RHODE ISLAND'S HEALTH ASSESSMENT AND HEALTH IMPROVEMENT PLAN

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DIRECTOR

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THIS DOCUMENT IS THE RESULT OF A STATEWIDE COLLABORATION… PLEASE USE IT TO LEARN MORE ABOUT WHAT YOUR HEALTH DEPARTMENT IS DOING TO PROMOTE HEALTH, PREVENT DISEASE AND PROTECT THE PUBLIC.

FROM THE DIRECTOR

Dear Colleagues,

The role of the Department of Health is to protect the health and safety of Rhode Islanders. We do this in many ways, and because of our hard-working staff and the close collaboration of our partners, including healthcare professionals, community organizations, advocates, and parents, we are often considered national leaders.

One of the most important aspects of our mission is to maintain accurate data about disease and injury. Accurate data assists us in identifying both problems and opportunities for improving. It also allows us to compare ourselves with other states in order to provide optimal health for all Rhode Islanders. A critical component of this process is hearing from you, what you see as our state's health priorities, and how we can work together to make our cities, towns and neighborhoods healthier places to live, work, and learn.

This document is the result of a statewide collaboration and includes selected qualitative and quantitative data from a variety of sources and partners. Please use it to learn more about what your Health Department is doing to promote health, prevent disease and protect the public. Together we can foster healthier environments in Rhode Island.

I thank all of our partners who made this assessment possible through their hard work and ongoing support, as we work together to make Rhode Island the healthiest state in the nation.

Michael Fine, MD
Director of Health

MISSION

PREVENT DISEASE AND PROTECT AND PROMOTE THE HEALTH AND SAFETY OF THE PEOPLE OF RHODE ISLAND

VISION

EVERY RHODE ISLANDER SHOULD HAVE ACCESS TO HIGH QUALITY, AFFORDABLE HEALTHCARE DELIVERED AT THE MOST APPROPRIATE TIME AND PLACE. ALL PEOPLE IN RHODE ISLAND WILL HAVE THE OPPORTUNITY TO LIVE A SAFE AND HEALTHY LIFE IN A SAFE AND HEALTHY COMMUNITY.

VALUES

ADVOCACY
COLLABORATION
INTEGRITY

ABOUT THE DEPARTMENT OF HEALTH

Location and Population Served

The Rhode Island Department of Health (HEALTH) is located at Three Capitol Hill in the City of Providence, Rhode Island, within Providence County. In Rhode Island, county government was abolished in 1842 and today remains only for the purpose of delineating judicial administrative boundaries.

According to the 2010 U.S. Census data, the current population of Rhode Island is 1,050,567, with 86.3% of inhabitants being of white or Caucasian origin. There are no local public health agencies in Rhode Island; all public health services are managed by one centralized state-run health department.

Mission, Vision and Values

Mission: Prevent disease and protect and promote the health and safety of the people of Rhode Island

Vision: Every Rhode Islander should have access to high quality, affordable healthcare delivered at the most appropriate time and place. All people in Rhode Island will have the opportunity to live a safe and healthy life in a safe and healthy community.

Values: Advocacy, collaboration, integrity

To meet the community's expectations for high-quality, affordable healthcare, the delivery system must:

- Deliver healthcare according to the latest scientific evidence, using current evidence-based guidelines whenever available.
- Improve the quality, efficiency, and accessibility of healthcare services.
- Improve affordability by ensuring efficient utilization of healthcare providers and services.
- Partner with the consumer in his/her healthcare.
- Orient the system toward person-centered care, with family involvement as appropriate.
- Respond to the healthcare needs of the community with cultural and linguistic competency.
- Improve the health status of the population.

Governance

HEALTH falls under the oversight of the Executive Office of Health and Human Services (EOHHS). EOHHS was created in December 2005 to facilitate cooperation and coordination among the state departments that administer Rhode Island's health and social services programs.

Other agencies joined by HEALTH under the EOHHS umbrella include: Department of Children, Youth, and Families (DCYF), Department of Human Services (DHS), Division of Elderly Affairs (DEA), Division of Veteran Affairs (VA), and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). These departments collectively affect the lives of virtually all Rhode Islanders, providing direct services and benefits to more than 300,000 citizens while working to protect the overall health, safety, and independence of all Rhode Islanders.

Michael Fine, MD, has served as Director of Health since July of 2011. In this role, Dr. Fine oversees the single state agency's work that involves more than 400 employees across a broad range of public health programs and services with an annual operating budget of $110 million.


Organizational Structure

HEALTH is led by the Director and an Executive Committee. As Rhode Island has no local health departments, the agency's divisions and centers coordinate public health activities across the state, involving a wide variety of programs and services (see Organizational Chart in Appendix 1). Main areas of responsibility include:

1. Community, Family Health, & Equity: Works to eliminate disparities in health and access to care, to ensure healthy homes and environments, to prevent and control diseases and disability, to promote health and wellness activities, and to support early childhood development.

2. Center for Emergency Preparedness & Response: Protects health during catastrophic events and large-scale disasters and emergencies by coordinating education, assessment, planning, response, and support services with healthcare providers, public safety agencies, and government officials.

3. Environmental Health Services Regulation: Licenses and regulates health professionals, facilities, and health plans; monitors the safety of public drinking water and beaches; and ensures the safety of the food supply and of radiological equipment.

4. Center for Health Data & Analysis: Collects and analyzes health data about Rhode Islanders and uses the data to identify health problems among the state's population and groups.

5. Health Information Technology: Promotes and supports the use of health information technology across the state, including electronic medical records, the use of an electronic prescription monitoring system, and the development of a statewide health information exchange.

6. State Health Laboratories: Provides analytical surveillance, prevention, and technical laboratory information to support disease surveillance, prevention, and control; environmental health protection; food safety; and emergency response activities.

7. Infectious Disease & Epidemiology: Monitors the prevalence of diseases in the community and investigates, controls, and prevent outbreaks.

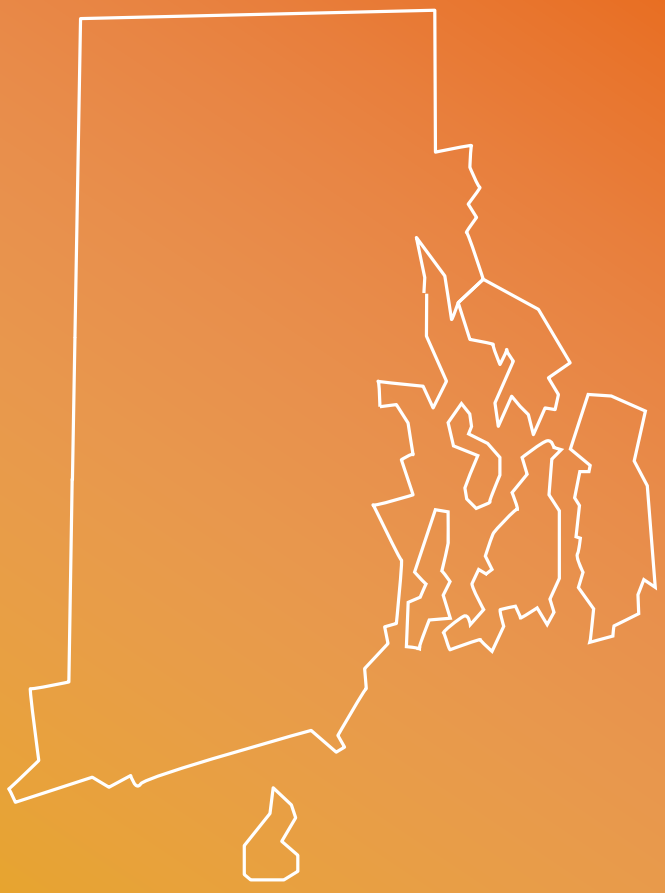
8. Management Services: Manages and delivers efficient personnel, purchasing, finance, and systems support services.

9. Office of State Medical Examiners: Screens deaths for public health significance and determines the cause and manner of deaths.

10. Center for Public Health Communication: Provides high-quality, timely, and accurate health information for the public so they can understand health risks and make healthy and safe choices.

11. Vital Records: Registers, files, and maintains birth, death, and marriage certificates and publishes related data.

THE SMALLEST IN LAND MASS IN THE UNITED STATES, RHODE ISLAND IS THE SECOND MOST DENSELY POPULATED STATE



ABOUT THE STATE OF RHODE ISLAND

The State of Rhode Island and Providence Plantations—usually referred to as Rhode Island and often called the "Ocean State"— is a small and unique state. Although it is the smallest in land mass among the United States, Rhode Island is the second most densely populated state. (Overall, the vast majority of Rhode Islanders are adults ages 18 and older). However, in the last 10 years, Rhode Island has seen a decrease in people 65 years of age and older and an increase in the number of children less than five years of age.

Rhode Island is becoming more diverse, as seen by the white, non-Hispanic population declining by 6% between 2000 and 2010, similar to other states in the Northeast such as Connecticut, Massachusetts, New Jersey, New York, and Pennsylvania[1]. Nonetheless, the majority of the population remains white, non-Hispanic (76.8% compared to 64.2% for the United States overall), with an estimated 0.9% of inhabitants identifying as American Indian and Alaskan Native, according to the U.S Census Bureau.

Ethnic Composition of Rhode Island Population

Group	Population
Non-Hispanic/Latino	911,654 (85.9%)
Hispanic/Latino	138,638 (13.2%)
TOTAL	1,050,567 (100%)

Source: US Census Bureau 2012

Table 1. Ethnic composition of Rhode Island

The minority population in Rhode Island experienced an overall increase of 31.1% between 2000 and 2010. This has been due in part to a 43.9% increase in the Hispanic and Latino population, now the largest minority ethnic group in Rhode Island comprising 13.2% of inhabitants. Persons of Puerto Rican origin are most represented in the Latino/Hispanic population, followed by Dominicans and Colombians. African Americans make up 7.3% of the population and are the next largest minority group. Seventy-nine percent of the state's population speaks only English at home.

Rhode Island is divided into 39 municipalities that oversee local governance and administration. The cities of Providence and Warwick are the two most populated municipalities in Rhode Island. West Greenwich, Richmond, Charlestown, and New Shoreham are experiencing the greatest percentage of population growth (more than 30%) [2].

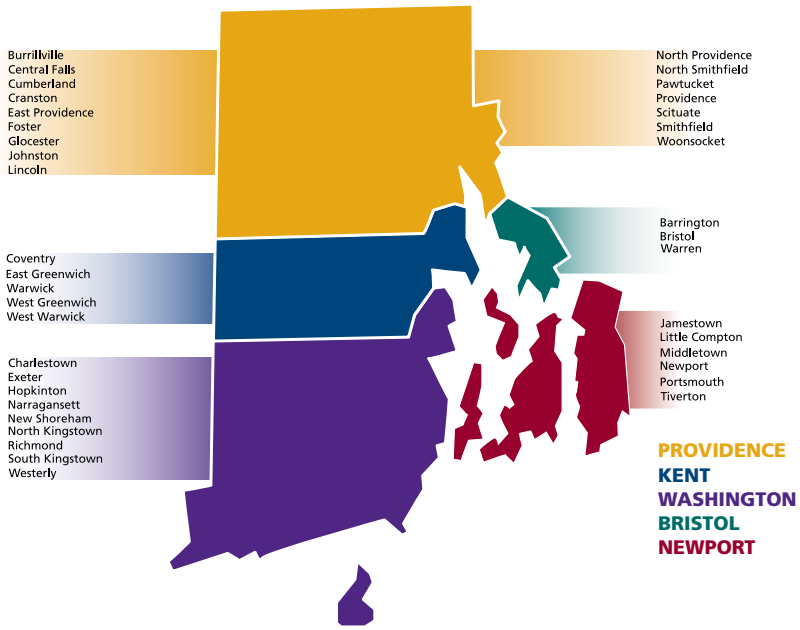


Figure 1. Map of Rhode Island's five counties

All businesses and municipal affairs are managed by state offices and/or municipalities. Although Rhode Island has five counties, this governmental structure primarily serves the organizational structure of the judicial. The Rhode Island General Assembly, the state's legislature, consists of a 75-member House of Representatives and a 38-member Senate.

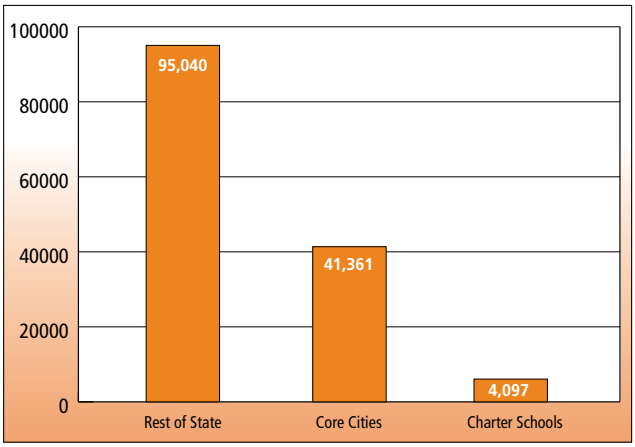
Education

A total of 142,481 students were enrolled in Rhode Island public schools from preschool through grade 12 as of October 2012, with an additional 21,568 students enrolled in private schools. For public schools, this marked a 9.9% decrease from the previous year [3].

Of the total student population, the majority (62%) were white non-Hispanics, followed by Hispanics (23%). However, within the core cities, white non-Hispanic students only made up 20% of the student populations, while Hispanics made up 53% [3].

Overall, Rhode Islanders finish high school and have bachelor's degrees or higher at a similar level as that of the United States, according to the 2010 U.S Census Bureau. Two-thirds of Rhode Island seniors who graduated from high school in 2008 matriculated at a two- or four-year college, which is higher than the national average [1].

STUDENTS ENROLLED BY TYPE



Source: Rhode Island Department of Elementary and Secondary Education, October 2010

Figure 2. School enrollment by school type.

Rhode Island High School Graduation Rates	RI	US
Adults 25 or older with high school diploma	84.3%	85.4%
Adults 25 or older with bachelor's degree or higher	30.6%	28.2%

Source: US Census Bureau 2012

Table 2. Percent of Rhode Island adults with high school and college diplomas

According to the Rhode Island Department of Elementary and Secondary Education, black and Hispanic students show less student engagement than their white and Asian classmates. Likewise, male students are less engaged than their female classmates, and older students (ages 12-17) are less engaged than younger ones (ages 6-11) [4].

For the school year 2011-2012, more than half of the student population in elementary schools (54% of the 12,924 students) participated in organized after-school activities, specifically those organized by the 21st Century Community Learning Centers. This number decreased with older students, with only a third of the middle school student population (30%) partaking in such activities and even less participation (16%) by those in high school. (The federal 21st Century Community Learning Centers serve students attending high poverty, low-performing schools.)

The majority of public school students (pre-kindergarten through grade 12) who received bilingual education services, deemed as "English Language Learners (ELL)" are from core cities. For example, during the 2011-2012 school year, 6% of the total public school population were ELL students; and 76% of the population resided within the core cities. While the ELL students spoke 84 different languages, the vast majority (75%) spoke Spanish. Both nationally and within Rhode Island, ELL students scored significantly lower on standardized exams than their classmates [5].

As of the 2010-2011 school year, there were 24,836 children (18% of all K-12 students) enrolled in special education, but fewer students with disabilities (58%) graduated as compared to the students without disabilities (82%).

ECONOMY

Rhode Island was ranked as the 15th richest state in the United States, with 12% of the population below the poverty line as of 2011 [6].

As of 2000, the eligible labor force made up 64.6% of the state population (ages 16 and over). As of June 2013, the unemployment rate reached 8.9% and was one of the highest in the United States. Rhode Island's unemployment rate peaked in December 2006, a full year before America hit its peak [6]. Rhode Island ended 2011 with unemployment rates increasing during November and December, according to the Department of Labor and Training. During that time, 600 jobs were lost. The state's total labor workforce totaled 558,500 at the end of 2013.

With one in 10 jobs in Rhode Island related to real estate or construction, the production of homes has been at a dramatic low. In Rhode Island, four out of five homes were built prior to 1940, when lead paint was allowed [7]. Over time, weather conditions cause homes to deteriorate. Subsequently, lead paint chipping and cracking from old windows and doors exposes young children to unhealthy amounts of lead, causing lead poisoning. Despite the Lead Poisoning Prevention Law passed in 1991 and the federal funding that the state has received through the years for housing lead repairs, children are still exposed to lead. In 2012 alone, 180 children had an elevated blood lead level (greater than or equal to 10 mcg/dL) for the first time in their lives [8].

As of 2011, the median family income for Rhode Island for a family of four was $88,593, slightly higher than the national median household income [9].

Income Level 2009

Family Size	Median Income
1	$46,136
2	$58,511
3	$72,184
4	$88,593

Source: WPRI 2011

Table 3. Median family income for a Rhode Island family

Between 2007 and 2009, 7% of the Rhode Island youth population (ages 16 to 19) were not in school but were working. Proportionately, Native Americans were the dominant racial/ethnic group of the youth population who were working instead of attending school (15%). Overall, Hispanics represented the largest number of youth working, and the lowest high school graduation rates. [10].

The Asian population had the lowest unemployment rate when compared to the remaining minority groups. Compared to the non-Hispanic white population, all minorities had a higher percentage of their populations living in poverty [10].

Rhode Island's economy is made up of the healthcare, financial services, marine products, defense, and manufacturing sectors. The largest industry in Rhode Island is health services, followed by manufacturing. The largest employer as of March 2011 in Rhode Island was the State of Rhode Island, followed by Lifespan hospital group (Rhode Island Hospital, The Miriam Hospital, Newport Hospital) and nine other hospitals [11]. The state is also known as a center for higher education, being the home of Brown University, the University of Rhode Island, Johnson and Wales, and more.

Rhode Island Economy	
Industry Sector	**Size (%)**
Educational Services and Healthcare	26
Retail Trade	12.8
Manufacturing	11.6
Arts & Entertainment	11

Source: Commerce RI (2011)

Table 4. Industries that make up Rhode Island economy

The state and municipal governments within Rhode Island are struggling with revenue shortfalls, funding cuts, and increasing education and pension bills [12]. Rhode Island is ranked the third worst state in the country to retire due to fiscal health, property taxes, income taxes, cost of living, and climate [13]. The state has severely underfunded pensions/health liabilities and budget deficits, and one of the highest property tax rates.

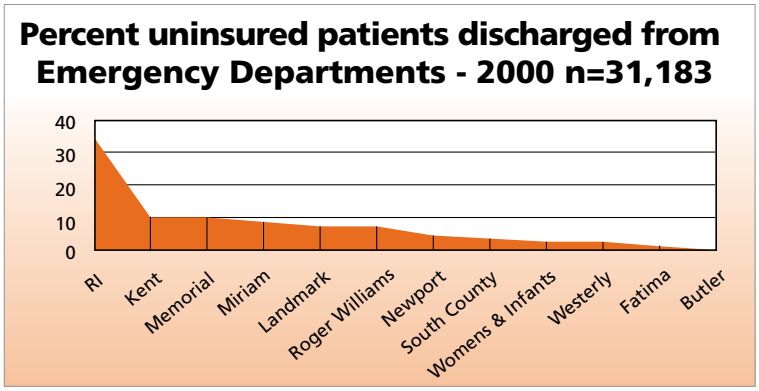
Health

There are 11 acute-care hospitals, including the regional perinatal center (Women & Infants Hospital) and three specialty hospitals (Butler, Bradley and Rhode Island Rehabilitation). There were 10 community health centers with 29 sites throughout the state that served more than 123,095 patients in 2011, including almost 38,225 of Latino descent [2].

In Rhode Island, adults 18 years of age or older account for 78% of the total population . The state sees about 12,000 deaths per year and more than 11,000 births. Lack of medical insurance continues to be a challenge for the state, although with the expansion of RIte Care (i.e., Rhode Island's Medicaid managed care program), more women now receive adequate prenatal care. Nonetheless, 10% of adults ages 18-64 and 7.7% of children younger than age 18 are uninsured. In 2010, 31,183 uninsured patients were seen and discharged from a hospital emergency department [14].

Oral Health

Good oral health is critical to an individual's overall health and well-being. Although the oral health status has improved for many Rhode Islanders in the past decade, oral diseases still cause pain and disability for children and adults each year. Dental decay is a significant public health problem for Rhode Island's pre-school and school-age children; 30% of children age 3–5 in Head Start and half of third grade children have decay experience (cavities and/or fillings). From 2006-2010, 30,911 hospital Emergency Department (ED) visits in Rhode Island were associated with tooth decay, tooth decay originated-inflammatory pulp/periapical lesions, or toothache. These preventable oral health conditions were more frequently reported by Medicaid-enrolled and uninsured adults. Obtaining oral healthcare is a persistently challenging issue for certain Rhode Island



Source: Rhode Island Department of Health, Emergency Departments, 2010

Figure 3. Uninsured patients seen by hospitals' Emergency Departments.

populations – children and families with low-income, those of racial and ethnic minorities, pregnant women, individuals with special healthcare needs, and the elderly. Because of separation or exclusion of dental benefits from medical insurance, more than a quarter of Rhode Island adults ages 18–64, and six out of ten older adults (65 years and older) do not have any dental insurance. Rhode Island adults with no dental coverage report a lower utilization of dental services.

Obesity

In Rhode Island, 61% of adults were reported as overweight based on height and weight, and 24% were identified as being obese. Men are more likely to be overweight than women, and non-Hispanic African American men have the highest prevalence of being overweight or obese. Asians and Pacific Islanders have the lowest overweight and obesity rates, with rates lower than the state overall [15].

The majority of women with less than $49,999 income were noted as obese or overweight, but as income increased, this was less common. For men, 70% at every income level were noted as obese, and there were no significant trends as this income level increased or decreased [15].

Infant Mortality

Rhode Island's small population (and relatively small number of infant deaths) results in infant mortality rates that fluctuate from year to year. Although infant mortality rates declined during the 1970s and 1980s, and reached a low in 1994 of 5.0 (the lowest in the country that year), progress has slowed. Although Rhode Island has experienced rates below 6.0 in 1994 (5.0), 1996 (5.2), 1999 (5.7) and 2004 (5.3 provisional), the annual fluctuations make it difficult to predict whether Rhode Island will achieve and maintain the Healthy People 2010 objective of 4.5. Provisional data indicate that during 2012, there were 71 infant deaths among 10,854 live births resulting in an infant mortality rate of 6.5 per 1,000 live births. This rate is higher than the Healthy People 2020 target of 6.0 per 1,000.

One of the factors contributing to the lack of improvement in the infant mortality rate in Rhode Island over the past decade may be the rise in the number of infants born at low birthweight. During 2008-2012, low birthweight (less than 2,500 grams) was associated with 272 (75.3%) of the 361 infant deaths in that period. Although very low birthweight infants (less than 1,500 grams) account for only one percent of all births in Rhode Island, they comprise two-thirds (67.0%) of all infant deaths in the state. Infants born less than 500 grams comprise one-third (41.3%) of all infant deaths.

Infants who died within 28 days of birth (neonatal mortality) accounted for 270 (74.8%) of the 361 infant deaths during 2008-2012. During this period, the neonatal mortality rates fluctuated from 4.4 per 1,000 live births to 5.3 per 1,000 with a five-year average of 4.8 per 1,000. Infant deaths that occur between 28-365 days represent postneonatal mortality. During 2008-2012, the average postneonatal mortality rate was 1.6 per 1,000. Neonatal mortality can be an indicator of access to prenatal and perinatal care and postneonatal mortality can be an indicator of access to pediatric care.

Low Birthweight

During the 1990s, Rhode Island saw a rise in the percentage of babies born at low birthweight (less than 2,500 grams or 5.5 lbs). In 1991, babies born at low birthweights accounted for 5.9% of all births and by 2003, they accounted for 8.6% of all births. Provisional data indicate that in 2012, the low birthweight rate was 8.0%. Specifically, of the 10,854 births among Rhode Island residents, 186 (1.7%) weighed less than 1,500 grams and 684 (6.63%) weighed between 1,500 and 2,499 grams. Based on these 2012 data, Rhode Island's low birthweight and very low birthweight rates are higher than the Healthy People 2020 targets of 7.8% and 1.4%, respectively.

The rate of low birthweight vary by race and ethnicity and during 2008-2012, Native Americans (11.9%), Black/African Americans (11.2%), and Asians (9.5%) had the highest rates of low birthweight compared to Whites (7.1%) and those of Hispanic ethnicity (7.8%). The statewide low birthweight rate during this period was 7.8%.

Preterm Births

Mirroring the trend of low birthweight, the percentage of babies born prior to 37 weeks gestation (preterm) has been rising in Rhode Island and in the nation. Preterm birth is the leading cause of infant mortality in Rhode Island; and nationally, it is the second leading cause after birth defects. Babies born prematurely are more likely to have complications such as breathing/lung problems, heart problems, anemia, jaundice, or infections. Although not all risk factors for preterm delivery are known, those that have been identified include multiple gestation pregnancy (twins, triplets or more), previous history of preterm delivery, maternal age, infections, diabetes, certain birth defects and assisted reproductive technology.

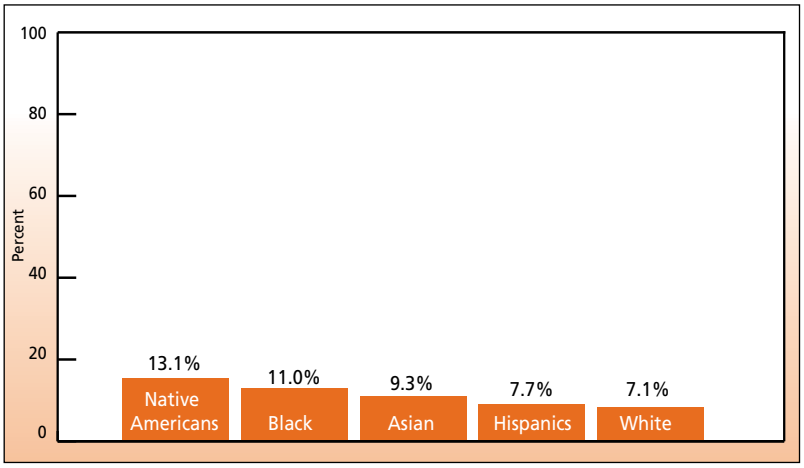
Between 1995 and 2007, the percentage of preterm births rose among Rhode Island residents from 9.2% to 12.5%, a 35.9% increase. Since 2007, the rates have declined and provisional data indicate that during 2012, of the 10,854 births, 1,183 (10.9%) were born preterm. This rate is lower than the Healthy People 2020 target of 11.4%.

Prenatal Care

During 2008-2012, the percentage of Rhode Island women who received prenatal care in the first trimester rose from 81.9% in 2008 to 87.9% in 2012. The average rate for the five-year period was 85.8%. These rates surpass the Healthy People 2020 target of 77.9%. Although the majority of pregnant women in Rhode Island receive prenatal care in the first trimester, there are disparities among racial/ethnic groups. Black/African Americans (74.7%) had the lowest rate of first trimester prenatal care, followed by Native Americans (76.6%), those of Hispanic ethnicity (77.6%) and Asians (77.9%).

Pediatric Health

The health of Rhode Island children remains a concern. Nearly one in six children (15.5%) entering kindergarten during the 2011-2012 school year were obese. From 2007-2011, 7.9% of total births in Rhode Island were low birthweight babies, and the majority were born to minority women (see Table 5). Infants were still dying at higher rates before age one. From the 376 infant deaths, 77% were low birthweight [16].



Source: Rhode Island Department of Health, Maternal and Child Health database

Table 5. Infants born with low birthweight in Rhode Island by mother's race

Overall, whites and the general state population have better maternal and child health outcomes than the racial and ethnic minority populations. Native Americans have the highest birth rates and the highest number of infants with low birthweight. Among all racial and ethnic groups, African Americans have the highest rate of infant mortality [16].

Teenage Health Risks

Health-compromising behaviors adopted during adolescence often translate into poor health status later in adulthood, so early recognition and interventions are critical to improving the public's health. This section examines 15 risk factors from the Youth Risk Behavior Surveys (YRBS) of Rhode Island high schoolers. All the measures are unfavorable indicators, so lower/declining values are preferred.

Improving Measures:

Eight measures improved significantly from 2007 to 2013:

- Alcohol consumption fell from 43% to 31%.
- Students not wearing seat belts fell from 14% to 6%.
- Sexually active students fell from 33% to 27%.
- Occasional smoking decreased from 15% to 8%.
- Daily smoking decreased from 12% to 6%.
- The use of any tobacco product fell from 22% to 15%. [Boys are more likely to use tobacco than girls (18% vs. 12%).]
- Physical fighting decreased from 26% to 19%. [Boys fight more than girls (23% vs. 14%).]
- Dating violence decreased from 14% to 8%.

Worsening Measures:

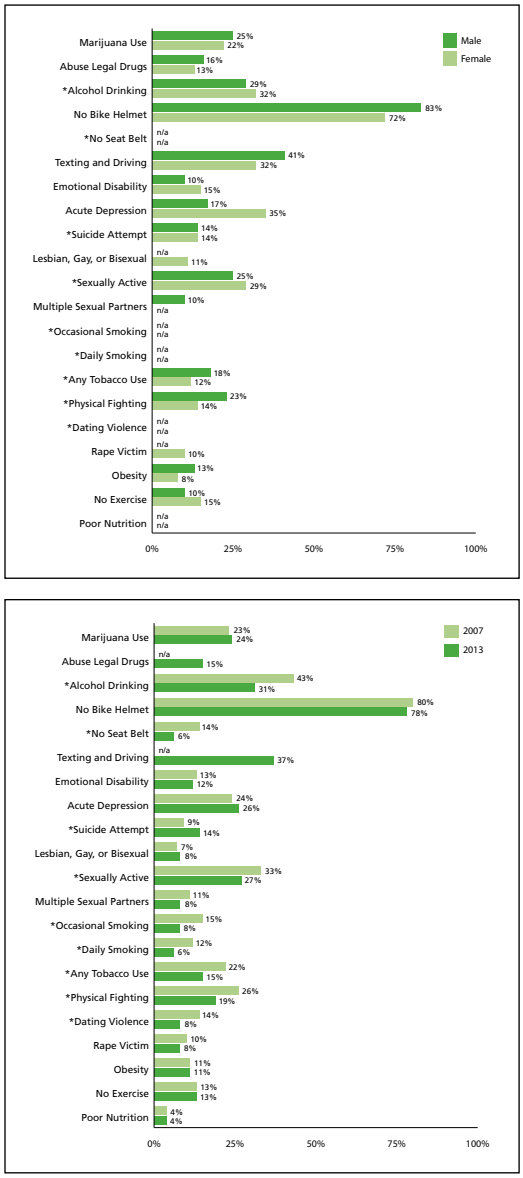
One measure worsened significantly from 2007 to 2013:

- Students attempting suicide increased from 9% to 14%.

Other Measures:

Six measures were not significantly different from 2007 to 2013:

- 24% of students use marijuana.
- One in four (26%) high schoolers is acutely depressed, and more girls suffer from depression than boys (35% vs. 17%).
- 8% of high schoolers were victims of forced sexual intercourse.
- 11% of students are obese, and more boys are obese than girls (13% vs. 8%).
- 13% of students are not physically active and get no exercise.
- 4% of students have poor nutrition and don't eat fruits or vegetables.



Source: RI Youth Risk Behavior Survey data from 2011.

Figure 4. Teenage risky behavior

Despite the considerable improvement in eight risk measures, current rates remain unacceptably high, and the rise in attempted suicides is alarming. For public health to improve and healthcare costs to moderate, these risk factors need to be addressed through concerted, committed effort.

The birth rate for teenagers 15-19 years old decreased from 29 births per 1,000 in 2008 to 22 births per 1,000 in 2011 [17].

Teen Pregnancy

In 1990, the number of pregnancies per 1,000 females ages 15-19 was 80.6 and by 2012, the rate had decreased by 62.5% to 30.2. Provisional data indicate that during 2012, there were 1,116 pregnancies among teens ages 15-19, which represents a 53.1% decrease from the 1990 figure of 2,830 pregnancies. More than two-thirds (67.9%) of the pregnancies that occurred in 2012 resulted in a live birth (n = 758), while 29.2% (n = 326) resulted in an induced termination and 2.9% (n = 32) were spontaneous fetal deaths (e.g., miscarriages).

Although teen pregnancy rates have been decreasing, there is much variation among racial/ethnic groups. During 2009-2011, Native Americans had the highest rate of teen pregnancy (172.1 per 1,000), a rate that was nearly four times the rate for Whites (46.3). However, it is important to note that since the number of Native American females aged 15-19 in Rhode Island is very small (~251 per year or 1,255 over five years), the teen pregnancy rates are statistically unreliable. Blacks/African Americans (116.4) and those of Hispanic/Latino ethnicity (111.0) also had high teen pregnancy rates that were approximately 2.5 times the rate of Whites. The teen pregnancy rate among Asians (58.6) was close to the statewide rate (53.1) for this time period, but was still 27% higher than the rate for Whites.

Disability

Nearly one in five (or 18%) of Rhode Islanders have disabilities, which is consistent with national statistics. Disabilities are evenly distributed between males and females. Adults ages 75 and older (51.3%) have the majority of disabilities. Among the non-elderly population (younger than age 64), one in six Rhode Islanders (17%) reported having a disability. The disabled population is also more likely to be unemployed (33.2%).

Disabled individuals in Rhode Island are found to exhibit obesity rates that are nearly double of those without disabilities. Also, those with disabilities are slightly more likely to smoke than those without, but less likely to partake in substance abuse [18].

There are very few Native Americans in Rhode Island. As of 2009, this racial/ethnic group had the highest number of individuals with disabilities and self-care limitations. Similarly, there are slightly more Hispanic/Latinos that are disabled (24.7%) than non-Hispanic/Latinos (19.8%). The white population was noted to have the highest daily activity limitations from disabilities.

Diabetes

Diabetes is a serious issue in Rhode Island. Diabetes is the eighth leading cause of death in Rhode Island, and sixth in the nation overall. Approximately 23.1% of adults ages 30-60 are at high risk for developing diabetes and 0.2% (estimated 530 people using 2008 Census) of those younger than age 20 are diagnosed with diabetes [19].

The number of diabetes diagnoses is estimated to have increased by one-third in Rhode Island. As of 2008, 7.4% of the population had been diagnosed with having diabetes. However, 31,000 cases of diabetes were believed to have remained undiagnosed, putting the estimated diabetic population in Rhode Island closer to 12% [19].

