



National Injury and Violence Prevention Resource Center

Rhode Island 2013 State Fact Sheet

Unintentional injuries and violence are the leading causes of death, hospitalization, and disability for children ages 1-18. This fact sheet provides a state snapshot of data on the injury-related Maternal and Child Health Block Grant National Performance Measures and Health Status Indicators, with a special focus on disparities based on race, gender, and rural/urban residence. The fact sheet is intended to be a helpful and easy-to-use tool for needs assessments, planning, program development, and presentations.

The Children's Safety Network (CSN) National Injury and Violence Prevention Resource Center, funded by the Maternal and Child Health (MCH) Bureau, works with states to utilize a science-based, public health approach for injury and violence prevention (IVP). CSN is available to provide information and technical assistance on injury surveillance and data; needs assessments; best practices; and the design, implementation, and evaluation of programs to prevent child and adolescent injuries.

Major Causes of Injury Death

Table 1: Leading Causes and Total 5-Year Incidence of Deaths by Age Group, Rhode Island, 2006-2010

Rank	Age Groups					
	<1	1 - 4	5 - 9	10 - 14	15-19	20-24
1	Short Gestation 81	Unintentional Injury ****	Unintentional Injury ****	Unintentional Injury 12	Unintentional Injury 70	Unintentional Injury 118
2	Congenital Anomalies 59	Congenital Anomalies ****	Homicide ****	Malignant Neoplasms ****	Homicide 21	Suicide 35
3	Placenta Cord Membranes 50	Heart Disease ****	Malignant Neoplasms ****	Septicemia ****	Suicide 18	Homicide 31
4	SIDS 30	Malignant Neoplasms ****	Chronic Lower Respiratory Disease ---	Suicide ****	Malignant Neoplasms ****	Malignant Neoplasms 15
5	Maternal Pregnancy Comp. 18	Homicide ****	Congenital Anomalies ****	Benign Neoplasms ****	Influenza & Pneumonia ****	Heart Disease ****

Note. **** = indicates that the cell values range from 1-9 and are suppressed for data confidentiality purposes.

Table 2. Leading Causes and Total 5-Year Incidence of Injury Deaths by Age Group, Rhode Island, 2006-2010

Age Groups								
Rank	<1	1 - 4		5 - 9	10 - 14	15-19		20-24
1	Homicide ****	Drowning ****	Homicide ****	Homicide ****	MV Traffic ****	MV Traffic 46		MV Traffic 60
2	Fire/Burn ****	Fire/ Burn ****	Fall ****	MV Traffic ****	Drowning ****	Homicide 21		Suicide 35
3	*Five Tied ****			Suffocation ****	Suicide ****	Suicide 18		Poisoning 32
4				*Three Tied ****	*Three Tied ****	Poisoning 16		Homicide 31
5						Fire/ Burn ****	Other transport ****	Drowning ****

Note. All mechanisms of suicide and homicide were combined according to intent. Each listed mechanism is unintentional except those otherwise noted. **** = indicates that the cell values range from 1-9 and are suppressed for data confidentiality purposes. *For ages <1, five mechanisms were tied for the third ranking including Fall, Fire/Burn, Natural/environmental, Struck by/against, and Unspecified. Each of these mechanisms had fewer than 10 deaths. *For ages 5-9, three mechanisms were tied for the fourth ranking including Drowning, Fire/Burn, and Unspecified. Each of these mechanisms had fewer than 10 deaths. *For ages 10-14, three mechanisms were tied for the fourth ranking including Cut/pierce, Fire/Burn, and Poisoning. Each of these mechanisms had fewer than 10 deaths.

