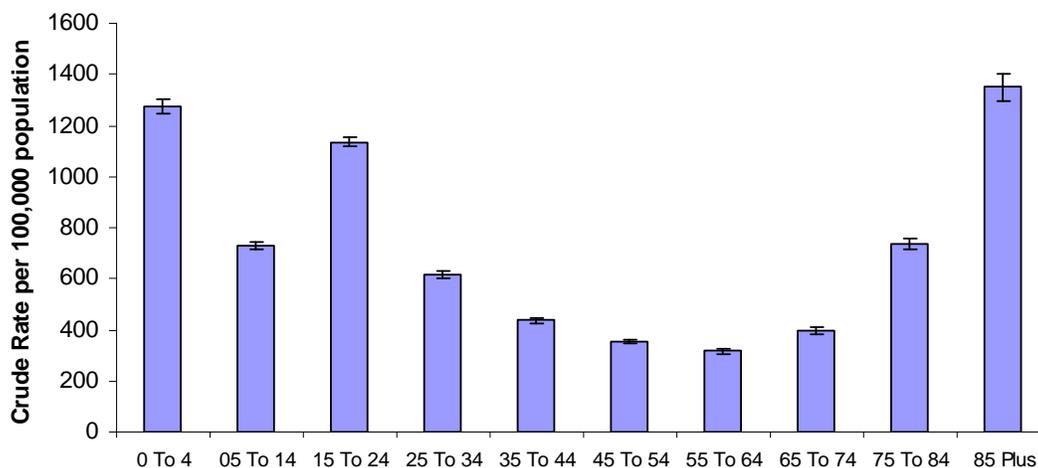
**Figure 81: Inpatient Discharge Rates, Traumatic Brain Injury, by Gender, NH Residents, 2001-2009**



Source: NH DPHS Inpatient Hospital Discharge Data

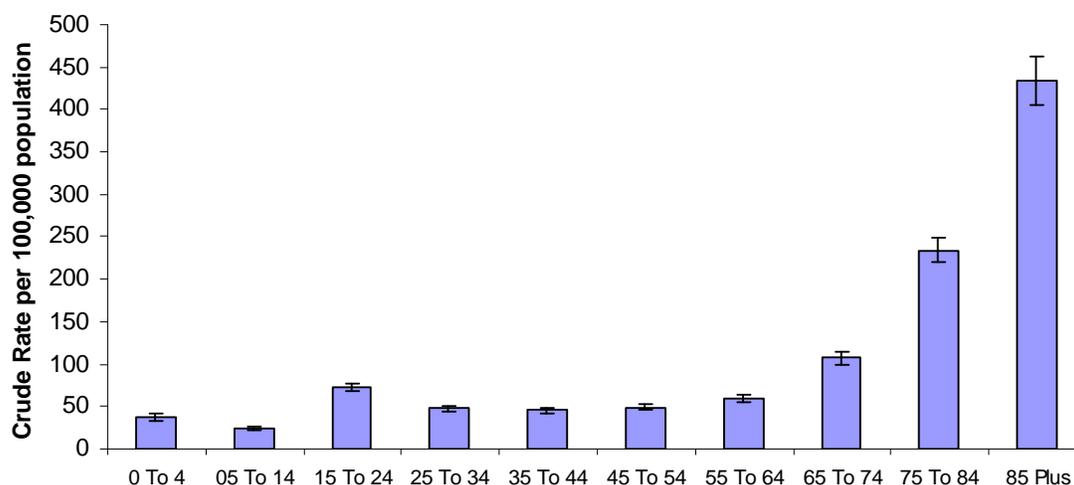
Males have a higher hospital discharge rate for TBI than females. ED discharges have increased year to year between 2001 and 2009 (Figure 80). This increase may be due to increased awareness of the severe potential outcomes of concussion. Inpatient discharge rates have also significantly increased between 2001 and 2009 (Figure 81).

