

Center for Health Statistics Report

Injury & Violence Prevention and Occupational Safety & Health

Progress Review on Injury and Violence Prevention*

The review of the Healthy People 2010 objectives for Injury and Violence Prevention focused on three categories of injury: injury prevention, unintentional injury prevention and violence and abuse prevention. The data for these categories shows both favorable and unfavorable progress. The review also covers data for unintentional injury deaths, detailing progress towards motor vehicle crashes, residential fires, and child maltreatment. In the category of injury prevention, improvement is evident for nonfatal spinal cord injury hospitalizations and nonfatal firearm-related injuries. However, several other objectives reveal a worsening trend, including hospitalizations for nonfatal

head injury, emergency department visits caused by injuries, nonfatal poisonings, poisoning deaths, and suffocation deaths. In the category of unintentional injury prevention, the most recent data presents a mixed picture. Positive trends are shown for objectives related to hip fractures, deaths from drowning, nonfatal motor vehicle injuries, safety belt use, child restraint use, pedestrian deaths, and emergency room visits for dog bite injuries. Unfavorable trends include motor vehicle crash deaths, nonfatal pedestrian injuries, and motorcycle helmet use. In the category of violence and abuse prevention objectives, the overall picture is encouraging. Trends indicate improvement in the objectives for child maltreatment, physical assaults, physical assault by intimate partners, rape and attempted rape, sexual assault other than rape, physical fighting among adolescents, and weapon carrying by adolescents on school property. However, areas not meeting the 2010 objectives are child maltreatment fatalities and homicides.

Following are detailed updates on data for the three objectives selected for highlighting during the Progress Review. In 2001, the age-adjusted rate of deaths from motor vehicle crashes for the total population was 14.9 per 100,000, which also was the rate for non-Hispanic whites. Rates for Hispanics and for blacks were similar, while the rate for American Indians/Alaska Natives was the high-

Progress Review on Occupational Safety and Health*

There were 5,524 work-related injury deaths that occurred in the United States in 2002. More than 4.7 million new nonfatal injuries and illnesses were reported in private industry alone in that year. The direct costs of occupational injuries and illnesses are estimated at \$45.8 billion, and indirect costs may range up to \$229 billion. Nonetheless, 8 of the 11 objectives in the focus area, can be assessed, and all of these have shown improvement in this decade. The 2010 target has been met for the reduction of work-related homicides of 0.4 per 100,000 workers aged 16 years and older. The target for occupational skin diseases or disorders has been achieved showing a rate of 4.9 per 10,000 full time workers. Progress was also shown in reducing work-related injuries resulting in medical treatment, loss of time from work, or restricted work activity. In 2002, the incidence of such injuries had been reduced 63 percent. The target for this objective is 10.2 injuries per 100 full-time workers in all industries.

The major topics highlighted in this Progress Review include the challenge of eliminating health disparities (illustrated using occupational injury deaths among young work-

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* Cited from Healthy People 2010, U.S. Department of Health and Human Services.

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Jacksonville Injury & Violence Prevention and Occupational Safety and Health Report Card

