Substantially lower than levels among adults aged ≥65 years. In addition, both influenza and pneumococcal vaccination levels among adults aged ≥65 years were substantially below the 2010 national health objective of 90% coverage.

Estimates of influenza vaccination coverage among adults aged 50-64 years were low despite the revised ACIP recommendations in 2000. The universal recommendations were broadened to address the prevalence of high-risk medical conditions in adults aged 50-64 years, of whom approximately 29% have one or more chronic medical condition. Age-based strategies for vaccination have been implemented more successfully than patient-selection strategies based on medical conditions. Efforts are needed to increase awareness of the revised recommendations among health-care providers and the general public. Information regarding the adult immunization schedule is available at http://www.cdc.gov/nip.

Factors predictive of influenza and pneumococcal vaccination were similar, and having a source for regular health care was the factor most associated with receiving either vaccination. After adjustments were made for known potential confounding factors measured by BRFSS (i.e., education level but not direct measures of access to care, which were not available), non-Hispanic whites remained more likely to be vaccinated than non-Hispanic blacks and Hispanics. Strategies for addressing these disparities are being assessed by the Racial and Ethnic Adult Disparities Immunization Initiative (READII) through a 2-year demonstration project.

Vaccine production for the 2003-04 influenza season is proceeding on schedule, and projected production and distribution schedules will allow for a sufficient supply of influenza vaccine during October-November. Influenza vaccination may proceed for all persons at high risk and healthy persons, individually and through mass campaigns, as soon as vaccine is available and should continue until supplies are depleted. Pneumococcal vaccine should be offered all year to adults aged ≥65 years and other persons at high risk.

The findings in this report are subject to at least three limitations. First, influenza and pneumococcal vaccination status was based on self-report and not validated. The validity of self-reported pneumococcal vaccination is lower than that of influenza vaccination. Second, the median BRFSS response rate (98.3%) in this survey was low. BRFSS results have been compared with results from the National Health Interview Survey (NHIS), a household-based, face-to-face interview survey with higher response rates. Comparisons show similar trends and subgroup differences; however, BRFSS vaccination estimates are consistently higher than NHIS estimates. Finally, because the survey is conducted during a 12-month period, questions regarding receipt of influenza vaccination do not reflect a single influenza season.

The variation in influenza and pneumococcal vaccination coverage observed among states/areas suggests that opportunities exist to improve vaccination coverage. Although systems-based approaches (e.g., standing orders) have been effective in increasing vaccination coverage levels, these strategies are not implemented widely. To increase vaccination coverage levels, states/areas should promote these and other evidence-based strategies. Low provider reimbursement might be a barrier to vaccination; however, in 2003, Medicare increased its payment rates by 94% for administering influenza and pneumococcal vaccine. Influenza vaccination coverage among adults aged ≥65 years has leveled since 1997, and unless substantial efforts and innovative approaches are undertaken in collaboration with public, private, and community partners, the 2010 national health objective might not be achieved.

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REFERENCES
10 available

Public Health and Aging: Nonfatal Injuries Among Older Adults Treated in Hospital Emergency Departments—United States, 2001

MMWR. 2003;52:1019-1022
1 table omitted

Because injuries generally are considered a problem of the young, injuries among older adults (i.e., persons aged ≥65 years) have received little attention. However, injuries are the eighth leading cause of death among older adults in the United States. In 2001, approximately 2.7 million older adults were treated for nonfatal injuries in hospital emergency departments (EDs); the majority of these injuries were the result of falls. To characterize nonfatal injuries among older adults, CDC analyzed data from the National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP). This report summarizes the results of that analysis, which indicate differences in type and mechanism of injury by sex, suggesting that prevention programs should be designed and tailored differently for men and women.