**Figure 82: Emergency Department Discharge Rates, Traumatic Brain Injury, by Age Group, NH Residents, 2001-2009**



Source: NH DPHS Emergency Department Hospital Discharge Data

**Figure 83: Inpatient Discharge Rates, Traumatic Brain Injury, by Age Group, NH Residents, 2001-2009**

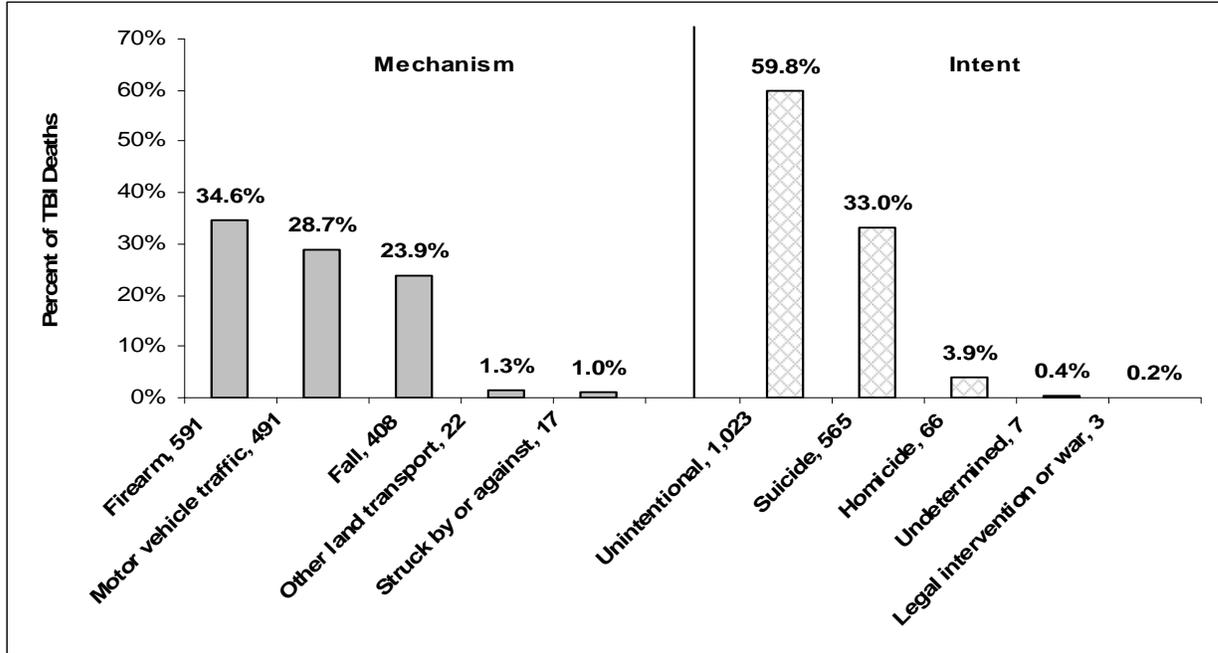


Source: NH DPHS Inpatient Hospital Discharge Data

ED discharge rates are highest in the very young (age 0 to 4 years) and older adults (age 85 and older) (Figure 82). Inpatient rates are highest in patients age 65 and older. Within the older age group, TBI injury rates are highest in patients age 85 and older (Figure 83).

For more detailed information about TBI, see New Hampshire’s full report on this topic, “Traumatic Brain Injury: Occurrence and Mortality in New Hampshire.” The following charts and tables are from that report. The full report is posted on the following website: <http://www.dhhs.nh.gov/dphs/bchs/mch/injury.htm>.

**Figure 84: Top 5 TBI Related Deaths by Intent and Top 5 TBI Related Deaths by Mechanism, 2001-2009**



Source: New Hampshire Bureau of Vital Records, Death Certificate Data

**Figure 85: Percent of Inpatient Discharges, TBI Occurrences by Diagnosis, across Principle Diagnosis and All Secondary Diagnosis Fields, 2001-2009**

TBI Diagnosis	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Fracture of Vault or Base of Skull	25%	25%	25%	27%	27%	29%	29%	28%	26%	27%
Other Skull Fractures	2%	2%	2%	2%	3%	1%	1%	2%	2%	2%
Intracranial Injury or Concussion	62%	60%	63%	64%	60%	59%	59%	61%	62%	61%
Head Injury, unspecified	11%	12%	10%	8%	10%	11%	11%	9%	10%	10%
Shaken Infant Syndrome	0.3%	0.5%	0.3%		0.1%	0.2%	0.1%			0.2%

Source: NH DPHS Inpatient Hospital Discharge Data

**Figure 86: Percent of ED Discharges, TBI Occurrences by Diagnosis, across Principle Diagnosis and All Secondary Diagnosis Fields, 2001-2009**

TBI Diagnosis	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Fracture of the Vault or Base of Skull	3%	3%	3%	3%	3%	2%	2%	3%	2%	3%
Other Skull Fracture	0.4%	0.4%	0.6%	0.5%	0.5%	0.4%	0.5%	0.4%	0.5%	0.4%
Intracranial Injury or Concussion	40%	41%	42%	41%	36%	36%	34%	36%	36%	38%
Head Injury, unspecified	57%	55%	55%	56%	61%	61%	64%	61%	61%	59%
Shaken Infant Syndrome	0.02%	0.05%	0.02%		0.03%	0.02%			0.02%	0.02%

Source: NH DPHS Emergency Department Hospital Discharge Data

**Additional Note about Sports-Related Injuries and Head Trauma:**

Sports-Related Injury Hospitalization ICD-9-CM Codes:

E917.0 In sports without subsequent fall

E917.5 Object in sports with subsequent fall

New Hampshire’s ED plus inpatient hospital discharge rate in year 2007 for teens (ages 15 to 19) that were struck by or against something during sporting activities is 1,875.6 per 100,000 population.

Nearly 13% of hospital discharges for struck by or against result in a concussion, skull fracture, or serious head injury (Figure 87).

**Figure 87: Types of Sports-related Injuries, ED plus Inpatient Discharges, 2007, ages 15-19.**

Type of Injury	Percent
Contusion	27.0%
Fracture	19.6%
Sprain	18.9%
Open Wound	13.4%
Concussion without Coma	6.1%
Other	5.4%
Head Injury	4.7%
Dislocation	2.9%
Concussion with Coma	1.5%
Skull Fracture	0.3%
Abrasion	0.1%
Spine Fracture	0.1%

Source: NH DPHS Emergency Department plus Inpatient Hospital Discharge Data

Around 1,800 New Hampshire teens are injured while participating in sports every year (Figure 88).

**Figure 88: Discharge Rate for Sports-related Injuries, Ages 15-19 by Year, 2001-2007**

DISCHARGE_YR	Count	Est. NH Pop	Crude Rate	Lower 95% CI	Upper 95% CI
2001	1739	89042	1953.0	1861.2	2044.8
2002	1853	90955	2037.3	1944.5	2130.0
2003	1690	92650	1824.1	1737.1	1911.0
2004	1805	94214	1915.9	1827.5	2004.2
2005	1823	95761	1903.7	1816.3	1991.1
2006	1877	96995	1935.2	1847.6	2022.7
2007	1842	98207	1875.6	1790.0	1961.3

Source: NH DPHS Emergency Department plus Inpatient Hospital Discharge Data

In 2007, 72% of the hospital discharges for sports injuries were male. Since males tend to participate in sports that involve physical contact, this disparity makes sense.