Obj #	Objective	U.S. (2002)	FL (2003)	Duval (2003)	2010 Target
15-1	Reduce hospitalization for nonfatal head injuries. (Per 100,000)	66.0	52.8 ¹	49.8 ¹	45.0
15-2	Reduce hospitalization for nonfatal spinal cord injuries. (Per 100,000)	3.7	2.8 ¹	3.9 ¹	2.4
15-3	Reduce firearm-related deaths. (Per 100,000)	10.4	11.0 ²	18.9 ²	4.1
15-6	(Developmental) Extend State-level child fatality review of deaths due to external causes for children aged 14 years and under.		FL has CDR	DC has CDR	
15-8	Reduce deaths caused by poisonings. (Per 100,000)	9.2	13.3 ²	16.0 ²	1.5
15-9	Reduce deaths caused by suffocation. (Per 100,000)	4.4	4.4 ²	4.6 ²	3.0
15-13	Reduce deaths caused by unintentional injuries. (Per 100,000)	36.9	43.5 ²	42.4 ²	17.5
15-15	Reduce deaths caused by motor vehicle crashes. (Per 100,000)	15.2	18.3 ²	16.7 ²	9.2
15-16	Reduce pedestrian deaths on public roads. (Per 100,000)	2.1	2.8 ²	2.5 ²	1.0
15-19	Increase use of safety belts. (Percent)	75%	75.1% ³ (2002)	65.1% ⁴ (2002)	92%
15-20	Increase use of child restraints. (Percent)	95%	64.2% ³ (2002)	67.1% ⁴ (2004)	100%
15-22	Increase the number of States and the District of Columbia that have adopted a graduated driver licensing model law.	23 States	State Law ⁵	State Law ⁵	All
15-23	(Developmental) Increase use of helmets by bicyclists. (Percent)		23.6% ⁶ (1996)	31.2% ⁷ (2004)	
15-24	Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders.	10 States	State Law ⁸	State Law ⁸	All
15-25	Reduce residential fire deaths. (Per 100,000)	.9	.64 ²	DSU ²	.2
15-27	Reduce deaths from falls. (Per 100,000)	5.9	7.92 ²	6.07 ²	3.0
15-28	Reduce hip fractures among older adults.				
15-28a	Females aged 65 years and older (Per 100,000)	1,029.2 (2001)	850.5 ¹	902.8 ¹	416
15-28b	Males aged 65 years and older. (Per 100,000)	484.2 (2001)	407.8 ¹	405.0 ¹	474
15-29	Reduce drownings. (Per 100,000)	1.4	2.48 ²	2.44 ²	.9
15-32	Reduce homicides. (Per 100,000)	6.1	6.12 ²	11.6 ²	3.0
18-1	Reduce suicides. (Per 100,000)	11.0	12.7 ²	15.5 ²	5.0

¹ Agency for Health Care Administration

² Florida Department of Health, Office of Vital Statistics

³ 2002 Observational Survey of Safety Belt and Child Restraint Use in Florida, Duval County Health Department

⁴ 2004 Duval County Seat Belt/Child Restraint Device Use Observational Survey, Duval County Health Department

⁵ Insurance Institute for Highway Safety

⁶ Florida Bicycle Helmet Use Survey, Florida Department of Transportation

⁷ 2004 Duval County Bicycle Helmet and Child Bicycle Riding Behavior in Traffic Observational Survey, Duval County Health Department

⁸ National Safe Kids Campaign

⁹ Data were not available at the state & county levels, however Vital Statistics data were used to calculate rates.

* Used 18 and over population, while nation used 16 and over population.

¹⁰ National Center for Injury Prevention and Control, http://webapp.cdc.gov/sasweb/ncipc/mortrate10_sy.html

CDR - Child Death Review, 2003

DSU - Data Statistically Unreliable

Data Report Card Overview

The majority of data for this report were provided by the Florida Department of Health’s Office of Vital Statistics and the Agency for Health Care Administration. Other data sources include the Duval County Health Department’s Injury Prevention Program Office (local surveillance studies addressing safety behaviors), Safe Kids Worldwide Campaign, Florida Department of Transportation (Florida Bicycle Helmet Use Survey), and Insurance Institute for Highway Safety.

When comparing injury-related morbidity rates, Duval County had lower rates than the nation except in one area: spinal cord injuries. Those rates were slightly higher than the national rate (3.9 vs. 3.7). Duval County had lower rates of nonfatal head injuries and hip fractures among older adults. The hip fracture morbidity rate

among older male adults has decreased from 2001 to 2003 to 405 per 100,000 which is even lower than the Healthy People 2010 target set at 474 per 100,000.

When looking at unintentional injuries, motor vehicle crashes (MVC) have a significant impact. MVC deaths are the number one cause of unintentional injury deaths in Duval County. This translates into an increased overall unintentional injury mortality rate for Duval County. When comparing injury-related mortality rates, Duval County had higher rates than the nation, yet most of them are lower than those of the state. Of particular significance are the firearm-related deaths and homicides (18.9 and 11.6 per 100,000). They are close to twice the rates of the U.S. in 2002 (10.4 and 6.1 per 100,000). Duval County also has a higher suicide rate than the nation. Not

only did Duval County have higher injury mortality rates than the nation, it also had lower percentages of safety behaviors. For example, for objective 15-19, data shows the nation had a higher seat belt use percentage than Duval County (75% vs. 65.1%) for adults. Even when comparing use of child restraints, Duval County had a lower percentage of use than did the nation. The U.S. had 95% child restraint use while Duval County was more than 27 percentage points below with 67.1%.