Major Causes of Hospital-Admitted Injuries

Table 3: Leading Causes and Annual Incidence of Hospital-Admitted Injuries by Age Group, Rhode Island Residents, 2010

Age Groups								
Rank	<1	1 - 4		5 - 9	10 - 14	15-19	20-24	
1	Fall 15	Fall 23		Fall 33	Self-Inflicted 43	Self-Inflicted 131	Self-Inflicted 112	
2	Other Specified, NEC 12	Poisoning 14	Other SPEC, NEC 14	MV Traffic *	Other SPEC, NEC *	Fall 34	MV Traffic 65	MV Traffic 72
3	Assault *	Fire/Burn *		Struck By/ Against *	Assault 12	Fall 39	Assault 62	
4	Other Natural/ Environmental *	Bites & Stings *		Cut/Pierce *	Other Specified, NEC 11	Assault 35	Fall 43	
5	Poisoning *	Struck By/ Against *		Bites & Stings *	MV Traffic *	Other Specified, NEC 25	Other Specified, NEC 18	

Note: MV = Motor Vehicle. SPEC = Specified. NEC = Not Elsewhere Classifiable. Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at the Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2013. Incidence based on 2010 data obtained from the Rhode Island Department of Health. State Inpatient Data (SID) from the Healthcare Cost and Utilization Project (HCUP) developed by the Agency for Healthcare Research and Quality (AHRQ). These injuries exclude patients who were dead at the time of discharge, readmission cases, transfers (e.g., from another short or long-term care facility, different acute care hospital), medical misadventures, and/or who suffered non-acute injuries. All counts were based on the patients' state of residence.

Table 4: Leading Causes and Total Medical Cost in Thousands (\$1,000) for Hospital-Admitted Injuries by Age Group, Rhode Island Residents, 2010

Rank	Age Groups					
	<1	1 - 4	5 - 9	10 - 14	15-19	20-24
1	Fall \$770	Fall \$466	Fall \$1,362	Self-inflicted \$1,141	MV Traffic \$2,729	MV Traffic \$3,897
2	Other Natural/ Environmental *	Other Specified, NEC \$146	Other Specified, NEC *	Fall \$907	Fall \$1,657	Transport, other *
3	Other Specified, NEC *	Unspecified *	Struck By/ Against *	Pedal cyclist, other \$799	MVT Unspecified *	Fall \$1,546
4	Unspecified *	Pedestrian *	Pedestrian *	Pedestrian *	Other Specified, NEC \$786	Self-inflicted \$1,296
5	Other Specified, NEC *	Poisoning \$141	Unspecified *	Other Specified, NEC *	Poisoning \$754	Motorcyclist \$1,112

Note: MV = Motor Vehicle. NEC = Not Elsewhere Classifiable. Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2013. Incidence based on 2010 data from the state and obtained from the XYZ State Inpatient Databases (SID), Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality (AHRQ). Costs presented are medical costs in thousands. These injuries exclude patients who were dead at the time of discharge, readmission cases, transfers (e.g., from another short or long-term care facility, different acute care hospital), medical misadventures, and/or who suffered non-acute injuries. All counts were based on the patients' state of residence.

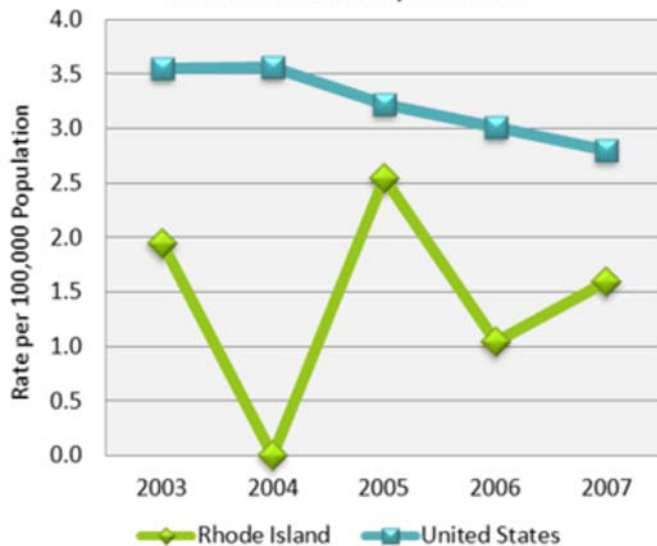
National Performance Measures

The Federal Maternal and Child Health Bureau Block Grant program requires State MCH programs to report on 18 National Performance Measures (NPM), two of which directly address injuries. NPM #10 addresses the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. NPM #16 addresses the rate (per 100,000) of suicide deaths among youths aged 15 through 19.