Number of People with Diabetes by Race/Ethnicity and Language in Rhode Island, 2006-2008

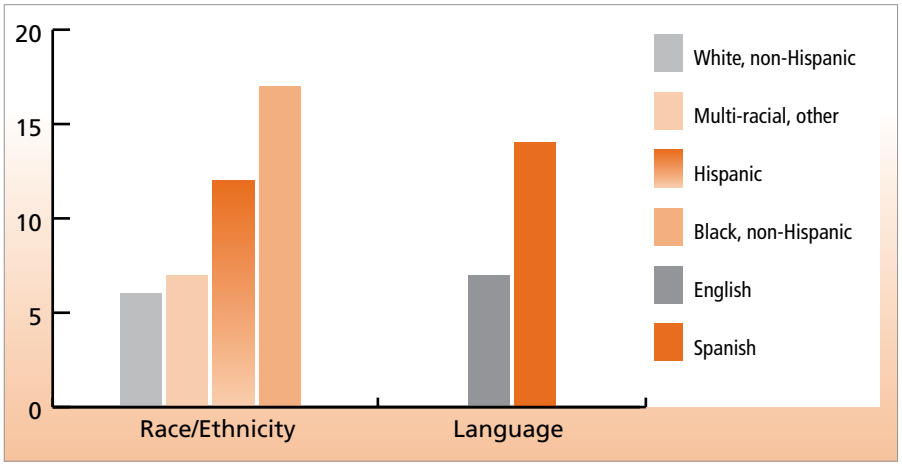


Figure 5. Diabetes in Rhode Island, by race/ethnicity and language

In Rhode Island, people ages 65 years or older make up the majority of the diabetic population (41.3%). Males make up only a slightly higher percentage of diabetics than females. Regarding race/ethnicity, black, non-Hispanic adults make up the greatest number of diabetics, totaling 15.7% of the population, followed closely by Hispanic adults (11.3%). Diabetes prevalence is increasing mostly among black non-Hispanic adults. Rhode Island adults whose primary language is Spanish are diagnosed with diabetes two times more often than those whose first language is English [20].

Low-income populations are twice as likely to have diabetes than wealthier populations; approximately 14.5% of Rhode Island adults with reported annual incomes of less than $25,000 are diagnosed with diabetes, compared to 7.9% of adults diagnosed with diabetes with annual incomes of more than $75,000. Similarly, those with less education are more likely to be diagnosed with diabetes. For instance, 12.0% of adults without a high school diploma are diagnosed with diabetes, compared to 6.4% of Rhode Island adults with at least some college education. Forty-two percent (42%) of adult diabetics in Rhode Island are disabled [20].

Infectious Disease

Rhode Island has experienced a decrease in the number of laboratory-confirmed cases of tuberculosis (TB). From 1996 to 2005, Rhode Island saw an average of 49 cases per year, and that number dropped to an average of 31 cases per year between 2006 and 2010. The number of gonorrhea cases in Rhode Island also has decreased, from 973 cases in 2003 to 291 in 2010 [21]. Gonorrhea, chlamydia, and HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) are more common among African Americans than other minority groups. However, Asian and Pacific Islanders had the most cases of tuberculosis.

In 2010, investigations of acute infectious disease outbreaks in Rhode Island pertained to Salmonella (most notably involving separate cases traced back to contaminated tomatoes and zepolles), Hepatitis A, pertussis, and one confirmed human case of Eastern Equine Encephalitis (EEE) [21].

HIV/AIDS

As of 2008, Rhode Island had 2,982 reported AIDS cases. From 2000 to 2008, 1,220 new cases of HIV had been reported. Between 1993 and 2008, AIDS incidence had decreased by 82%. The majority of new HIV cases among adults were in the men having sex with men (MSM) population. The majority of new cases reported were male (75%), white (54%), and between ages 30-39 (42%) [22].

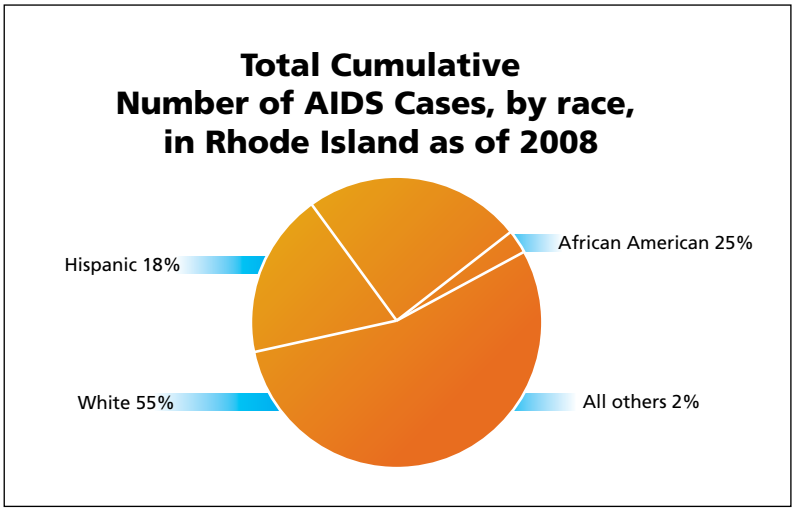


Figure 6. AIDS cases in Rhode Island

Although there have been more males than females in Rhode Island diagnosed with AIDS, the difference between the two has been decreasing since 1993. AIDS cases among 30-39 year olds have been highest, followed by ages 40-49. Followed by Caucasians/whites (43%), the next dominant races are African American (29%) and Hispanics (24%). However, African Americans account for the greatest number of all AIDS cases in Rhode Island, despite only making up 5% of the Rhode Island population. Hispanics make up the next largest proportion. They represent 9% of the total population but account for 24% of all AIDS cases in Rhode Island [22].

From 1982-2008, 29 children (ages 0-12) were diagnosed with AIDS in Rhode Island; the majority were male (69%) and African-American (52%). The main reason was transmission from a mother infected with HIV (86%) [22]. Since the AIDS epidemic started in 1993, the incidence of AIDS has decreased dramatically by 78%. In Rhode Island, from 2008 to 2012, 161 deaths occurred among persons with HIV/AIDS and since 1983 (through 2012), a total of 1,591 deaths have occurred among Rhode Island residents diagnosed with HIV/AIDS. The number of deaths caused by AIDS has decreased steadily along with the incidence rate.

Deaths

Rhode Island has led the nation in the percentage of residents who attempt suicide, with one in 67 Rhode Islanders reportedly attempting suicide in 2010. Rhode Island's high suicide attempt rate may be associated with social factors, such as unemployment rates, and behaviors such as substance abuse. Deaths resulting from suicides have resulted in a state suicide rate of 11/100,000, compared to the national rate of more than 12/100,000. Hence, while a large number of Rhode Islanders attempt suicide, a smaller number succeed [23]. Still, suicide was Rhode Island's fourth leading cause of death in 2010 [23]. Nationally, suicide was reported as the tenth leading cause of death in 2008.

Rhode Islanders are dying of heart disease, lung cancer, stroke, and Alzheimer's disease. Minorities, including Hispanic/Latinos, African Americans, Native Americans, and Asian and Pacific Islanders are dying of heart disease and cancer. In 2009 alone, heart disease (32%) and cancer (29%) caused the death of 61% of Rhode Islanders. Other major causes of death were chronic lower respiratory disease (6.75%), unintentional injuries (6%), stroke (6%), and Alzheimer's disease (4%).

Causes of Death in Rhode Island

Cause	Rank
Coronary Heart Disease	1
Cancer	2
Chronic Lower Respiratory Disease	3
Unintentional Injuries	4
Stroke	5

Source: Office of Vital Records, Rhode Island Department of Health, 2009

Table 6. Cause of Death in Rhode Island

Cancer of the lungs and bronchus, colon and rectum, female breast, and prostate make up 51% of all cancer deaths in Rhode Island. Over time, deaths caused by cancer among men have been decreasing, and deaths from breast and colon-rectum cancer in women have declined as well [24]. Four percent of the total Rhode Island population is made up of cancer survivors. Within this population, 55% are women and the majority is between ages 50 and 70. Furthermore, approximately 25% of cancer survivors are noted to have at least one disability, with the majority of those survivors with disabilities being women [24].

Rhode Island ranks 13th in the nation for overdose deaths [25]. Moreover, Rhode Island is one of 20 states where unintentional drug overdose is responsible for the most unintentional, injury-related deaths. In Rhode Island, drugs were involved in the deaths of nearly four people per week in 2008. The most common drugs were opioids, such as heroin and oxycodone. Non-Hispanic, white Rhode Islanders experience the most poisoning events overall, while non-Hispanic African American Rhode Islanders proportionately experience the greatest burden of overdose events [25].

From 2007 to 2011, for children ages 1-4 and youth ages 15-24, the leading cause of death was unintentional injuries. Unintentional injuries include unintentional suffocation, unintentional drowning, and unintentional motor vehicle traffic crashes. Homicide was the second leading cause of death for youth ages 15-24, followed by suicide [26].

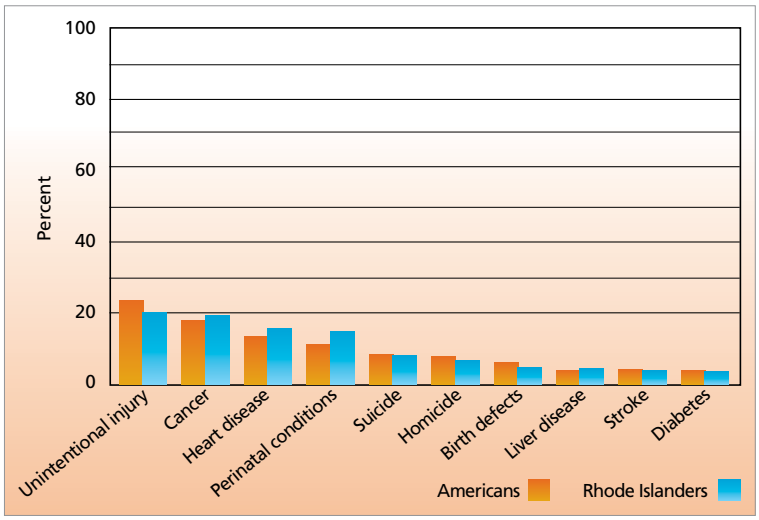


Figure 7. Premature deaths in adults 65 and older in RI and the United States

Deaths among adults younger than 65 years of age are considered premature. Based on this measure, we calculate a rate for years of potential life lost. In the United States, there is a loss rate of 4,396 per 100,000, and in Rhode Island the loss rate is 3,591 per 100,000. Among the most common causes of premature death in Rhode Island are unintentional injuries, cancer, and heart disease. (webappa.cdc.gov/sasweb/ncipc/ypll10.html)

AT HEALTH, KEEPING RHODE ISLANDERS HEALTHY IS OUR MISSION. IN ORDER TO SET STATE POLICIES THAT CAN HELP PROTECT THE HEALTH OF OUR CHILDREN, YOUTH, ADULTS, AND ELDERS, WE MUST CONTINUOUSLY EXAMINE THE DATA, AND HEAR FROM RHODE ISLANDERS ABOUT WHAT THEY THINK WOULD MAKE THEM HEALTHIER.

Introduction

At HEALTH, keeping Rhode Islanders healthy is our mission. In order to set state policies that can help protect the health of our children, youth, adults, and elders, we must continuously examine the data, and hear from Rhode Islanders about what they think would make them healthier.

Our State Health Assessment report displays and discusses what the data reveal about the health of our state. In this report, we examine data gathered over years and even decades to describe the health of Rhode Island communities. We know that our state is diverse and has multiple needs, but our comprehensive databases reveal more details about diseases, conditions, and other health matters, the people who are most affected, and the barriers that often prevent some of those people from accessing the care and services they need. As such, in this report we are providing the most relevant data points from our comprehensive databases in order to best present and explain the most important public health matters affecting Rhode Islanders.

This document is the result of months of conversations and data analyses discussed with communities and a key group of stakeholders convened by the Department of Health. The "State Assessment" group (see appendix 2 for the list of agencies represented) was formed in early 2012 and has supported the goals of the state's health assessment process that leads to the health improvement plan.

But data tells us only half the story. Your health department needs your help in setting the future health priorities for our state so that together we can make Rhode Island an even healthier place to live and grow. Through a new federally-funded grant initiative, for years to come HEALTH will meet with different communities each year to hear directly from each community about the health issues that matter most. These community meetings will bring together parents and families, civic leaders, representatives from local health agencies, neighborhood businesses, and environmental and other advocacy groups to gather this important feedback. Understanding our diverse communities' needs and concerns is critical to the work we do, and we highly value your input.

In 2013, we learned a great deal from Rhode Islanders: HEALTH again gathered communities together for feedback on our Maternal and Child Health Block Grant; communities were mobilized to support legislative efforts to restrict tobacco sales; nearly 100 Central Falls residents gathered in October at a Community Health Forum to learn more about pressing health matters in their neighborhoods and to share their concerns. Many Rhode Islanders visit our offices in Providence every day to conduct routine business related to licensing for health, emergency, and service industry professionals, and to obtain birth certificates and other vital records. As such, HEALTH staff regularly receives and considers feedback from the general public, as well as a diverse range of vendors and businesses, licensed facilities and professionals, healthcare providers, community leaders, and researchers. Various HEALTH programs also conduct numerous focus groups and surveys to better learn about the needs and wants of various populations and communities. This work gives us important data that reveals the extent or severity of an issue, problem, or health matter, and when analyzed with the insights gathered from other forms of community engagement, our HEALTH staff is better able to prioritize our work within the funding and resources available to Rhode Island for public health.

All of this information guides us in shaping our companion report—the State Health Improvement Plan, which presents ideas born from data and feedback collected through various forms of community engagement. The Improvement Plan outlines a clear set of goals and objectives for the work HEALTH plans to do in the coming years to address problems and find feasible solutions.

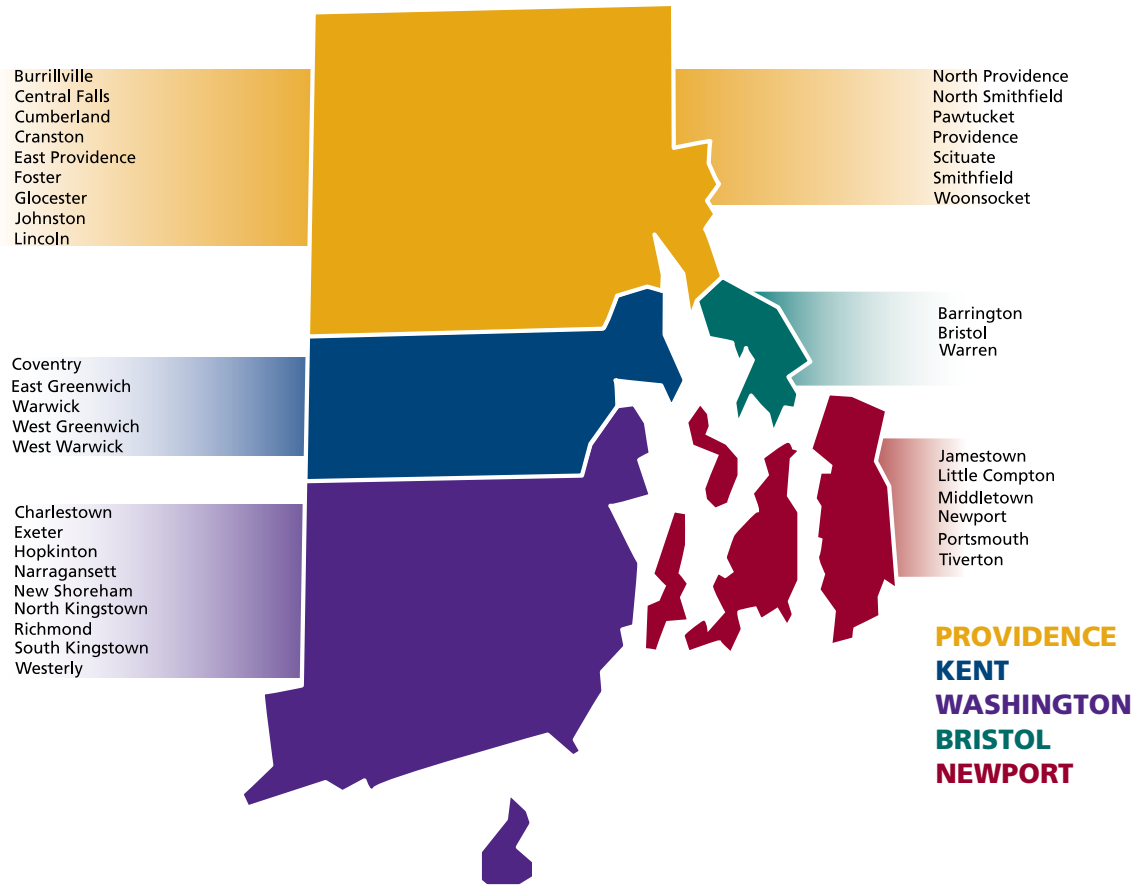
The second part of this document presents a State Health Improvement Plan. This plan describes efforts currently underway, including regular community meetings throughout the coming years. When HEALTH visits your community, you will be invited to attend and share your ideas. You'll also learn about opportunities available to you to help put make some important projects happen. As a community member, you are a valuable resource.

Please review this report, look for community meetings in your area, visit our website, send us feedback, and help Rhode Island to become the healthiest state in the nation!

DESPITE BEING THE SMALLEST STATE IN THE NATION, RHODE ISLAND HAS 39 CITIES AND TOWNS AND FIVE COUNTIES.

A. Rhode Island's 39 Cities and Towns

Despite being the smallest state in the nation, Rhode Island has 39 cities and towns and five counties. The next section includes a snapshot of each of the municipalities' data, compared to the state. With just a few data points, you can learn more about your city and think about what you can do to make your community healthier.

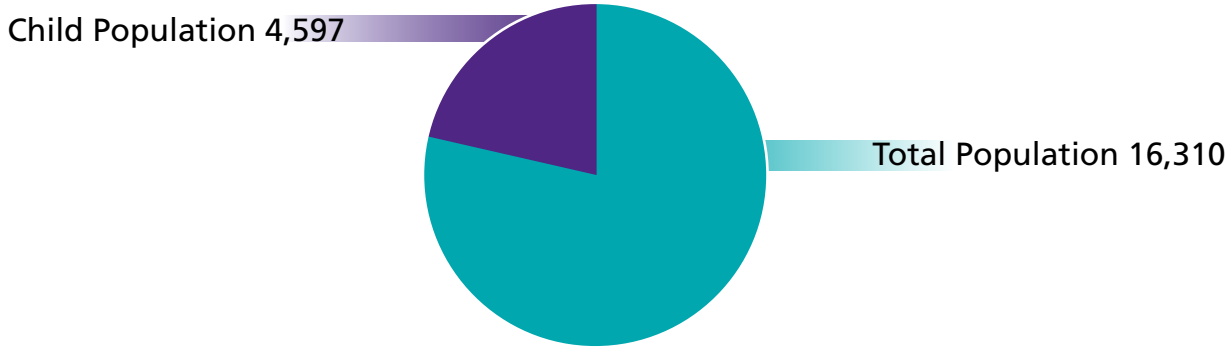


The cities are listed in alphabetical order, and most of the data came from the Rhode Island KIDS COUNT Factbook (www.rikidscount.org) which is issued annually and is also available on their website, listed by city and town. If you need to learn more about these data items, you can visit our website at www.health.ri.gov/data/ and look through the A-Z listing to search for the topic you are interested in.

BARRINGTON

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income [1]	Barrington	Bristol County	RI	Data Year
	$123,667	$62,312	$68,507	2011



	Barrington	RI	Data Year
Low Birthweight [2]	4.4%	7.9%	2011
Infant Mortality Rate [3]	0.0	6.5	2011
Teen Birth Rate [4]	4.0	25.5	2011
High School Graduation Rate [5]	94.0%	77.0%	2012
Bachelor's Degree or Higher [6]	65.0%	30.6%	2011
Foreign Born [7]	5.9%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Barrington. http://www.rikidscount.org/matriarch/documents/Barrington_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

1 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

2 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

3 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

4 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

5 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

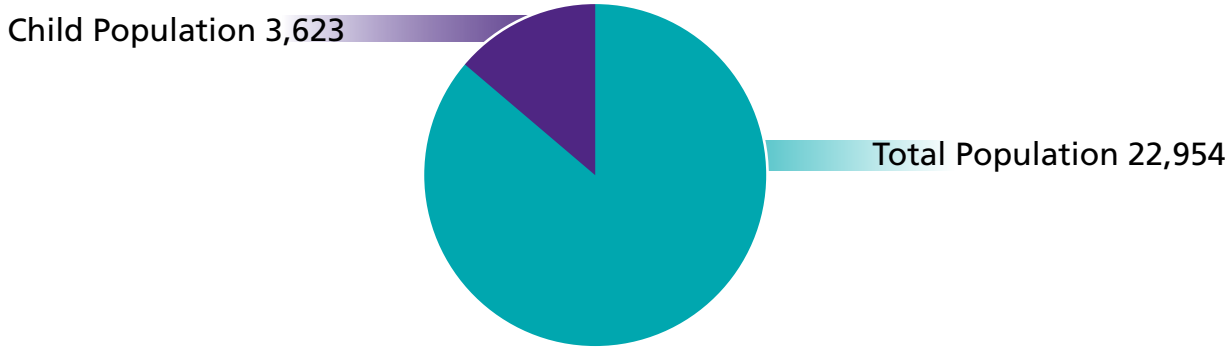
6 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

7 Foreign Born is the percentage of people who are born outside the United States.

BRISTOL

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[8]	Bristol	Bristol County	RI	Data Year
	$94,688	$62,312	$68,507	2011



	Bristol	RI	Data Year
Low Birthweight [9]	6.5%	7.9%	2011
Infant Mortality Rate [10]	1.2	6.5	2011
Teen Birth Rate [11]	6.4	25.5	2011
High School Graduation Rate [12]	85.0%	77.0%	2012
Bachelor's Degree or Higher [13]	11.2%	30.6%	2011
Foreign Born [14]	32.7%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Bristol. http://www.rikidscount.org/matriarch/documents/Bristol_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

8 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

9 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

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12 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

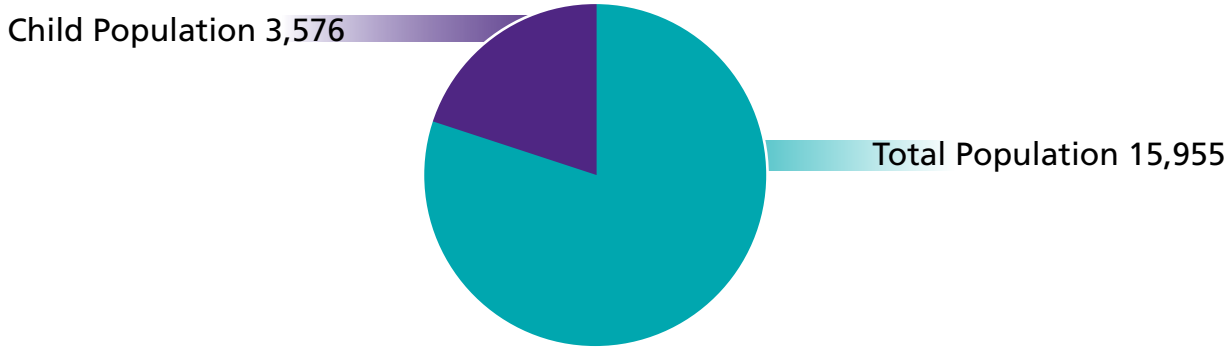
13 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

14 Foreign Born is the percentage of people who are born outside the United States.

BURRILLVILLE

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[15]	Burrillville	Prov. County	RI	Data Year
	$83,623	$49,411	$68,507	2011



	Burrillville	RI	Data Year
Low Birthweight [16]	7.6%	7.9%	2011
Infant Mortality Rate [17]	4.4	6.5	2011
Teen Birth Rate [18]	12.9	25.5	2011
High School Graduation Rate [19]	81.0%	77.0%	2012
Bachelor's Degree or Higher [20]	22.4%	30.6%	2011
Foreign Born [21]	3.2%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Burrillville. http://www.rikidscount.org/matriarch/documents/Burrillville_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

15 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

16 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

17 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

18 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

19 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

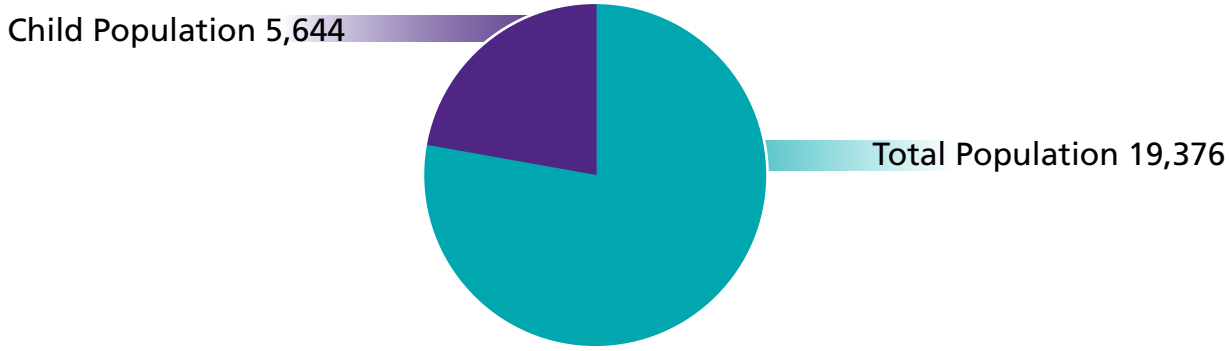
20 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

21 Foreign Born is the percentage of people who are born outside the United States.

CENTRAL FALLS

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[22]	Central Falls	Prov. County	RI	Data Year
	$35,183	$49,411	$68,507	2011



	Central Falls	RI	Data Year
Low Birthweight [23]	7.6%	7.9%	2011
Infant Mortality Rate [24]	7.3	6.5	2011
Teen Birth Rate [25]	79.7	25.5	2011
High School Graduation Rate [26]	68.0%	77.0%	2012
Bachelor's Degree or Higher [27]	6.7%	30.6%	2011
Foreign Born [28]	40.3%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Central Falls. http://www.rikidscount.org/matriarch/documents/Central_Falls_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

22 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

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25 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

26 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

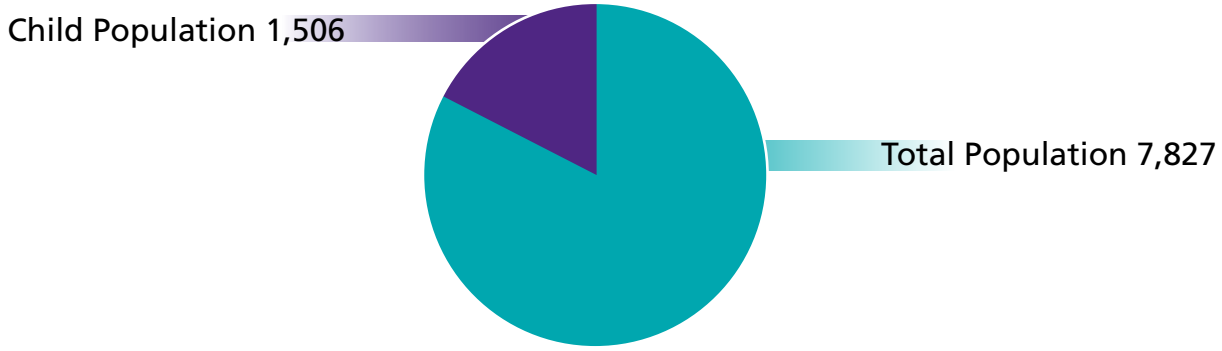
27 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

28 Foreign Born is the percentage of people who are born outside the United States.

CHARLESTOWN

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[29]	Charlestown	Wash. County	RI	Data Year
	$74,853	$72,163	$68,507	2011



	Charlestown	RI	Data Year
Low Birthweight [30]	NA	7.9%	2011
Infant Mortality Rate [31]	NA	6.5	2011
Teen Birth Rate [32]	11.4	25.5	2011
High School Graduation Rate [33]	87.0%	77.0%	2012
Bachelor's Degree or Higher [34]	35.8%	30.6%	2011
Foreign Born [35]	2.4%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Charlestown. http://www.rikidscount.org/matriarch/documents/Charlestown_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

29 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

30 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

31 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

32 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

33 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

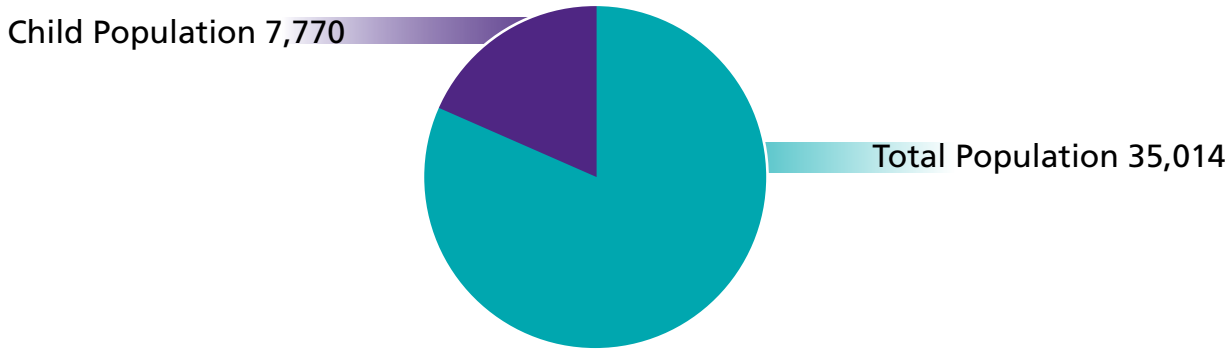
34 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

35 Foreign Born is the percentage of people who are born outside the United States.

COVENTRY

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[36]	Coventry	Kent County	RI	Data Year
	$89,088	$61,279	$68,507	2011



	Coventry	RI	Data Year
Low Birthweight [37]	8.0%	7.9%	2011
Infant Mortality Rate [38]	7.4	6.5	2011
Teen Birth Rate [39]	15.8	25.5	2011
High School Graduation Rate [40]	87.0%	77.0%	2012
Bachelor's Degree or Higher [41]	2.6%	30.6%	2011
Foreign Born [42]	24.6%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Coventry. http://www.rikidscount.org/matriarch/documents/Coventry_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

36 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

37 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

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40 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

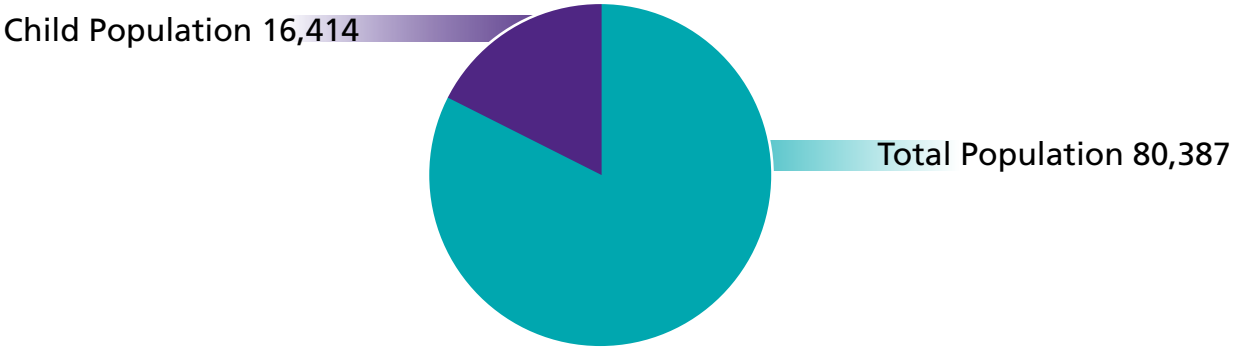
41 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

42 Foreign Born is the percentage of people who are born outside the United States.

CRANSTON

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[43]	Cranston	Prov. County	RI	Data Year
	$74,328	$49,411	$68,507	2011



	Cranston	RI	Data Year
Low Birthweight [44]	8.1%	7.9%	2011
Infant Mortality Rate [45]	6.2	6.5	2011
Teen Birth Rate [46]	19.6	25.5	2011
High School Graduation Rate [47]	81.0%	77.0%	2012
Bachelor's Degree or Higher [48]	29.2%	30.6%	2011
Foreign Born [49]	11.9%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Cranston. http://www.rikidscount.org/matriarch/documents/Cranston_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

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45 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

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47 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

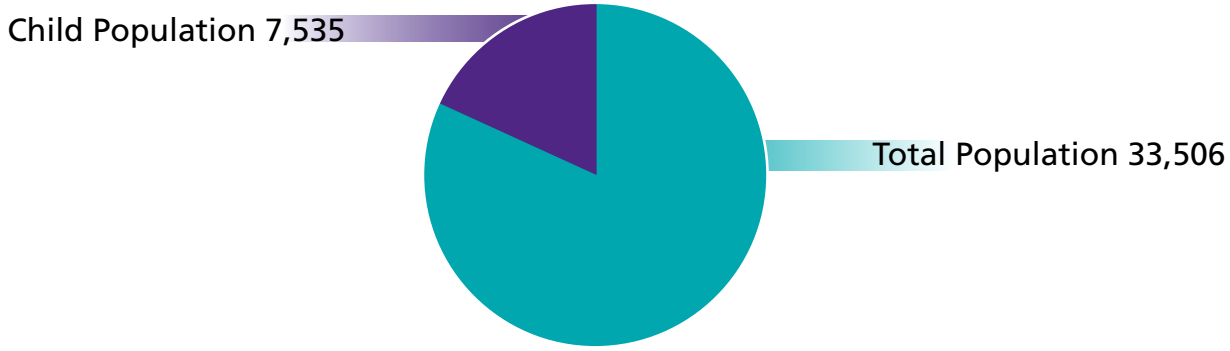
48 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

49 Foreign Born is the percentage of people who are born outside the United States.

CUMBERLAND

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[50]	Cumberland	Prov. County	RI	Data Year
	$99,053	$49,411	$68,507	2011



	Cumberland	RI	Data Year
Low Birthweight [51]	5.8%	7.9%	2011
Infant Mortality Rate [52]	4.9	6.5	2011
Teen Birth Rate [53]	13.2	25.5	2011
High School Graduation Rate [54]	81.0%	77.0%	2012
Bachelor's Degree or Higher [55]	35.9%	30.6%	2011
Foreign Born [56]	9.1%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Cumberland. http://www.rikidscount.org/matriarch/documents/Cumberland_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

50 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

51 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

52 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

53 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

54 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

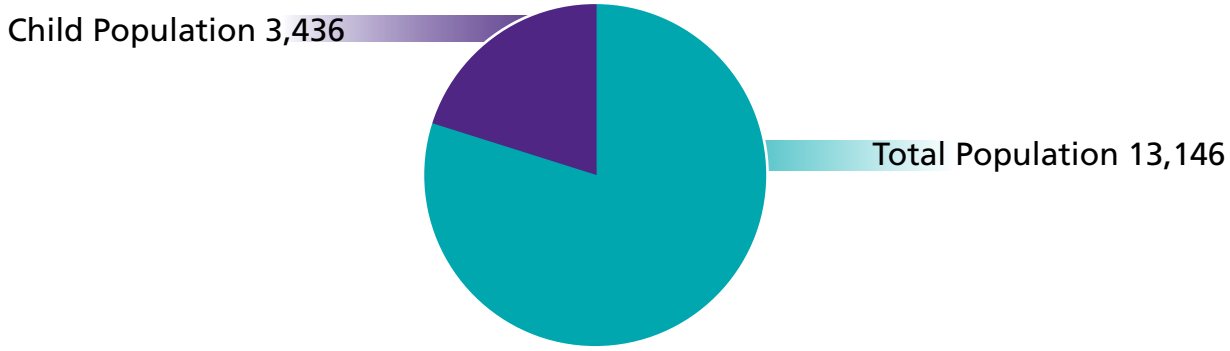
55 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

56 Foreign Born is the percentage of people who are born outside the United States.

EAST GREENWICH

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[57]	East Greenwich	Kent County	RI	Data Year
	$105,147	$61,279	$68,507	2011