Another aspect of injury prevention is legislation. Since Duval County falls under Florida State laws, Duval County met the two legislative objectives: 15-22 adopted a graduated driver licensing model law and 15-24 required bicycle helmets for bicycle riders.

Figure 1

Duval County Unintentional Injuries Death Rates by Health Zone, 2003

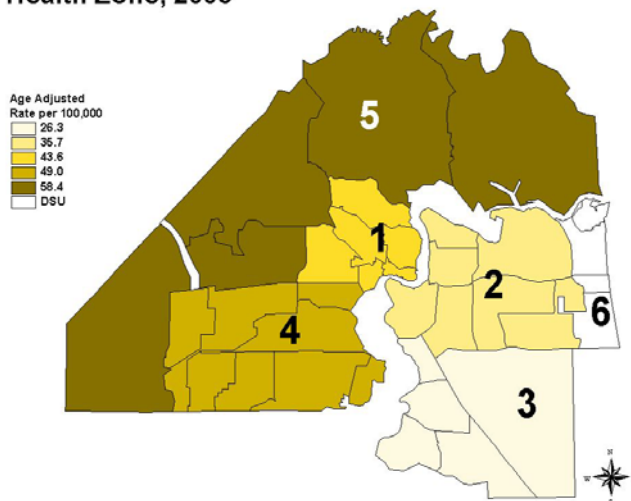
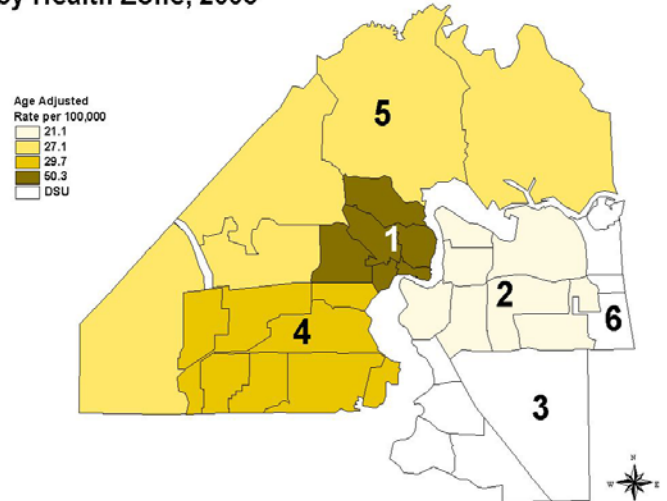


Figure 2

Duval County Intentional Injuries Death Rates by Health Zone, 2003



Source: Florida Department of Health, Death Certificate System, 2001-2003

Prepared by DCHD, Institute for Health, Policy and Evaluation Research, February 2005

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Violence: Health Disparities at the Local Level

Eliminating disparities among different population segments is one of the Healthy People 2010 goals. Unfortunately there are still many gaps in health related to race, ethnicity, gender and age. This is especially true of violence.

Specific racial communities suffer disproportionately when it comes to homicide deaths and homicide incidents. A homicide incident in this report is defined as an act with intent to cause the death of another. The black population in Duval county is more likely to die from a homicide with a rate of 30 per 100,000 or be injured due to a homicide incident (97.4 per 100,000) compared to the white population, 6.6 and 36.1 per 100,000 respectively (see Graph 1). From the years 2000-2004, the homicide death rate has increased by 50% in the black population. Conversely, the white population has shown a slight decline in homicide death rates of 2.7% over these same years. The homicide death rate for the Duval County black population is also 76% higher than the rate for Florida using the same population in 2004. In addition, men are more likely to be a victim of a homicide death than women with a rate of 22 per 100,000 vs. 5.5 per 100,000. The same is true for homicidal incidents with men yielding a rate of 93.2 per 100,000 compared to women at a rate of 19 per 100,000.

In the area of suicide, racial disparities are the opposite from homicide deaths and incidents. When comparing suicide deaths in Duval County, the white population rate is 18 per 100,000 vs. 3.6 per 100,000 for the black population. Men are also more likely to succeed at suicide

than women with a rate of 21.7 per 100,000 vs. 5.5 per 100,000 (see Graph 2). However, women are more likely to attempt suicide with a rate of 79 per 100,000 compared to men at 61 per 100,000. While individuals ages 20 years and older are more likely to attempt and succeed at suicide than those ages 0-19, there is still a large number of the younger population in Duval County that attempts suicide with a rate of 36.2 per 100,000.