## Glossary of Terms, Definitions, and Notes

### AGE ADJUSTMENT AND RATES

All rates in this document are age-adjusted to the 2000 U.S. standard population. This allows the comparison of rates among populations having different age distributions by standardizing the age-specific rates in each population to one standard population. Age-adjusted rates refer to the number of events that would be expected per 100,000 persons in a selected population if that population had the same age distribution as a standard population. Age-adjusted rates were calculated using the direct method as follows:

Where,

m = number of age groups

$d_i$  = number of events in age group i

$p_i$  = population in age group i

$S_i$  = proportion of the standard population in age group i

This is a weighted sum of Poisson random variables, with the weights being ( $S_i / p_i$ )

$$\hat{R} = \sum_{i=1}^m s_i (d_i / p_i) = \sum_{i=1}^m w_i d_i$$

### AGE-SPECIFIC RATE/CRUDE RATES

The age-specific rate or crude rate is the number of individuals with the same health issue per year within a specific age group, divided by the estimated number of individuals of that age living in the same geographic area at the midpoint of the year.

### CONFIDENCE INTERVALS (CI)

The standard error can be used to evaluate statistically significant differences between two rates by calculating the confidence interval. If the interval produced for one rate does not overlap the interval for another, the probability that the rates are statistically different is 95% or higher.

The formula used is:

Where,

R = age-adjusted rate of one population

z = 1.96 for 95% confidence limits

SE = standard error as calculated below

$$R \pm z (SE)$$

A confidence interval is a range of values within which the true rate is expected to fall. If the confidence intervals of two groups (such as New Hampshire and the U.S.) overlap, then any difference between the two rates is not statistically significant. All rates in this report are calculated at a 95 percent confidence level.

### DATA COLLECTION

The Behavioral Risk Factor Surveillance System (BRFSS) is a telephone survey conducted annually by the health departments of all 50 states, including New Hampshire. The survey is conducted with assistance from the federal Centers for Disease Control and Prevention (CDC). The BRFSS is the largest continually conducted telephone health survey in the world and is the primary source of information for states and the nation on the health-related behaviors of adults. BRFSS has been conducted in New Hampshire since 1987. Health Statistics and Data Management Section (HSDM) develops the annual questionnaire, plans survey protocol, locates financial support, and monitors data collection progress and quality with the assistance of CDC. HSDM employs a contractor for telephone data collection. Survey data are submitted monthly to CDC by the contractor for cleaning and processing and then returned to HSDM for analysis and reporting.

Death certificate data are collected by the Department of Vital Records in New Hampshire and provided to the Health Statistics and Data Management Section through a Memorandum of Understanding. Death certificate data are available to the Office of Health Statistics and Data Management through the state Electronic Data Warehouse (EDW), a secure data server.

Hospital Discharge Data for inpatient and emergency department care is compiled and de-identified at the Maine Health Information Center, delivered to the Office of Medicaid Business and Policy for further cleaning, then available to the Office of Health Statistics and Data Management through the state Electronic Data Warehouse (EDW). Starting with hospital data for years 2010 and on, this process will be managed in total by the New Hampshire Office of Health Statistics and Data Management.

State and county population estimates for New Hampshire data are provided by the Health Statistics and Data Management Section (HSDM), Bureau of Public Health Statistics and Informatics (BPHSI) Division of Public Health Services (DPHS), New Hampshire Department of Health and Human Services (DHHS). Population data are based on U.S. Census data apportioned to towns using New Hampshire Office of Economic Planning (OEP) estimates and projections and further apportioned to age groups and gender using Claritas Corporation estimates and projections to the town, age group, and gender levels. Data adds up to U.S. Census data at the county level between 1990 and 2005 but do not add to OEP or Claritas data at smaller geographic levels.

#### **DATA CONFIDENTIALITY**

The data provided in this report adheres to the New Hampshire Department of Health and Human Services “Guidelines for Release of Public Health Data” and the Health Insurance Portability and Accountability Act (HIPAA). Data are aggregated into groups large enough to prevent constructive identification of individuals who were discharged for hospitals or who are deceased.

#### **GRAPHS**

Graphs have varying scales depending on the range of the data displayed. Therefore, caution should be exercised when comparing such graphs.

#### **INCIDENCE**

Incidence refers to the number or rate of new cases in a population. Incidence rate is the probability of developing a particular disease or injury occurring during a given period of time; the numerator is the number of new cases during the specified time period and the denominator is the population at risk during the period. Rates are age-adjusted to 2000 U.S. standard population. Some of the rates also include age-specific rates. Rates based on 10 or fewer cases are not calculated, because they are not reliable.

#### **DEATH RATE**

Death rate is the number of deaths per 100,000 population in a certain region in a certain time period and is based on ICD-10 classification. Cause of death before 1999 was coded according to ICD-9; beginning with deaths in 1999, ICD-10 was used.

#### **RELIABILITY OF RATES**

Several important notes should be kept in mind when examining rates. Rates based on small numbers of events (e.g., less than 10 events) can show considerable variation. This limits the usefulness of these rates in comparisons and estimations of future occurrences. Unadjusted rates

(age-specific or crude rates) are not reliable for drawing definitive conclusions when making comparisons because they do not take factors such as age distribution among populations into account. Age-adjusted rates offer a more refined measurement when comparing events over geographic areas or time periods. When a difference in rates appears to be significant, care should be exercised in attributing the difference to any particular factor or set of factors. Many variables may influence rate differences. Interpretation of a rate difference requires substantial data and exacting analysis.