	East Greenwich	RI	Data Year
Low Birthweight [58]	5.1%	7.9%	2011
Infant Mortality Rate [59]	3.9	6.5	2011
Teen Birth Rate [60]	5.8	25.5	2011
High School Graduation Rate [61]	94.0%	77.0%	2012
Bachelor's Degree or Higher [62]	59.4%	30.6%	2011
Foreign Born [63]	6.2%	12.9%	2011

Data Sources:

a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none

b. 2013 RI KIDS COUNT City and Town Fact Sheet, East Greenwich. http://www.rikidscount.org/matriarch/documents/East_Greenwich_2013.pdf

c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

57 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

58 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

59 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

60 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

61 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

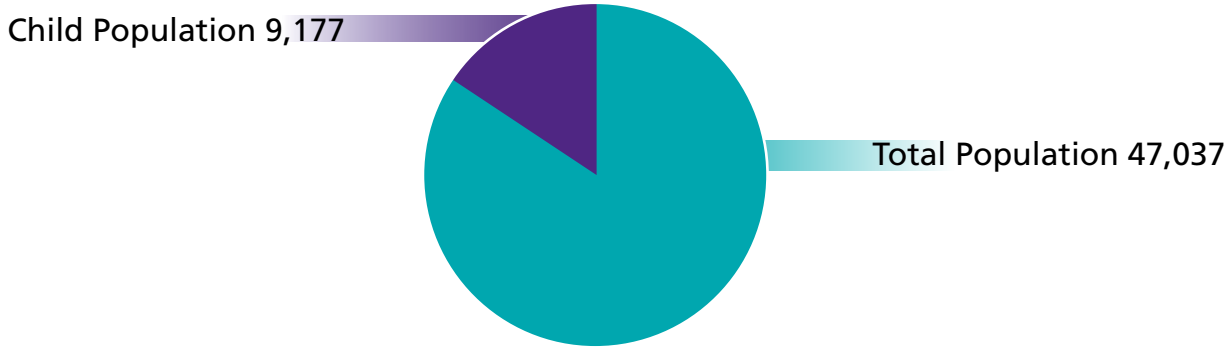
62 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

63 Foreign Born is the percentage of people who are born outside the United States.

EAST PROVIDENCE

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[64]	East Providence	Prov. County	RI	Data Year
	$64,650	$49,411	$68,507	2011



	East Providence	RI	Data Year
Low Birthweight [65]	7.2%	7.9%	2011
Infant Mortality Rate [66]	5.0	6.5	2011
Teen Birth Rate [67]	26.1	25.5	2011
High School Graduation Rate [68]	69.0%	77.0%	2012
Bachelor's Degree or Higher [69]	23.5%	30.6%	2011
Foreign Born [70]	15.2%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, East Providence. http://www.rikidscount.org/matriarch/documents/East_Providence_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

64 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

65 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

66 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

67 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

68 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

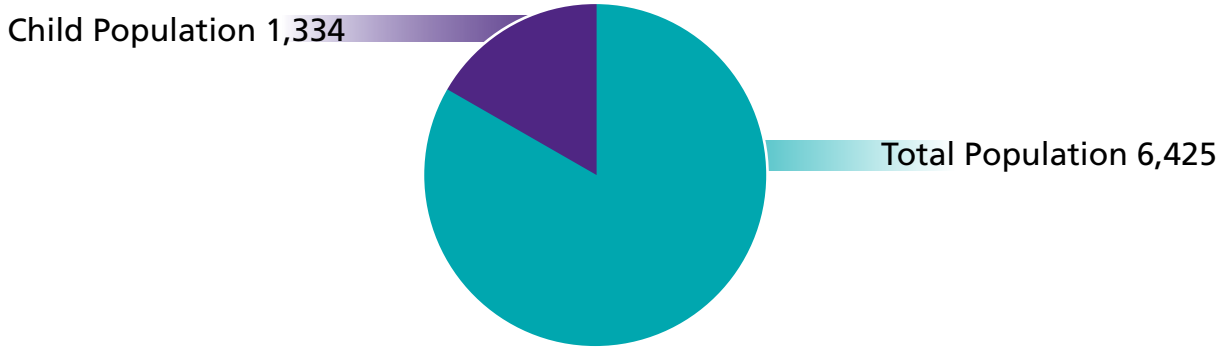
69 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

70 Foreign Born is the percentage of people who are born outside the United States.

EXETER

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[71]	Exeter	Wash. County	RI	Data Year
	$115,636	$72,163	$68,507	2011



	Exeter	RI	Data Year
Low Birthweight [72]	NA	7.9%	2011
Infant Mortality Rate [73]	NA	6.5	2011
Teen Birth Rate [74]	9.3	25.5	2011
High School Graduation Rate [75]	90.0%	77.0%	2012
Bachelor's Degree or Higher [76]	40.5%	30.6%	2011
Foreign Born [77]	3.5%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Exeter. http://www.rikidscount.org/matriarch/documents/Exeter_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

71 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

72 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

73 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

74 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

75 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

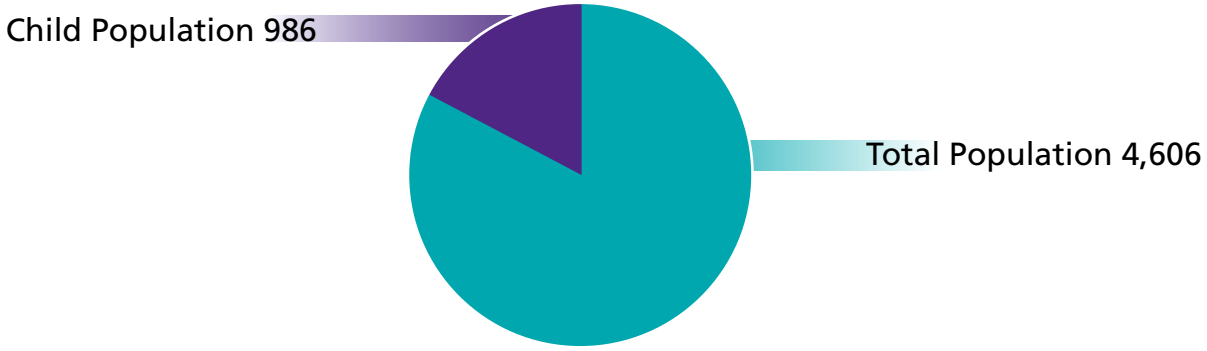
76 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

77 Foreign Born is the percentage of people who are born outside the United States.

FOSTER

Extract from Rhode Island KIDS COUNT Factbook 2013

	Foster	Prov. County	RI	Data Year
Median Family Income[78]	$77,434	$49,411	$68,507	2011



	Foster	RI	Data Year
Low Birthweight [79]	NA	7.9%	2011
Infant Mortality Rate [80]	NA	6.5	2011
Teen Birth Rate [81]	7.8	25.5	2011
High School Graduation Rate [82]	86.0%	77.0%	2012
Bachelor's Degree or Higher [83]	30.2%	30.6%	2011
Foreign Born [84]	1.9%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Foster. http://www.rikidscount.org/matriarch/documents/Foster_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

78 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

79 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

80 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

81 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

82 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

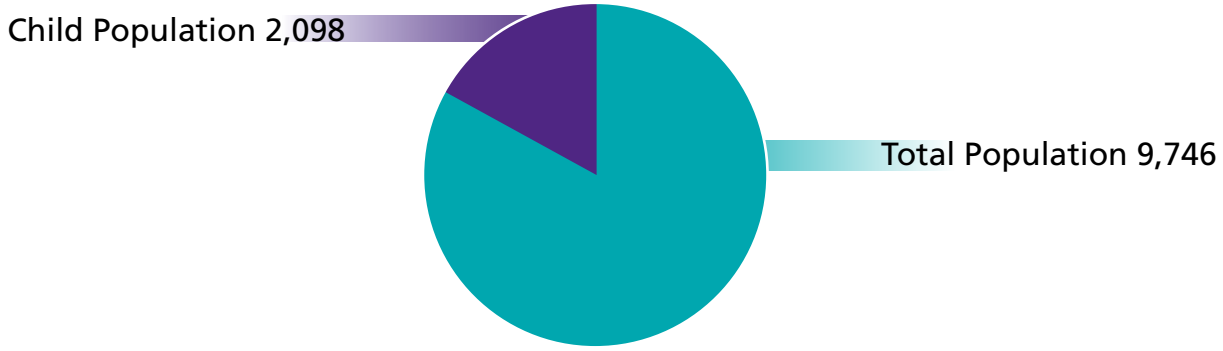
83 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

84 Foreign Born is the percentage of people who are born outside the United States.

GLOCESTER

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[85]	Glocester	Prov. County	RI	Data Year
	$86,989	$49,411	$68,507	2011



	Glocester	RI	Data Year
Low Birthweight [86]	NA	7.9%	2011
Infant Mortality Rate [87]	NA	6.5	2011
Teen Birth Rate [88]	8.2	25.5	2011
High School Graduation Rate [89]	86.0%	77.0%	2012
Bachelor's Degree or Higher [90]	30.0%	30.6%	2011
Foreign Born [91]	2.2%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Glocester. http://www.rikidscount.org/matriarch/documents/Glocester_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

85 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

86 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

87 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

88 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

89 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

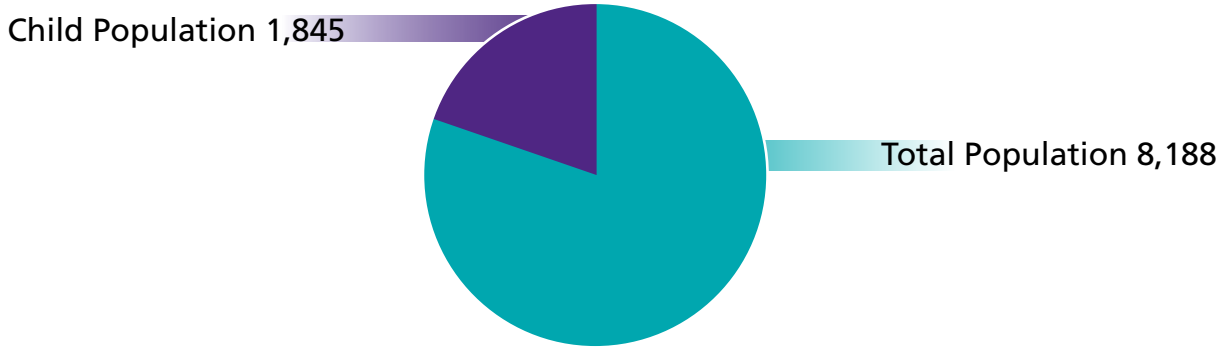
90 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

91 Foreign Born is the percentage of people who are born outside the United States.

HOPKINTON

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[92]	Hopkinton	Wash. County	RI	Data Year
	$73,475	$72,163	$68,507	2011



	Hopkinton	RI	Data Year
Low Birthweight [93]	NA	7.9%	2011
Infant Mortality Rate [94]	NA	6.5	2011
Teen Birth Rate [95]	19.8	25.5	2011
High School Graduation Rate [96]	87.0%	77.0%	2012
Bachelor's Degree or Higher [97]	24.9%	30.6%	2011
Foreign Born [98]	2.4%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Hopkinton. http://www.rikidscount.org/matriarch/documents/Hopkinton_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

92 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

93 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

94 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

95 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

96 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

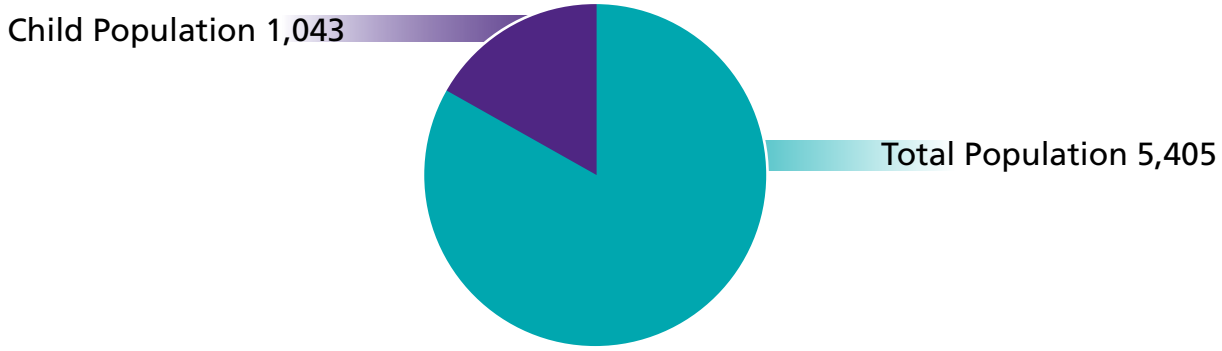
97 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

98 Foreign Born is the percentage of people who are born outside the United States.

JAMESTOWN

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[99]	Jamestown	Newport County	RI	Data Year
	$84,773	$69,369	$68,507	2011



	Jamestown	RI	Data Year
Low Birthweight [100]	NA	7.9%	2011
Infant Mortality Rate [101]	NA	6.5	2011
Teen Birth Rate [102]	2.8	25.5	2011
High School Graduation Rate [103]	88.0%	77.0%	2012
Bachelor's Degree or Higher [104]	60.3%	30.6%	2011
Foreign Born [105]	6.1%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Jamestown. http://www.rikidscount.org/matriarch/documents/Jamestown_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

99 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

100 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

101 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

102 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

103 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

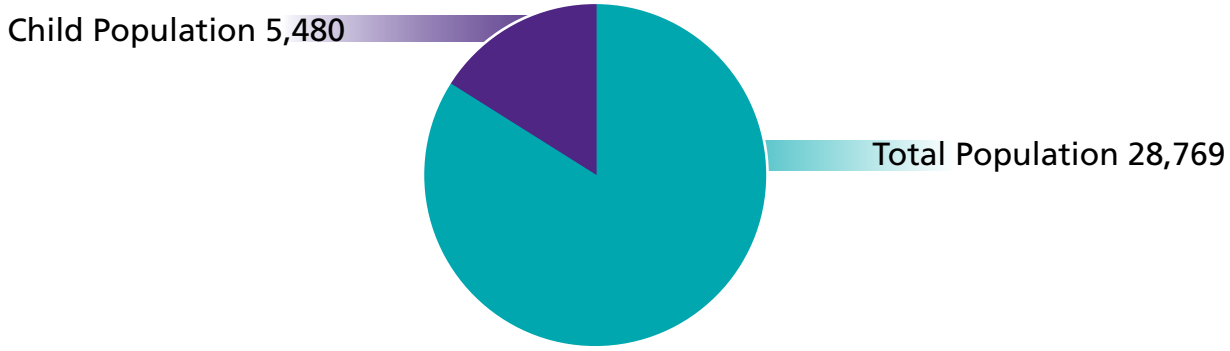
104 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

105 Foreign Born is the percentage of people who are born outside the United States.

JOHNSTON

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[106]	Johnston	Prov. County	RI	Data Year
	$73,2603	$49,411	$68,507	2011



	Johnston	RI	Data Year
Low Birthweight [107]	6.6%	7.9%	2011
Infant Mortality Rate [108]	3.7	6.5	2011
Teen Birth Rate [109]	19.5	25.5	2011
High School Graduation Rate [110]	82.0%	77.0%	2012
Bachelor's Degree or Higher [111]	22.1%	30.6%	2011
Foreign Born [112]	8.3%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Johnston. http://www.rikidscount.org/matriarch/documents/Johnston_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

106 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

107 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

108 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

109 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

110 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

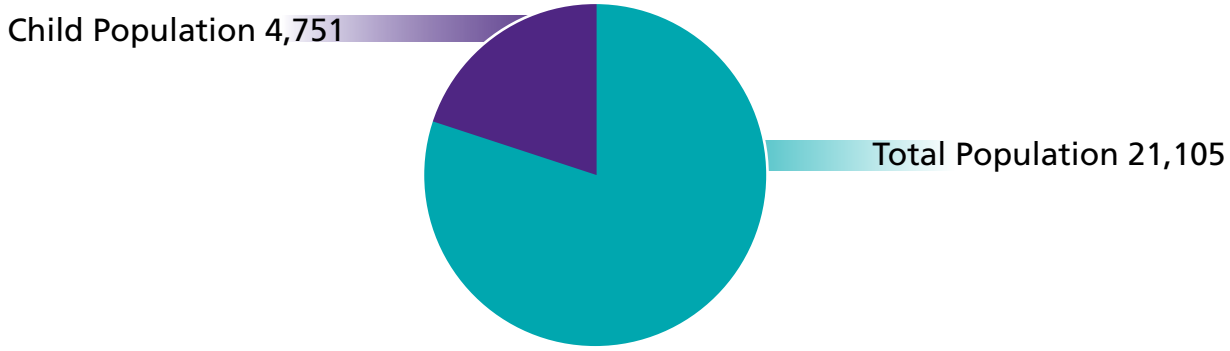
111 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

112 Foreign Born is the percentage of people who are born outside the United States.

LINCOLN

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[113]	Lincoln	Prov. County	RI	Data Year
	$98,039	$49,411	$68,507	2011



	Lincoln	RI	Data Year
Low Birthweight [114]	5.7%	7.9%	2011
Infant Mortality Rate [115]	6.7	6.5	2011
Teen Birth Rate [116]	11.2	25.5	2011
High School Graduation Rate [117]	83.0%	77.0%	2012
Bachelor's Degree or Higher [118]	36.0%	30.6%	2011
Foreign Born [119]	7.2%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Lincoln. http://www.rikidscount.org/matriarch/documents/Lincoln_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

113 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

114 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

115 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

116 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

117 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

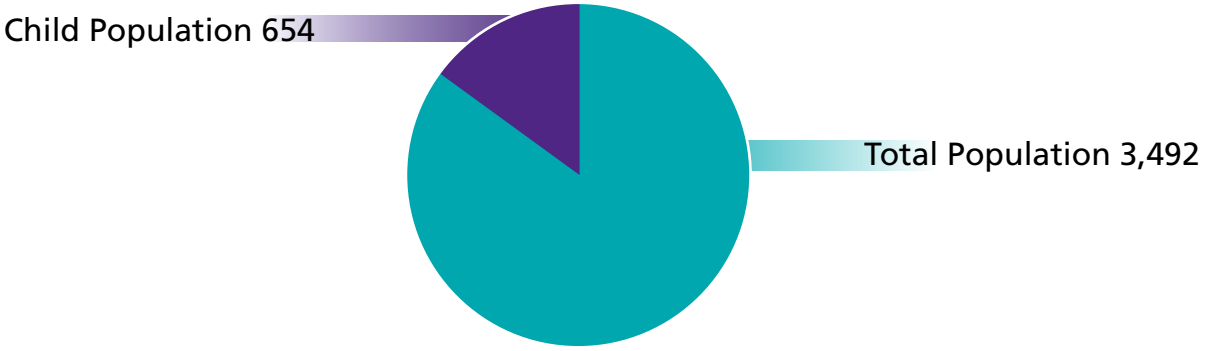
118 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

119 Foreign Born is the percentage of people who are born outside the United States.

LITTLE COMPTON

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[120]	Little Compton	Newport County	RI	Data Year
	$119,107	$69,369	$68,507	2011



	Little Compton	RI	Data Year
Low Birthweight [121]	NA	7.9%	2011
Infant Mortality Rate [122]	NA	6.5	2011
Teen Birth Rate [123]	NA	25.5	2011
High School Graduation Rate [124]	91.0%	77.0%	2012
Bachelor's Degree or Higher [125]	48.1%	30.6%	2011
Foreign Born [126]	2.6%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Little Compton. http://www.rikidscount.org/matriarch/documents/Little_Compton_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

120 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

121 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

122 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

123 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

124 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

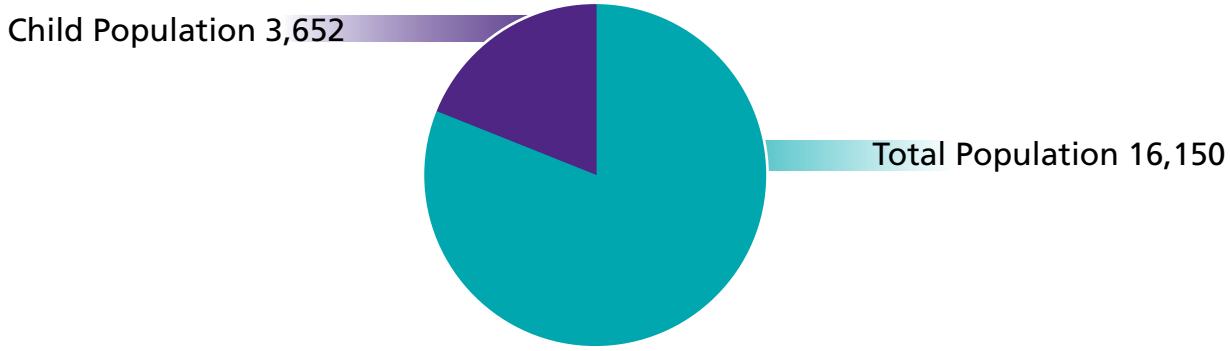
125 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

126 Foreign Born is the percentage of people who are born outside the United States.

MIDDLETOWN

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[127]	Middletown	Newport County	RI	Data Year
	$119,107	$69,369	$68,507	2011



	Middletown	RI	Data Year
Low Birthweight [128]	5.8%	7.9%	2011
Infant Mortality Rate [129]	3.3	6.5	2011
Teen Birth Rate [130]	21.2	25.5	2011
High School Graduation Rate [131]	81.0%	77.0%	2012
Bachelor's Degree or Higher [132]	39.8%	30.6%	2011
Foreign Born [133]	8.9%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Middletown. http://www.rikidscount.org/matriarch/documents/Middletown_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

127 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

128 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

129 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

130 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

131 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

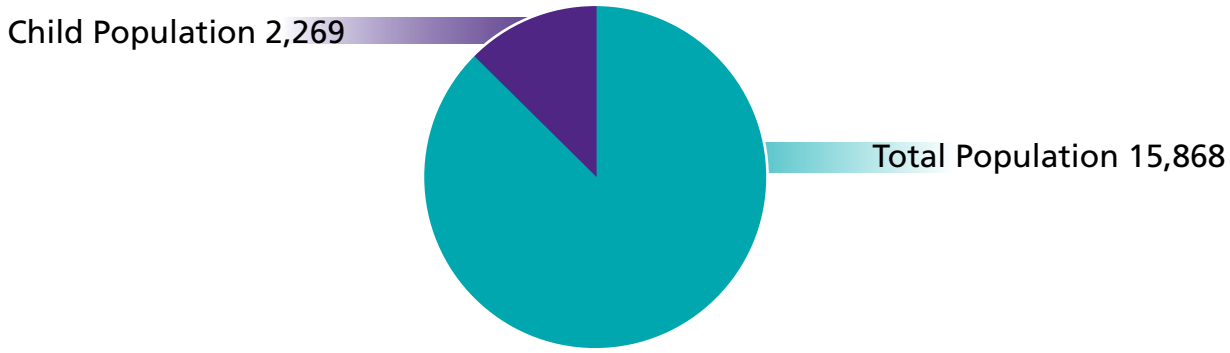
132 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

133 Foreign Born is the percentage of people who are born outside the United States.

NARRAGANSETT

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[134]	Narragansett	Wash. County	RI	Data Year
	$95,208	$72,163	$68,507	2011



	Narragansett	RI	Data Year
Low Birthweight [135]	NA	7.9%	2011
Infant Mortality Rate [136]	NA	6.5	2011
Teen Birth Rate [137]	4.3	25.5	2011
High School Graduation Rate [138]	83.0%	77.0%	2012
Bachelor's Degree or Higher [139]	52.2%	30.6%	2011
Foreign Born [140]	2.8%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Narragansett. http://www.rikidscount.org/matriarch/documents/Narragansett_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

134 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

135 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

136 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

137 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

138 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

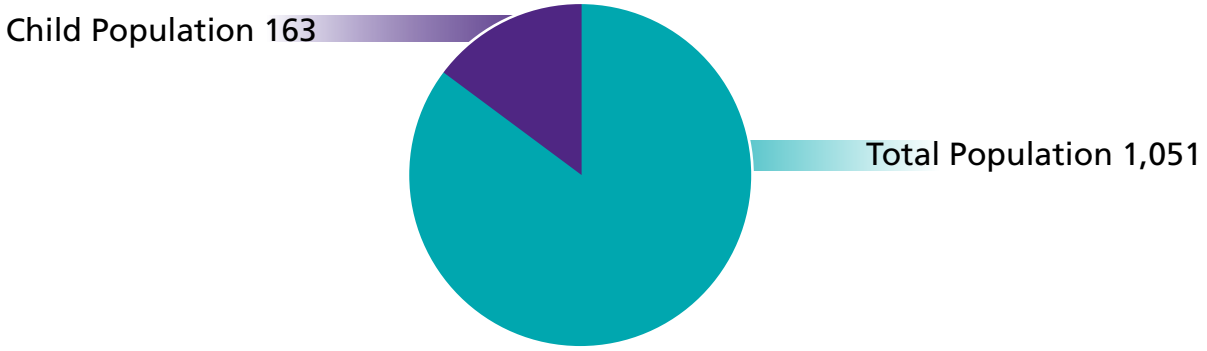
139 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

140 Foreign Born is the percentage of people who are born outside the United States.

NEW SHOREHAM (BLOCK ISLAND)

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[141]	New Shoreham	Wash. County	RI	Data Year
	$99,167	$72,163	$68,507	2011



	New Shoreham	RI	Data Year
Low Birthweight [142]	NA	7.9%	2011
Infant Mortality Rate [143]	NA	6.5	2011
Teen Birth Rate [144]	NA	25.5	2011
High School Graduation Rate [145]	NA	77.0%	2012
Bachelor's Degree or Higher [146]	55.3%	30.6%	2011
Foreign Born [147]	2.6%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, New Shoreham.http://www.rikidscount.org/matriarch/documents/New_Shoreham_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

141 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

142 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

143 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

144 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

145 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

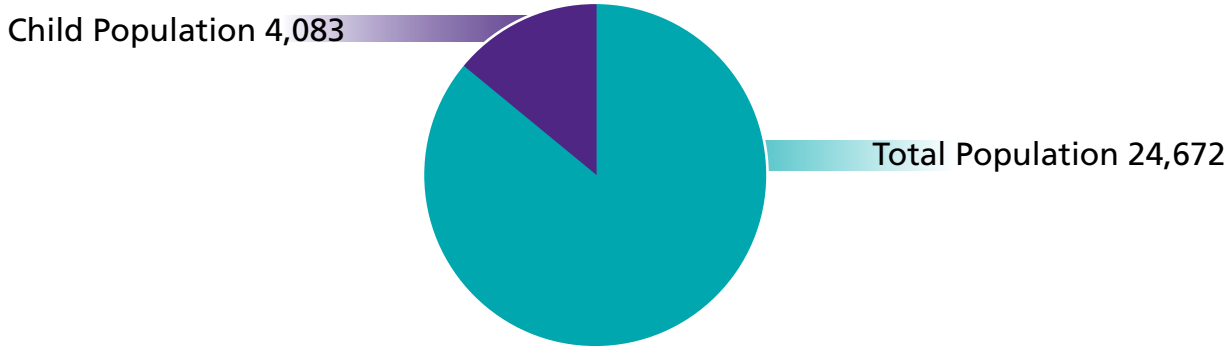
146 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

147 Foreign Born is the percentage of people who are born outside the United States.

NEWPORT

Extract from Rhode Island KIDS COUNT Factbook 2013

	Newport	Newport County	RI	Data Year
Median Family Income[148]	$59,444	$69,369	$68,507	2011



	Newport	RI	Data Year
Low Birthweight [149]	7.7%	7.9%	2011
Infant Mortality Rate [150]	8.6	6.5	2011
Teen Birth Rate [151]	23.9	25.5	2011
High School Graduation Rate [152]	74.0%	77.0%	2012
Bachelor's Degree or Higher [153]	47.2%	30.6%	2011
Foreign Born [154]	7.5%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Newport. http://www.rikidscount.org/matriarch/documents/Newport_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

148 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

149 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

150 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

151 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

152 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

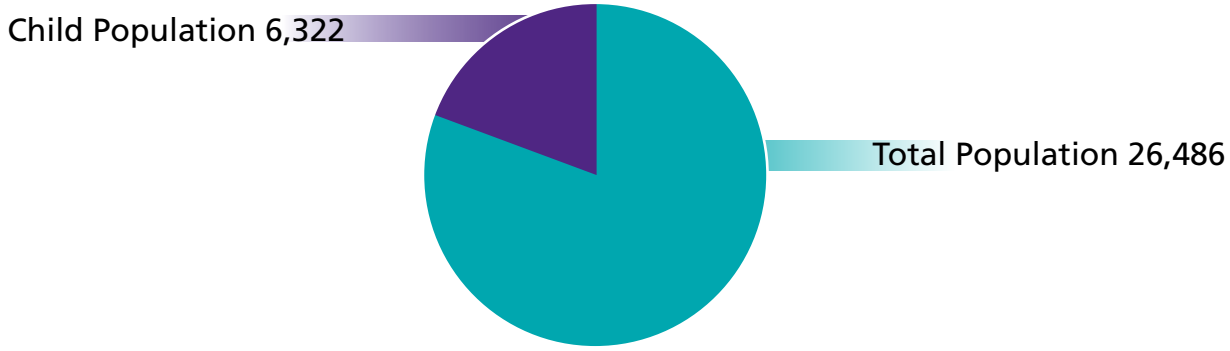
153 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

154 Foreign Born is the percentage of people who are born outside the United States.

NORTH KINGSTOWN

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[155]	North Kingstown	Wash. County	RI	Data Year
	$104,539	$72,163	$68,507	2011



	North Kingstown	RI	Data Year
Low Birthweight [156]	5.2%	7.9%	2011
Infant Mortality Rate [157]	8.4	6.5	2011
Teen Birth Rate [158]	11.3	25.5	2011
High School Graduation Rate [159]	88.0%	77.0%	2012
Bachelor's Degree or Higher [160]	47.4%	30.6%	2011
Foreign Born [161]	4.5%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, North Kingstown. http://www.rikidscount.org/matriarch/documents/North_Kingstown_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

155 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

156 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

157 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

158 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

159 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

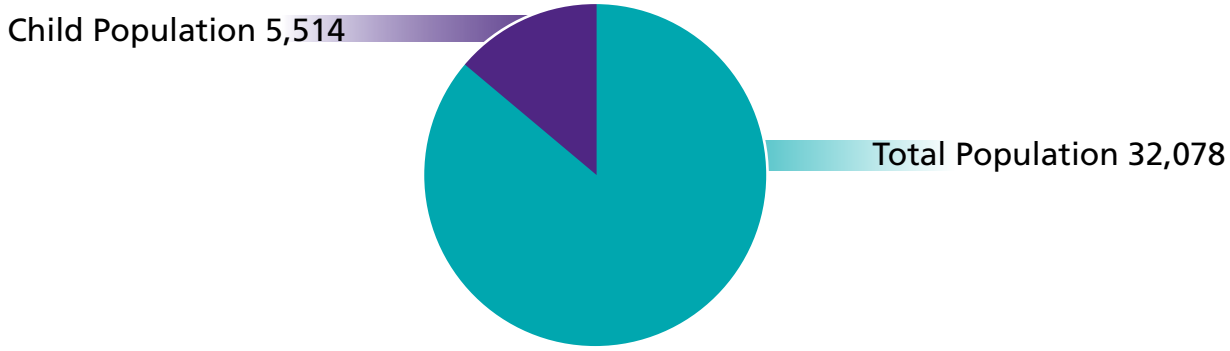
160 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

161 Foreign Born is the percentage of people who are born outside the United States.

NORTH PROVIDENCE

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[162]	North Providence	Prov. County	RI	Data Year
	$63,686	$49,411	$68,507	2011



	North Providence	RI	Data Year
Low Birthweight [163]	7.8%	7.9%	2011
Infant Mortality Rate [164]	5.9	6.5	2011
Teen Birth Rate [165]	18.8	25.5	2011
High School Graduation Rate [166]	87.0%	77.0%	2012
Bachelor's Degree or Higher [167]	25.5%	30.6%	2011
Foreign Born [168]	9.4%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, North Providence. http://www.rikidscount.org/matriarch/documents/North_Providence_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

162 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

163 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

164 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

165 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

166 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

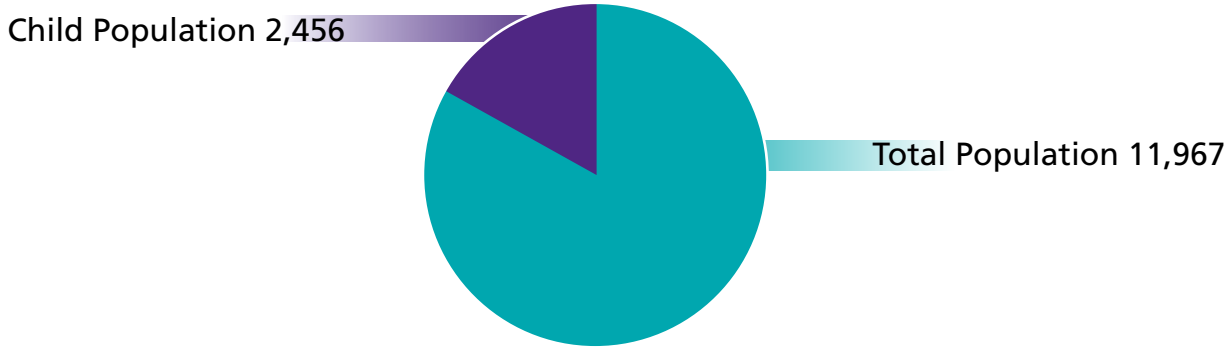
167 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

168 Foreign Born is the percentage of people who are born outside the United States.

NORTH SMITHFIELD

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[169]	North Smithfield	Prov. County	RI	Data Year
	$113,636	$49,411	$68,507	2011



	North Smithfield	RI	Data Year
Low Birthweight [170]	NA	7.9%	2011
Infant Mortality Rate [171]	NA	6.5	2011
Teen Birth Rate [172]	8.1	25.5	2011
High School Graduation Rate [173]	78.0%	77.0%	2012
Bachelor's Degree or Higher [174]	31.6%	30.6%	2011
Foreign Born [175]	3.4%	12.9%	2011

Data Sources:

a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none

b. 2013 RI KIDS COUNT City and Town Fact Sheet, North Smithfield. http://www.rikidscount.org/matriarch/documents/North_Smithfield_2013.pdf

c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

169 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

170 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

171 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

172 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

173 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

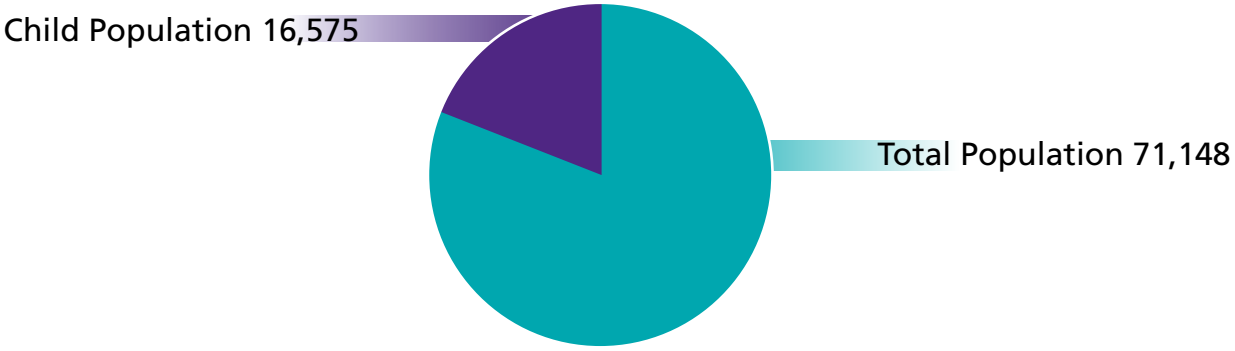
174 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