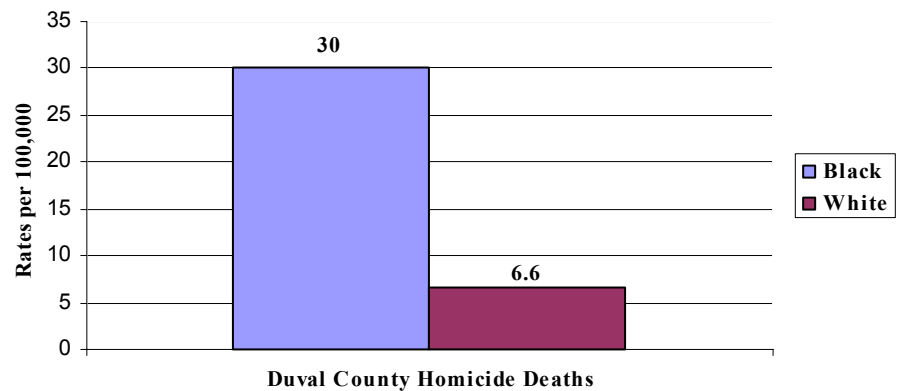
Data tend to be statistically unreliable across racial, gender, and differing age populations especially in the areas of domestic violence, aggra-

vated assault, and forcible sex offenses. Single causes for these disparities remain elusive due to complex social factors that contribute to the differences. The underlying inequities may need to be addressed to effectively eliminate the health disparities in Duval County. For more information, on violence disparities visit the National Center for Injury Prevention and Control website at <http://www.cdc.gov/ncipc/default.htm>.

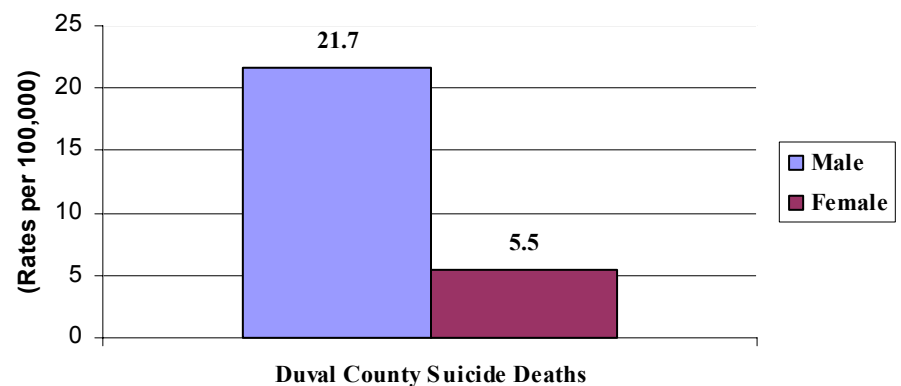
Sources:

Agency for Health Care Administration, Hospitalization Data, 2004
 Florida Department of Health, Office of Vital Statistics, 2000-2004
 Florida Legislature's Office of Economic and Demographic Research, 2000-2004

Graph 1 Homicide Death Rates by Race, Duval County, 2004



Graph 2 Suicide Death Rates by Gender, Duval County, 2004



Are Seat Belt Laws Improved by Legislation?

Stephen M. McCloskey, Injury Prevention Program Manager

By the year 2020 the third leading cause of death will likely be traffic crashes. Currently the U.S. ranks 9th in the world in traffic-related fatalities. These fatalities are mostly from lack of seat belt usage.

In 2002 there were almost 43,000 deaths in the United States due to motor vehicle crashes. This is equal to 118 deaths per day or 5 per hour, the same as a jumbo jet full of passengers crashing daily.

The National Highway Traffic Safety Administration has rated seat belts to be 45% effective in saving lives during fatal crashes and they also result in a 50% reduction in severe injuries. Of the 32,598 passenger vehicle occupants killed in crashes in 2002, 59 % were not wearing a safety belt. Among passenger vehicle occupants over 4 years old, safety belts saved an estimated 14,164 lives in 2002. If all passenger vehicle occupants over age 4 wore safety belts, 21,317 lives could have been saved in 2002.