### **SMALL NUMBERS**

With very small counts, it is often difficult to distinguish between random fluctuation and meaningful change. According to the National Center for Health Statistics, considerable caution must be observed in interpreting the data when the number of events is small (perhaps less than 100) and the probability of such an event is small (such as being diagnosed with a rare disease). The limited number of years of data in the registry and the small population of the state require policies and procedures to prevent the unintentional identification of individuals. Data on rare events, and other variables that could potentially identify individuals are not published.

### **STANDARD ERRORS**

The standard errors (S.E.) of the rates were calculated using the following formula:

Where,

$w_j$  = fraction of the standard population in age category

$n_j$  = number of cases in that age category

$p_j$  = person-years denominator

$$\text{S.E.} = \sqrt{\frac{w_j^2 n_j}{p_j^2}}$$

## **Data Resources**

### **Background on State Vital Records**

Death certificate data are collected by the Department of Vital Records in New Hampshire and provided to the Health Statistics and Data Management Section through a Memorandum of Understanding. Death certificate data are available to the Office of Health Statistics and Data Management through the State Electronic Data Warehouse (EDW), a secure data server.

#### **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.

### **Background on State Hospital Discharge Data**

New Hampshire's Office of Medicaid and Billing maintains electronic databases of hospital discharge records for nonfederal, acute care hospitals located within New Hampshire borders. Like many states, New Hampshire uses the standard uniform billing form (UB-92) as the basis for their hospital discharge database. Others use only a subset of variables from the UB-92 for their databases, and a few collect additional variables.<sup>10</sup> The UB-92, developed by the National Uniform Billing Committee, includes the following data elements: patient's age, sex, zip code, admission date, length of stay, total charges, principal diagnosis, and up to eight additional diagnoses.

#### **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.

### **Behavioral Risk Factor Surveillance System (BRFSS)**

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) manages the BRFSS. This is a broad, ongoing state-based, random-digit-dialed telephone survey of the non-institutionalized U.S. population over age 17. BRFSS monitors risk behaviors associated with the leading causes of disease, injury, and death.<sup>12</sup>

Because BRFSS is telephone-based, population subgroups less likely to have telephones, such as persons of low socioeconomic status, may be underrepresented. In addition, data are self-reported and may be biased. For risk-reduction factors such as self-reported use or testing of smoke alarms, these data may not uniformly represent safe and effective use.<sup>12</sup>

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

#### **LIMITATIONS OF DATA RESOURCES**

As with all self-reported sample surveys, BRFSS data might be subject to systematic error resulting from non-coverage (e.g., lower telephone coverage among populations of low

socioeconomic status), non-response (e.g., refusal to participate in the survey or to answer specific questions), or measurement (e.g., social desirability or recall bias).

### **Youth Risk Behavior Survey (YRBS)**

YRBS, a component of the Youth Risk Behavior Surveillance System, is managed by NCCDPHP at CDC. The YRBS monitors risk behaviors associated with the leading causes of injury and death among teenagers.<sup>13</sup> 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 are analyzed by CDC. YRBS data apply only to youth who attend school. The extent of underreporting or over-reporting 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.<sup>13</sup>

Among the 30 funded states, 23 conducted a YRBS in 2005 with overall participation rates of at least 60%.<sup>14</sup> CDC requires a minimum overall participation rate of 60% to generalize the results to the State’s population. States with YRBS data meeting this criterion will be included. Results will be reported as a percentage of respondents. No age adjustment will be applied. The YRBS was not administered in 2006.

### **Fatality Analysis Reporting System (FARS)**

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

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.<sup>15</sup>

### **LIMITATIONS OF DATA RESOURCES**

FARS does not include non-traffic 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 discriminate analysis of information from all cases where BAC data are available.

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## **Appendix of County-Level Injury Indicators**

<b>Injury Indicators (per 100,000 population unless otherwise noted)</b>	<b>2009 New Hampshire Rate</b>	<b>NH Lower CI</b>	<b>NH Upper CI</b>	<b>Healthy People 2020 Target</b>	<b>Significantly Higher or Lower than Target</b>
All Injury Fatalities	43.1	39.6	46.6	53.3	Lower
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	Lower
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	Higher
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	Same
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	Same
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	Same
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	Lower
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	Lower
Homicides	0.8	0.4	1.4	5.5	Lower
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	Lower
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	Lower
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		
Seat Belt Use	68.9			92.4	Lower
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4	Lower
Poisoning Fatalities	12.9	11.0	14.9	13.1	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		
Poisoning Emergency Department Visits	195.0	187.1	202.8		
Fatal Suicides	11.4	9.6	14.3	10.2	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	Same
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	Lower
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	Same
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	Higher

<b>Belknap County Injury Indicators (per 100,000 population unless otherwise noted)</b>	<b>2009 New Hampshire Rate</b>	<b>NH Lower CI</b>	<b>NH Upper CI</b>	<b>Healthy People 2020 Target</b>	<b>2009 Belknap County Rate</b>	<b>Belknap County Lower CI</b>	<b>Belknap County Upper CI</b>	<b>County Significantly Higher or Lower than Target</b>	<b>County Significantly Higher or Lower than State</b>
All Injury Fatalities	43.1	39.6	46.6	53.3	62.3	44.5	84.8	Same	Same
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	568.5	510.0	627.0	Same	Higher
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	16,241.1	15,894.7	16,587.6	Higher	Higher
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	5.0	1.0	14.6	Same	Same
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		0.0				Lower
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		3.3	0.4	12.0		Same
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	9.8	4.2	19.3	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		287.2	248.7	325.7		Same
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		4,284.1	4,109.4	4,458.9		Higher
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		525.4	392.4	688.9		Higher
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		111.1	55.5	198.8		Same
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	5,354.6	4,898.7	5,810.5	Higher	Higher
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	0.00			Lower	Lower
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		1.7	0.0	9.3		Same
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		58.2	40.5	80.9		Higher
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	13.3	5.7	26.2	Same	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		5.0	1.0	14.6		Same
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	6.6	1.8	17.0	Lower	Same
Homicides	0.8	0.4	1.4	5.5	0.0			Lower	Lower
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	374.7	320.5	428.9	Lower	Higher
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	1.7	0.0	9.3	Lower	Same
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		64.1	45.4	88.0		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		972.0	886.8	1,057.2		Higher
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	22.8	11.8	39.9	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		110.9	85.6	141.3		Same
Poisoning Emergency Department Visits	195.0	187.1	202.8		352.7	300.5	404.9		Higher
Fatal Suicides	11.4	9.6	14.3	10.2	20.9	10.4	37.3	Higher	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		72.3	51.9	98.0		Same
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	157.3	125.1	195.3	Higher	Higher
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	16.6	8.0	30.6	Same	Same
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	76.8	57.5	100.5	Same	Same
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	997.2	911.7	1,082.7	Higher	Same