175 Foreign Born is the percentage of people who are born outside the United States.

PAWTUCKET

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[176]	Pawtucket	Prov. County	RI	Data Year
	$38,471	$49,411	$68,507	2011



	Pawtucket	RI	Data Year
Low Birthweight [177]	8.6%	7.9%	2011
Infant Mortality Rate [178]	7.3	6.5	2011
Teen Birth Rate [179]	49.2	25.5	2011
High School Graduation Rate [180]	67.0%	77.0%	2012
Bachelor's Degree or Higher [181]	17.7%	30.6%	2011
Foreign Born [182]	25.6%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Pawtucket. http://www.rikidscount.org/matriarch/documents/Pawtucket_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

176 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

177 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

178 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

179 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

180 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

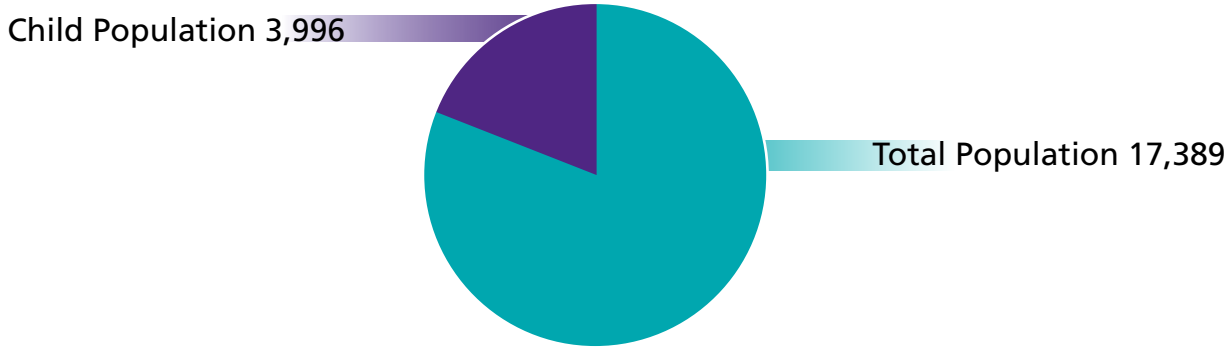
181 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

182 Foreign Born is the percentage of people who are born outside the United States.

PORTSMOUTH

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[183]	Portsmouth	Newport County	RI	Data Year
	$122,633	$69,369	$68,507	2011



	Portsmouth	RI	Data Year
Low Birthweight [184]	5.8%	7.9%	2011
Infant Mortality Rate [185]	3.1	6.5	2011
Teen Birth Rate [186]	4.3	25.5	2011
High School Graduation Rate [187]	91.0%	77.0%	2012
Bachelor's Degree or Higher [188]	49.6%	30.6%	2011
Foreign Born [189]	3.9%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Portsmouth. http://www.rikidscount.org/matriarch/documents/Portsmouth_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

183 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

184 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

185 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

186 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

187 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

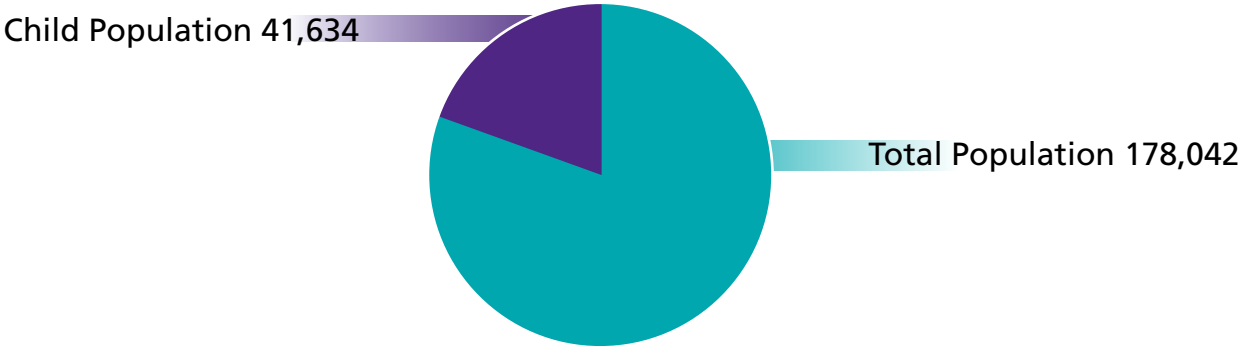
188 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

189 Foreign Born is the percentage of people who are born outside the United States.

PROVIDENCE

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[190]	Providence	Prov. County	RI	Data Year
	$34,877	$49,411	$68,507	2011



	Providence	RI	Data Year
Low Birthweight [191]	9.1%	7.9%	2011
Infant Mortality Rate [192]	8.7	6.5	2011
Teen Birth Rate [193]	38.3	25.5	2011
High School Graduation Rate [194]	65.0%	77.0%	2012
Bachelor's Degree or Higher [195]	29.1%	30.6%	2011
Foreign Born [196]	29.4%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Providence. http://www.rikidscount.org/matriarch/documents/Providence_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

190 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

191 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

192 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

193 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

194 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

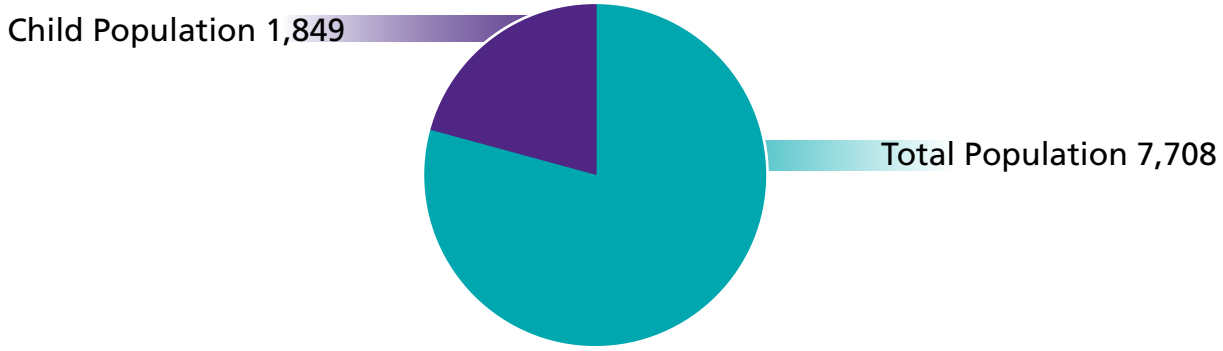
195 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

196 Foreign Born is the percentage of people who are born outside the United States.

RICHMOND

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[197]	Richmond	Wash. County	RI	Data Year
	$101,420	$72,163	$68,507	2011



	Richmond	RI	Data Year
Low Birthweight [198]	NA	7.9%	2011
Infant Mortality Rate [199]	NA	6.5	2011
Teen Birth Rate [200]	25.1	25.5	2011
High School Graduation Rate [201]	87.0%	77.0%	2012
Bachelor's Degree or Higher [202]	33.4%	30.6%	2011
Foreign Born [203]	3.4%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Richmond. http://www.rikidscount.org/matriarch/documents/Richmond_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

197 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

198 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

199 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

200 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

201 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

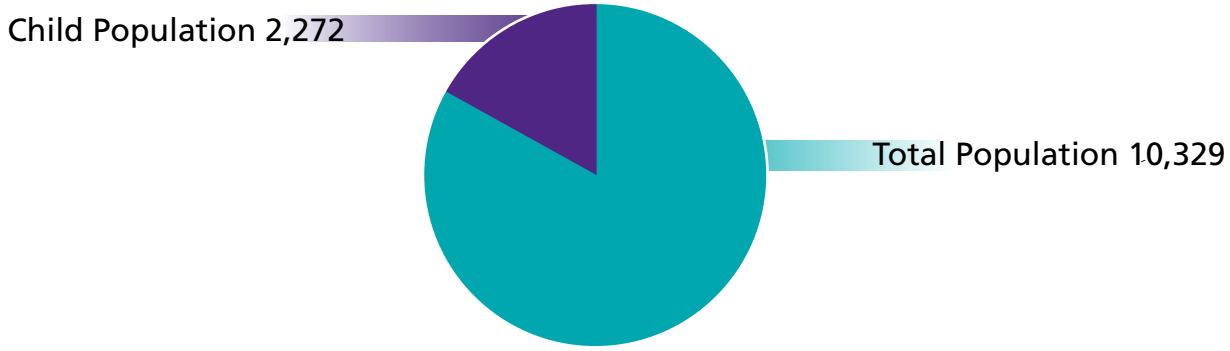
202 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

203 Foreign Born is the percentage of people who are born outside the United States.

SCITUATE

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[204]	Scituate	Prov. County	RI	Data Year
	$90,789	$49,411	$68,507	2011



	Scituate	RI	Data Year
Low Birthweight [205]	NA	7.9%	2011
Infant Mortality Rate [206]	NA	6.5	2011
Teen Birth Rate [207]	4.1	25.5	2011
High School Graduation Rate [208]	91.0%	77.0%	2012
Bachelor's Degree or Higher [209]	29.5%	30.6%	2011
Foreign Born [210]	3.2%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Scituate. http://www.rikidscount.org/matriarch/documents/Scituate_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

204 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

205 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

206 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

207 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

208 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

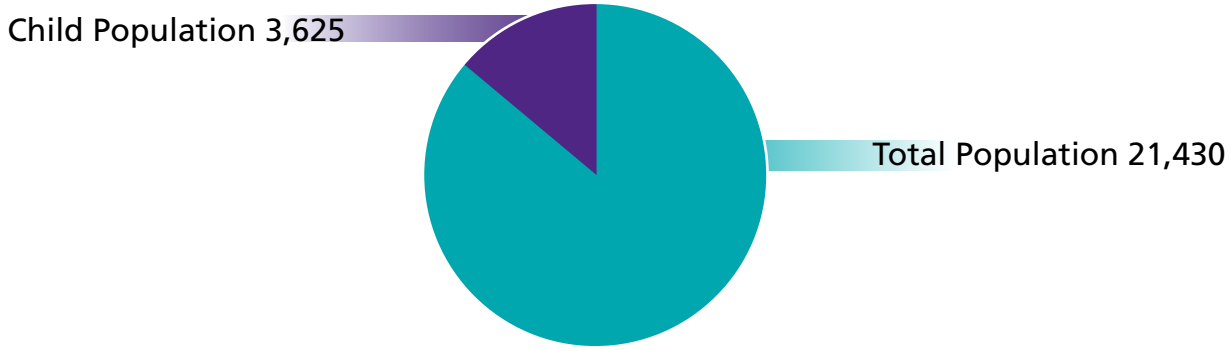
209 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

210 Foreign Born is the percentage of people who are born outside the United States.

SMITHFIELD

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[211]	Smithfield	Prov. County	RI	Data Year
	$98,808	$49,411	$68,507	2011



	Smithfield	RI	Data Year
Low Birthweight [212]	7.4%	7.9%	2011
Infant Mortality Rate [213]	0.0	6.5	2011
Teen Birth Rate [214]	3.1	25.5	2011
High School Graduation Rate [215]	94.0%	77.0%	2012
Bachelor's Degree or Higher [216]	34.8%	30.6%	2011
Foreign Born [217]	5.2%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Smithfield. http://www.rikidscount.org/matriarch/documents/Smithfield_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

211 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

212 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

213 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

214 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

215 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

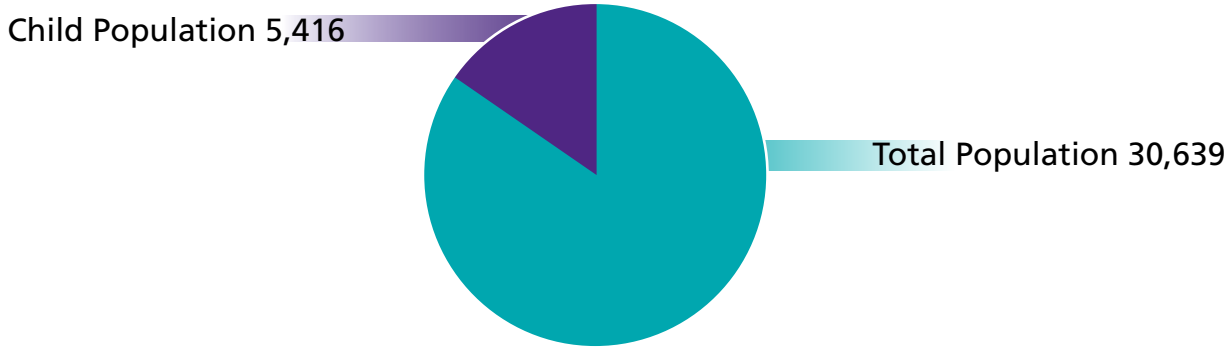
216 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

217 Foreign Born is the percentage of people who are born outside the United States.

SOUTH KINGSTOWN

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[218]	South Kingstown	Wash. County	RI	Data Year
	$101,857	$72,163	$68,507	2011



	South Kingstown	RI	Data Year
Low Birthweight [219]	7.4%	7.9%	2011
Infant Mortality Rate [220]	4.9	6.5	2011
Teen Birth Rate [221]	3.8	25.5	2011
High School Graduation Rate [222]	80.0%	77.0%	2012
Bachelor's Degree or Higher [223]	54.7%	30.6%	2011
Foreign Born [224]	5.2%	12.9%	2011

Data Sources:

a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none

b. 2013 RI KIDS COUNT City and Town Fact Sheet, South Kingstown. http://www.rikidscount.org/matriarch/documents/South_Kingstown_2013.pdf

c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

218 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

219 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

220 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

221 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

222 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

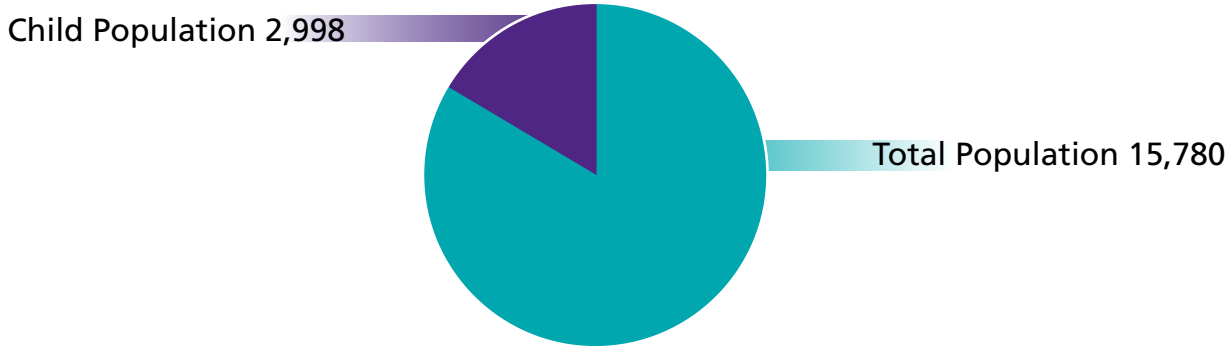
223 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

224 Foreign Born is the percentage of people who are born outside the United States.

TIVERTON

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[225]	Tiverton	Newport County	RI	Data Year
	$83,886	$69,369	$68,507	2011



	Tiverton	RI	Data Year
Low Birthweight [226]	6.3%	7.9%	2011
Infant Mortality Rate [227]	1.7	6.5	2011
Teen Birth Rate [228]	10.2	25.5	2011
High School Graduation Rate [229]	83.0%	77.0%	2012
Bachelor's Degree or Higher [230]	31.6%	30.6%	2011
Foreign Born [231]	5.2%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Tiverton. http://www.rikidscount.org/matriarch/documents/Tiverton_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

225 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

226 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

227 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

228 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

229 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

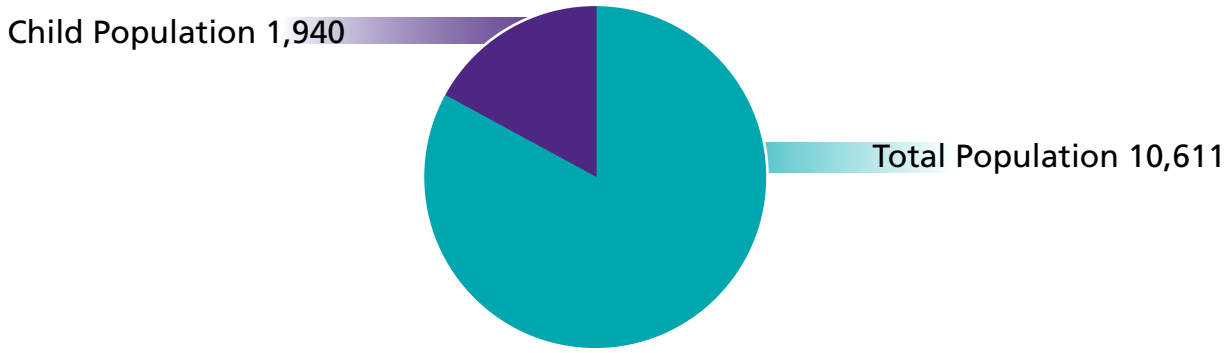
230 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

231 Foreign Born is the percentage of people who are born outside the United States.

WARREN

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[232]	Warren	Bristol County	RI	Data Year
	$75,771	$70,553	$68,507	2011



	Warren	RI	Data Year
Low Birthweight [233]	NA	7.9%	2011
Infant Mortality Rate [234]	NA	6.5	2011
Teen Birth Rate [235]	20.7	25.5	2011
High School Graduation Rate [236]	85.0%	77.0%	2012
Bachelor's Degree or Higher [237]	28.5%	30.6%	2011
Foreign Born [238]	7.1%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Warren. http://www.rikidscount.org/matriarch/documents/Warren_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

232 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

233 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

234 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

235 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

236 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

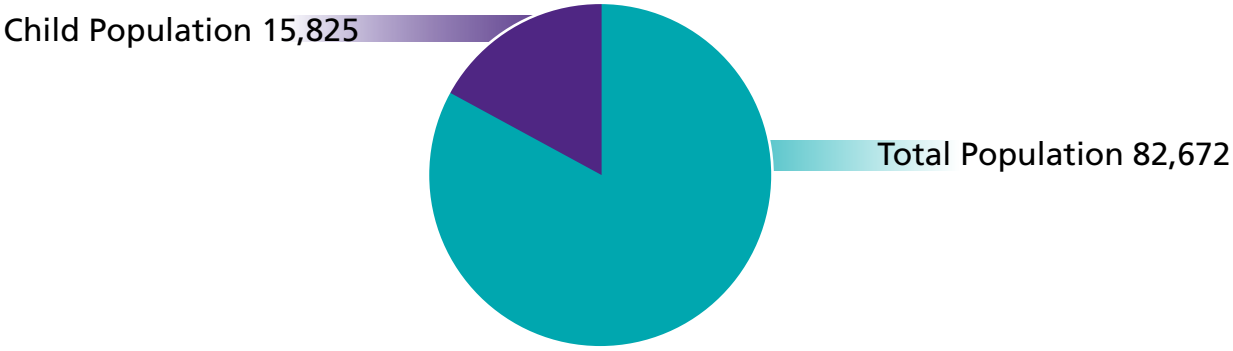
237 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

238 Foreign Born is the percentage of people who are born outside the United States.

WARWICK

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[239]	Warwick	Kent County	RI	Data Year
	$76,689	$61,279	$68,507	2011



	Warwick	RI	Data Year
Low Birthweight [240]	7.5%	7.9%	2011
Infant Mortality Rate [241]	6.0	6.5	2011
Teen Birth Rate [242]	20.1	25.5	2011
High School Graduation Rate [243]	79.0%	77.0%	2012
Bachelor's Degree or Higher [244]	28.6%	30.6%	2011
Foreign Born [245]	5.9%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Warwick. http://www.rikidscount.org/matriarch/documents/Warwick_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

239 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

240 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

241 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

242 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

243 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

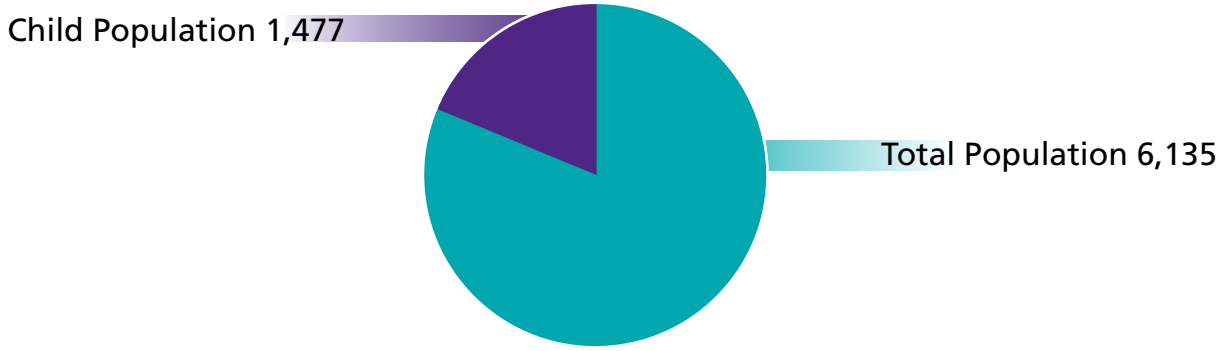
244 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

245 Foreign Born is the percentage of people who are born outside the United States.

WEST GREENWICH

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[246]	West Greenwich	Kent County	RI	Data Year
	$103,897	$61,279	$68,507	2011



	West Greenwich	RI	Data Year
Low Birthweight [247]	NA	7.9%	2011
Infant Mortality Rate [248]	NA	6.5	2011
Teen Birth Rate [249]	9.9	25.5	2011
High School Graduation Rate [250]	90.0%	77.0%	2012
Bachelor's Degree or Higher [251]	30.8%	30.6%	2011
Foreign Born [252]	3.0%	12.9%	2011

Data Sources:

a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none

b. 2013 RI KIDS COUNT City and Town Fact Sheet, West Greenwich. http://www.rikidscount.org/matriarch/documents/West_Greenwich_2013.pdf

c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

246 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

247 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

248 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

249 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

250 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

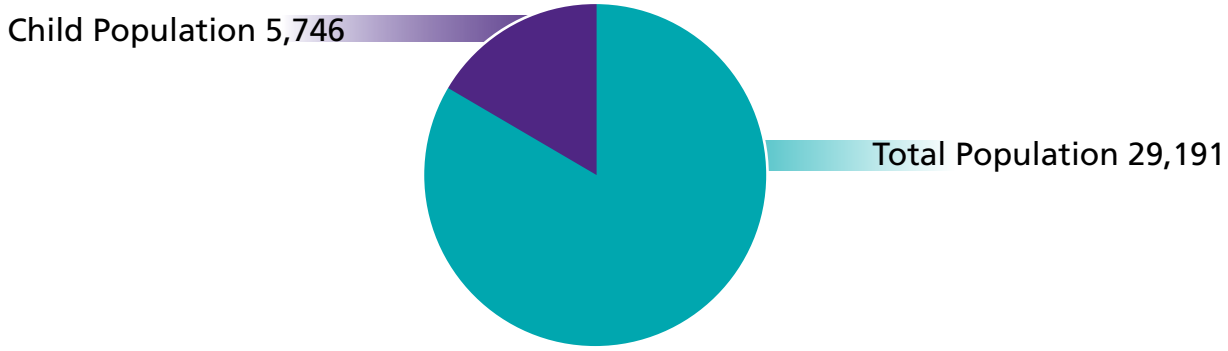
251 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

252 Foreign Born is the percentage of people who are born outside the United States.

WEST WARWICK

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[253]	West Warwick	Kent County	RI	Data Year
	$65,617	$61,279	$68,507	2011



	West Warwick	RI	Data Year
Low Birthweight [254]	8.1%	7.9%	2011
Infant Mortality Rate [255]	4.1	6.5	2011
Teen Birth Rate [256]	41.7	25.5	2011
High School Graduation Rate [257]	70.0%	77.0%	2012
Bachelor's Degree or Higher [258]	21.5%	30.6%	2011
Foreign Born [259]	7.8%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, West Warwick. http://www.rikidscount.org/matriarch/documents/West_Warwick_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

253 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

254 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

255 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

256 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

257 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

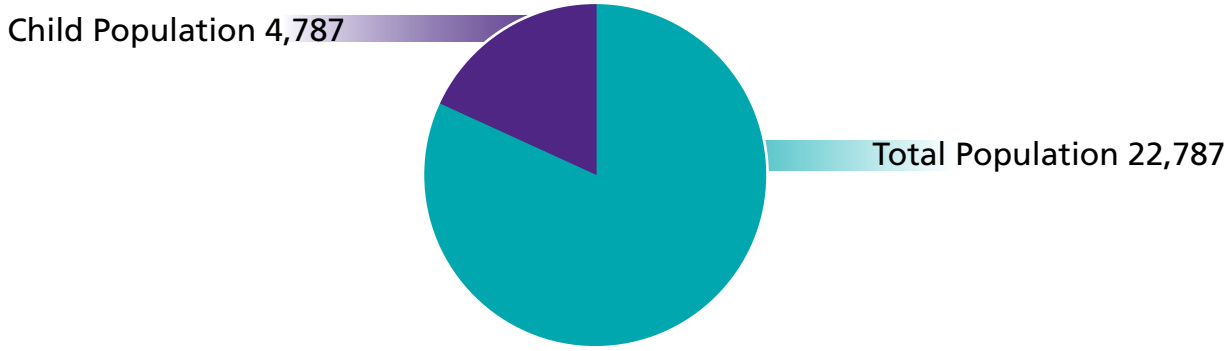
258 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

259 Foreign Born is the percentage of people who are born outside the United States.

WESTERLY

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[260]	Westerly	Wash. County	RI	Data Year
	$85,182	$72,163	$68,507	2011



	Westerly	RI	Data Year
Low Birthweight [261]	7.6%	7.9%	2011
Infant Mortality Rate [262]	6.7	6.5	2011
Teen Birth Rate [263]	23.2	25.5	2011
High School Graduation Rate [264]	87.0%	77.0%	2012
Bachelor's Degree or Higher [265]	29.6%	30.6%	2011
Foreign Born [266]	5.0%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Westerly. http://www.rikidscount.org/matriarch/documents/Westerly_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

260 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

261 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

262 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

263 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

264 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

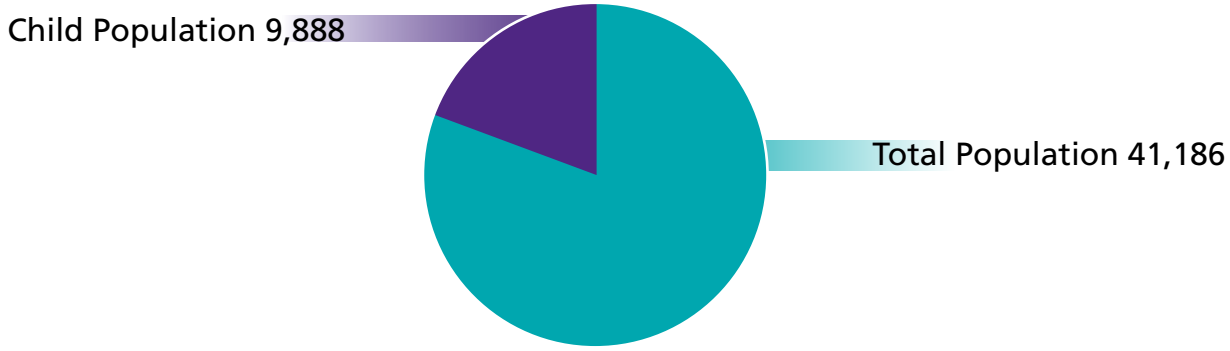
265 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

266 Foreign Born is the percentage of people who are born outside the United States.

WOONSOCKET

Extract from Rhode Island KIDS COUNT Factbook 2013

Median Family Income[267]	Woonsocket	Prov. County	RI	Data Year
	$35,256	$49,411	$68,507	2011



	Woonsocket	RI	Data Year
Low Birthweight [268]	10.1%	7.9%	2011
Infant Mortality Rate [269]	7.1	6.5	2011
Teen Birth Rate [270]	71.4	25.5	2011
High School Graduation Rate [271]	65.0%	77.0%	2012
Bachelor's Degree or Higher [272]	13.8%	30.6%	2011
Foreign Born [273]	9.1%	12.9%	2011

Data Sources:
a. U.S. Census, http://factfinder2.Census.gov/faces/nav/jsf/pages/community_facts.xhtml#none
b. 2013 RI KIDS COUNT City and Town Fact Sheet, Woonsocket. http://www.rikidscount.org/matriarch/documents/Woonsocket_2013.pdf
c. U.S. Census, http://factfinder2.Census.gov/faces/tableservices/jsf/pages/producctview.xhtml?pid=ACS_11_5YR_DP02

267 Median Family Income is the dollar amount which divides Rhode Island families' income distribution into two equal groups-half with incomes above the median, and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

268 Low Birthweight is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces).

269 Infant Mortality Rate is the number of deaths of infants under one year of age per 1,000 live births.

270 Teen Birth Rate is the number of births to teen girls ages 15 to 19 per 1,000 teen girls.

271 High School Graduation Rate is the percentage of students who graduate from high school within four years of entering.

272 Bachelor's Degree or Higher is the percentage of people who have obtained a bachelor's degree or higher.

273 Foreign Born is the percentage of people who are born outside the United States.

B. America's Health Ranking Indicators

HEALTH is presenting a State Health Assessment following the structure of the America's Health Ranking (www.americashealthrankings.org) indicators. Since 1990, America's Health Rankings (AHR) has published an annual state-by-state analysis of health throughout the United States and the factors that affect it. The goal of the rankings is to engage each state's communities, partners, and health officials to stimulate actions to improve the state population's health. The annual report further identifies states with the best rankings, so others may learn from best practices.

HEALTH is utilizing AHR for the purposes of this report because these annual indicators efficiently track HEALTH's goal of making Rhode Island the healthiest state in the nation. As of 2013, Rhode Island was ranked #19 in the United States. While this is a respectable ranking, HEALTH ranked behind New England's five other states (Vermont, New Hampshire, Massachusetts, Connecticut, and Maine). Hawaii was ranked as the healthiest state in the nation.

HEALTH refers to these rankings for inspiration to set targets and as measures to identify areas where one can make a difference in public health. HEALTH has established an internal workgroup to select priorities and explore innovative ways to make progress in those areas. Four indicators have been identified as priorities for the coming years:

- Binge drinking
- Preventable hospitalizations
- Graduation rates
- Sedentary lifestyle

While important work will be planned to make improvements within these four areas, all of the AHR indicators are being presented within this report, as compared to other New England states and to the nation. All Rhode Island communities, legislators, decision-makers, health advocates, and residents are encouraged to pay attention to these rankings and look for ways to support public efforts and community partnerships to make Rhode Island healthier. Each of the indicators discuss current efforts underway to address health issues and shares how all Rhode Islanders can get involved as part of the solution.

Please let us know if you have additional ideas, resources, contacts or information that can be added to any of the indicators.

Rhode Island indicators, according to America's Health Rankings 2013

		2013 VALUE	2013 RANK	NO 1 STATE
DETERMINANTS	**BEHAVIORS**			
	Smoking (Percent of adult population)	17.4	14	10.6
	Binge Drinking (Percent of adult population)	17.2	30	10.2
	Drug Deaths (Deaths per 100,000 population)	16.0	42	5.0
	Obesity (Percent of adult population)	25.7	13	20.5
	Physical Inactivity (Percent of adult population)	23.4	30	16.2
	High School Graduation Rate (Percent of incoming ninth graders)	76.4	33	91.4
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	252	13	123
	Occupational Fatalities (Deaths per 100,000 workers)	3.7	15	1.9
	Infectious Diseases (Combined score Chlamydia, Pertussis, Salmonella*)	-0.11	27	-0.90
	Chlamydia (Cases per 100,000 population)	393.9	23	140.6
	Pertussis (Cases per 100,000 population)	5.9	28	0.7
	Salmonella (Cases per 100,000 population)	18.4	37	6.6
	Children in Poverty (Percent younger than 18 years)	20.4	28	9.7
	Air Pollution (Micrograms of fine particles per cubic meter)	8.5	16	5.3
	POLICY			
	Lack of Health Insurance (Percent without health insurance)	12.2	14	3.8
	Public Health Funding (Dollars per person)	$114	10	$225
	Immunization--Children (Percent aged 19 to 35 months)	72.5	15	80.2
	Immunization--Adolescents (Percent aged 13 to 17 years)	82.0	1	82.0
	CLINICAL CARE			
	Low Birthweight (Percent of live births)	7.4	19	6.0
	Primary Care Physicians (Number per 100,000 population)	173.4	3	196.1
	Dentists (Number per 100,000 population)	59.1	23	85.6
	Preventable Hospitalizations (Number per 100,000 Medicare enrollees)	70.3	37	27.4
	ALL DETERMINANTS	**0.32**	**13**	**0.70**
OUTCOMES				
	Diabetes (Percent of adult population)	9.8	26	7.0
	Poor Mental Health Days (Days in previous 30 days)	4.1	35	2.8
	Poor Physical Health Days (Days in previous 30 days)	4.1	29	2.9
	Disparity in Health Status (By educational attainment**)	31.5	36	19.7
	Infant Mortality (Deaths per 100,000 live births)	6.6	28	4.4
	Cardiovascular Deaths (Deaths per 100,000 population)	238.6	22	186.9
	Cancer Deaths (Deaths per 100,000 population)	193.1	31	141.3
	Premature Death (Years lost per 100,000 population)	6,662	20	5,493
	ALL OUTCOMES	0.00	30	0.33
	OVERALL	**0.32**	**19**	**0.92**

Source: America's Health Rankings Report, 2013, page 111 (www.americashealthrankings.org)

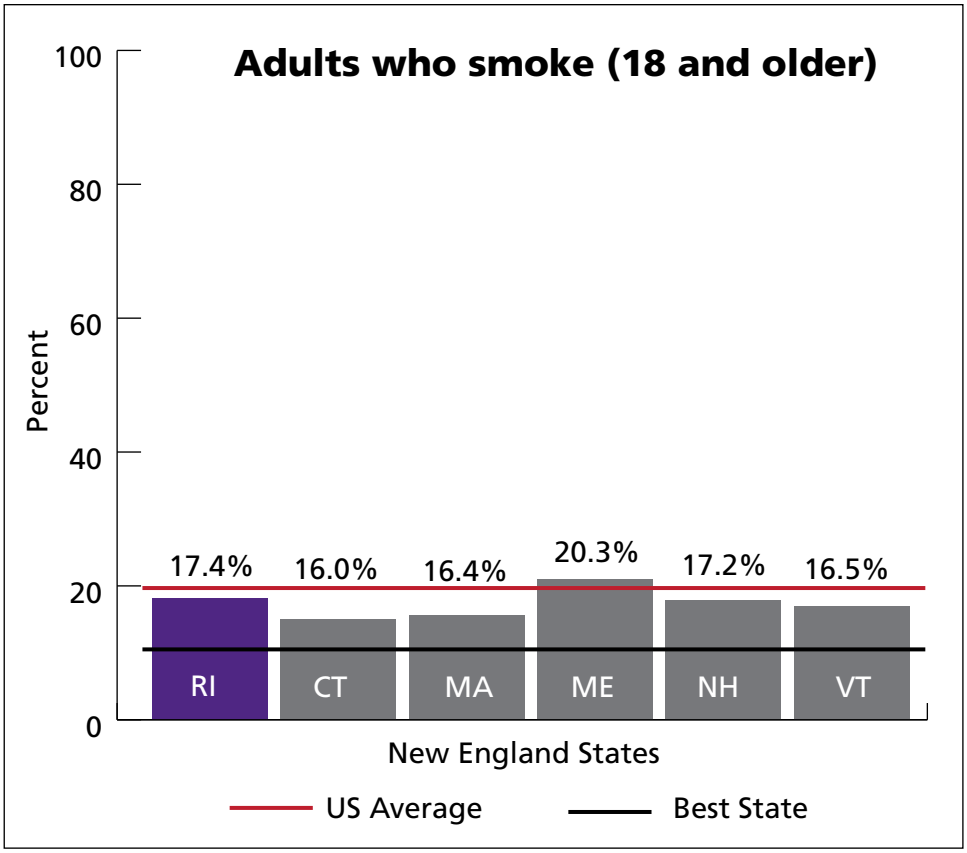
Table 7. America's Health Ranking Indicators for Rhode Island, 2013

* Negative score denotes less disease than US average, positive score indicates more than US average

**Difference in high health status between adults aged 25 and older without a high school education and those with at least a high school education

SMOKING

Percentage of adults who are current smokers (smoked at least 100 cigarettes in their lifetime and currently smoke)
(Data Year: 2012)



Data Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), Public Health Surveillance System Program Office

The Numbers at a Glance

- 153,000 adults smoke in RI
- RI: 17.4%
- U.S. Average: 19.6%
- Best State: Utah, 10.6%
- Healthy People 2020 Target: Reduce to 12% nationally

Why It's Important

Rhode Island adults smoke cigarettes at a rate of 17.4% and nearly 1,600 will die each year from smoking-related illness. For every one person who dies from tobacco use, 20 more people suffer from serious tobacco-related illnesses, including cancer, heart disease, and respiratory illnesses. Smoking in Rhode Island costs $506 million every year in healthcare costs, $179 million in Medicaid expenditures, and nearly $4 million in lost productivity. Tobacco use disproportionately affects a few minority populations in Rhode Island: African Americans, pregnant women, people with disabilities, people with chronic disease, and people with low socioeconomic status.