Motor vehicle crashes in 2000 cost a total of \$230 billion, an amount equal to 2.3 percent of the gross domestic product, or \$820 for every person living in the U.S. In the last 26 years, safety belts prevented 135,000 fatalities and 3.8 million injuries, saving \$585 billion in medical and other costs. If all vehicle occupants had used safety belts during that period, 315,000 deaths and 5.2 million injuries could have been prevented – and \$913 billion in costs saved. The general public pays nearly three-quarters of all crash costs, primarily through insurance premiums, taxes, travel delays and lost productivity.

There are two types of safety belt laws: primary and secondary. A primary law allows an officer to stop and write a ticket if he or she observes an unbelted driver or passenger. Under a secondary law, an officer cannot ticket anyone for

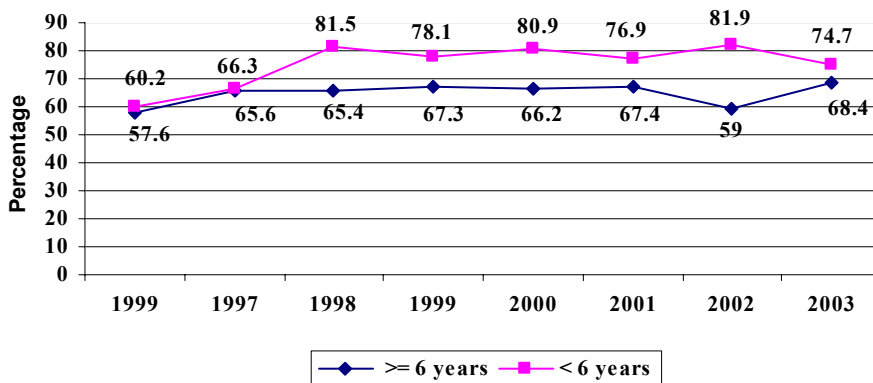
a safety belt violation unless the motorist is stopped for another infraction. Primary laws are very effective in increasing safety belt use. In 2003, seat belt use in states with primary law enforcement was 83%, compared with 75% in states without primary seat belt laws. When states convert from secondary to primary seat belt enforcement legislation the seat belt use rate increases from an average of 10% to 15% according to the National Highway Traffic Safety Administration. Each percentage-point increase in safety belt usage represents 2.8 million more people buckling up, approximately 270 more lives saved and 6,400 injuries prevented annually. Until July 2005, Florida has had a secondary enforcement law. Florida ranks 39th out of 52 states and territories of the United States of America in seat belt use with a 69.5% usage rate. The Injury Prevention Program Office at DCHD has been conducting seat belt and child restraint observational survey studies since 1996. The longitudinal findings of DCHD/TIPPO's observational studies are shown in Figure 5. Last year's study revealed a seat belt use rate of 58.4% for motor vehicle occupants ages 6 and older. This is 11% lower than the use in Florida as a whole. The 0-5 age population is excluded because Florida already requires primary enforcement for this age group as per Florida Statute 316.613. When compar-

ing the primary enforcement rates for the 0-5 age population in Duval County with the secondary usage rates from 1996 – 2003 there is an 8% average difference with a higher usage rate for the primary enforcement group (see Graph 3). Currently a record high 82% of Americans wear their safety belts while driving or riding in their vehicles—up from 71% since 2000. The U.S. Transportation Secretary notes that this increase was “due in large part to states that have passed primary safety belt laws.”

The data suggests that the public benefits from a primary seat belt enforcement law in reduced mortality and morbidity. For the past four years, Representative Irv. Slosberg, D-Boca Raton, whose daughter was fatally injured while not wearing a seatbelt, has made it his mission to sponsor such a bill. This bill was officially passed during the 2005 Legislative Session (F.S. 316.614). For more information on Florida seatbelt laws contact Stephen McCloskey at 665-2308.