<b>Carroll County Injury Indicators (per 100,000 population unless otherwise noted)</b>	<b>2009 New Hampshire Rate</b>	<b>NH Lower CI</b>	<b>NH Upper CI</b>	<b>Healthy People 2020 Target</b>	<b>2009 Carroll County Rate</b>	<b>Carroll County Lower CI</b>	<b>Carroll County Upper CI</b>	<b>County Significantly Higher or Lower than Target</b>	<b>County Significantly Higher or Lower than State</b>
All Injury Fatalities	43.1	39.6	46.6	53.3	70.1	49.6	96.3	Same	Same
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	602.4	531.4	673.3	Same	Higher
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	14,195.6	13,813.2	14,577.9	Higher	Higher
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	2.1	0.1	11.7	Same	Same
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		0.0				Lower
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		0.0				Lower
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	11.2	4.8	22.0	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		267.7	226.3	309.2		Same
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		3,918.0	3,723.8	4,112.1		Higher
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		445.4	322.3	600.0		Same
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		310.8	209.7	443.6		Higher
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	5,635.0	5,161.4	6,108.5	Higher	Higher
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	0.00			Lower	Lower
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		4.2	0.5	15.1		Same
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		41.9	25.6	64.7		Same
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	10.5	3.4	24.4	Same	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		0.0				Lower
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	4.2	0.5	15.1	Same	Same
Homicides	0.8	0.4	1.4	5.5	4.2	0.5	15.1	Same	Same
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	205.7	162.1	257.5	Lower	Same
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	14.7	5.9	30.2	Same	Same
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		74.6	51.6	104.2		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		788.2	696.3	880.1		Same
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	22.2	11.1	39.8	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		130.8	98.8	169.8		Higher
Poisoning Emergency Department Visits	195.0	187.1	202.8		250.2	198.9	301.4		Same
Fatal Suicides	11.4	9.6	14.3	10.2	15.7	6.8	31.0	Same	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		76.4	51.6	109.1		Same
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	89.1	60.9	125.8	Same	Same
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	18.8	8.6	35.8	Same	Same
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	63.7	44.9	87.8	Same	Same
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	1,007.8	906.2	1,109.4	Higher	Same

Cheshire County Injury Indicators (per 100,000 population unless otherwise noted)	2009 New Hampshire Rate	NH Lower CI	NH Upper CI	Healthy People 2020 Target	2009 Cheshire County Rate	Cheshire County Lower CI	Cheshire County Upper CI	County Significantly Higher or Lower than Target	County Significantly Higher or Lower than State
All Injury Fatalities	43.1	39.6	46.6	53.3	51.6	37.3	69.5	Same	Same
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	494.9	445.8	544.1	Lower	Same
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	12,746.2	12,481.7	13,010.7	Higher	Higher
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	0.0			Lower	Lower
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		0.0				Lower
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		2.6	0.3	9.3		Same
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	9.9	4.5	18.8	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		244.0	211.1	277.0		Same
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		3,264.8	3,132.0	3,397.6		Same
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		802.5	645.3	986.4		Higher
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		124.8	68.2	209.4		Same
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	5,118.1	4,699.4	5,536.9	Same	Higher
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	0.00			Lower	Lower
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		6.5	2.1	15.1		Same
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		40.1	27.2	56.9		Same
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	5.2	1.4	13.2	Same	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		2.6	0.3	9.3		Same
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	5.2	1.4	13.2	Lower	Same
Homicides	0.8	0.4	1.4	5.5	0.0			Lower	Lower
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	250.4	213.5	287.4	Lower	Same
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	10.3	4.5	20.4	Same	Same
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		57.8	42.5	76.9		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		745.6	682.3	808.8		Same
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	13.5	6.5	24.7	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		85.5	65.9	109.2		Same
Poisoning Emergency Department Visits	195.0	187.1	202.8		173.9	142.8	205.0		Same
Fatal Suicides	11.4	9.6	14.3	10.2	10.7	4.6	21.0	Same	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		70.5	52.6	92.4		Same
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	75.9	57.7	98.2	Lower	Lower
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	10.3	4.5	20.4	Same	Same
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	93.6	74.0	116.9	Same	Same
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	1,073.3	996.4	1,150.1	Higher	Higher