Strengths

- The adult smoking rate in Rhode Island declined by 5% between 2004 and 2010.
- The Rhode Island Tobacco Control Program measured a decrease in inpatient hospitalizations from heart disease after implementation of the statewide ban on indoor smoking in public places.
- 63% of Rhode Island adult smokers make a quit attempt annually.
- The percentage of pregnant women who made a quit attempt increased from 49% in 2004 to 58% in 2009.

Challenges

- The Centers for Disease Control and Prevention (CDC) best practices recommended a funding level for a comprehensive tobacco control program is $15 million. The actual state funding for Rhode Island is approximately $1.5 million for fiscal year 2014.
- African Americans experience higher rates of hypertension and heart disease and report greater difficulty quitting or reducing smoking. This is likely due to greater nicotine inhalation as a result of smoking mentholated cigarettes.
- 11% of pregnant women still smoke during their pregnancy.
- People with disabilities have a 50% higher smoking rate than those without disabilities.
- 25% of people with household incomes less than $25,000 per year smoke.
- 11% of people with household incomes above $50,000 per year smoke.
- The tobacco industry creates new tobacco and nicotine products regularly, maintaining smokers' addictions and often circumventing existing best practice tobacco control policies and pricing standards. Many of these products are used in conjunction with smoking cigarettes to maintain smokers' nicotine addiction when smoking a cigarette is not available to them.

What can be done

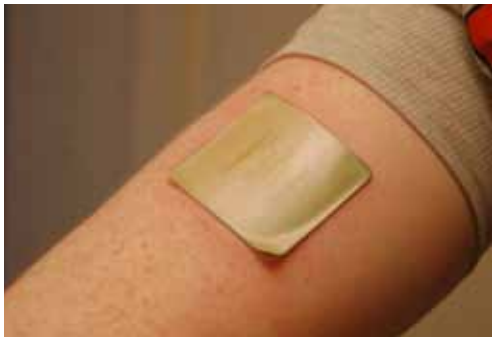
Five evidence-based strategies supported by the CDC, when combined, produce significant gains in tobacco control efforts by changing community environments:

- Media: Hard-hitting, counter-advertising campaigns are effective at prompting cessation attempts. Rhode Island efforts include a campaign called Tobacco Made Me which features local residents who have been affected by tobacco use and urge other smokers to make a quit attempt. An active Facebook page supports the campaign. These messages can be used to educate the community. Visit: www.facebook.com/TobaccoMadeMe
- Access: Establishing smoke-free public space limits access to tobacco. Rhode Island passed a ban on smoking in the workplace. Recent efforts include expanding smoke-free areas to include community recreation areas and beaches, state beaches and parks, public housing authorities and other multi-unit dwellings. A new initiative to ban smoking at area colleges is underway.

- Point of Purchase/Promotion: Establishing municipal tobacco retailer licenses assists communities in restricting tobacco retail sales locally. Each may utilize enforcement authority through a municipal retailer license to enact and enforce policies relative to banning tobacco coupons and flavored tobacco sales, which attracts youth.
- Price: The most effective way to reduce tobacco use is to increase the price of tobacco. Raising the Rhode Island cigarette tax, currently $3.50, will further reduce smoking rates. As more smokeless tobacco products enter the market, capturing these products in existing cigarette tax rates would have the impact of reducing use. These products help to initiate a nicotine addiction, or help a smoker maintain their addiction in places where smoking is restricted.
- Social Support & Services: Quitline sustainability and availability of cessation services for underinsured and uninsured assist smokers to quit should be maintained.

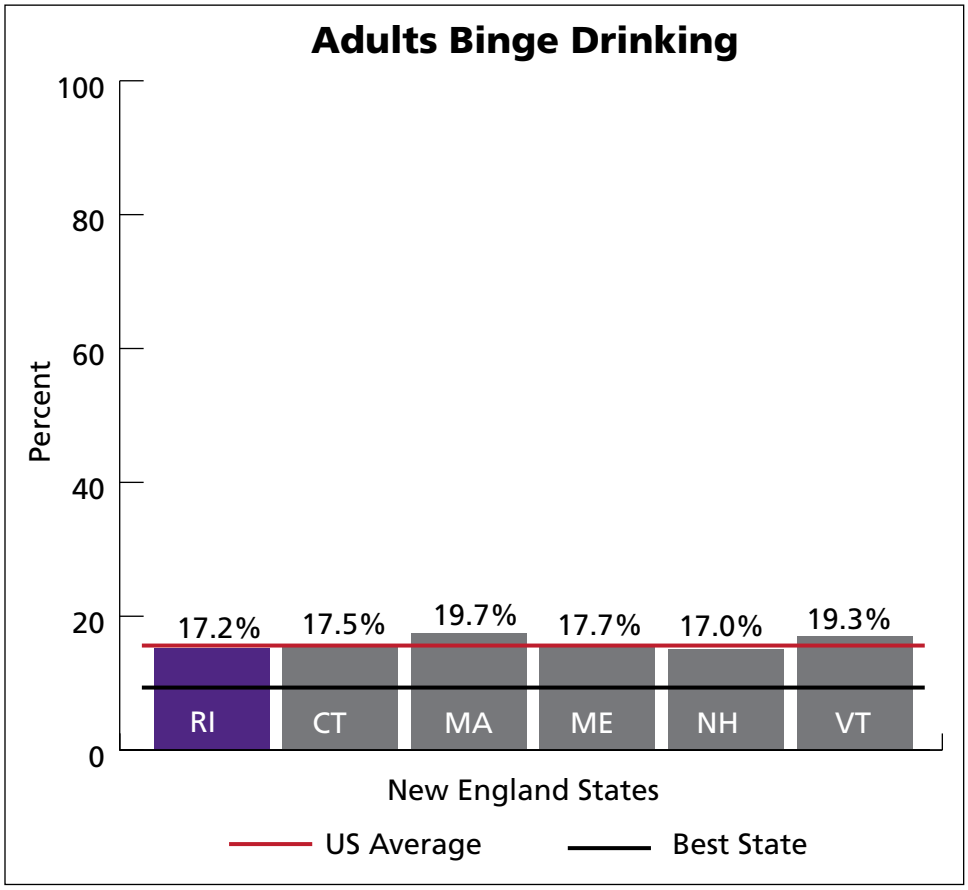
Resources

- Tobacco Free Rhode Island (tobaccofree-ri.org)
- Facebook.com/tobaccomademe



BINGE DRINKING

Percentage of adults who self-report having four or more (women) or five or more (men) alcoholic beverages on at least one occasion in the past 30 days. (Data Year: 2012)



Data Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS)

The Numbers at a Glance

- RI: 17.2%
- U.S. Average: 16.9%
- Best State: West Virginia, 10.2%
- Healthy People 2020 Target: Improve rates by 10%

Why It's Important

Binge drinking measures the percentage of the population age 18 or older who drank excessively within the last 30 days. Binge drinking has many negative effects. Binge drinking leads to acute impairment and has many adverse effects on health including:

- Alcohol-related motor vehicle injuries and deaths
- Increased aggression
- Unintentional injuries

- Fetal damage
- Liver disease
- Cardiovascular disease

In addition to personal health risks, binge drinking costs Rhode Island and its taxpayers thousands of dollars due to alcohol-related hospital visits.

Strengths

- Promoting legislation for higher alcohol taxes is feasible.
- Impaired driving due to alcohol use is enforced and has serious consequences.

Challenges

- Rhode Island's binge drinking rate (17.2%) is higher than the national average.
- Rhode Island recently repealed the sales tax on liquor and wine.
- Binge drinking rates are highest among 18-25-year-old young adults.
- Approximately 54,000 underage youth in Rhode Island drink each year.
- Adolescents who begin drinking before age 15 are four times more likely to develop an alcohol dependence and are two and a half times more likely to become abusers of alcohol than those who begin drinking at age 21.
- Excessive alcohol consumption is the third leading cause of death in the United States.

What can be done

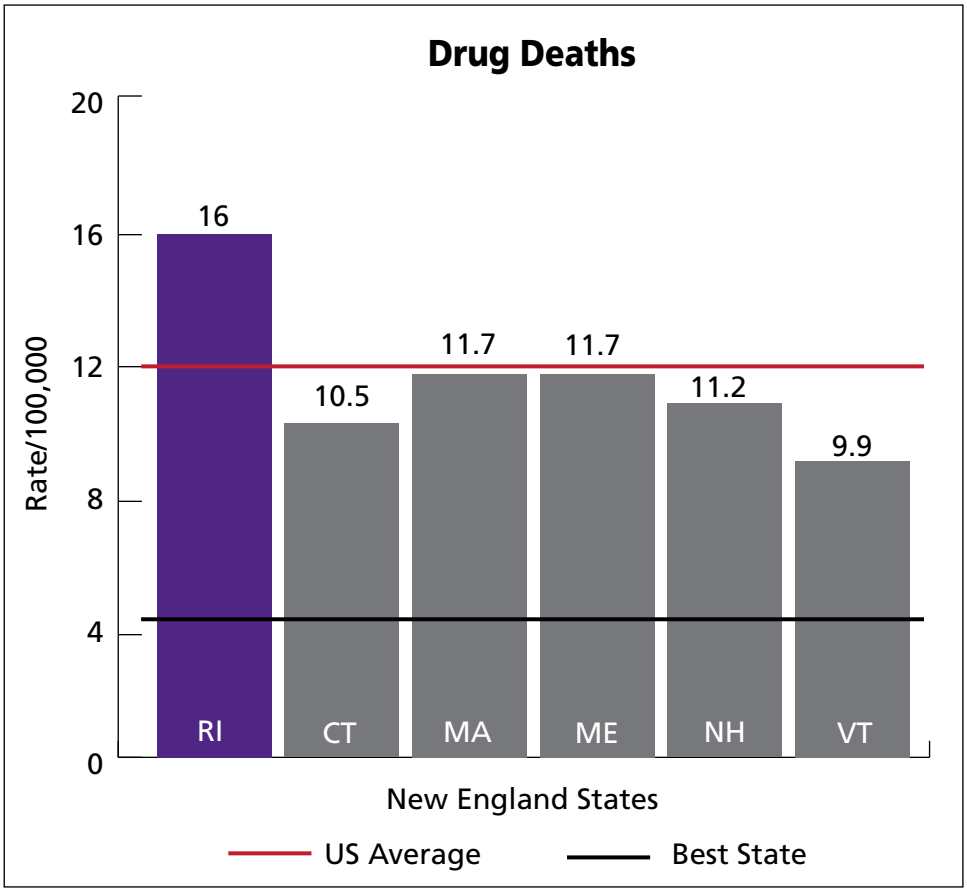
- Increase alcoholic beverage costs and excise taxes.
- Limit the number of retail alcohol outlets that sell alcoholic beverages in any given area.
- Restrict access to alcohol by maintaining limits on the days and hours of alcohol retail sales.
- Encourage consistent enforcement of laws against underage drinking and alcohol impaired driving.
- Maintain government controls on alcohol sales.
- Screen and counsel for alcohol misuse or abuse.
- Educate the public on the health risks associated with binge drinking.

Resources

- Centers for Disease Control and Prevention
- Rhode Island Alcoholics Anonymous Central Services
- Drug and Alcohol Treatment Association of Rhode Island

DRUG DEATHS

The three-year average, age-adjusted number of deaths due to drug injury of any intent (unintentional, suicide, homicide, or undetermined) per 100,000 population (Data year: 2008-2010)



Data source: Centers for Disease Control and Prevention, National Center for Health Statistics (CDC NCHS)

The Numbers at a Glance

- RI: 16.0 per 100,000 population
- U.S. Average: 12.2 per 100,000 population
- Best State: North Dakota, 5.0 per 100,000 population
- Healthy People 2020 Target: Reduce to 11.3 per 100,000 population

Why It's Important

Drug overdose was the leading cause of death in Rhode Island from 2009 to 2011. In 2012, it was the second leading cause of death. In the first two months of 2014, Rhode Island reported that there have been 22 deaths due to accidental drug overdose. This number is twice the number of deaths seen for this same time period last year. The deaths were geographically spread throughout the state, and the age range was 20-62 years old. The deaths happened most frequently on weekends, with 18 of the 22 happening between Fridays and Mondays.

Strengths

- Commitment from key state agencies including HEALTH, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), and the Rhode Island State Police to work together on this important public health issue.
- Rhode Island's Good Samaritan Drug Overdose Prevention Act provides some legal immunity to people who call 911 to report drug overdoses. This law is intended to encourage people to report drug overdoses as soon as possible, even if drugs are present at the scene.

Challenges

- Mixing prescription medications with alcohol is highly dangerous. From 2009 through 2012, many people died each year due to combining alcohol with prescription drugs than combining illicit drugs and alcohol.

What can be done

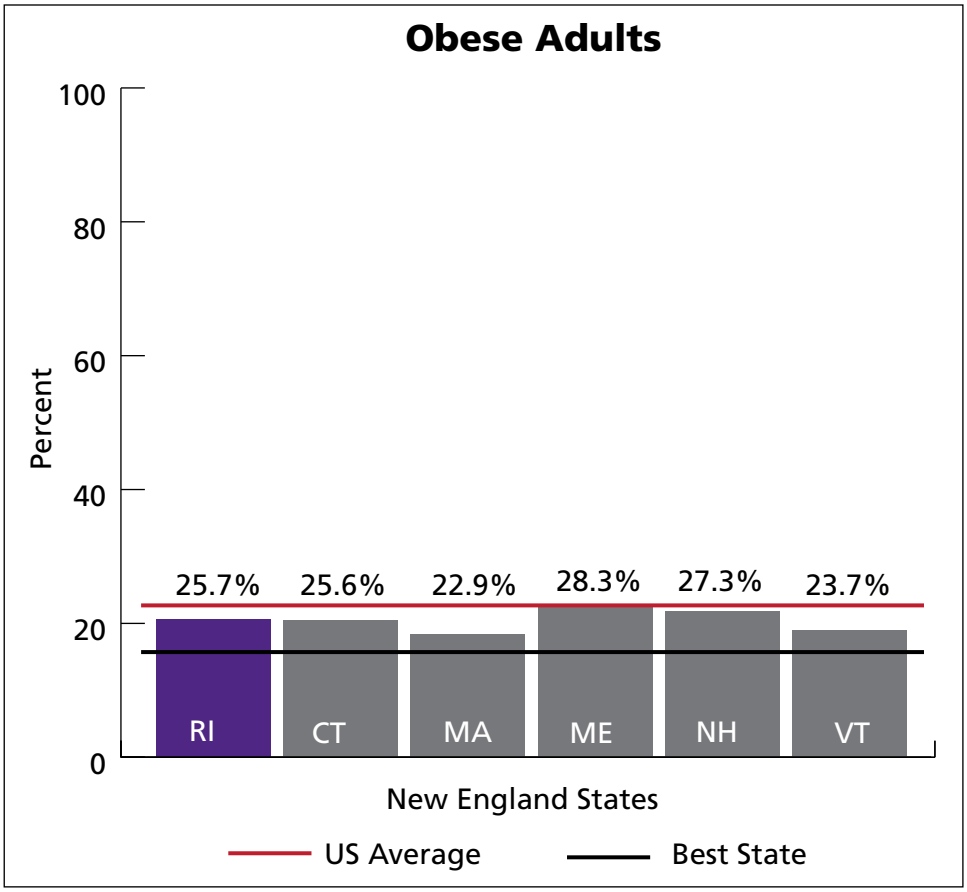
- Tighten monitoring of prescription medication dispensing.
- Provide health education to the medical community and the general public about the dangers of prescription medication abuse.
- Alert the community of Naloxone (Narcan), an emergency antidote to opioid overdose available without prescription at all Walgreens pharmacies in Rhode Island.

Resources

- Mental health services http://www.bhddh.ri.gov/MH/description.php
- Substance abuse services http://www.bhddh.ri.gov/SA/treatDescription.php
- 911
- Walgreens pharmacies

OBESITY

Percentage of adults who are obese, with a body mass index (BMI) of 30.0 or higher. (Data Year: 2012)



Data Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS)

The Numbers at a Glance

- RI: 25.7%
- U.S. Average: 27.6%
- Best State: Colorado, 20.5%
- Healthy People 2020 Target: Reducing proportion by 10%

Why It's Important

Obesity is a significant public health problem. In Rhode Island, 25.4% of adults are obese. Obesity contributes to chronic disease, including heart disease, cancer, stroke, and diabetes, which are leading causes of death and disability in the United States, accounting for seven of every 10 deaths. Heart disease, cancer, and stroke account for more than 50% of deaths each year. Diabetes is a leading cause of kidney failure, non-traumatic lower-extremity amputations and blindness among adults, and is a major cause of heart disease and stroke. Rhode Island spends $539 million annually in obesity-related healthcare costs.

Strengths

- Deaths and disability due to chronic disease, including heart disease, cancer, stroke, and diabetes can be reduced by addressing obesity.
- Improved nutrition and increased physical activity can reduce obesity.

Challenges

- Obesity is a complex problem influenced by the social determinants of health, biological predisposition, and other factors.
- Disparities in obesity rates in sub-populations stem from inequities in access to healthy foods, and opportunities for active living.
- Solutions require complex strategies and changes to the built environment to support and reinforce healthy behaviors in the places where people live, work and play.
- Solutions require the collaboration of non-traditional partners to make changes to environments, policies and systems.
- Resources are limited at federal, state, and municipal levels, and there is resistance to change from the food industry, community developers, schools, and others.

What Can Be Done

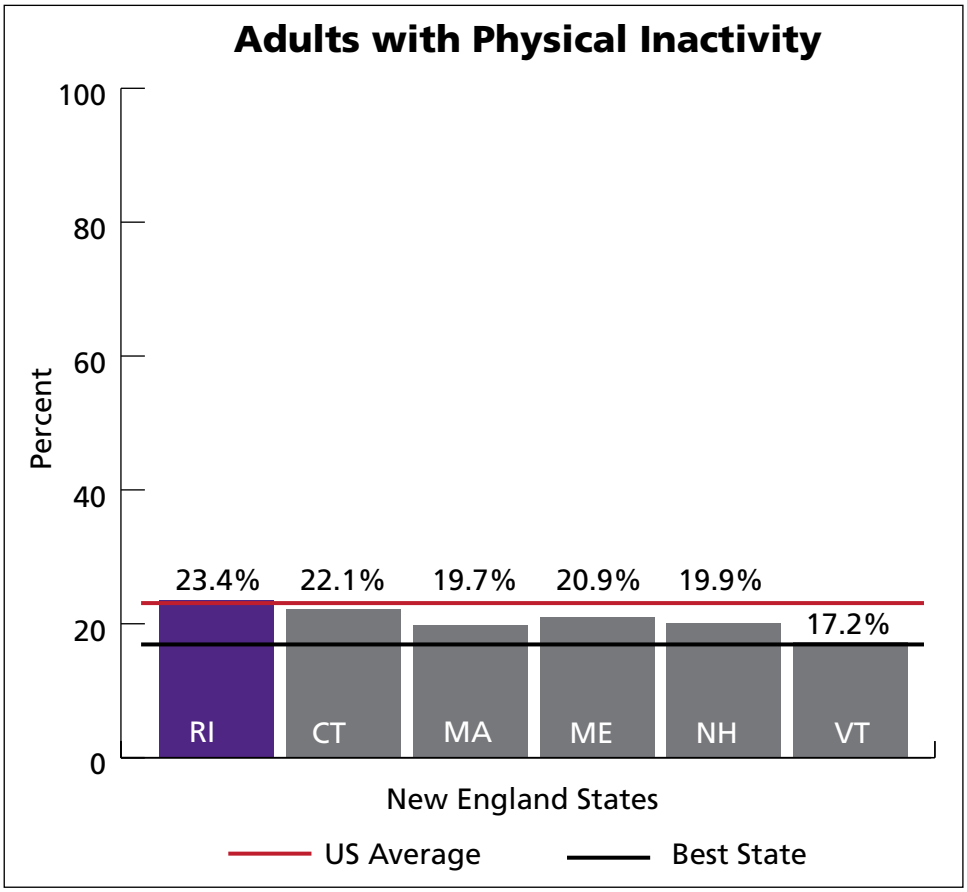
- Promote the adoption of food service guidelines and nutrition standards in schools and worksites.
- Create supportive nutrition environments in schools.
- Promote and implement quality physical education and physical activity in K-12 schools.
- Promote the adoption of physical activity in worksites.
- Increase access to breastfeeding-friendly worksite environments.
- Promote and implement physical education and physical activity in early care and education settings.
- Increase access to healthy foods and beverages in communities and through state government policies and practices.
- Increase physical activity and access and outreach in communities.

Resources

- The Community Guide, USDHHS Community Preventive Services Task Force Guide to Community Preventive Services
- National Prevention Strategy, Office of the Surgeon General National Prevention Council
- United Health Foundation America's Health Rankings: A Call to Action, Keener, D., Goodman, K., Lowry, A., Zaro, S., & Kettel Khan, L. (2009)
- Recommended Community Strategies and Measurements to Prevent Obesity in the United States: Implementation and Measurement Guide, Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation, Institute of Medicine

PHYSICAL INACTIVITY

Percentage of adults who report doing no physical activity or exercise (such as running, calisthenics, golf, gardening, or walking) other than their regular job within the last 30 days. (Data Year: 2012)



Data Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS)

The Numbers at a Glance

- RI: 23.4%
- U.S. Average: 22.9%
- Best State: Oregon, 16.2%
- Healthy People 2020 Target: Reducing proportion by 10%

Why It's Important

Physical activity strengthens bones and muscles, reduces stress and depression, and makes it easier to maintain a healthy body weight or to reduce weight if overweight or obese. Even people who do not lose weight get substantial benefits from regular physical activity, including lower rates of high blood pressure, diabetes, and cancer. Healthy physical activity includes aerobic activity, muscle-strengthening activities, and activities to increase balance and flexibility. (National Prevention Council, June 2011) Currently one in four Rhode Islanders reports doing no physical activity or exercise other than their regular job.

Strengths

- Strengthens bones and muscles, reduces stress and depression, and makes it easier to maintain a healthy body weight or to reduce weight if overweight or obese.
- Lowers rates of high blood pressure, diabetes, and cancer.
- Improves balance and flexibility.
- Reduces healthcare costs and increases productivity.

Challenges

- Physical inactivity is a primary contributor to overweight and obesity.
- Physical activity levels may be lower in low-income communities and among racial/ethnic minorities due to feeling unsafe in communities and/or lack of infrastructure like green space and sidewalks.
- Physical activity levels decline with age, despite physical and emotional benefits.
- Many communities lack an active transportation infrastructure or pedestrian friendly environments.
- Resources are limited at federal, state and municipal levels for changes to the built environment.

What Can Be Done

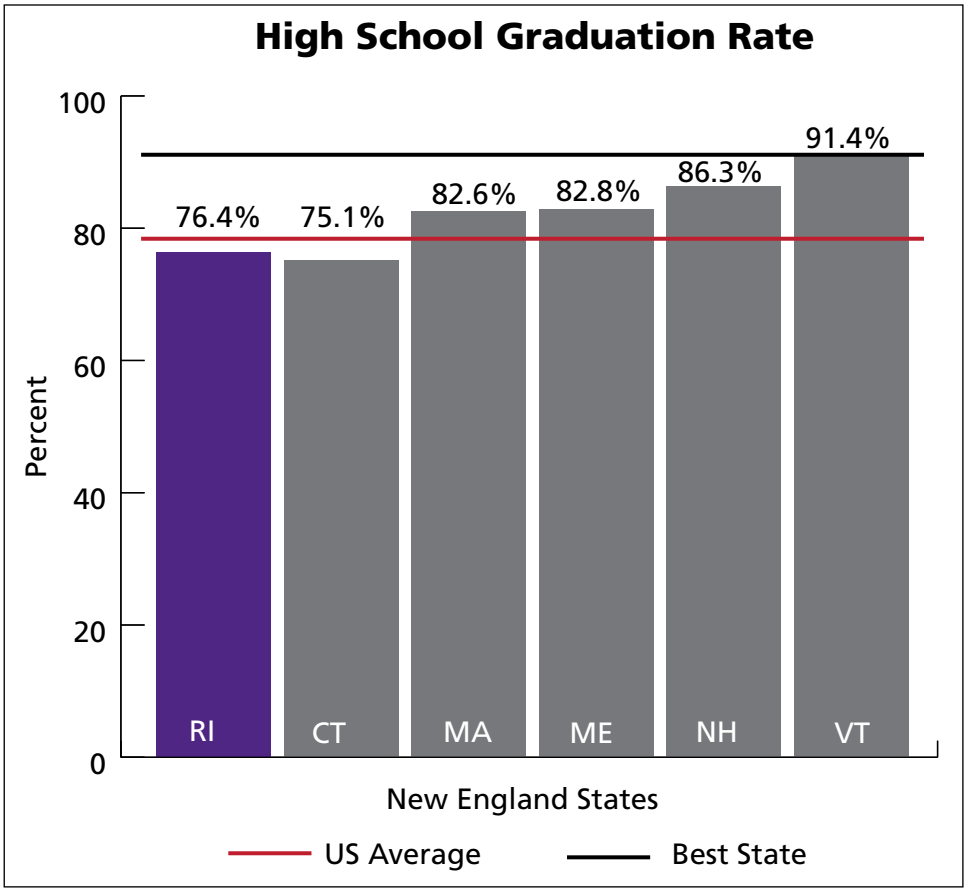
- Increase access to places for physical activity, with a focus on walking through community design and development.
- Implement physical education and physical activity in early care and education settings.
- Increase quality physical education and physical activity in K–12 schools.
- Promote the adoption of physical activity in worksites.

Resources

- USDHHS Community Preventive Services Task Force Guide to Community Preventive Services "The Community Guide"
- Office of the Surgeon General National Prevention Council, National Prevention Strategy
- United Health Foundation America's Health Rankings: A Call to Action • Keener, D., Goodman, K., Lowry, A., Zaro, S., & Kettel Khan, L. (2009).
- Recommended community strategies and measurements to prevent obesity in the United States: Implementation and measurement guide. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation, Institute of Medicine

HIGH SCHOOL GRADUATION

Percentage of incoming Grade 9 students who graduate in four years from a high school. (Data Year: 2010)



Data Source: National Center for Education Statistics (NCES)

The Numbers at a Glance

- RI: 76.4%
- U.S. Average: 78.2%
- Best State: Vermont, 91.4%
- Healthy People 2020 Target: Increase to 82.4% (from 74.9%)

Why It's Important

Education is a vital contributor to health as people must be able to learn about, create, and maintain a healthy lifestyle. Education is strongly tied to higher earnings, which is associated with lower rates of uninsurance, allowing for greater access to quality healthcare. Adults without high school diplomas are more likely to be unemployed, live unhealthy lifestyles, and end up in poverty. Graduating from high school is the minimum requisite for college and most employment and therefore is crucial to the future of the workforce in Rhode Island.

Strengths

- People with more education are more likely to practice health-promoting behaviors, to be able to access needed care, to have better health outcomes, and to live longer than those with less education.
- Children who attend high quality preschool programs and read at grade level in elementary school are more likely to graduate from high school than their peers.
- Personalized and timely academic supports are put in place to help students get "on track" for graduation.
- Each additional year of education is associated with an increase in many health promoting behaviors.

Challenges

- Adults without high school diplomas are more than four times as likely to be unemployed than those who have bachelor's degrees.
- Poverty is strongly linked to the likelihood of dropping out.
- Students in Rhode Island's four core cities are more than twice as likely to drop out of high school than students in the remainder of the state.
- Between 2009 and 2011 in Rhode Island, the median income of adults without high school diplomas was $21,736 compared to $29,838 for adults with high school degrees.
- Closing gaps in education attainment would help reduce health disparities.

What Can Be Done

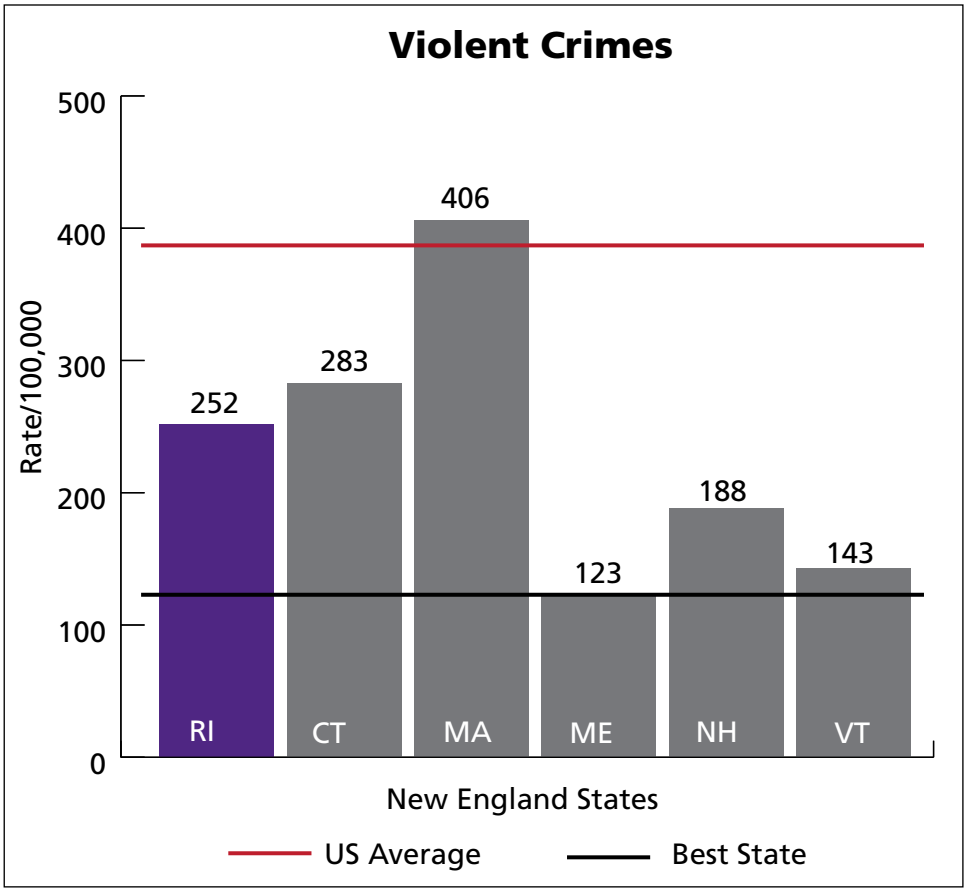
- Early warning and intervention systems to identify students who are off-track.
- Ensure students are reading proficiently by the end of third grade.
- Reduce chronic absenteeism.
- Create eighth and ninth grade transition programs.
- Support personalized learning and meaningful student connections with adults in school.
- Implement rigorous, engaging, and relevant curricula.
- Provide clear pathways from high school to college and career training.
- Offer dropout recovery programs.

Resources

- Rhode Island Department of Education support and technical assistance

VIOLENT CRIMES

Number of murders, rapes, robberies, and aggravated assaults per 100,000 population (Data Year: 2012)



Data Source: Federal Bureau of Investigation (FBI)

The Numbers at a Glance

- RI: 252 per 100,000 population
- U.S. Average: 387 per 100,000 population
- Best State: Maine, 123 per 100,000 population
- No Healthy People 2020 Target

Why It's Important

Violent crime is an important quality-of-life indicator. Violence affects people in all stages of life. Survivors of violent crime are left with physical and emotional scars that increase the risk for poor mental health and suicide. Violent crime also leads to community deterioration which is a deterrent to making healthy lifestyle choices such as being physically active. In 2010, homicide was the third leading cause of death for Rhode Islanders ages 15-34 and the sixth leading cause of death for ages 35-44.

Strengths

- There is an increasing body of evidence for violence prevention programs that work.
- The U.S. Centers for Disease Control and Prevention provides a systematic review of promising and effective violence prevention programs in the Community Guide to Preventive Services.
- The Office of Justice Programs provides a review of promising and effective interventions for high-risk youth.

Challenges

- Violent crime is a significant public health problem that is associated with race and class. African American and Hispanic males ages 15-24 are disproportionately affected by violence.
- There is a strong correlation between violence and poverty, one of the social determinants of health.
- Criminal justice interventions focus on incarceration rather than rehabilitation and prevention.