The following figures provide information related to NPMs #10 and #16.

NPM 10: Reducing Unintentional Motor Vehicle Deaths to Children Ages 0-14

Figure 1: Rate of Deaths Caused by Motor Vehicle Crashes, Children Aged 0 through 14, Rhode Island and US, 2003-2007



Motor vehicle-related deaths remain a major cause of death for children 14 and under. Figure 1 shows the change in the rate of state motor vehicle-related deaths compared to the US rate from 2003-2007. Overall, the rate of death per 100,000 population declined steadily across the US during this period. Figure 2 provides a breakout of the fatalities by type distinguishing motor vehicle occupant deaths (of any vehicle type) from pedestrian and pedal cyclist fatalities. This information allows states to understand which types are responsible for most of the fatalities.

Figure 3 breaks out the fatalities by race and age group. There are considerable differences between races suggesting variations in social norms, safety practices, and the presence of risk factors, including child restraint system (CRS) or safety belt usage, alcohol involved crashes, and the use of helmets. Many factors may affect this variation. Figure 4 provides a breakdown of fatalities by gender and, although there is little variability between males and females for the 10-14 age group,

there is an increasing difference in the 15-24 age group. Figure 4 suggests that the female rate decreased for 20-24 year olds compared with the 15-19 year olds while male fatalities increased for 20-24 year olds.

Figure 2: Percentage Distribution of Motor Vehicle Fatalities by Type, Children Aged 0 through 14, Rhode Island, 2003-2007

57% of children ages 0 through 14 involved in a motor vehicle fatality were occupants of the vehicle.

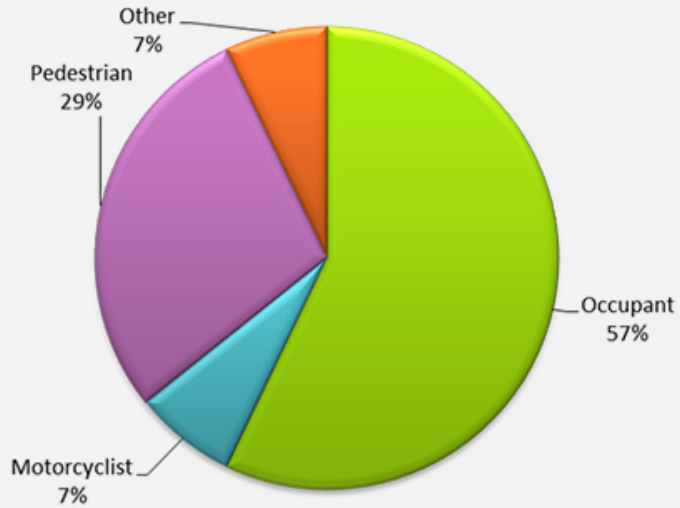


Figure 3: Motor Vehicle Traffic Fatality Rates by Race, Children and Youths Aged 0 through 24, Rhode Island, 2003-2007