<b>Coos County Injury Indicators (per 100,000 population unless otherwise noted)</b>	<b>2009 New Hampshire Rate</b>	<b>NH Lower CI</b>	<b>NH Upper CI</b>	<b>Healthy People 2020 Target</b>	<b>2009 Coos County Rate</b>	<b>Coos County Lower CI</b>	<b>Coos County Upper CI</b>	<b>County Significantly Higher or Lower than Target</b>	<b>County Significantly Higher or Lower than State</b>
All Injury Fatalities	43.1	39.6	46.6	53.3	48.6	29.7	75.1	Same	Same
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	636.2	556.1	716.4	Same	Higher
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	16,286.5	15,811.2	16,761.8	Higher	Higher
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	3.0	0.1	16.8	Same	Same
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		0.0				Lower
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		0.0				Lower
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	11.5	4.2	24.9	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		308.4	258.7	358.2		Higher
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		4,169.8	3,936.1	4,403.5		Higher
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		735.8	540.6	978.4		Higher
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		563.6	394.7	780.2		Higher
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	5,964.3	5,365.4	6,563.2	Higher	Higher
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	3.01	0.08	16.77	Same	Same
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		0.0				Lower
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		51.2	29.8	81.9		Same
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	18.1	6.6	39.3	Same	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		3.0	0.1	16.8		Same
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	15.0	4.9	35.1	Same	Same
Homicides	0.8	0.4	1.4	5.5	3.0	0.1	16.8	Same	Same
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	554.8	464.0	645.6	Higher	Higher
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	6.0	0.7	21.7	Same	Same
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		53.7	33.7	81.3		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		886.3	775.6	997.0		Same
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	6.7	0.8	24.1	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		152.5	113.9	200.0		Higher
Poisoning Emergency Department Visits	195.0	187.1	202.8		285.7	229.5	351.6		Higher
Fatal Suicides	11.4	9.6	14.3	10.2	20.6	8.9	40.6	Same	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		116.6	82.1	160.7		Higher
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	194.4	148.0	250.8	Higher	Higher
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	33.1	16.5	59.2	Higher	Higher
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	115.6	85.8	152.4	Higher	Higher
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	1,374.6	1,236.2	1,513.1	Higher	Higher

<b>Grafton County Injury Indicators (per 100,000 population unless otherwise noted)</b>	<b>2009 New Hampshire Rate</b>	<b>NH Lower CI</b>	<b>NH Upper CI</b>	<b>Healthy People 2020 Target</b>	<b>2009 Grafton County Rate</b>	<b>Grafton County Lower CI</b>	<b>Grafton County Upper CI</b>	<b>County Significantly Higher or Lower than Target</b>	<b>County Significantly Higher or Lower than State</b>
All Injury Fatalities	43.1	39.6	46.6	53.3	27.7	18.1	40.6	Lower	Same
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	381.8	341.8	421.8	Lower	Lower
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	11,323.6	11,087.9	11,559.3	Higher	Lower
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	0.0			Lower	Lower
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		0.0				Lower
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		1.1	0.0	6.3		Same
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	4.1	1.3	9.7	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		208.2	179.8	236.6		Lower
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		3,153.7	3,029.6	3,277.8		Lower
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		648.3	520.0	798.7		Higher
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		346.3	254.4	460.4		Higher
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	4,022.4	3,685.0	4,359.8	Lower	Lower
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	1.12	0.03	6.27	Same	Same
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		5.6	1.8	13.1		Same
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		37.1	25.5	52.1		Same
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	5.6	1.8	13.1	Same	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		2.2	0.3	8.1		Same
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	4.5	1.2	11.5	Lower	Same
Homicides	0.8	0.4	1.4	5.5	1.1	0.0	6.3	Same	Same
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	211.7	180.0	243.5	Lower	Lower
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	5.6	1.8	13.1	Same	Same
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		43.7	31.4	59.3		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		468.3	421.6	514.9		Lower
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	6.3	2.0	14.7	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		46.5	33.4	63.1		Lower
Poisoning Emergency Department Visits	195.0	187.1	202.8		135.8	110.1	161.5		Lower
Fatal Suicides	11.4	9.6	14.3	10.2	4.7	1.5	11.0	Same	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		27.5	17.4	41.3		Lower
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	51.2	37.3	68.5	Lower	Lower
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	11.2	5.4	20.7	Same	Same
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	87.1	69.8	107.2	Same	Same
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	765.1	703.9	826.4	Higher	Lower

Hillsborough County Injury Indicators (per 100,000 population unless otherwise noted)	2009 New Hampshire Rate	NH Lower CI	NH Upper CI	Healthy People 2020 Target	2009 Hills- borough County Rate	Hills- borough County Lower CI	Hills- borough County Upper CI	County Significantly Higher or Lower than Target	County Significantly Higher or Lower than State
All Injury Fatalities	43.1	39.6	46.6	53.3	39.7	33.5	45.9	Lower	Lower
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	473.3	451.8	494.8	Lower	Lower
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	11,244.9	11,138.6	11,351.3	Higher	Lower
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	0.2	0.0	1.4	Same	Same
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		0.5	0.1	1.8		Same
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		1.2	0.4	2.9		Same
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	6.4	4.1	9.4	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		241.7	226.3	257.1		Same
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		3,082.5	3,026.8	3,138.1		Lower
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		607.4	536.7	678.0		Higher
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		59.9	39.8	86.5		Same
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	4,638.7	4,443.5	4,833.9	Higher	Same
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	0.50	0.06	1.81	Same	Same
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		2.7	1.4	4.9		Same
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		22.0	17.6	27.1		Lower
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	5.2	3.2	8.0	Lower	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		2.0	0.9	3.9		Same
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	6.5	4.2	9.5	Lower	Same
Homicides	0.8	0.4	1.4	5.5	1.2	0.4	2.9	Lower	Same
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	351.3	332.4	370.2	Lower	Higher
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	4.7	2.9	7.4	Lower	Same
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		45.2	38.6	51.9		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		895.4	865.5	925.3		Higher
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	13.4	10.1	17.4	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		87.9	78.6	97.1		Same
Poisoning Emergency Department Visits	195.0	187.1	202.8		198.0	183.9	212.2		Same
Fatal Suicides	11.4	9.6	14.3	10.2	10.8	7.9	14.4	Same	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		57.9	50.3	65.4		Same
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	124.5	113.3	135.8	Higher	Same
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	9.0	6.3	12.5	Lower	Same
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	66.1	58.1	74.2	Lower	Same
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	1,069.1	1,036.1	1,102.1	Higher	Higher