What Can Be Done

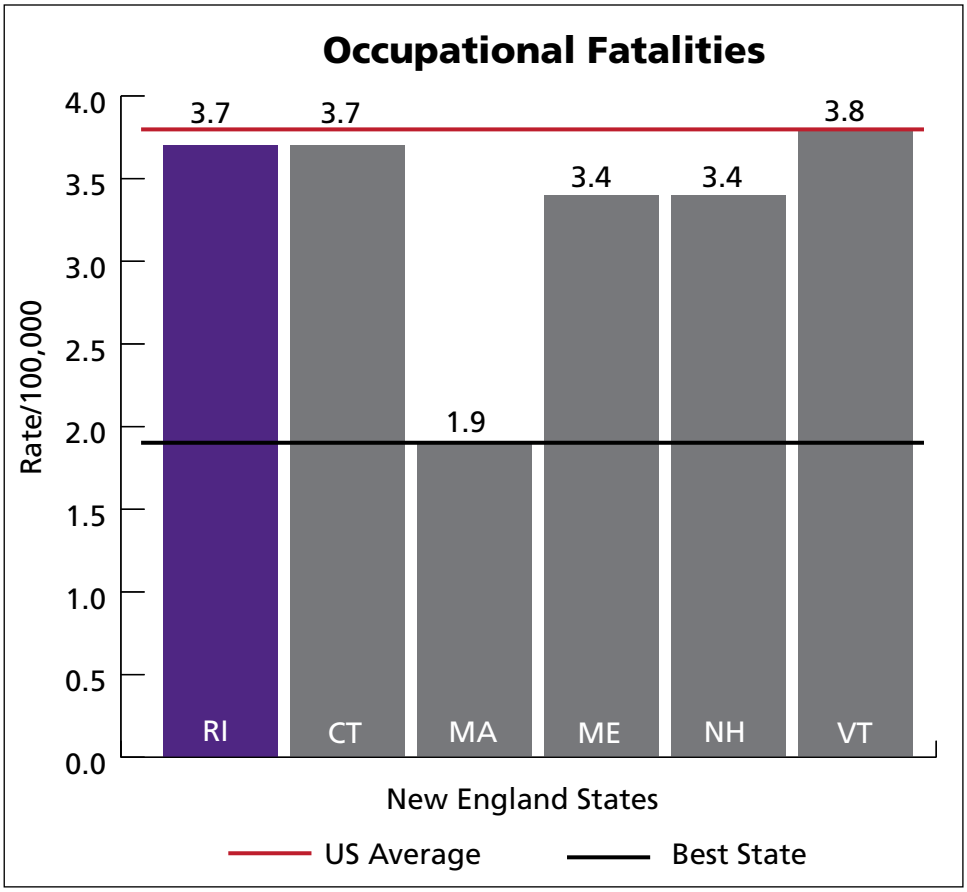
- Support the implementation of prevention programs that work such as early childhood home visiting and therapeutic foster care.
- Support the implementation of interventions for high-risk youth such as adolescent diversion programs and multilevel family-centered interventions.

Resources

- Community policing
- Center for the Study and Practice of Nonviolence
- Victims of Crime Hotline
- Community mental health centers
- Psychiatric hospitals
- Crime victims indemnity fund
- Domestic violence victim fund

OCCUPATIONAL FATALITIES

Number of fatalities from occupational injuries per 100,000 workers. (Data Year: 2010-prelim 2012)



Data Source: Census of Occupational Injuries-Bureau of Labor Statistics (CFOI BLS)

The Numbers at a Glance

- RI: 3.7 per 100,000
- U.S. Average: 3.8 per 100,000
- Best State: Massachusetts, 1.9 per 100,000
- Healthy People 2020 Target: 3.6 deaths per 100,000 workers

Why It's Important

- Occupational fatalities in high-hazard industries are tragedies that are almost always preventable.
- Missed days at work, injuries to workers, and the cost of medical care could be avoided.

Strengths

- Fatalities are decreasing over time.
- Represents the most severe impacts of occupational hazards.
- Data are collected for all 50 states.
- Addresses high-hazard industries

Challenges

- Fatalities are a poor indicator of the magnitude of occupational hazards.
- Injuries, injuries resulting in lost-work days, or the number of lost workdays are better measures, but data are not collected consistently across states.
- Data apply to only a small subset of the workforce.
- Insensitive indicator of major improvements in overall occupational safety and health.
- A single fatality can skew the statistics.

What Can Be Done

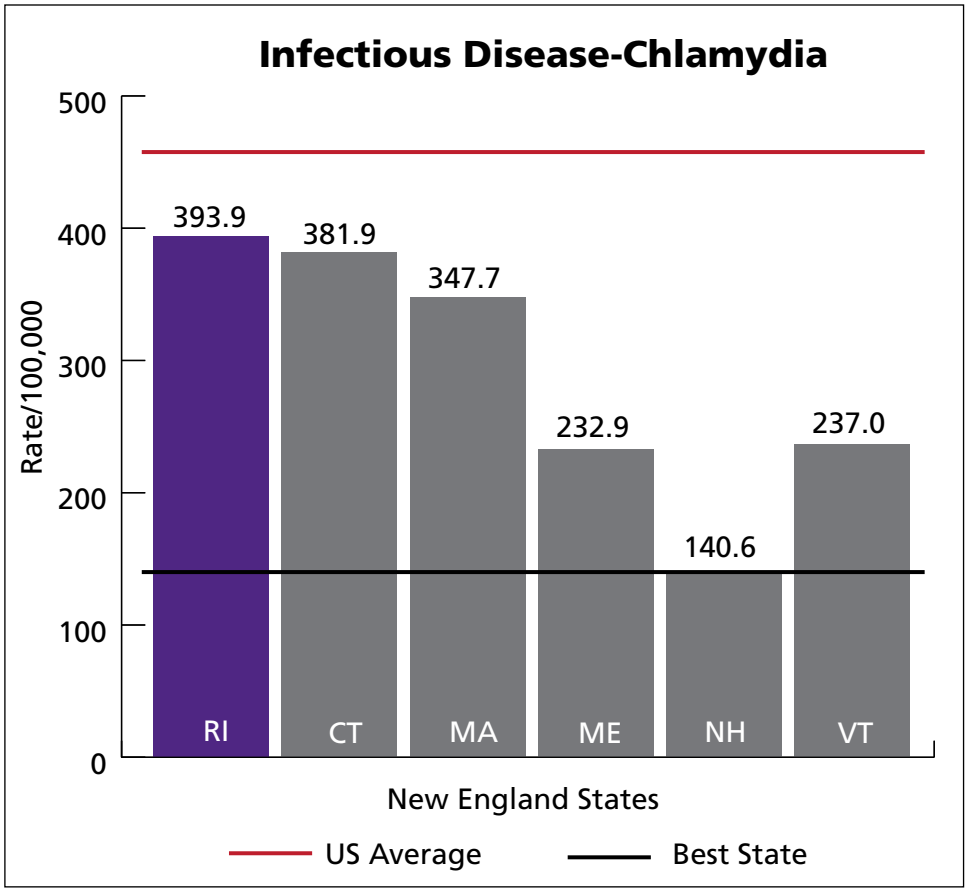
- Support HEALTH's OSHA Consultation Program, a free service for Rhode Island's small businesses.
- Promote teen/youth worker safety initiatives.
- Promote occupational health and safety services and resources as part of Rhode Island's outreach to small businesses.
- Promote health and safety committees for every workplace.
- Promote occupational health and safety training in youth employment programs.

Resources

- Rhode Island Department of Labor
- HEALTH OSHA Consultation Program
- RI Committee for Occupational Safety and Health
- Pawtucket Red Sox Teen Worker Safety Day
- Federal OSHA Regional Office
- The Beacon Mutual Insurance Company

INFECTIOUS DISEASE: CHLAMYDIA

The number of new cases of chlamydia per 100,000 population (Data Year: 2011)



Source: Centers for Disease Control and Prevention, MMWR (Mortality and Morbidity Weekly Report) 2011

The Numbers at a Glance

- RI: 393.9 per 100,000 population
- U.S. Average: 457.6 per 100,000 population
- Best State: New Hampshire 140.6 per 100,000 population
- No Healthy People 2020 Target

Why It's Important

Chlamydia is the most commonly reported prevalent sexually transmitted infection. In 2011, a record 1,412,791 cases (457.6 cases per 100,000) of chlamydia were reported to the CDC representing the largest number of cases ever reported to CDC for any condition in one year. Nationally, rates increased eight percent from 2010 to 2011. (Sexually Transmitted Disease (STD) Surveillance 2011, CDC). Similar to national trends, chlamydia rates have risen an average of five percent in Rhode Island annually since 2009.

Chlamydia, if left untreated, can lead to other more serious and costly health concerns such as Pelvic Inflammatory Disease (PID), ectopic pregnancy, and infertility in women. Symptoms and complications in men are uncommon; however, women are often re-infected by their untreated partners.

Strengths

- Rhode Island has robust reporting and surveillance from laboratories and clinical providers on all positive Chlamydia infections
- The Rhode Island STD Program has strong relationships with community partners (clinical STD safety net providers/ organizations and health plans)
- The Rhode Island STD Program conducts academic detailing to primary care offices (138 practices/439 providers in 2013) to increase awareness about CDC screening and treatment guidelines and reporting requirements
- The Rhode Island STD Program conducts active outreach for all untreated/inadequately treated chlamydia patients

Challenges

- CDC grant funding was cut by 10% for 2014 and is expected to be cut an additional 3% every year for the next five years
- Prevalence estimates are difficult to ascertain due to differences in screening practices among providers as well as urban/ suburban/rural communities

What can be done

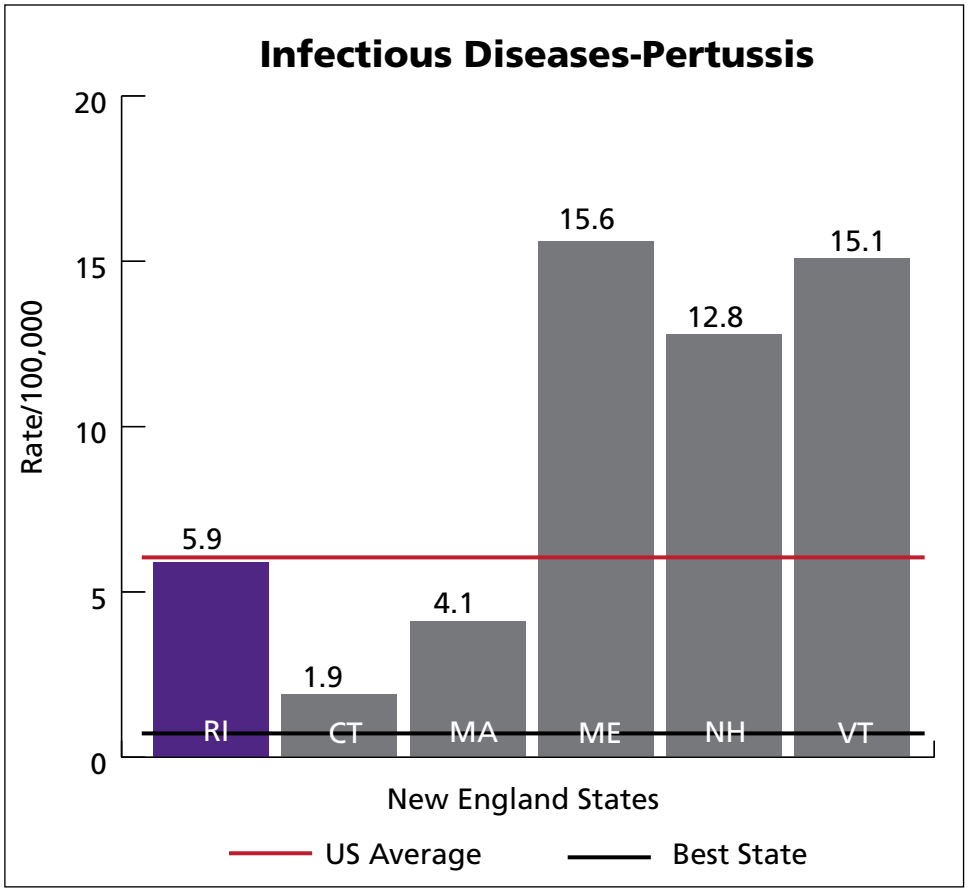
- Continue academic detailing targeting obstetrician/gynecologists and pediatricians
- Work with Medicaid and private health insurance plans to increase chlamydia screening in women ages 15-24
- Continue to promote Expedited Partner Therapy (EPT)
- Educate and link uninsured/underinsured patients and their partners to expanded Medicaid coverage or the marketplace.
- Continue collaboration with HIV/AIDS, Family Planning, and Adolescent Health Programs and the Rhode Island Department of Education to leverage health promotion and primary prevention activities
- Identify health disparities (gender, race, ethnicity, social, geography) that exist and target limited resources

Resources

- State Public Health Laboratory
- Experienced STD program staff and leadership
- The Miriam Hospital Immunology Free STD clinic
- Sylvie Ratelle STD/HIV Prevention Training Center of New England

INFECTIOUS DISEASE: PERTUSSIS

The number of new cases of Pertussis per 100,000 population. (Data Year: 2011)



Data Source: Centers for Disease Control and Prevention, MMWR (Mortality and Morbidity Weekly Report) 2011

The Numbers at a Glance

- RI: 5.9 per 100,000 population
- U.S. Average: 6.1 per 100,000 population
- Best State: Louisiana, 0.7 per 100,000 population
- No Healthy People 2020 Target

Why It's Important

Pertussis is a highly contagious respiratory disease that is characterized by an uncontrollable, violent cough that often makes it difficult to breathe. Anyone can get pertussis, but it can be most severe and sometimes fatal for infants and children younger than one year of age.

Strengths

- Rhode Island has high childhood immunization rates which helps prevent pertussis in the short term.
    - Rhode Island case manages each pertussis case reported to HEALTH by:
    - Ensuring the individual has received appropriate antibiotic treatment
    - Instructing the individual to stay out of group activities until antibiotic treatment is complete
    - Encouraging prophylaxis of all close contacts; if the patient attends school, sending letters and fact sheets to schools notifying parents that their child may have been exposed to pertussis.

Challenges

- Protection conferred by pertussis-containing vaccine wanes quickly, so controlling this disease is challenging despite high immunization rates.
- Pertussis is highly contagious.
- People with pertussis often do not see a healthcare provider to get diagnosed and appropriately treated, leading to increased spread of the disease.

What can be done

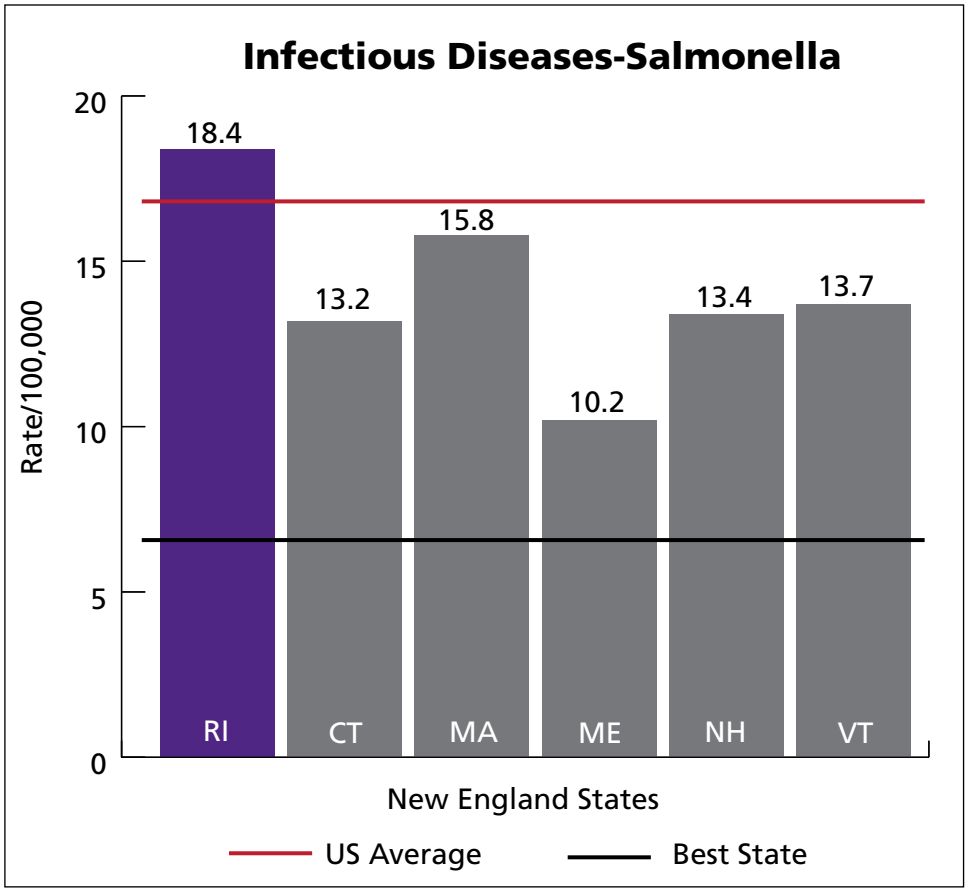
- Support development of an improved pertussis vaccine
- Educate the public about the importance of early diagnosis and treatment of pertussis to prevent its spread
- Encourage pregnant women to get vaccinated against pertussis in order to protect their newborn baby.
- Encourage those who spend time around babies to get vaccinated in order to protect themselves, and the babies from getting pertussis.

Resources

- HEALTH's Immunization Program
- State Health Laboratory
- Experienced infectious disease and epidemiology staff and leadership

INFECTIOUS DISEASE: SALMONELLA

The number of new cases of Salmonella per 100,000 population. (Data Year: 2011)



Data Source: Centers for Disease Control and Prevention, MMWR (Mortality and Morbidity Weekly Report) 2011

The Numbers at a Glance

- RI: 18.4 per 100,000 population
- U.S. Average: 16.8 per 100,000 population
- Best State: Nevada, 6.6 per 100,000 population
- Healthy People 2020 Target: 11.4 infections per 100,000 population

Why It's Important

Salmonella is one of the most common foodborne illnesses, but can also be contracted through contact with animals. Individuals infected with Salmonella usually develop diarrhea, fever, and abdominal cramps that last four to seven days. In severe cases, salmonellosis can result in hospitalization or even death. Being ill with salmonellosis not only results in increased healthcare costs, but also additional time out of work or school, lost productivity, and reduced quality of life.

Strengths

- HEALTH interviews all reported cases of salmonellosis
- HEALTH's Division of Infectious Disease and Epidemiology (IDE) has a strong collaborative relationship with the HEALTH's Office of Food Protection and the State Health Laboratory and works close to investigate foodborne illness clusters and outbreaks.
- HEALTH recommends implements of strong infection control guidelines in facilities and institution to ensure individuals ill with salmonella do not work until 48 hours after symptoms resolve.
- Rhode Island urges all food establishments to have an ill food worker policy in place to ensure that food workers report illness to management and are excluded from food handling responsibilities until 48 hours after symptoms resolve.

Challenges

- Food history recall is sometimes poor due to the time between illness onset and the lab results being reported to HEALTH.
- The time lag between illness onset and identifying the pulsed field gel electrophoresis (PFGE) pattern often leads to a delay in identifying clusters or outbreaks of salmonellosis.
- Ill food worker policies are not always enforced.

What can be done

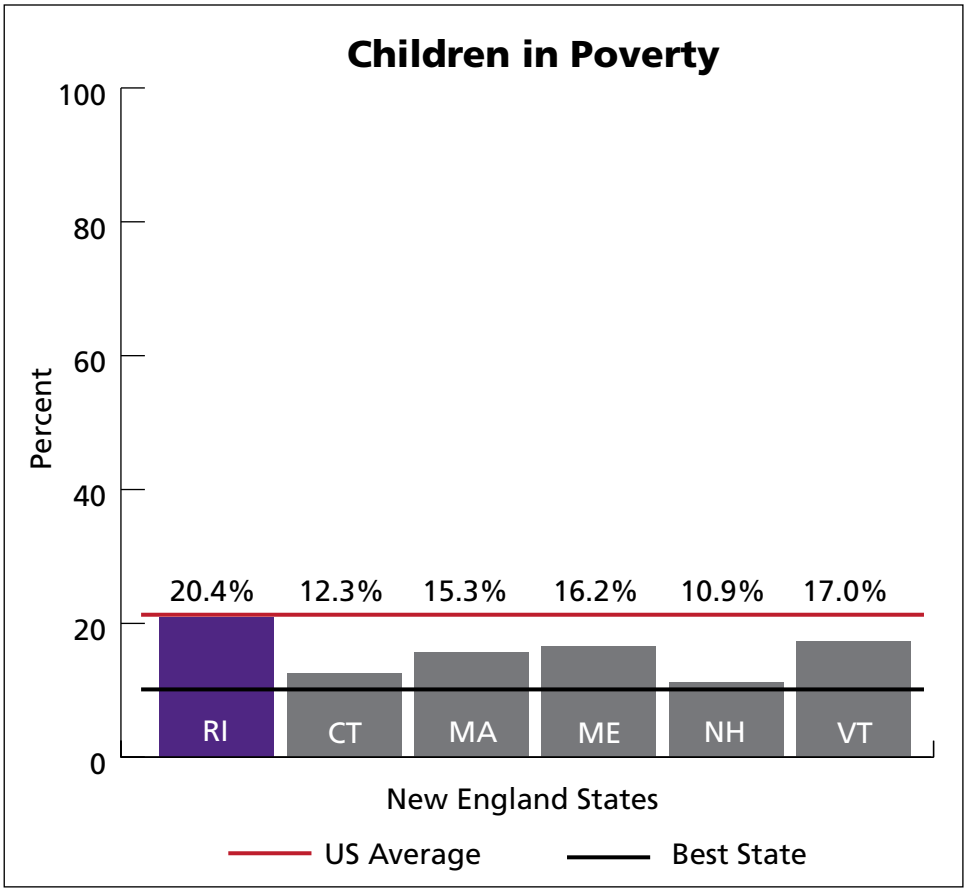
- Support research to decrease the time to get PFGE results.
- Encourage food service managers to enforce ill food worker policies in food establishments.
- Educate the public about safe food handling practices.

Resources

- HEALTH's Office of Food Protection
- State Health Laboratory
- Centers for Disease Control and Prevention

CHILDREN IN POVERTY

Percentage of persons younger than 18 years who live in households at or below the poverty threshold. (Data Year: 2012)



Data Source: U.S. Census Bureau Current Population Survey (CPS)

The Numbers at a Glance

- RI: 20.4%
- U.S. Average: 21.3%
- Best State: Wyoming, 9.7%
- No Healthy People 2020 Target

Why It's Important

The effect of poverty on health has been clearly documented with higher rates of many chronic diseases and shorter life expectancy. Poverty directly influences the family's ability to meet the basic needs of their children including lack of access to healthcare. Children in poverty, especially those who experience poverty in early childhood and for extended periods, are more likely to have physical and behavioral health problems, experience difficulty in school, become teen parents, and earn less or be unemployed as adults. Children in poverty are more likely to attend schools that lack resources and rigor and have fewer opportunities to participate in extracurricular activities. They have a reduced capacity to reach their full potential.

Strengths

- The Supplemental Poverty Measure provides policy makers with a new way to evaluate the effects of anti-poverty policies.
- Rhode Island ranks sixth in New England and 27th nationally on poverty rates in children.
- In 2011 Income Support Programs kept many families from falling into poverty.
- Children who receive health insurance through poverty programs are more likely to have a regular and accessible source of healthcare.

Challenges

- Minority children are more likely to grow up poorer than white children.
- People with incomes below the poverty level are at the highest risk of being uninsured.
- A single-parent family with two children would need $49,272 a year to meet its basic needs, far more than the federal poverty level for a family of three.
- Sixty-five percent (65%) of Rhode Island's children living in poverty live in four core cities: Central Falls, Pawtucket, Providence, and Woonsocket.
- Children younger than six years of age are at higher risk of living in poverty than any other age group.

What Can Be Done

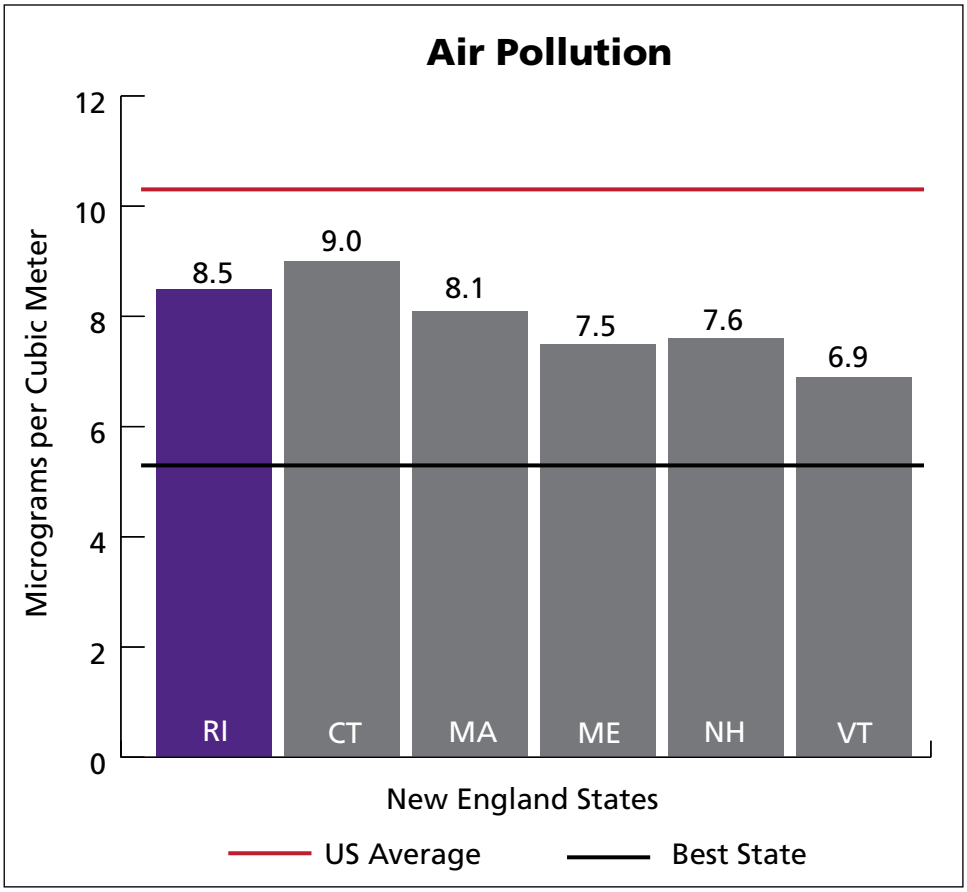
- Increase education levels to increase income.
- Provide financial education and counseling.
- Work on preventing predatory lending.
- Connect families to safe and affordable financial products to support families in using traditional banking institutions and increase their savings.
- Child care subsidies can help poor families afford the cost of high-quality healthcare.
- Increase availability of housing vouchers to help families afford the high cost of housing.

Resources

- Family Independence Program
- SNAP program
- WIC program
- Childcare subsidies
- Home visiting

AIR POLLUTION

Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5) (Data Year: 2010-2012)



Data Source: U.S. Environmental Protection Agency, U.S. Census Bureau

The Numbers at a Glance

- RI: 8.5 micrograms per cubic meter
- U.S. Average: 10.3 micrograms per cubic meter
- Best State: Wyoming, 5.3 micrograms of fine particulate per cubic meter
- No Healthy People 2020 Target

Why It's Important

Air pollution impacts the health of all individuals. Risk of illness or death from heart disease increases on days with high levels of air pollution from small soot particles (particulate matter of 2.5 microns in size or PM 2.5). Air pollution limits the ability of those with asthma and other respiratory conditions to be active and to exercise. Even healthy adults are impacted on air-quality alert days. Air pollution is a regional problem affecting all areas of Rhode Island, although highways and other sources can cause local impacts.

Strengths

- Air pollution levels have been steadily declining over the past decade.
- Reducing transportation-related air pollution via investments in public transit, bikeways, etc. benefits many aspects of public health.
- Reducing air pollution can address some racial/ethnic disparities in disease.
- Air pollution impacts everyone.

Challenges

- Air pollution sources in other states are major contributors to air pollution levels in Rhode Island.
- Further progress on reducing large industrial sources of particulate matter will be difficult.
- Diffuse sources of pollution, such as cars, trucks and home heating systems, are difficult to control.
- Particulate matter is only one of many important air pollutants.
- Unlike ozone, air pollution from particulate matter impacts indoor environments.

What can be done

- Support public transit.
- Support bikeways and other alternative sources of transportation.
- Support energy conservation measures, including weatherization.
- Support measures to reduce fossil fuels, such as wind and solar power.
- Promote public awareness of the Air Quality Index.
- Support Smart Growth, Complete Streets and Sustainability initiatives.
- Consider air pollution sources when citing housing, schools or recreational facilities.
- Reduce diesel idling.
- Promote walking to school.

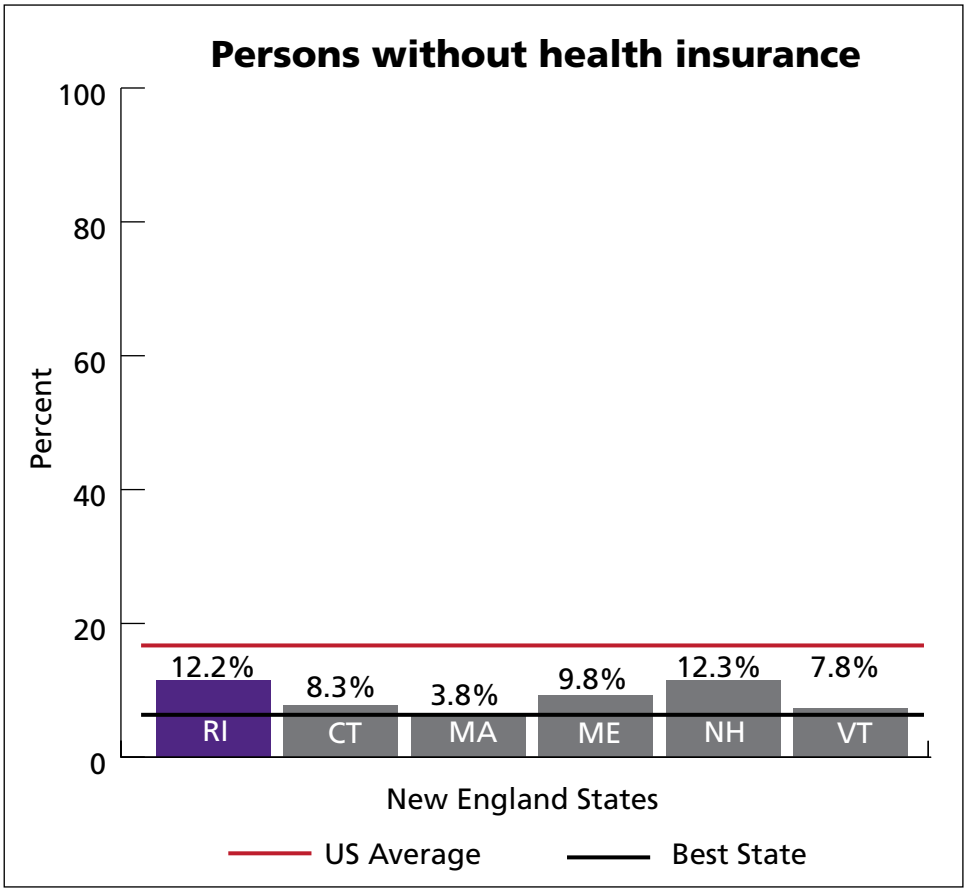
Resources

- Office of Energy Resources
- DEM Air Resources
- Green and Healthy Homes
- Weatherization Assistance
- Rhode Map Sustainability Project
- Safe Routes to School
- Coalition for Transportation Choices
- Grow Smart

LACK OF HEALTH INSURANCE

Percentage of the population that does not have health insurance privately, through their employer, or the government.

(Data Year: 2011-2012)



Data Source: U.S. Census Bureau Current Population Survey (CPS)

The Numbers at a Glance

- RI: 12.2%
- U.S. Average: 15.6%
- Best State: Massachusetts, 3.8%
- Healthy People 2020 Target: 100%

Why It's Important

- No one plans to get sick or hurt, but most people need medical care at some point.
- Health insurance covers these costs and protects you from very high expenses.

Strengths

- In January 2014, the Patient Protection and Affordable Care Act (PPACA) will require most people to purchase health insurance from plans or on the health insurance exchange, HealthSource RI.
- Rhode Island is engaged in developing a State Health Care Plan funded through Centers for Medicare and Medicaid Services (CMS), and engaging the uninsured is a current topic.
- Having insurance reduces likelihood of economic ruin.
- Having insurance increases likelihood of preventing chronic diseases.

Challenges

- Some of the uninsured are undocumented aliens and may resist signing up for fear of deportation.
- Many uninsured cannot afford even $25 per month for insurance on a regular basis as their income is seasonal.
- Self-insured companies are beginning to drop coverage.
- Choosing the right insurance plan is a complex process.
- Even with insurance, people may not engage with a primary care provider.

What Can Be Done

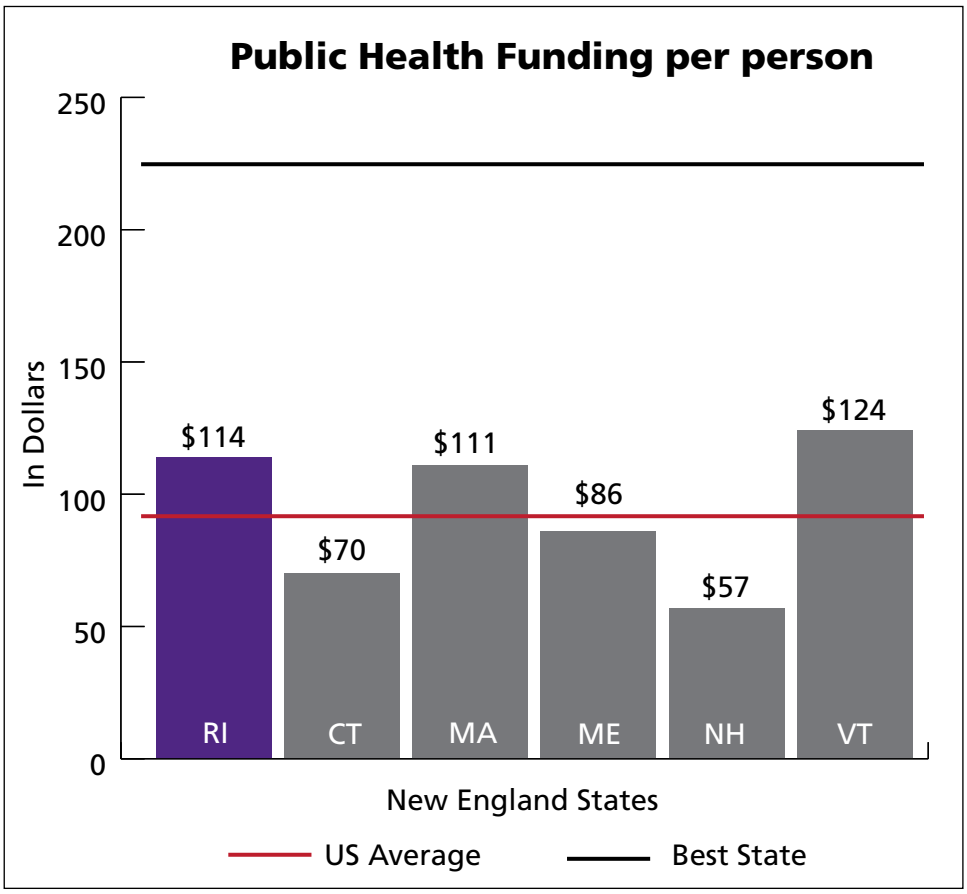
- Make the selection of an insurance plan simple and transparent.
- Engage self-insured companies in learning benefits of purchasing insurance for employees.
- Simplify payment systems, and adapt them to different employment conditions.
- Provide educational programs and incentives for signing up for insurance.
- Reach out to community organizations and empower them to be knowledgeable about the benefits of insurance.
- Reach out to faith communities to learn how to help their members apply for insurance through HealthSource RI.
- Develop signage that motivates people to purchase insurance.
- Learn from people who do not engage in health insurance plans or primary care what prevents them from doing so.