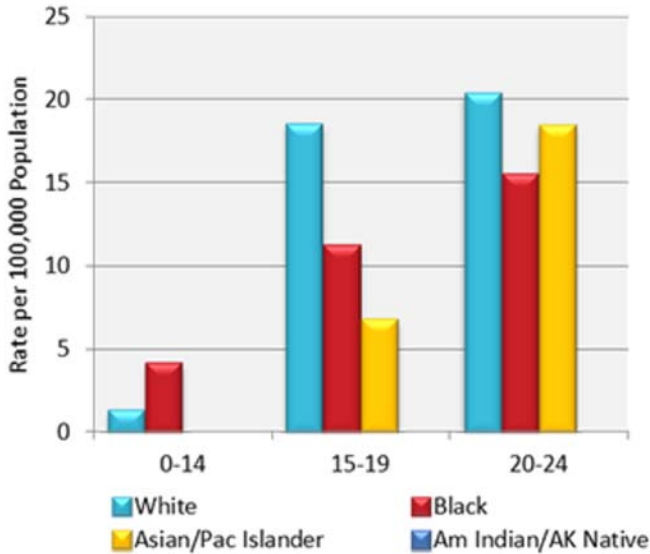
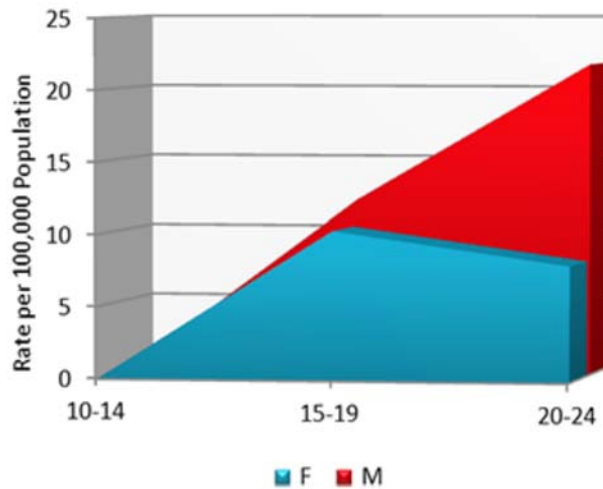


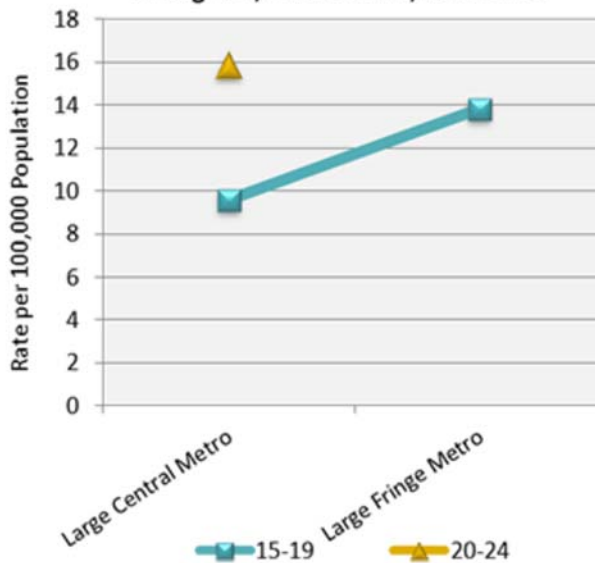
Figure 4: Motor Vehicle Traffic Fatality Rates by Gender, Children and Youths Aged 10 through 24, Rhode Island, 2006-2010



One way of understanding disparities is to look at the rate of injuries by place of occurrence. To show this, CSN has provided the rates for the 15-19 and 20-24 age groups using the urban-rural classification system developed by the National Center for Health Statistics (NCHS). To show how injury rates vary by level of urbanization, a [table based on the classification system can be found here](#) and defines six levels of urbanization: large central metro, large fringe metro, medium metro, small metro, micropolitan, and noncore. Figure 5 shows how the rate varies by age group by place of occurrence/urban-rural setting. This information allows the state to better understand any disparity that may occur between the different settings. Data are provided only for those areas in which 20 or more deaths occurred.