Sources:
 National Highway Traffic Safety Administration, 2005
 NY Times, Nov. 27, 2003
 National Highway Traffic, Safety Administration
 NHTSA Technical Report, DOT HS 809, 199, December 2000
 NHTSA, Annual Assessment of Motor Vehicle Crashes, 2002
 NHTSA, Traffic Safety Facts Occupant Protection, 2002
 NHTSA, Economic Impact of Crashes, 2002
 NHTSA, Technical Report, Safety Belt Use in 2003, September 2003
 NHTSA, FY2003 Performance Plan, 2002
 Meharry-State Farm Alliance,
www.meharry.org/Research?Alliance_Resources/Seatbelt_Use_by_State_2003

Graph 3 1996 - 2003 Duval County Seat Belt and Child Restraint Device (CRD) Usage Rate



Source: 1996-2003 Duval County Seat Belt and CRD Observational Studies Reporting: DCHD/The Injury Prevention Program Office

Healthy Jacksonville's Injury Prevention Coalition

Stephen M. McCloskey, Injury Prevention Program Manager

There are four main coalitions in Duval County addressing the problem of injury in some scope and capacity. The first coalition, which the Duval County Health Department's Injury Prevention Program (DCHD/TIPPO) partnered with in 1994, was The *Bicycle and Pedestrian Advisory Committee (B/PAC)*. This committee's focus is to develop a comprehensive plan for bicycling and pedestrian issues facing Jacksonville and its vicinity. The committee votes on major planning and development issues approved by the Mayoral Office of Jacksonville.

The second injury prevention related coalition is *The Jacksonville Pediatric Injury Control System (JPICS)* later renamed *The Injury Free Coalition for Kids of Jacksonville (IFCKJ)* with the award of a 3-year grant from the Robert Wood Johnson Foundation. This forum was initiated as a quality control mechanism for the treatment of child trauma patients through their continuum of care. The committee or coalition is comprised of secondary and tertiary injury control disciplines. DCHD/TIPPO has advised the IFCKJ to use the health depart-

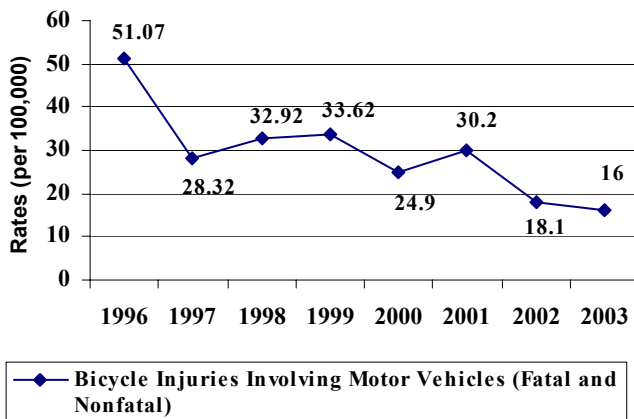
ment's geographical Health Zones (HZ) to rank the highest injury incidence area in Jacksonville by reviewing five retrospective years of Trauma Registry experience. The data revealed that HZ 1 (zip codes ending in 02,04,06,08,09, & 54) had the highest rate of traumatic injury occurring to the children of Jacksonville, Fl.

The third injury prevention coalition that appeared in recent Jacksonville history is *The Duval County Community Traffic Safety Team (DCTST)*. The DCTST was formed as a federal mandate from the National Highway Traffic Safety Administration (NHTSA) to bring together four disciplines to address the traffic-related injuries occurring in their respective communities of jurisdiction. The method was termed "The 4E's" of traffic safety and represents the Emergency Medical, Enforcement, Engineering and Education disciplines. The coalition's holistic approach was incorporated to combine traffic safety educational activities, improved emergency response plans, vigilant traffic enforcement and upgraded road safety engineering to reduce the frequency and severity of traffic crash mortality and morbidity.

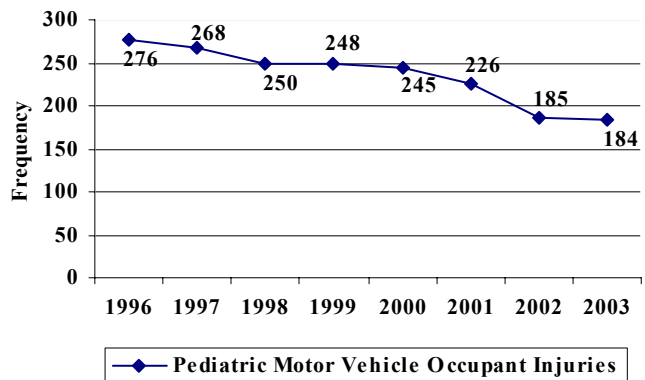
The most recent injury prevention coalition that appeared on the Jacksonville scene is called *SAFE KIDS Coalition of Northeast Florida*. SAFE KIDS Northeast Florida is a local chapter of SAFE KIDS Florida, and a member of the Safe Kids Worldwide Campaign. This Campaign encompasses over 450 coalitions in 16 countries working in their communities to prevent accidental injuries in children 14 and under. Motor vehicle, pedestrian, drowning, bicycle, choking, suffocation, poisoning and firearm injuries are the main causes of death in children and are program areas addressed by SAFE KIDS organizations.