Resources

- HEALTH's Office of Primary Care and Rural Health
- Rhode Island Rural Health Network
- Primary Care Physician Advisory Committee (PCPAC)
- HealthSource RI
- Rhode Island Parent Information Network (RIPIN)
- Rhode Island Health Center Association

PUBLIC HEALTH FUNDING

State funding dedicated to public health as well as federal funding directed to states by the Centers for Disease Control and Prevention and the Health Resources and Services Administration. (Date Year: 2011-2012)



Data Source: Trust for America's Health (TFAH)

The Numbers at a Glance

- RI: $114 per person
- U.S. Average: $92 per person
- Best State: Hawaii, $225 per person
- No Healthy People 2020 Target

Why It's Important

Public health funding measures the dollars per person that are spent on public or population health. High levels of spending on public-health programs are indicative of states that are proactively implementing preventive and educational programs aimed at improving health. Spending on public-health programs represents only a small fraction of all healthcare spending (~2 percent), yet its impact can be tremendous. Recent research has shown that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and reduce smoking or other tobacco use could save the country more than $16 billion annually within five years.

Strengths

- Public health funding has increased by $20 per person in Rhode Island in the past five years.
- Rhode Island ranks 11th in the United States in public health funding.

Challenges

- Public health funding from the federal government continues to be cut yearly in Rhode Island.
- State funding continues to decline given the national economy.

What Can Be Done

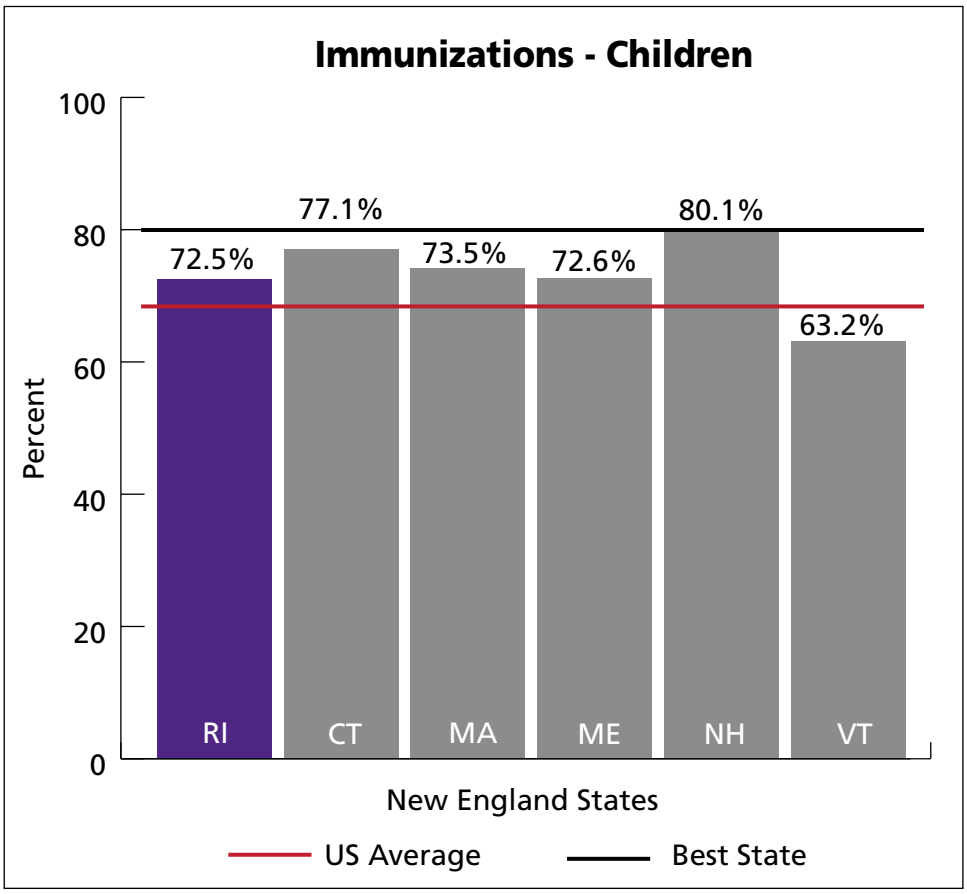
- Diagnose and investigate health problems in the community.
- Develop policies that support individual and community health efforts.
- Assure a competent public health and individual healthcare workforce.

Resources

- State funding
- Federal government funding
- Legislative support

IMMUNIZATION FOR CHILDREN

Percentage of children receiving the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines by age 19 to 35 months (Data Year: 2012)



Data Source: Centers for Disease Control and Prevention (CDC) National Immunization Survey (NIS)

The Numbers at a Glance

- RI: 72.5%
- U.S. Average: 68.4%
- Best State: Hawaii, 80.2%
- Healthy People 2020 Target: 80%

Why It's Important

High rates of immunization coverage in children protect not only children but also others in our communities from serious vaccine-preventable diseases and potential complications. Statewide monitoring of annual childhood vaccination coverage levels over time is important in identifying unvaccinated populations and barriers to vaccination as well as monitoring progress toward achieving Healthy People 2020 childhood immunization objectives.

Strengths

- Universal Vaccine Policy: All childhood vaccines are purchased/distributed through the state program at no cost to the provider.
- Robust immunization registry: KIDSNET provides quality-improvement capacity for monitoring immunization coverage at state and provider levels.

- Strong partnership with primary care provider community, including 27 federally-qualified health center sites across the state committed to vaccinating children,
- Rhode Island's immunization laws requires all childhood vaccines for entry into childcare settings.

Challenges

- Increasing complexity of the childhood vaccine schedule: Providers need to give as many as three to four injections at an office visit in order to keep children on schedule. The increase in the number of injections needed often leads to deferral of doses and future missed opportunities for vaccination.
- Inadequate access to vaccines due to vaccine shortages, inadequate clinic or practice hours.
- Timeliness of vaccines due to missed appointments, delaying vaccines at sick visits.
- Vaccine safety concerns/vaccine-hesitant parents.
- Incomplete reporting of data to registry by providers due to transition to Electronic Health Records.

What Can Be Done

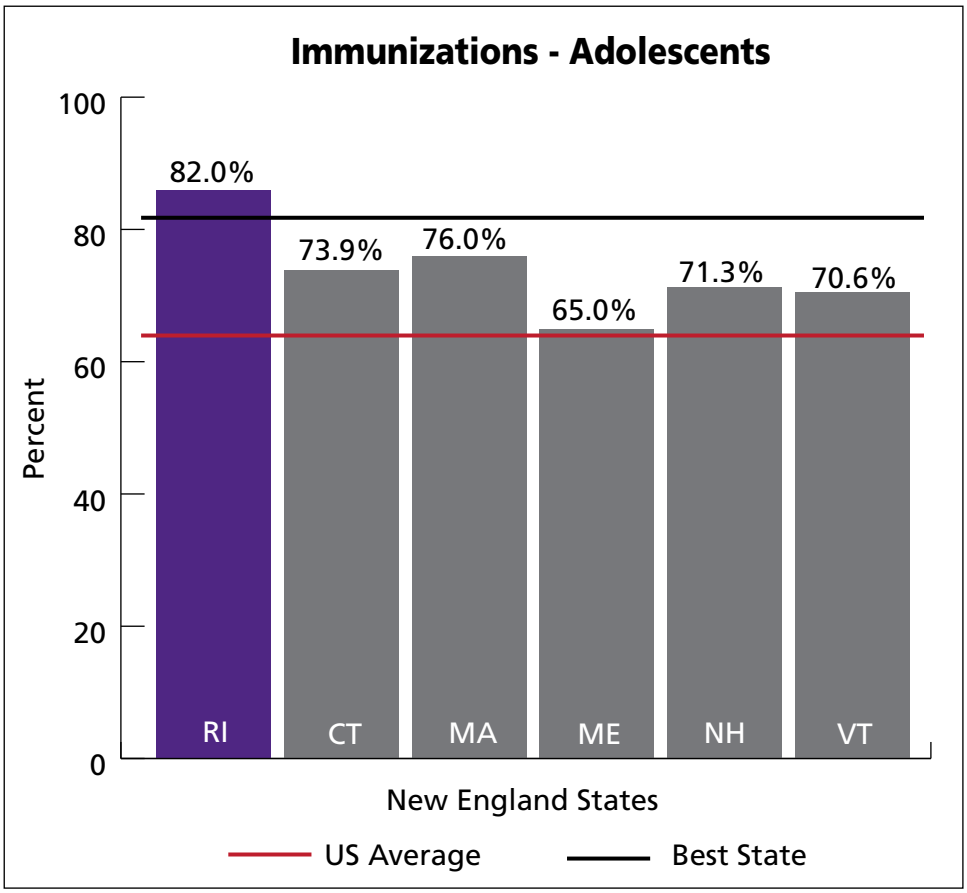
- Maintain universal vaccine policy; Monitor coverage rates using KIDSNET.
- Conduct provider quality assurance site visits; Train providers to use KIDSNET to identify children with missing immunizations.
- Conduct reminder/recall; Support free immunization clinics for uninsured children.
- Support Rhode Island Childhood Coalition activities; Share immunization data with insurers for Healthcare Effectiveness Data and Information Set (HEDIS).
- Provide current vaccine schedules and updates through Health Connections; Partner with AAP, AAFP.
- Actions for Providers: Follow CDC recommended immunization schedules for routine and catch-up vaccination.
- Review CDC guide to valid vaccine contraindications; Assess child vaccination status at well and sick visits.
- Use KIDSNET to identify children who are missing immunizations; Schedule vaccinations at the earliest opportunity within the recommended age range for routine vaccination.
- Encourage parents/guardians to keep current records of child immunizations; Maintain adequate supplies of vaccine.
- Train office staff: Ensure that office staff is aware of the minimum intervals between vaccine doses when scheduling appointments.

Resources

- Statewide Immunization Quality Improvement Initiative
- Primary care healthcare provider community
- RI Chapters of the AAP and AAFP
- Health plans
- RI Childhood Immunization Coalition
- Preschool Immunization Initiative (Head Start and Childcare workgroup)
- Department of Children Youth and Families (promulgates regulations for daycare and childcare centers)
- KIDSNET Program
- Maintain legislation supporting annual assessment of insurers for universal vaccine purchase policy

IMMUNIZATION FOR ADOLESCENTS

Percentage of adolescents aged 13 to 17 years who have received 1 dose of Tdap since the age of 10, 1 dose of meningococcal conjugate vaccine, and 3 doses of HPV vaccine (females only). (Data Year: 2012)



Data Source: Centers for Disease Control and Prevention (CDC) National Immunization Survey (NIS)

The Numbers at a Glance

- RI: 82.0%
- U.S. Average: 64.0%
- Best State: Rhode Island, 82.0%
- No Healthy People 2020 Target for combined vaccines

Why It's Important

High rates of immunization coverage in adolescents protect not only adolescents but also others in our communities from serious vaccine-preventable diseases and potential complications. Statewide monitoring of annual adolescent vaccination coverage levels over time is important in identifying unvaccinated populations, missed opportunities, and barriers to vaccination as well as monitoring progress toward achieving Healthy People 2020 adolescent immunization objectives.

Strengths

- HEALTH's Vaccinate Before You Graduate (VBYG) works to ensure high school seniors have all doses of all recommended vaccinations before they graduate.
- Universal Vaccine Policy: All adolescent vaccines are purchased/distributed through the state program at no cost to the provider.
- Robust immunization registry: KIDSNET provides quality-improvement capacity for monitoring immunization coverage at state and provider levels.
- Strong partnership with primary care provider community, including 27 federally qualified health center sites across the state committed to vaccinating adolescents.
- Rhode Island immunization laws require Tdap and Meningococcal adolescent vaccines for entry into Grade 7.

Challenges

- Providers need to give as many as three injections in one office visit in order to keep adolescents on schedule. The increase in the number of injections needed often leads to deferral of doses and future missed opportunities for vaccination.
- While the Tdap and Meningococcal vaccines are recommended to be provided at the same time as the HPV vaccine, HPV coverage rates are well below the other two vaccines for adolescents.
- The HPV vaccine is a three-dose series provided within six months. This is often difficult for parents to arrange for return visits for their children for subsequent doses.
- Inadequate access to vaccines due to vaccine shortages, inadequate clinic or practice hours etc.
- Timeliness of vaccines due to missed appointments, delaying vaccines at sick visits.
- Vaccine safety concerns/vaccine hesitant parents.
- Incomplete reporting of data to registry by providers due to transition to Electronic Health Records, etc.

What can be done

Actions for Public Health:

- Maintain universal vaccine policy; Monitor coverage rates using KIDSNET.
- Conduct provider quality assurance site visits; Train providers to use KIDSNET to identify adolescents with missing immunizations.
- Conduct reminder/recall; Support free immunization clinics for uninsured children.
- Support RI Childhood Coalition activities; share immunization data with insurers for Healthcare Effectiveness Data and Information Set (HEDIS).
- Provide vaccine schedules and updates through Health Connections; Partner with AAP, AAFP
- Conduct public health campaign on importance and safety of the HPV vaccine

Actions for Providers:

- Strongly recommend to parents all adolescent vaccinations following the CDC recommended immunization schedules for routine and catch-up vaccination.
- Provide information for vaccine hesitant parents.
- Review CDC guide to valid vaccine contraindications; Assess adolescent vaccination status at well and sick visits.
- Use KIDSNET to identify adolescents who are missing immunizations; Schedule vaccinations at the earliest opportunity within the recommended age range for routine vaccination.
- Encourage parents/guardians to keep current records of adolescent immunizations; Maintain adequate supplies of vaccine.
- Train office staff: Ensure that office staff is aware of the minimum intervals between vaccine doses when scheduling appointments.
- Implement reminder/ recall for vaccines that require multiple doses.
- Utilize the "Vaccinate Before You Graduate" program for adolescent vaccine catch-up.
- Maintain legislation supporting annual assessment of insurers for universal vaccine purchase policy

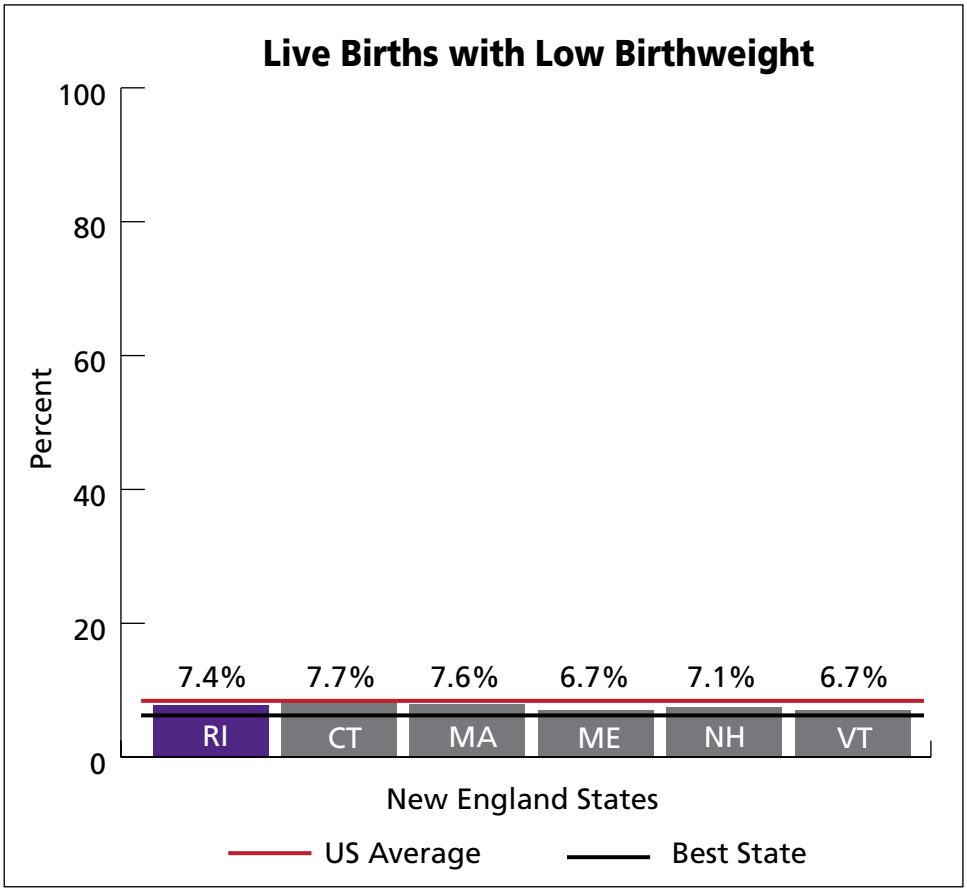
Resources

- Statewide Immunization Quality Improvement Initiative
- Primary care healthcare provider community
- RI Chapters of the AAP and AAFP
- Health plans
- RI Childhood Immunization Coalition
- KIDSNET Program

LOW BIRTHWEIGHT

Percentage of infants weight less than 2,500 grams (5 pounds, 8 ounces) at birth.

(Data Year: 2011)



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics (CDC NCHS)

The Numbers at a Glance

- RI: 7.4%
- U.S. Average: 8.1%
- Best State: Alaska, 6.0%
- Healthy People 2020 Target: 7.8%

Why It's Important

Low birthweight is a key indicator of infant health. Infants born at low birthweights are at greater risk for physical and developmental problems. Low birthweight disproportionably impacts racial and ethnic minorities.

Strengths

- Indicator is measurable.
- Indicator is measured on a population-wide basis.
- Indicator has been proven to be associated with outcomes.
- Indicator will allow for comparisons with all other states.

Challenges

- Low birthweight babies have longer hospital stays.
- Low birthweight babies tend to stay in the NICU longer, accumulating higher hospital bills.
- Low birthweight babies are generally sicker than babies of normal birthweight.

What Can Be Done

- Increase prenatal care.
- Reduce premature birth.
- Reduce cigarette smoking among pregnant women.
- Educate women about the importance of early prenatal care.
- Increase accessibility of prenatal care.

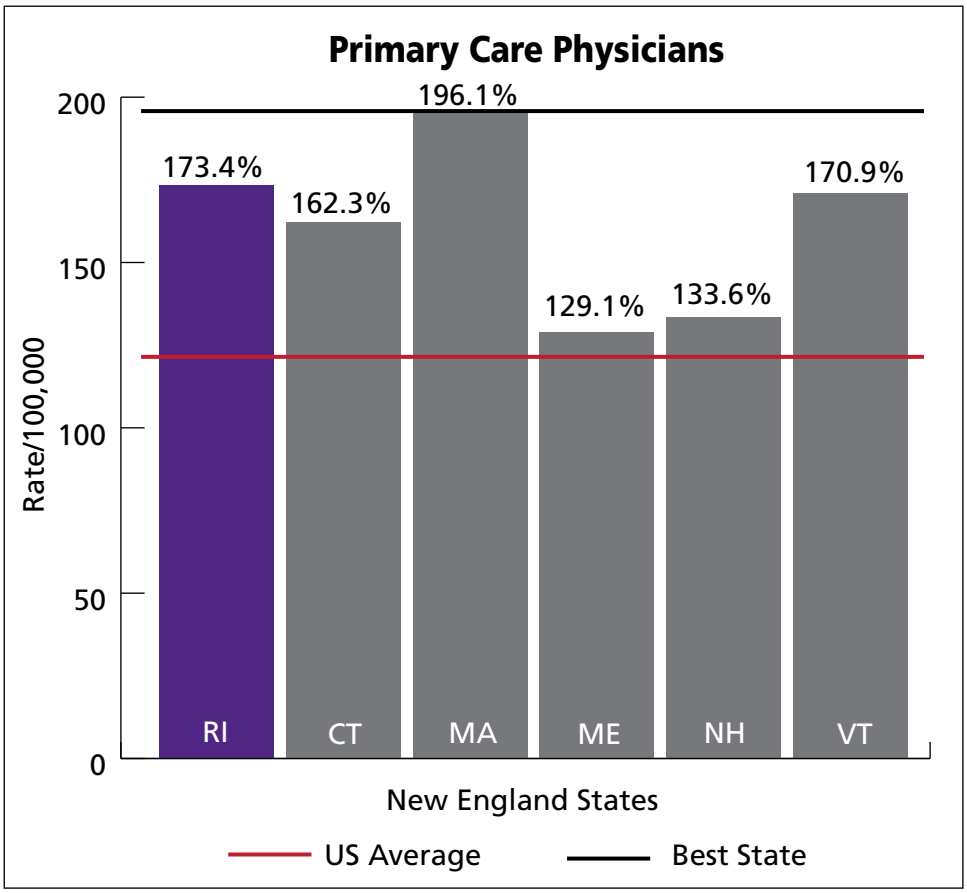
Resources

- Obstetricians
- Home visiting programs that provide services during the prenatal period
- Tobacco cessation programs
- Primary healthcare providers

PRIMARY CARE PHYSICIANS

Number of primary care physicians (including general practice, family practice, OB-GYN, pediatrics, and internal medicine) per 100,000 population.

(Data Year: 2011)



Data Source: American Medical Association (AMA)

The Numbers at a Glance

- RI: 173.4 per 100,000 population
- U.S. Average: 121.0 per 100,000 population
- Best State: Massachusetts, 196.0 per 100,000 population
- No Healthy People 2020 Target

Why It's Important

An adequate physician supply is important for the effective and efficient delivery of healthcare services and, therefore, for population health and the cost and quality of healthcare. Physician supply is important for healthcare spending and for population health because physician clinical decisions affect approximately 90% of each healthcare dollar spent.

Strengths

- A greater emphasis on primary care can be expected to lower the costs of care, improve health through access to more appropriate services, and reduce the inequities in the population's health.
- Health is better in areas with more primary care physicians.
- People who receive care from primary care physicians are healthier.
- The characteristics of primary care are associated with better health.

Challenges

- Some people do not understand the value of seeing their primary care provider annually.
- While Rhode Island has high levels of primary care providers, many people have trouble establishing a primary care provider.
- Not all primary care providers practice at the same quality level.
- Small practices of one or two providers may have difficulty achieving highest levels of quality due to limited resources.
- Primary care providers are each connected to different specialty services so residents of some communities receive disparate health services.

What Can Be Done

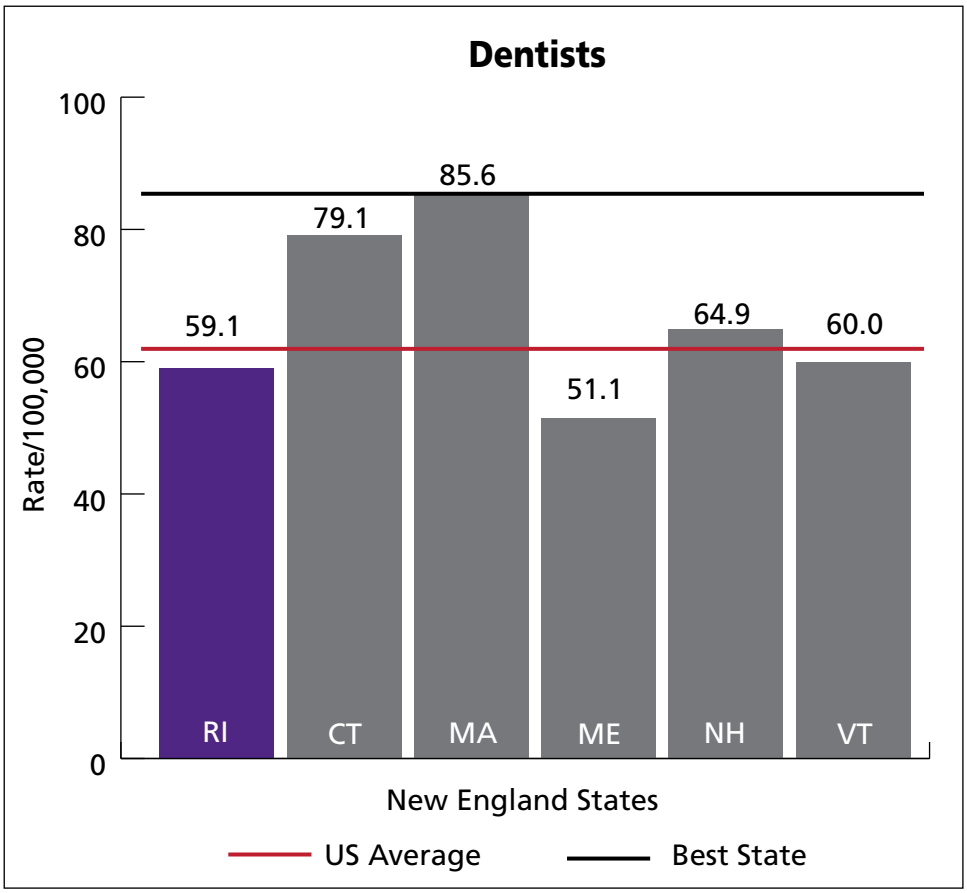
- Provide campaign to educate Rhode Islanders about the value of primary care providers.
- Continue to support programs like Rhode Island Chronic Care Collaborative and Chronic Care Sustainability Initiative to improve the quality of healthcare services.
- Assess the primary care provider supply by supporting improvements in the licensing database accuracy and completeness.
- Support the Primary Care Physician Advisory Committee (PCPAC) to explore ways to improve primary care supply.
- Continue to work with government and community stakeholders to develop strategic plans and funding for increasing primary healthcare quality.
- Work with the Rhode Island Legislative Study Commission to explore integration of behavioral health and primary care and sustaining funding for primary care improvement.

Resources

- HEALTH's Office of Primary Care and Rural Health
- Rhode Island Quality Institute
- Office of the Health Insurance Commissioner
- Office of the Lt. Governor
- Healthcentric Advisors
- Rhode Island Health Center Association
- Rhode Island Medical Society
- HealthRight RI

DENTISTS

Number of dentists working in dentistry per 100,000 population.
(Data Year: 2011).



Data Source: American Dental Association (ADA)

The Numbers at a Glance

- RI: 59.1 per 100,000 population
- U.S. Average: 62.0 per 100,000 population
- Best State: Massachusetts, 85.6 per 100,000 population
- No Healthy People 2020 Target

Why It's Important

With no in-state dental school and as more currently practicing professionals approach retirement age, Rhode Island's dentist shortage will likely become more critical in the coming years. The Rhode Island Department of Labor and Training (DLT) has reported that 300 additional dentists will be needed to serve the projected state population in 2020. A considerable proportion of the State has been designated as having insufficient oral health workforce capacity for low-income populations. The persistent shortage of oral health professionals will likely impact the state's most vulnerable populations –

families with low-income, underserved perinatal women and adults, elderly in nursing facilities, and those of minority race/ethnicity – who have difficulties to obtain readily accessible dental care due to geographic, cultural or financial barriers.

Strengths

- With recent years' federal and foundational funding support, Rhode Island oral health communities and stakeholders have worked collaboratively on a number of oral health initiatives including, but not limited to:
    - Establishment of post-doctoral dental education programs at inner-city hospitals that educate dentists for advanced clinical skills and help recruit dentists to practice in Rhode Island beyond their residency, and
    - Provision of a series of annual mini-residency programs for Rhode Island oral health professionals that focus on increasing the number of appropriately-trained and culturally-competent oral health providers.

Challenges

- **Insufficient supply.** Rhode Island does not have a dental school, and the American Dental Association's Survey of Dental Education for 2010-11 indicated that only seven Rhode Islanders were attending out-of-state dental schools. In addition, more than half of actively practicing Rhode Island dentists are approaching retirement age (50 years and older).
- **Limited diversity:** People of minority race/ethnicity are underrepresented in the state's oral health professions and among the existing dental education programs. Limited diversity among the oral health workforce is a significant barrier to underserved Rhode Islanders, especially racial and ethnic minority populations.
- **Dental health professional shortage areas (DHPSAs):** Approximately 97% of Rhode Island dentists work in private practices, while 3% work in a public health setting, such as in a dental safety net site. The majority of dentists in private settings do not uniformly accept individuals with all types of insurance coverage. Dental safety-net providers provide comprehensive oral healthcare services regardless of an individual's insurance status or ability to pay. However, their capacity does not and cannot meet the needs of all who need dental care. A significant proportion of the state has insufficient capacity to serve low-income populations. As of January 2014, the federal Bureau of Health Professions has designated all or part of 14 Rhode Island communities as DHPSAs that lack dental services. Rhode Island needs an estimated 33 additional primary care dentists (general and pediatric dentists) to provide oral healthcare to 167,310 underserved residents.

What can be done

The Rhode Island Oral Health Plan 2011-16, a guiding blueprint for the Rhode Island Oral Health Commission, was developed in collaboration between the HEALTH's Oral Health Program and numerous community partners, and identified specific objectives and recommendations to support oral health workforce initiatives:

- **Assess gaps in the oral health workforce in Rhode Island** and identify areas of under-service and oral health workforce needs.
- **Recruit and retain new oral health practitioners** and develop programs to incentivize primary care dentists, dental specialists, and other oral health professionals to practice in Rhode Island.
- **Promote dental careers** to math- and science-minded youth, particularly among youth of minority race/ethnicity or from disadvantaged families.
- **Expand advanced dental education programs in Rhode Island** and develop programs to incentivize dentists to practice in Rhode Island beyond the training.
- **Provide continuing education** to existing oral health providers to reduce the cultural and linguistic barriers, improve care for underserved with population-specific oral health knowledge and clinical skills, and continue to serve as access points.
- **Revise oral health practice regulation** and eliminate regulatory barriers that prevent an effective care delivery.
- **Enhance the integration of medicine and dentistry to improve the overall health status of Rhode Island residents.**

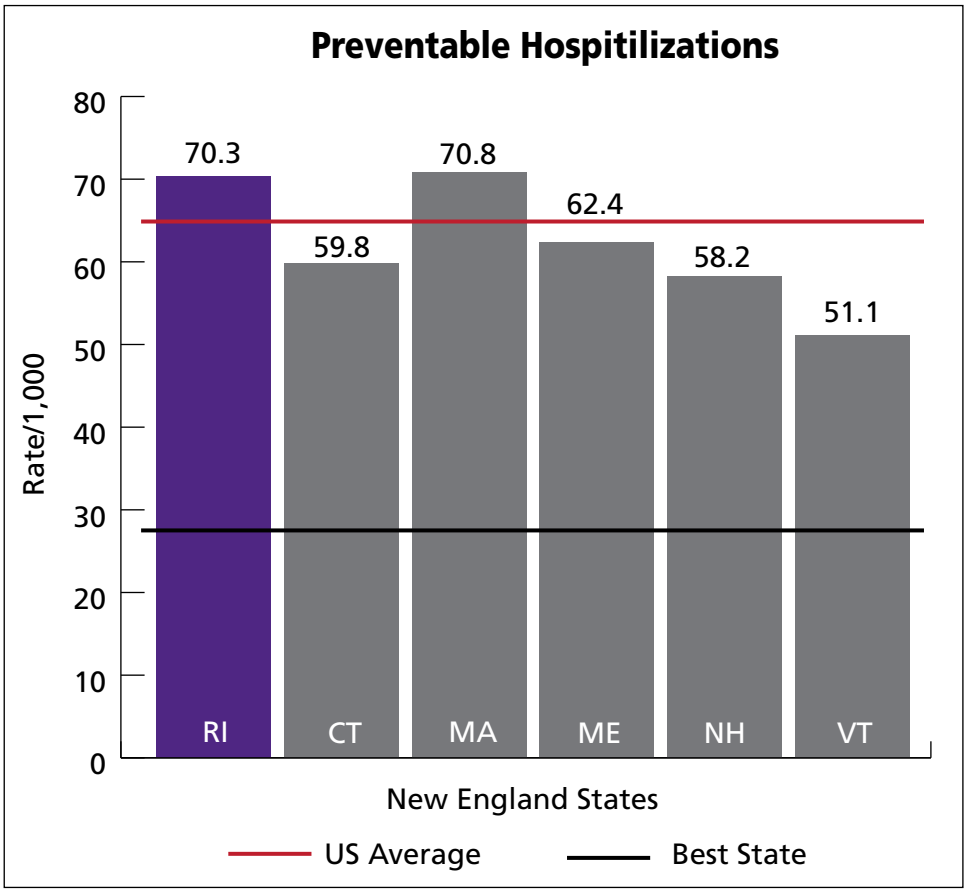
Resources

- HEALTH's Oral Health Program
- HEALTH's Office of Professionals Regulation
- Rhode Island Oral Health Commission
- The Rhode Island Oral Health Plan 2011-16
- Rhode Island Department of Labor and Training (DLT)
- Health Resources and Services Administration (HRSA)

PREVENTABLE HOSPITALIZATIONS

Discharge rate among the Medicare population for diagnoses that are amenable to non-hospital based care.

(Data Year: 2011)



Data Source: Dartmouth Atlas

The Numbers at a Glance

- RI: 70.3 per 1,000 Medicare enrollees
- U.S. Average: 64.9 per 1,000 Medicare enrollees
- Best State: Hawaii. 27.4 per 1,000 Medicare enrollees
- No Healthy People 2020 Target

Why It's Important

A preventable hospitalization is a measure of the discharge rate of Medicare enrollees, ages 65 to 99 (with full Part A entitlement and no HMO enrollment) from hospitals for ambulatory care-sensitive conditions. Ambulatory care-sensitive conditions are those with which good outpatient care can potentially prevent the need for hospitalization, or with which early intervention can prevent complication for more severe disease. Preventable hospitalizations reflect how efficiently a population uses the various healthcare delivery options for necessary care. Hospital care is expensive and makes up the largest component of healthcare spending in the country. Because Rhode Island has such high rates of hospitalizations this places a big toll on healthcare spending in the state.

Strengths

- Medicare population is largely insured.
- Sufficient supply of primary care providers in the state.

Challenges

- Rhode Island ranks 36th in the U.S. in preventable hospitalizations.
- Rhode Island has a high rate of preventable hospitalizations.
- Preventable hospitalizations often occur as a result of a failure to treat conditions early in an outpatient setting.
- Society has a tendency to overuse the hospital setting as a site for care.
- Preventable hospitalizations are more common in those who are uninsured, leading to unpaid medical bills.