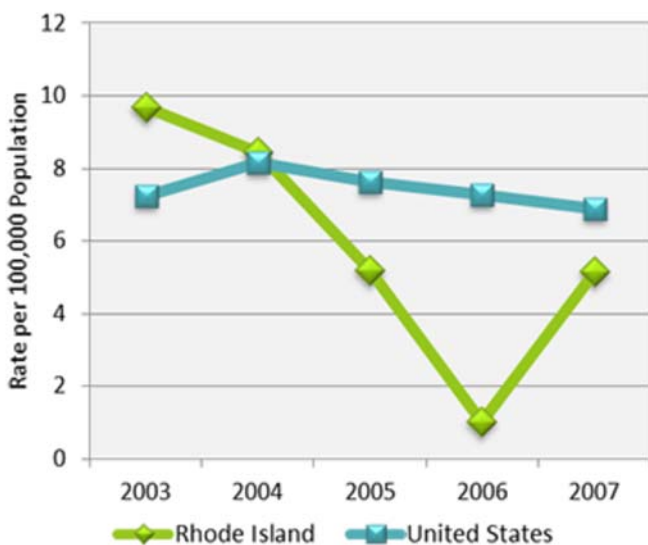
Many of these motor vehicle related deaths can be prevented through the implementation of a broad range of evidence-informed interventions and programs. These data are intended to provide a broad overview of the magnitude of the problem and to highlight possible disparities which may exist by race, gender, and urbanicity.

Figure 5: Motor Vehicle Traffic Fatality Rates by Urbanicity, Children and Youths Aged 15 through 24, Rhode Island, 2006-2010



NPM 16: Reducing Suicide Deaths Among Teens Ages 15-19

Figure 6: Rate of Suicide Deaths, Youths Aged 15 through 19, Rhode Island and US, 2003-2007



Suicide is the 4th leading cause of death and the 3rd leading cause of injury-related death among US youth 10-24 years of age. According to the 2011 Youth Risk Behavior Surveillance Survey (YRBSS), 15.8% of students seriously considered attempting suicide and 7.8% of students attempted suicide one or more times in the 12 months prior to the survey. Although progress has been made over the past decade in reducing the rate of completed suicides nationally, this reduction has leveled off in the last few years. The following figures provide state-specific data related to suicide. Figure 6 shows the state rate from 2003-2007 for 15-19 year olds in comparison to the US rate for the same age group and time period. Figure 7 provides information on the means used by the 15-19 year olds for completed suicides. It is important to note that the actual number of suicides is often quite small thus resulting in considerable variation when looking at year to year rates.



Figure 7: Percentage Distribution of Completed Suicides by Means, Youths Aged 15 through 19, Rhode Island, 2003-2007

67% of youth ages 15 through 19 completed suicide by using suffocation.

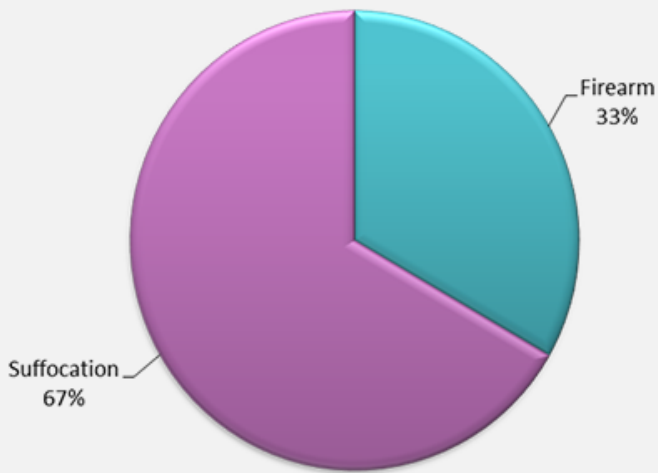


Figure 8: Percentage of High School-Aged Children with Suicide Ideation, Rhode Island and US, 2003-2011