Merrimack County Injury Indicators (per 100,000 population unless otherwise noted)	2009 New Hampshire Rate	NH Lower CI	NH Upper CI	Healthy People 2020 Target	2009 Merrimack County Rate	Merrimack County Lower CI	Merrimack County Upper CI	County Significantly Higher or Lower than Target	County Significantly Higher or Lower than State
All Injury Fatalities	43.1	39.6	46.6	53.3	54.0	43.2	66.7	Same	Same
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	484.8	449.6	520.0	Lower	Lower
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	13,436.7	13,241.7	13,631.8	Higher	Higher
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	2.7	0.7	7.0	Same	Same
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		1.4	0.2	4.9		Same
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		2.0	0.4	6.0		Same
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	9.0	5.1	14.6	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		240.5	216.5	264.6		Same
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		3,357.6	3,260.9	3,454.4		Same
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		683.2	568.0	798.5		Higher
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		86.0	50.1	137.8		Same
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	5,162.2	4,845.4	5,479.0	Higher	Higher
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	2.04	0.42	5.98	Same	Same
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		3.4	1.1	8.0		Same
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		37.5	28.2	48.8		Same
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	8.9	4.7	15.2	Same	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		4.1	1.5	8.9		Same
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	4.1	1.5	8.9	Lower	Same
Homicides	0.8	0.4	1.4	5.5	0.7	0.0	3.8	Same	Same
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	263.1	235.5	290.7	Lower	Same
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	11.6	6.7	18.6	Same	Same
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		70.9	57.2	84.6		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		839.0	790.5	887.6		Same
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	9.9	5.7	16.1	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		92.7	76.7	108.8		Same
Poisoning Emergency Department Visits	195.0	187.1	202.8		183.4	160.7	206.2		Same
Fatal Suicides	11.4	9.6	14.3	10.2	14.3	9.0	21.6	Same	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		49.7	38.8	62.8		Same
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	172.3	150.1	194.5	Higher	Higher
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	15.7	9.9	23.5	Same	Same
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	75.2	61.1	89.3	Same	Same
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	929.3	878.0	980.6	Higher	Same

Rockingham County Injury Indicators (per 100,000 population unless otherwise noted)	2009 New Hampshire Rate	NH Lower CI	NH Upper CI	Healthy People 2020 Target	2009 Rock- ingham County Rate	Rock- ingham County Lower CI	Rock- ingham County Upper CI	County Significantly Higher or Lower than Target	County Significantly Higher or Lower than State
All Injury Fatalities	43.1	39.6	46.6	53.3	39.2	32.0	46.5	Lower	Same
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	504.6	478.4	530.7	Lower	Same
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	11,367.4	11,239.5	11,495.3	Higher	Lower
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	1.4	0.4	3.5	Same	Same
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		0.3	0.0	1.9		Same
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		1.7	0.6	4.0		Same
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	10.1	6.8	14.5	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		261.1	242.4	279.8		Same
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		2,987.0	2,921.9	3,052.1		Lower
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		536.6	461.5	611.7		Higher
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		24.6	11.3	46.8		Lower
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	4,706.4	4,483.9	4,928.9	Same	Same
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	1.02	0.21	2.97	Same	Same
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		3.4	1.6	6.2		Same
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		24.1	18.8	30.3		Same
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	5.1	2.8	8.4	Lower	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		3.0	1.4	5.8		Same
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	5.4	3.1	8.8	Lower	Same
Homicides	0.8	0.4	1.4	5.5	0.0			Lower	Lower
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	220.1	201.8	238.4	Lower	Lower
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	3.4	1.6	6.2	Lower	Lower
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		58.6	49.7	67.5		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		865.4	829.9	900.8		Same
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	12.9	9.2	17.6	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		77.9	67.4	88.4		Same
Poisoning Emergency Department Visits	195.0	187.1	202.8		175.3	159.1	191.4		Same
Fatal Suicides	11.4	9.6	14.3	10.2	11.0	7.6	15.3	Same	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		47.4	39.2	55.5		Same
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	88.1	76.6	99.5	Lower	Lower
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	8.8	5.8	12.9	Lower	Same
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	86.6	75.6	97.5	Same	Same
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	962.6	925.2	1,000.0	Higher	Same