NEISS-AIP is operated by the U.S. Consumer Product Safety Commission and collects data about initial visits for all types and causes of injuries treated in U.S. EDs, drawing from a nationally representative sample of 66 hospitals selected as a stratified probability sample of hospitals in the United States. Data from these cases are weighted by the inverse of the probability of selection to produce national estimates. For this report, annualized estimates were calculated on the basis of weighted data for 36,752 nonfatal injuries among older adults treated in EDs during January-December 2001. U.S. Census Bureau population estimates for 2001 were used.
to calculate injury rates. A direct variance estimation procedure was used to calculate 95% confidence intervals and to account for the complex sample design. All nonfatal injuries were classified according to the mechanism of injury (e.g., fall, struck by/against, or motor vehicle crash), diagnosis, primary body part injured, disposition, location of injury, and intent. The diagnosis and intent of the injury were classified according to the most severe injury. Injuries of unknown intent were grouped with those classified as unintentional.

During 2001, an estimated 935,556 men and 1,731,640 women aged ≥65 years were treated in EDs for nonfatal injuries. The overall injury rate per 100,000 persons was higher among women (8,466 per 100,000 persons) than among men (6,404). Injury rates increased with age, to 15,272 for women aged ≥85 years and 11,547 for men aged ≥85 years. Nearly all injuries (99%) were classified as unintentional/unintentional intent.

Injuries among older adults were treated in EDs for monitoring trends, evaluating interventions, and characterizing nonfatal injuries among persons aged ≥65 years. Data from NEISS-AIP can continue to be a source for monitoring trends, evaluating interventions, and characterizing nonfatal injuries among persons aged ≥65 years.

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CDC Editorial Note: Falls remain the leading cause of both nonfatal and fatal injury among older adults aged ≥65 years in the United States. The findings in this report, which indicate that falls were the most common reason for injury-related ED visits among persons aged ≥65 years, are consistent with previous studies indicating that approximately 40% of older adults living in community settings (e.g., in private residences or minimally assisted environments) fall each year.

In this study, 82% of persons aged ≥65 years were treated and released following injury, compared with 93% of persons aged <65 years. Older adults were more than three times more likely (1,217 per 100,000 persons) to be hospitalized than persons aged <65 years (353). The findings in this report are subject to at least five limitations. First, NEISS-AIP provides national estimates and does not allow for estimates by region, state, or local jurisdiction. Second, injury outcomes are specific to ED visits and do not include subsequent outcomes. Third, NEISS-AIP data reflect only those injuries that were severe enough to require treatment in an ED. Fourth, in cases with multiple injuries, only data regarding the most severe injury are recorded. Finally, data for intent are classified on the basis of information contained in the medical record. Injuries for which intent cannot be determined conclusively from the ED record are grouped with unintentional injuries.

The findings in this report can form the basis for targeting prevention efforts to different populations of older adults. For example, exercise can reduce the risk for fall among older adults by 15%. Because women are more likely to sustain fall-related injuries, exercise can be an especially important preventive measure for this population.

International Conference on Emerging Infectious Diseases
MMWR. 2003;52:1025

CDC’S NATIONAL CENTER FOR INFECTIOUS DISEASES, The Council of State and Territorial Epidemiologists, the American Society for Microbiology, and the World Health Organization will cosponsor the International Conference on Emerging Infectious Diseases February 29—March 3, 2004, at the Marriott Marquis Hotel in Atlanta, Georgia. The conference will explore the most current research, surveillance, and prevention and control programs addressing all aspects of emerging infectious diseases. Attendance is limited to 2500 participants.

The conference will include general and plenary sessions, symposia, panels of speakers, presentations on emerging infections activities, oral and poster presentations, and exhibits. The deadline for abstract submission for presentations is November 14, 2003. Information about submitting abstracts is available at http://www.iceid.org/abssubmit.asp. Abstracts should address new, reemerging, or drug-resistant infectious diseases that affect human health. The deadline for latebreaker abstracts is January 16, 2004.

Registration information is available at http://www.iceid.org and at http://www.cdc.gov/ncidod and by e-mail at meetinginfo@asmusa.org or at dsys1@cdc.gov.