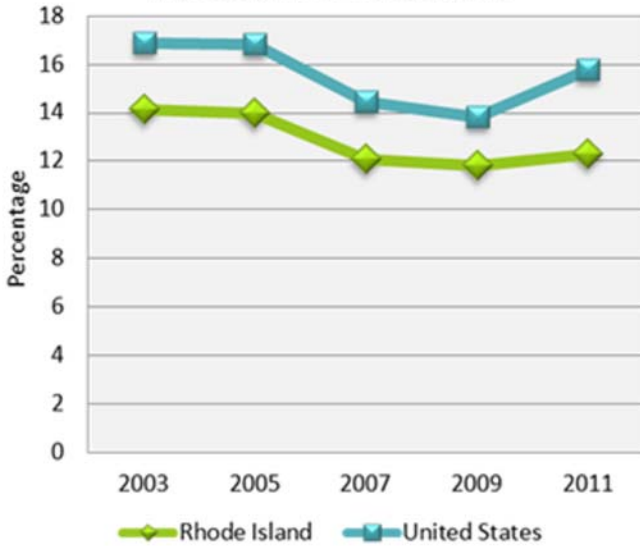


Figure 9: Percentage of High School-Aged Children Treated for Suicide Attempt, Rhode Island and US, 2003-2011

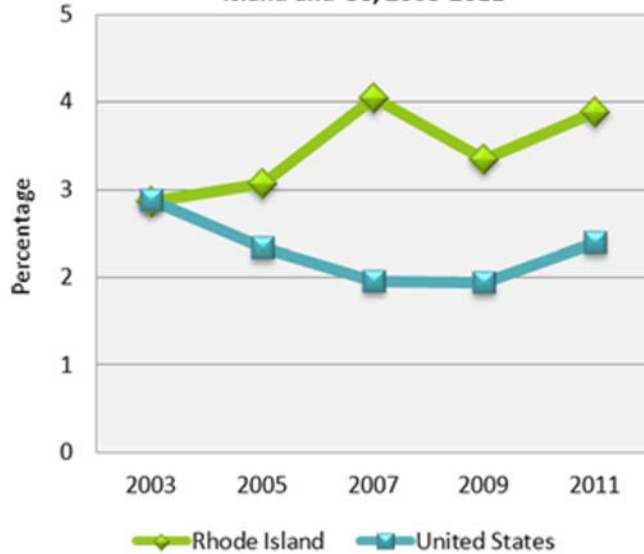


Figure 10: Rate of Completed Suicides by Race, Youths Aged 15 through 24, Rhode Island, 2003-2007

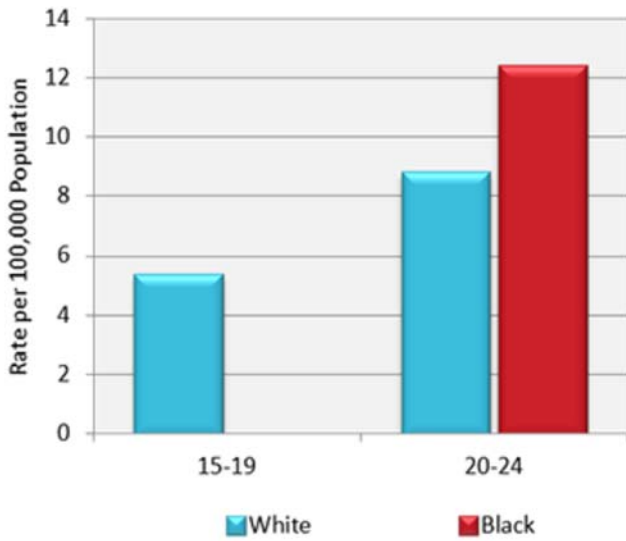
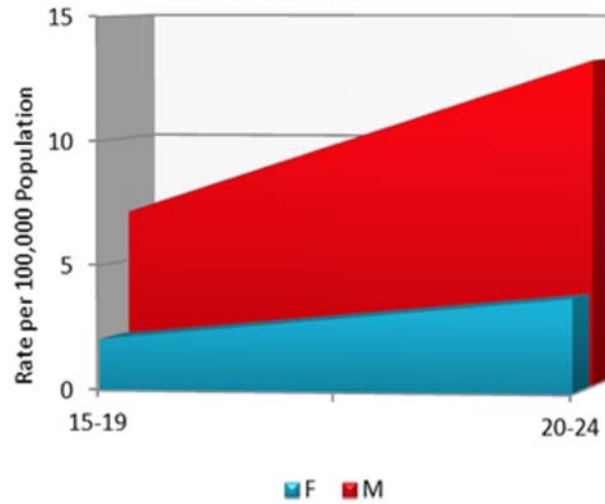