These coalitions have played a critical role in improving injury outcomes in Duval county. Some of the trends that can be attributed in part to the work of the coalitions involve bicycles and motor vehicle injuries in youth. Between 1996 and 2003, safety helmet usage increased by over 200% in the 0-14 age group. This increase corresponded with a reduction in bicycle injuries of youth. (see Graph 4). In addition, the child restraint usage rate during this same time period increased 29.69% in conjunction with a decreased rate of occupant injuries in ages 5 and below by 33% (see Graph 5). For more information on injury prevention coalitions contact Stephen McCloskey at 665-2308.

Graph 4 1996 - 2003 Duval County Comparison of Bicycle Helmet Usage Rates and Bicycle Injuries



Graph 5 1996 - 2003 Duval County Comparison of Seatbelt and Child Restraint Device Usage Rates vs. Number of Fatal and Non-Fatal Injuries in Ages 5 Years and below



Progress Review on Injury and Violence Prevention (continued from page 1)

est of five racial and ethnic groups at 25.1 per 100,000. The death rate from motor vehicle crashes was lowest for Asians at 7.9 per 100,000. The level of education completed was a large factor in fatal crashes: people who had not completed high school died at three times the rate of people who had at least some college (25.6 compared with 8.2 per 100,000). High school graduates had a rate of 20.6. Males continue to die from crashes at roughly twice the rate of females. However, the death rate for males aged 15 to 24 years—the group at highest risk—has declined by one-third over the past two decades, from 68.7 per 100,000 in 1979 to 37.0 per 100,000 in 2001. The 2010 target of 9.2 per 100,000 was met by five states in 2001.

Death rates from residential fires have shown a slow but steady decline for

more than two decades. Highlighted progress includes a decrease in the black male death rate from fire showing 11.1 in 1997 to 3.8 per 100,000 in 2001, representing an almost threefold decrease over that time period. The overall fire death rate for blacks in 2001 was 2.7 per 100,000 compared with 1.0 for whites, 1.8 for American Indians/Alaska Natives, and 3.1 for people older than 65 years of age. The target is 0.2 per 100,000, which would require a six-fold reduction from the 2001 rate of 1.2 per 100,000 for the total population. In general, the highest death rates from residential fires occur in the southern and more southerly mid-western states.

Highlighted data shown for 2001 for child maltreatment include a rate of 12.4 incidents per 1,000 population younger than 18. The target is 10.3 per 1,000

population under 18 years of age. The incidence of child maltreatment declined as the age group of the child increased, with the highest incidence, 16.1 per 1,000, occurring among children younger than 4 years of age. By type of maltreatment, neglect (including medical neglect) accounted for 52 percent of the incidents in 2001, compared with 16 percent for physical abuse, 8 percent for sexual abuse, and 6 percent for psychological maltreatment. Between 1998 and 2001, the fatality rate among children subjected to maltreatment increased from 1.6 to 1.8 per 1,000 younger than 18. This exceeds the target of 1.4 per 1,000. The principal causes of these fatalities in 2001 were neglect (including medical neglect)—36 percent; physical abuse—26 percent; and physical abuse combined with neglect—22 percent.