<b>Strafford County Injury Indicators (per 100,000 population unless otherwise noted)</b>	<b>2009 New Hampshire Rate</b>	<b>NH Lower CI</b>	<b>NH Upper CI</b>	<b>Healthy People 2020 Target</b>	<b>2009 Strafford County Rate</b>	<b>Strafford County Lower CI</b>	<b>Strafford County Upper CI</b>	<b>County Significantly Higher or Lower than Target</b>	<b>County Significantly Higher or Lower than State</b>
All Injury Fatalities	43.1	39.6	46.6	53.3	35.0	25.6	46.6	Lower	Same
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	542.2	500.3	584.1	Same	Same
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	13,281.8	13,072.1	13,491.5	Higher	Higher
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	0.0			Lower	Lower
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		0.0				Lower
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		1.6	0.2	5.9		Same
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	7.4	3.4	14.1	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		244.2	216.1	272.3		Same
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		3,337.2	3,231.1	3,443.2		Same
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		641.0	517.4	785.3		Higher
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		20.7	4.3	60.4		Same
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	4,707.7	4,354.7	5,060.8	Same	Same
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	0.00			Lower	Lower
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		1.6	0.2	5.9		Same
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		28.4	19.8	39.6		Same
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	3.3	0.9	8.3	Lower	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		2.4	0.5	7.1		Same
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	4.9	1.8	10.6	Lower	Same
Homicides	0.8	0.4	1.4	5.5	0.0			Lower	Lower
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	317.7	285.9	349.5	Lower	Same
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	6.5	2.8	12.8	Same	Same
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		56.6	44.2	71.4		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		793.1	743.2	842.9		Same
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	14.7	9.0	22.7	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		145.9	124.3	167.6		Higher
Poisoning Emergency Department Visits	195.0	187.1	202.8		192.5	167.4	217.6		Same
Fatal Suicides	11.4	9.6	14.3	10.2	9.8	5.2	16.7	Same	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		71.7	57.5	88.5		Same
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	103.3	85.2	121.4	Same	Same
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	10.6	5.6	18.1	Same	Same
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	60.0	47.1	75.4	Lower	Same
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	842.9	789.8	896.0	Higher	Lower

Sullivan County Injury Indicators (per 100,000 population unless otherwise noted)	2009 New Hampshire Rate	NH Lower CI	NH Upper CI	Healthy People 2020 Target	2009 Sullivan County Rate	Sullivan County Lower CI	Sullivan County Upper CI	County Significantly Higher or Lower than Target	County Significantly Higher or Lower than State
All Injury Fatalities	43.1	39.6	46.6	53.3	46.8	29.3	70.8	Same	Same
All Injury Inpatient Hospitalizations for All Injuries	496.4	484.5	508.4	555.8	555.6	488.0	623.2	Same	Same
All Injury Emergency Department Visits for All Injuries	12,311.0	12,219.0	12,373.0	7,533.4	14,729.8	14,344.0	15,115.7	Higher	Higher
Unintentional Drowning Fatalities	1.1	0.1	1.8	1.1	0.0			Lower	Lower
Drowning-Related Inpatient Hospitalizations	0.4	0.1	0.9		0.0				Lower
Drowning-Related Emergency Department Visits Hospitalizations	1.7	1.0	2.6		0.0				Lower
Unintentional Fall-Related Fatalities	8.3	6.8	9.8	7.0	9.2	3.0	21.6	Same	Same
Unintentional Fall-Related Inpatient Hospitalizations	249.6	241.3	257.9		272.6	228.1	317.2		Same
Unintentional Fall-Related Emergency Department Visits	3,261.7	3,229.9	3,293.5		3,889.0	3,695.1	4,082.9		Higher
Hip Fracture Inpatient Hospitalizations in Persons Aged 65 Years and Older	313.3	294.8	331.8		996.8	778.5	1,257.3		Higher
Hip Fracture Emergency Department Visits in Persons Aged 65 Years and Older	68.7	60.0	77.4		645.8	472.8	861.4		Higher
Falls in Adults Aged 65 Years or Older, Emergency Department Visits	4,622.8	4,432.0	4,720.7	4,711.6	5,278.7	4,745.1	5,812.2	Higher	Higher
Unintentional Fire-Related Fatalities	0.76	0.36	1.40	0.86	0.00			Lower	Lower
Unintentional Fire-Related Inpatient Hospitalizations	3.4	2.5	4.5		6.9	1.4	20.0		Same
Unintentional Fire-Related Emergency Department Visits	32.7	29.5	36.0		57.2	37.0	84.4		Higher
Firearm-Related Fatalities	6.5	5.2	8.0	9.2	9.1	2.5	23.4	Same	Same
Firearm-Related Inpatient Hospitalizations	2.9	2.0	3.9		6.9	1.4	20.0		Same
Firearm-Related Emergency Department Visits	9.0	7.3	10.6	18.6	18.3	7.9	36.0	Same	Same
Homicides	0.8	0.4	1.4	5.5	0.0			Lower	Lower
Assault-Related Emergency Department Visits	281.1	271.7	290.5	462.7	423.8	356.5	491.0	Same	Higher
Motor Vehicle Traffic Fatalities	8.3	6.8	9.8	12.4	6.9	1.4	20.0	Same	Same
Motor Vehicle Traffic Inpatient Hospitalizations	55.0	50.9	59.0		59.2	38.7	86.8		Same
Motor Vehicle Traffic Emergency Department Visits	824.6	808.6	840.5		811.7	721.2	902.2		Same
Seat Belt Use	68.9			92.4					
Alcohol-Related Crash Deaths (per 100 million vehicle miles traveled)	0.2			0.4					
Poisoning Fatalities	12.9	11.0	14.9	13.1	12.0	3.9	28.0	Same	Same
Poisoning Inpatient Hospitalizations	91.2	85.9	96.4		76.7	52.4	108.2		Same
Poisoning Emergency Department Visits	195.0	187.1	202.8		202.5	160.3	252.4		Same
Fatal Suicides	11.4	9.6	14.3	10.2	9.7	3.1	22.6	Same	Same
Suicide Attempt Inpatient Hospitalizations	56.9	52.7	61.1		62.4	41.1	90.8		Same
Suicide Attempt Emergency Department Visits	112.4	106.5	118.4	112.8	124.4	90.8	166.5	Same	Same
Traumatic Brain Injury Fatalities	11.0	9.2	12.7	15.6	20.6	9.4	39.1	Same	Same
Traumatic Brain Injury Inpatient Hospitalizations	77.6	72.8	82.3	77.0	118.0	90.0	151.8	Same	Higher
Traumatic Brain Injury Emergency Department Visits	930.2	913.1	947.4	336.5	985.9	885.8	1,085.9	Higher	Same