Figure 11: Rate of Completed Suicides by Gender among Youths Aged 15 through 24, Rhode Island, 2003-2007



Data for Figure 12: Rate of Completed Suicides by Urbanicity is not available.

The YRBSS provides information about behaviors that contribute to unintentional and intentional violence among youth. Figures 8 and 9 provide information on the percentage of high school students with suicide ideation and the percentage who reported being medically treated for a suicide attempt from 2003-2011, respectively. This information and other information available in the YRBSS can help states understand how behaviors are changing within this age group.

Figure 10 shows how the rate differs by race for 15-19 and 20-24 year olds from 2003-2007. Figure 11 shows the difference by gender for the same age group and time period with the male rate for both age groups exceeding the female rate.

IVP Health Status Indicators

The Maternal and Child Health Bureau requires every state to report on 12 Health Status Indicators. Six of the indicators are related to IVP. The two figures below reflect the data reported for the IVP Health Status Indicators by the state in their Maternal and Child Health Block Grant Application Form 17, 2012.

Figure 13: Nonfatal Injury Health Status Indicators, Rhode Island, 2007-2011

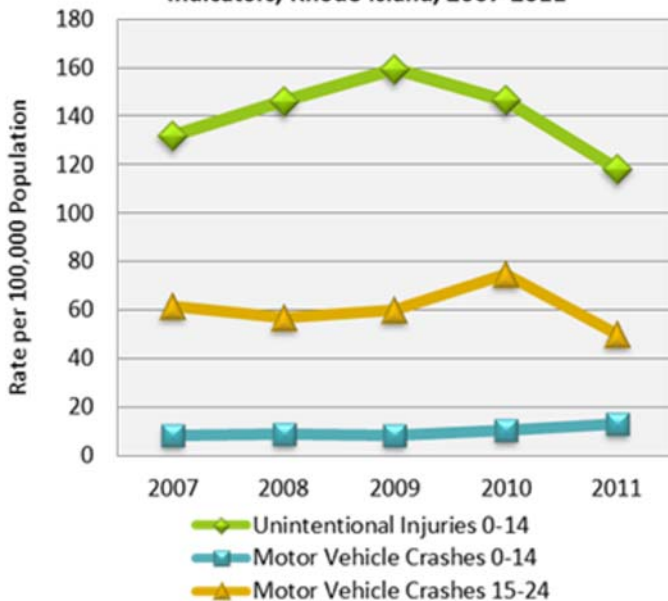
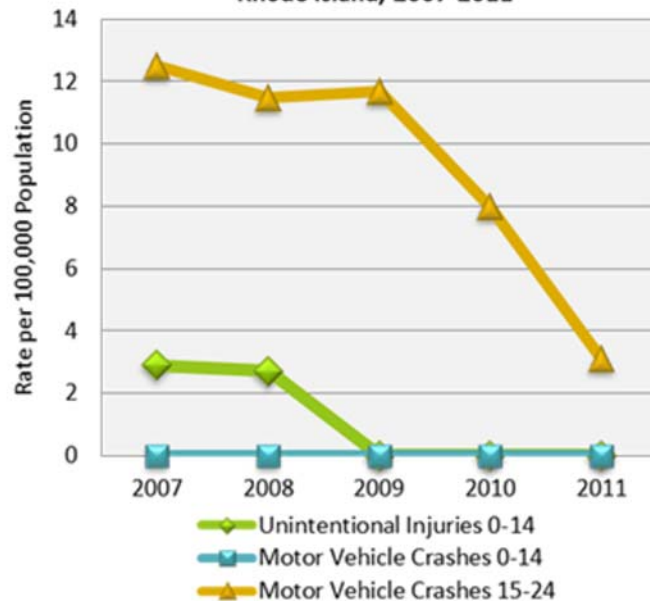