Occupational Safety and Health: Progress Review (continued from page 1)

ers), the challenge of improving workers' health and safety in high-risk industries (illustrated using injury deaths and pneumoconiosis in mining), and the notable success in reducing the burden of occupational skin diseases or disorders. Between 1998 and 2002, the rate of work-related injury deaths in all industries decreased from 4.5 to 4.0 per 100,000 workers aged 16 years and older. The 2010 target is 3.2 per 100,000. By industry, the highest rates of work-related injury deaths in 2002 were recorded for mining and agriculture (>20 per 100,000), followed by construction and transportation (>10 per 100,000). Of the total number of occupational injury deaths (5,524), 43 percent occurred in connection with transportation-associated activity. By gender, the rate of work-related injury deaths among males in 2002 was 6.9 per 100,000, compared with 0.7 per 100,000 among females, partly due to the preponderance of male employees in the more hazardous occupations. Among all workers younger than 18 years of age, 41 percent of work-related injury deaths in the pe-

riod 1992–2002 occurred among those employed in agriculture.

In the mining industry as a whole, the highest rate of work-related injury deaths in 2002 was recorded for coal mining, followed by the mining of nonmetals (other than coal), then by oil and gas extraction. In underground mining, 43.3 percent of work-related injury deaths in 1998–2002 were caused by cave-ins (e.g., collapse of the mining face or over-head). In surface mining, the largest proportion of deaths was caused by “powered haulage” (such as contact with equipment and vehicles used to haul materials).

Over the past three decades, the prevalence of coal workers' pneumoconiosis has declined sharply, most dramatically among miners who have worked in the industry for more than 25 years. In the period 1973–1978, 35 percent of this cohort had coal workers' pneumoconiosis, whereas in 1996–2002, only 5 percent did. In 2000, the number of deaths from this disease was 950, compared

with 1,003 deaths in 1999. Coal workers' pneumoconiosis accounted for about one-half of the total deaths (4,963) from all forms of pneumoconiosis in 1974, compared with about one-third of the total (2,864) in 2000. Deaths from other pneumoconioses increased by more than one-third between 1983 and 2000, with asbestosis playing a large role in the rise. The 2010 target for total number of pneumoconiosis deaths is 1,900.

In 2002, skin diseases or disorders accounted for 15.2 percent of nonfatal occupational illnesses, of which the total number was approximately 294,500. The 2010 target for all occupational skin diseases or disorders is 47 new cases per 100,000 full-time workers aged 16 years and older. The rate was 51 per 100,000 in 2002, a significant decline from 67 cases per 100,000 workers in 1997. Dermatitis, the largest cause of occupational skin diseases or disorders, declined from a rate of 1.2 cases involving days away from work per 10,000 workers in 1992 to 0.5 cases per 10,000 workers in 2001.

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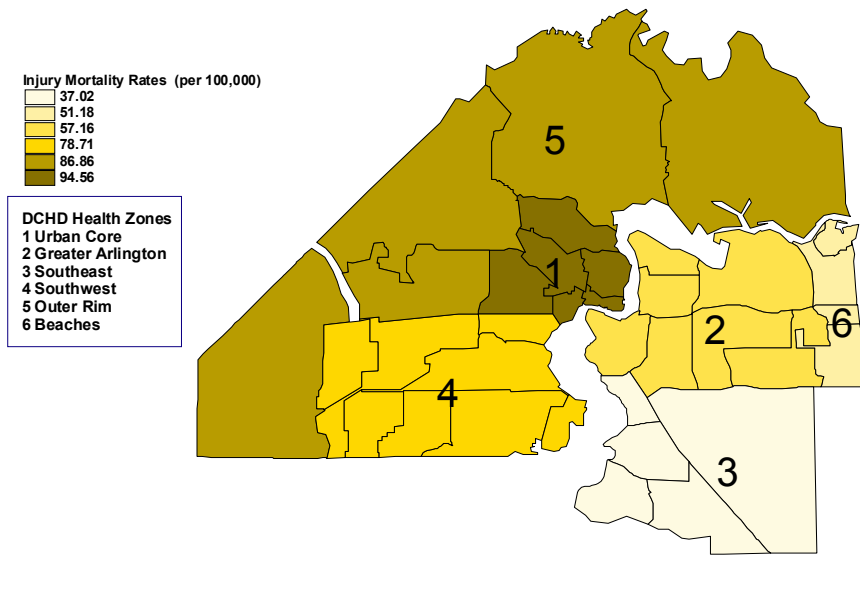
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Injury Mortality Rates by Health Zones Duval County 2003



*Rates for Age-Adjusted

Source: Florida Department of Health, Death Certificate System, 2001-2003

Prepared by DCHD, Institute for Health, Policy and Evaluation Research, February 2005

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