Figure 14: Fatal Injury Health Status Indicators, Rhode Island, 2007-2011



State Specific Performance Measures and Priority Needs

Each state develops up to 7 – 10 State Performance Measures and priority needs. The following provides information about the states' selected 2013 injury-related performance measures and priority needs.

Rhode Island has the following injury-related State Performance Measures:

- Increase the percent of Rhode Island resident families with at risk newborns that receive a home visit during the newborn period (<=90 days).
- Reduce the percent of high school students with special needs who report feeling sad or hopeless.
- Increase the percent of parents with children in early childhood that enroll in evidence-based parenting education/support programs.

Rhode Island has the following injury-related Priority Needs:

- Increase access and capacity to evidence-based parent education and family support programs.
- Promote health and wellness by decreasing the percentage of high school students with disabilities who report feeling sad or hopeless.

State Contact Information

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EMSC Contact (Interim): Thomas Kilday, thomas.kilday@health.ri.gov

CDR Coordinator: Anne Marie Silvia, asilvia@jsi.com

State Fact Sheets Figure & Table Source Data

Table 1 Source: [WISQARS Leading Causes of Death Reports, 2006-2010](#)

Table 2 Source: National Center for Health Statistics, Multiple Cause of Death Data, 2006-2010

Table 3 Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2013.

Table 4 Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2013.

Figure 1 Source: [WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007](#)

Figure 2 Source: [WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007](#)

Figure 3 Source: [WISQARS Injury Mortality Reports, 2006-2010](#)

Figure 4 Source: [WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007](#)

Figure 5 Source: [CDC WONDER Multiple Cause of Death data, 2006-2010 and Urban-Rural Definition Classification System](#)

The classification scheme can be found at: <http://wonder.cdc.gov/wonder/help/CMF/Urbanization-Methodology.html>. 2006 NCHS Urban-Rural Classification Scheme for Counties, by Deborah D. Ingram and Sheila Franco.

Figure 6 Source: [WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007](#)

Figure 7 Source: [WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007](#)

Figures 8 & 9 Source: [Youth Online: High School Youth Risk Behavior Survey \(YRBS\), 2003-2011](#)

Figure 10 Source: [WISQARS Injury Mortality Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007](#)

Figure 11 Source: [WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007](#)

Figure 12 Source: [CDC WONDER Multiple Cause of Death data, 2006-2010 and Urban-Rural Definition Classification System](#)

Figures 13 & 14 Source: [HRSA, Title V Information System Multi-Year Report](#). Some states may have changed their method of calculation.

About Children's Safety Network

The Children's Safety Network (CSN) National Injury and Violence Prevention Resource Center, funded by the Maternal and Child Health (MCH) Bureau, works with states to utilize a science-based, public health approach for injury and violence prevention (IVP). CSN is available to provide information and technical assistance on injury surveillance and data; needs assessments; best practices; and the design, implementation, and evaluation of programs to prevent child and adolescent injuries.

In this fact sheet CSN provides a cursory review of the injury morbidity and mortality data available for the state. The figures and tables in this fact sheet can help you understand the state's progress in addressing motor vehicle traffic injuries and suicide. To target and address these and other injury issues, it is critical to understand this data. CSN can assist you in conducting detailed data analyses, utilizing surveillance systems, and undertaking needs assessments. For assistance, contact the Children's Safety Network at csninfo@edc.org.

Connect with the Children's Safety Network

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CSN's website: <http://www.ChildrensSafetyNetwork.org>

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Need TA? Have Questions? E-mail: csninfo@edc.org

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