What Can Be Done

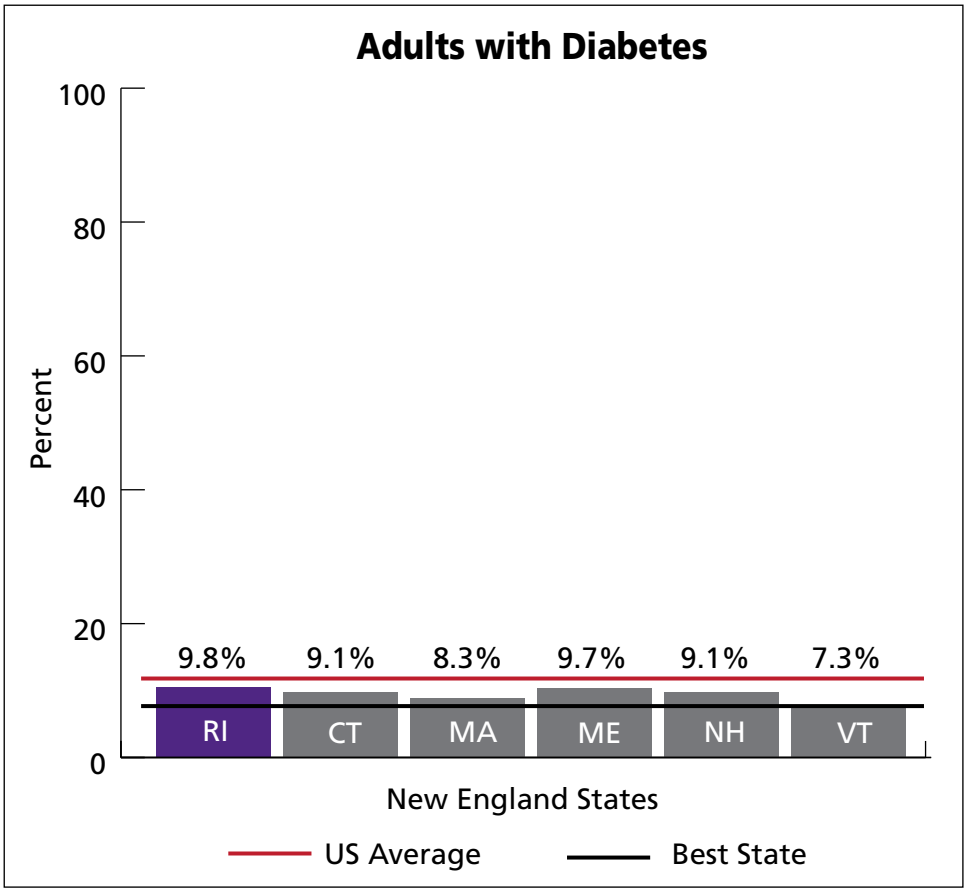
- Outreach to the 65 and older population for Medicare enrollment.
- Promote, expand, and implement the Affordable Care Act.
- Work with hospitals to formulate solutions.

Resources

- Rhode Island Medicaid
- Hospital Association of Rhode Island (HARI)
- Rhode Island-based health insurance companies
- Affordable Care Act

DIABETES

Percentage of adults who have been told by a health professional that they have diabetes (does not include pre-diabetes or diabetes during pregnancy). (Data Year: 2012)



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (CDC BRFSS)

The Numbers at a Glance

- RI: 9.8%
- U.S. Average: 9.7%
- Best State: Alaska, 7.0%
- No Healthy People 2020 Target

Why It's Important

Diabetes is a serious illness and can lead to complications such as blindness, kidney damage, cardiovascular disease, and lower-limb amputations, and can eventually lead to death. In Rhode Island, diabetes ranks eighth among the leading causes of death. Since diabetes is likely to be under-reported as a cause of death, experts estimate that people with diabetes have about two to four times the risk of death than people of similar age without diabetes.

Strengths

- At 9.8%, Rhode Island ranked 10th in the nation for the percentage of people who reported they were told by a healthcare professional that they had diabetes. This is a 3% improvement over the state's rank of 13th in 2011.
- Increased self-reporting of diabetes indicates that more people are aware they have the disease and can take steps to control the disease and minimize the health complications.
- The percent of deaths due to diabetes has decreased since 2003.

Challenges

- The percent of people who report being told they have diabetes increases yearly. In 10 years time, the percentage of Rhode Island adults with diabetes has increased 2.8%.
- Approximately one third of adults with diabetes in Rhode Island have not been diagnosed.
- Diabetes prevalence is increasing more quickly among African American, non-Hispanic adults and adults of multiple races than among Hispanic and white non-Hispanic adults.
- Low-income populations with less education have a higher prevalence of diabetes.

What Can Be Done

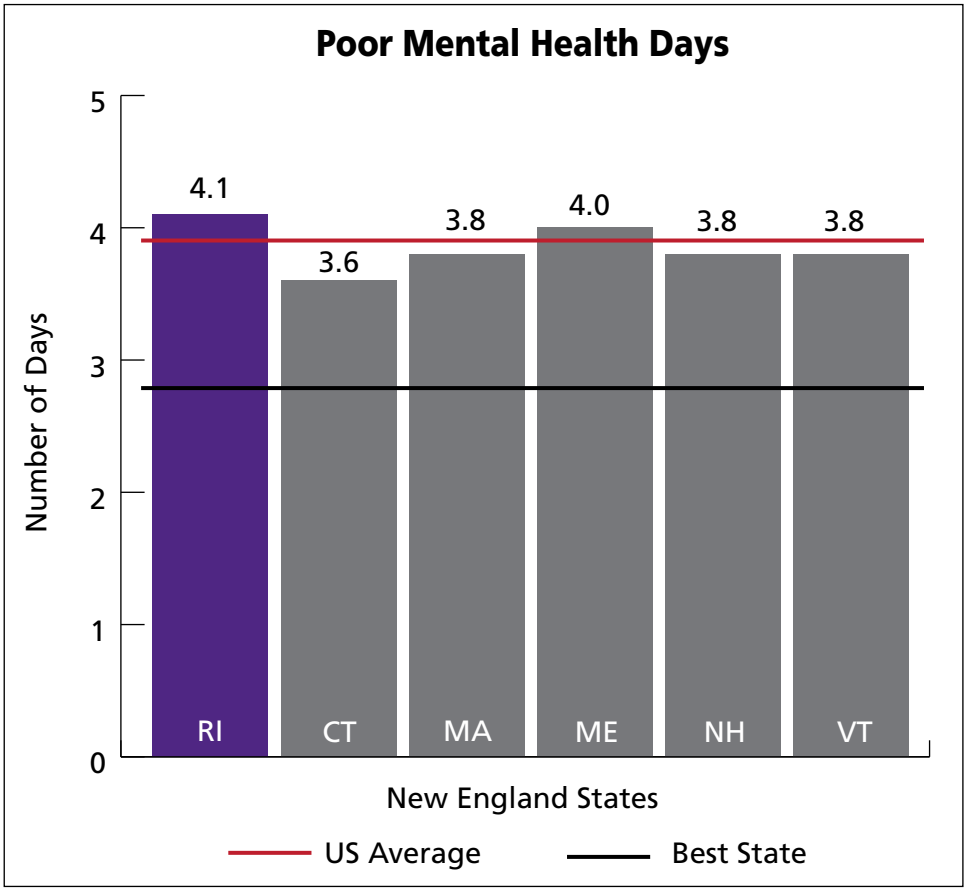
- All Rhode Islanders should take the Diabetes Risk Assessment Survey to learn whether or not they have risk factors for diabetes.
- People with risk factors should visit their doctor to determine if diabetes testing is indicated.
- People with diabetes should ask their doctor for a referral to a Certified Diabetes Outpatient Educator (CDOE) or a Living Well RI Diabetes Self-Management workshop to learn how to control and live better with diabetes.
- Women diagnosed with gestational diabetes should return for diabetes testing after the birth of their baby to determine their diabetes status.
- People with diabetes need to control their blood sugars and blood pressure to reduce complications, and get a yearly dilated eye exam, foot exam, dental exam and flu shot.

Resources

- HEALTH's Diabetes Prevention & Control Program
- Rhode Island Department of Health Diabetes Program
- Certified Diabetes Outpatient Educators
- American Diabetes Association

POOR MENTAL HEALTH DAYS

Number of days in the previous 30 days when a person indicates their activities were limited due to mental health difficulties. (Data Year: 2012)



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (CDC BRFSS)

The Numbers at a Glance

- RI: 4.1 days
- U.S. Average: 3.9 days
- Best State: North Dakota, 2.8 days
- No Healthy People 2020 Target

Why It's Important

Poor mental health days provide a general indication of health related to quality of life, mental distress, and the burden that more serious mental illnesses place on the population. Good mental health is essential to good overall health and wellness. Poor mental health days are an assessment of the impact of poor mental health on wellness. The number of poor mental health days is also a predictor of future health as it predicts one-month and 12-month office visits and hospitalizations. In extreme cases, poor mental health can lead to suicide, which is the 11th leading cause of death for all ages.

Strengths

- Medicaid has good coverage for kids.

Challenges

- Although occasional short periods of mental distress and a few poor mental health days may be unavoidable, more prolonged and serious episodes are treatable and preventable through early interventions.

What Can Be Done

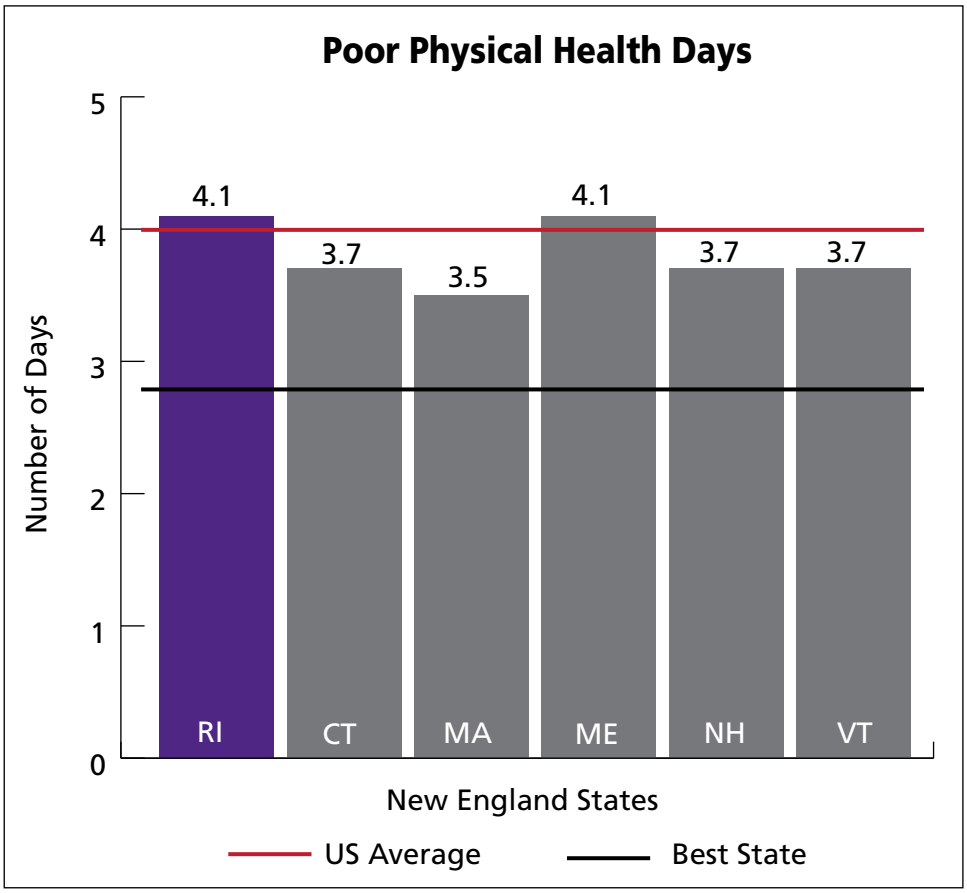
- Ensure access to mental health services, if needed, to help prevent mental health days from turning into prolonged episodes.
- Increase the number and location of mental health providers.

Resources

- Mental health centers and providers
- Health insurance companies policies

POOR PHYSICAL HEALTH DAYS

Number of days in the previous 30 days when a person indicates their activities were limited due to physical health difficulties. (Data Year: 2012)



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (CDC BRFSS)

The Numbers at a Glance

- RI: 4.1 days
- U.S. Average: 4.0 days
- Best State: Minnesota, 2.9 days
- No Healthy People 2020 Target

Why It's Important

Poor physical health days are the number of days in the previous 30 that a person could not perform work or household tasks due to physical illness. Poor physical health days are a general indicator of the population's health related to quality of life. The number of poor physical health days reveals information about all-cause morbidity within the population regardless of the disease or health condition, as well as providing insight into perceived overall health. Poor physical health is not only an indicator of current health status but a predictor of future health; it has been shown to be a predictor of one-month and 12-month hospitalizations and office visits.

Strengths

- New England states rank similarly in the number of the poor physical health days and therefore there is a potential for regional approaches to address this issue.

Challenges

- Rhode Island is above the national average of 4.0 days with an average of 4.1.
- Insufficient promotion of physical activities.
- Insufficient weather-permitting physical activities during the winter months.

What Can Be Done

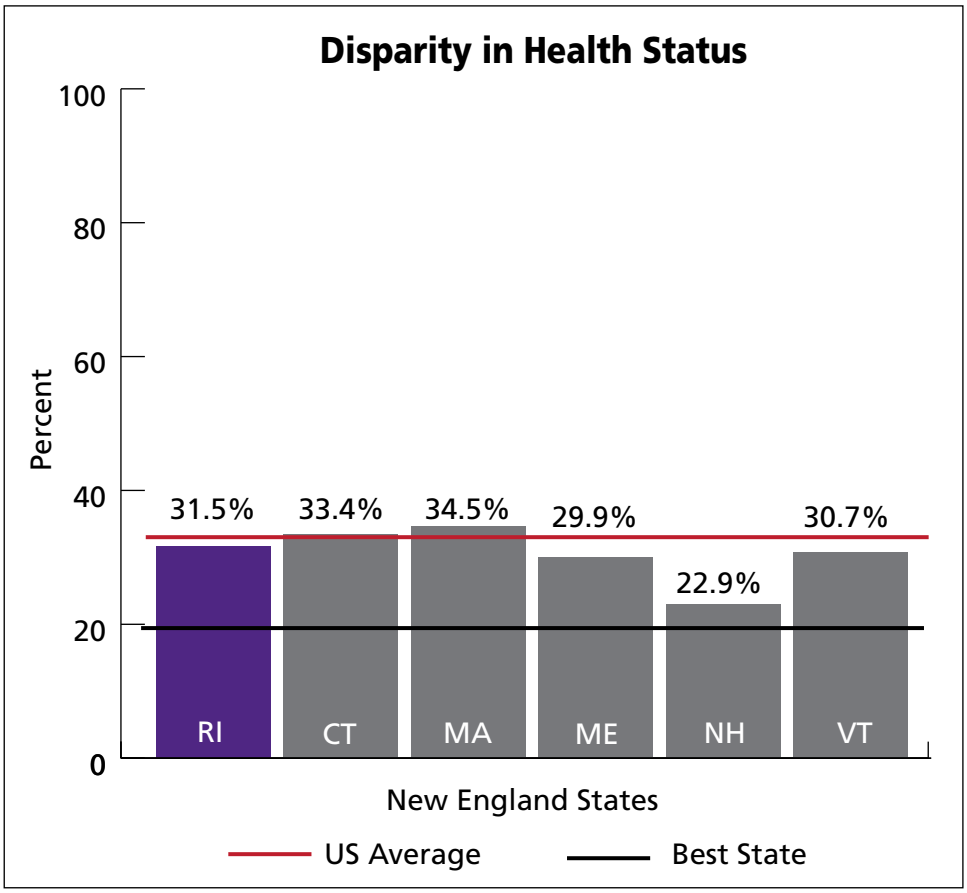
- Encourage general public to get flu shots in order to prevent acquiring the flu and other seasonal illnesses.
- Initiate a campaign promoting healthy eating and exercise to improve and maintain adequate physical health.
- Focus on maintaining individual physical health in the hopes of improving the physical health of the entire population.

Resources

- Federal funding and technical assistance support.

DISPARITY IN HEALTH STATUS

Percent difference in adults aged 25 and older who did not graduate high school and adults with at least a high school education who self-report being in excellent or very good health. (Data Year: 2012)



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (CDC BRFSS)

The Numbers at a Glance

- RI: 31.5%
- U.S. Average: 32.5%
- Best State: Alaska, 19.7%
- No Healthy People 2020 Target

Why It's Important

- Structural racism, environmental and economic barriers have a significant impact on a community's health, thus resulting in health disparities. Health disparities are differences in health, linked to social and economic disadvantage. Health disparities often exist in groups that have historically and systematically experienced barriers to health due to discrimination and exclusion. To be healthy, one needs to be in a state of complete physical, social, and mental well-being and not merely the absence of disease or infirmity. Health occurs in the community and is largely impacted by social, economic and environmental dynamics in addition to individual behaviors and biology.

Strengths

- Rhode Island is one of only 12 states selected as a winner of the Race to the Top funding and was awarded $75 million to be spent from 2010-2014 to improve the education system.

Challenges

- County indicators do not take into account municipalities or smaller neighborhood based disparities.
- County-level geographic data can be misleading because we have urban, rural, and suburban areas in most of our counties.

What Can Be Done

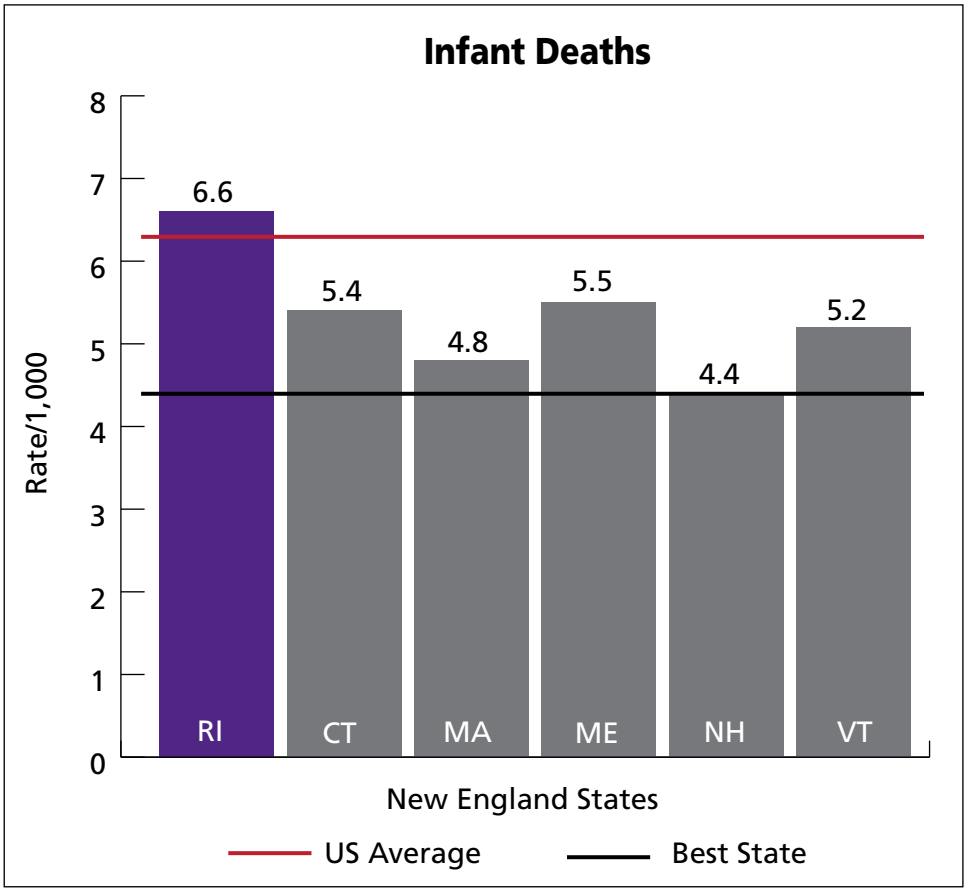
- Change the indicator to look at smaller geographic areas such as municipalities or neighborhood-level data.
- Identify alternative ways of measuring disparities in Rhode Island.

Resources

- Providence Plan

INFANT MORTALITY

Number of infant deaths (before age 1) per 1,000 live births. (Data Year 2008-2009)



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics (CDC NCHS)

The Numbers at a Glance

- RI: 6.6 per 1,000 live births
- U.S. Average: 6.3 per 1,000 live births
- Best State: New Hampshire, 4.4 deaths per 1,000 live births
- Healthy People 2020 Target: 6.0 per 1,000 live births

Why It's Important

Infant mortality rates are associated with maternal health, quality of and access to medical care, socio-economic conditions, and public health practices. The three main causes of infant deaths are congenital malformations, disorders relating to preterm birth and low birthweight, and Sudden Infant Death Syndrome (SIDS). The nation's overall infant mortality rate is consistently higher than other developed countries, and significant racial and ethnic disparities exist.

Strengths

- Nationally, the infant mortality rate has fallen from 26.0 deaths per 1,000 live births in 1960 to 6.9 deaths per 1,000 live births in 2000.
- Improvements in antibiotics, neonatology, and access to healthcare have helped lower the infant mortality rate.
- Rhode Island ranked sixth in infant mortality rates amongst New England.
- Rhode Island ranked 37th nationally in infant mortality rates.

Challenges

- Communities with high poverty and disadvantaged social conditions tend to have higher infant mortality rates than more affluent neighborhoods.
- Approximately 15% of Rhode Island infant deaths can be attributed to birth defects, which are more than twice as common in infants born preterm than among full-term births.
- Risk factors for infant mortality include low birthweight, preterm birth, delayed or no prenatal care, maternal age (older than 40 or younger than 20), and smoking during pregnancy.
- The infant mortality rate was 8.1 in the four core cities, compared to 5.3 in the remainder of the state.
- Preterm birth is the leading cause of infant death in Rhode Island.

What Can Be Done

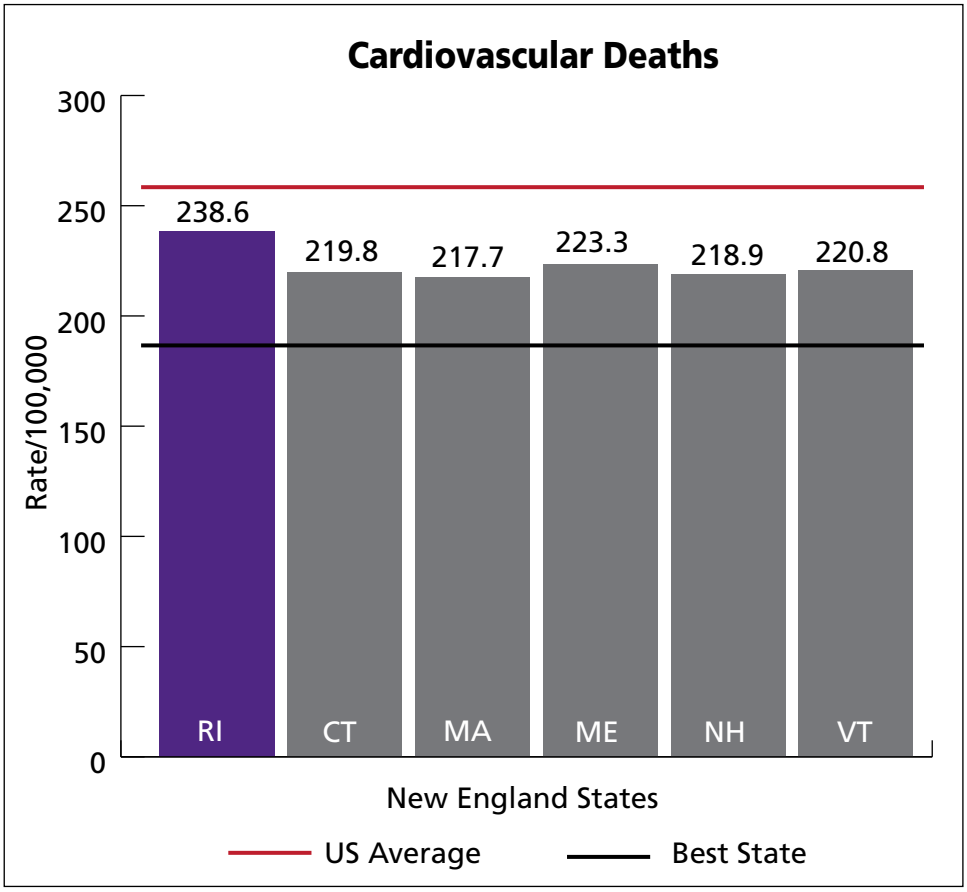
- Improve outcomes during the post-neonatal period.
- Increase healthcare access for people in poverty.
- Provide education on healthy pregnancies.
- Encourage enrollment in prenatal classes and support groups.
- Strive for a full-term pregnancy.
- Improve access to and utilization of ongoing prenatal care as a key strategy toward decreasing infant mortality, as well as reducing the teen birth rate and maternal smoking.

Resources

- Home visiting nurses network
- Newborn Screening programs and funding
- Maternity hospitals
- Prenatal care providers

CARDIOVASCULAR DEATHS

Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population.
(Data Year: 2008-2010)



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics (CDC NCHS)

The Numbers at a Glance

- RI: 238.6 deaths per 100,000 population
- U.S. Average: 258.7 per 100,000 population
- Best State: Minnesota, 186.9 deaths per 100,000 population
- No Healthy People 2020 Target for combined deaths

Why It's Important

Cardiovascular disease remains the leading cause of death in the United States.

Strengths

- Stroke mortality rates dropped in Rhode Island from 44 deaths per 100,000 in 2005 to 39 deaths per 100,000 in 2010.
- Coronary heart disease mortality rates dropped in Rhode Island from 249 deaths per 100,000 in 2005 to 178 deaths per 100,000 in 2010.
- Coronary heart disease mortality rates have greatly improved in Rhode Island since 2005, to now be near the US average.
- As of 2010, stroke mortality rates in Rhode Island (34 deaths per 100,000) are notably lower than the US average (39 per 100,000).

Challenges

- Elevated risk factors (obesity, hypertension, smoking, diabetes, and physical inactivity) remain a challenge in Rhode Island.
- Unsafe biking lanes in the city reduce opportunities for physical activity.
- Medication adherence is challenging for silent risk factors such as hypertension and hyperlipidemia.
- Long-term effectiveness of behavioral interventions is often questionable.
- Quality prevention and treatment options for uninsured and underinsured residents are lacking.

What Can Be Done

- Policy changes such as taxes on sugar-sweetened beverages may impact obesity and diabetes, and the resulting CVD.
- Increase risk factor screening for at-risk populations.
- More changes to the urban environment to promote physical activity.
- Consideration of social environment that may influence risk for cardiovascular disease such as quality of education provided to youth.

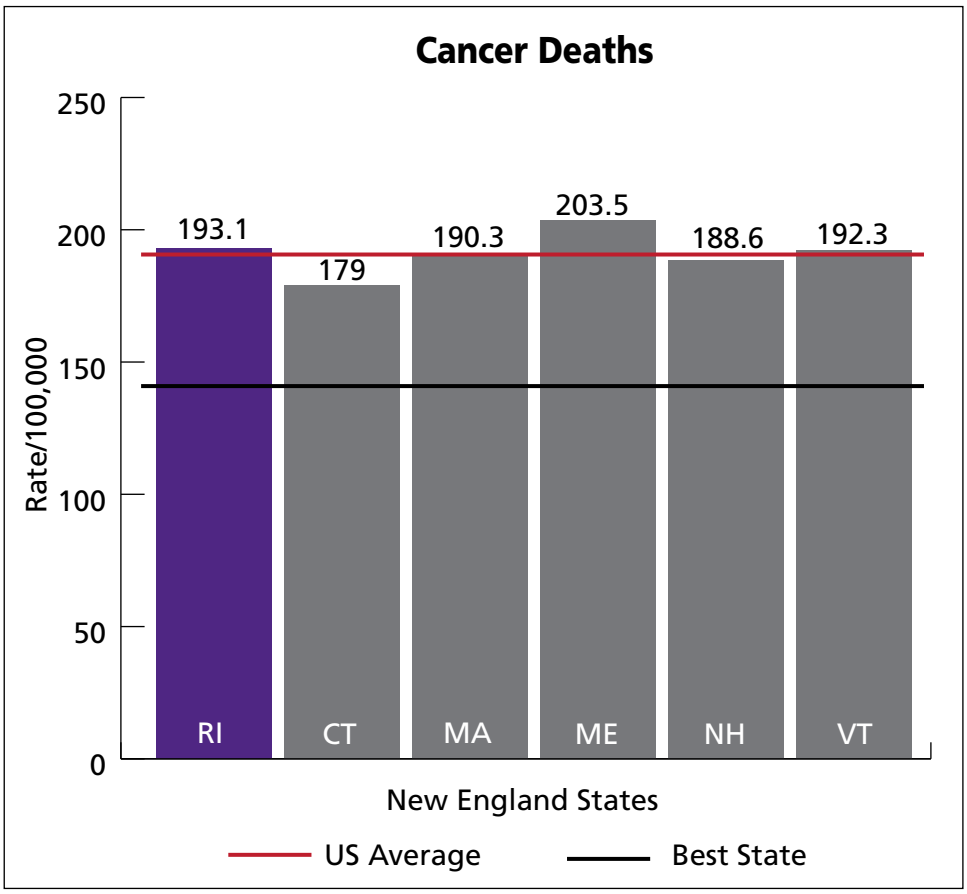
Resources

- WISEWOMAN program
- Rhode Island Chronic Care Collaborative
- Working groups including Stroke Task Force, Heart Disease and Stroke Prevention Steering Committee, EMS Working Group, amongst others
- American Heart Association

CANCER DEATHS

Number of deaths due to all causes of cancer per 100,000 population.

(Data Year: 2008-2010)



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics (CDC NCHS)

The Numbers at a Glance

- RI: 193.1 deaths per 100,000 population
- U.S. Average: 190.6 deaths per 100,000 population
- Best State: Utah, 141.3 deaths per 100,000 population
- Healthy People 2020 Target: 160.6 per 100,000 population

Why It's Important

Cancer is the second leading cause of death in Rhode Island, accounting for 23% of all deaths in the years 2006-2010.

Strengths

- Rhode Island's age-adjusted male cancer mortality rate ranked first among all states in the 1970s and 21st in 2006-2010.
- Rhode Island's age-adjusted female cancer mortality rate ranked fourth among all states in the 1970s and 31st in 2006-2010.
- Rhode Island's age-adjusted colorectal cancer mortality rate declined 60% from 1969-73 to 2006-2010 (vs. 43% for US).
- Rhode Island's age-adjusted breast cancer mortality rate declined 46% from 1969-73 to 2006-2010 (vs. 29% for US).

Challenges

- Rhode Island's age-adjusted melanoma-of-skin mortality rate increased 50% from 1969-73 to 2006-2010 (vs. 42% for US).
- Rhode Island's age-adjusted cancer mortality rate is 20% higher for African Americans than whites (2006-2010).
- Rhode Island's age-adjusted colorectal cancer mortality rate is 43% higher for African Americans than whites (2006-2010).
- Rhode Island's age-adjusted breast cancer mortality rate is 48% higher for African Americans than whites (2006-2010).

What Can Be Done

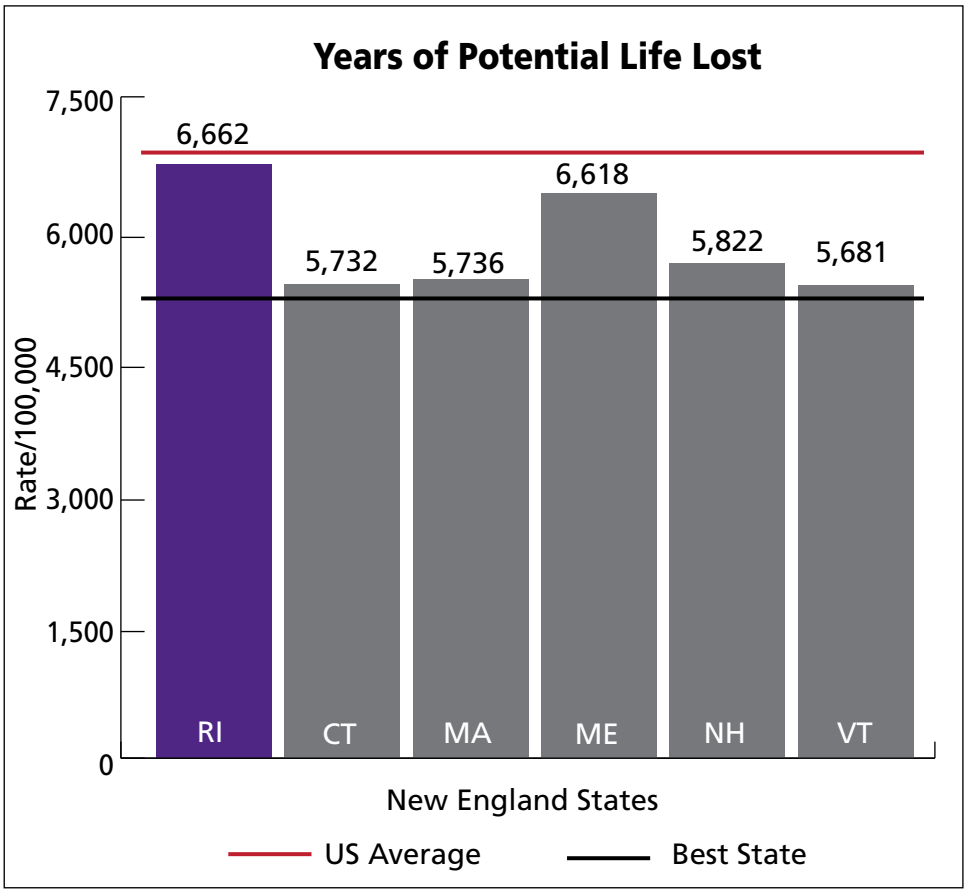
- Restrict teens' access to tanning booths.
- Increase access of African Americans to high-quality primary and secondary medical care.
- Increase colorectal cancer screening for African Americans.
- Increase breast cancer screening for African American women.

Resources

- Skin cancer control advocates
- Rhode Island's Health Insurance Exchange professionals
- Colorectal cancer screening professionals
- Breast cancer screening and treatment professionals
- American Cancer Society
- HEALTH's Women's Cancer Screening Program
- HEALTH's Comprehensive Cancer Control Program

PREMATURE DEATHS

Number of years of potential life lost prior to age 75 per 100,000 population (Data Year: 2009)



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics (CDC NCHS)

The Numbers at a Glance

- RI: 6,662 years lost per 100,000 population
- U.S. Average: 6,981 years lost per 100,000 population
- Best State: Minnesota, 5,493 years lost per 100,000 population
- No Healthy People 2020 Target

Why It's Important

Premature death measures the loss of years of life due to death before age 75. Thus, the death of a 25-year-old would account for 50 years of lost life, while the death of a 60-year-old would account for 15 years. A person who dies very young contributes more toward the overall measure and causes it to increase more than someone who dies closer to 75. Deaths occurring in younger people are more likely to be preventable than those occurring in older people, and are indicative of failures in the healthcare system and/or lifestyle factors. Cancer, unintentional injury, heart disease, suicide and deaths occurring during the perinatal period are the top five causes of premature death in the US.

Strengths

- Many of these causes of deaths are preventable through lifestyle modifications.

Challenges

- Lung cancer is the largest contributor toward premature cancer deaths, and smoking cessation can greatly decrease the risk of lung cancer.
- Heart disease is tied to several modifiable risk factors such as obesity, diabetes, and sedentary lifestyle.
- Motor vehicle accidents are the leading cause of premature death in those ages 5-34
- Suicide is the second leading cause of death in adults ages 25-34. (CDC)

What Can Be Done

- A variety of intervention strategies that encourage healthy lifestyles and preventative care can be effective in decreasing premature deaths.
- Smoking cessation campaigns, to decrease instances of lung cancer
- Heart disease education and prevention
- Promote seatbelt use every time you ride in a motor vehicle. Seat belts save lives.
- School-based programs to prevent violence
- Ignition interlocks, or in-car breathalyzers can reduce the rate of re-arrest among drivers convicted of driving under the influence.
- Increasing helmet use among motorcycle and bike riders.

Resources

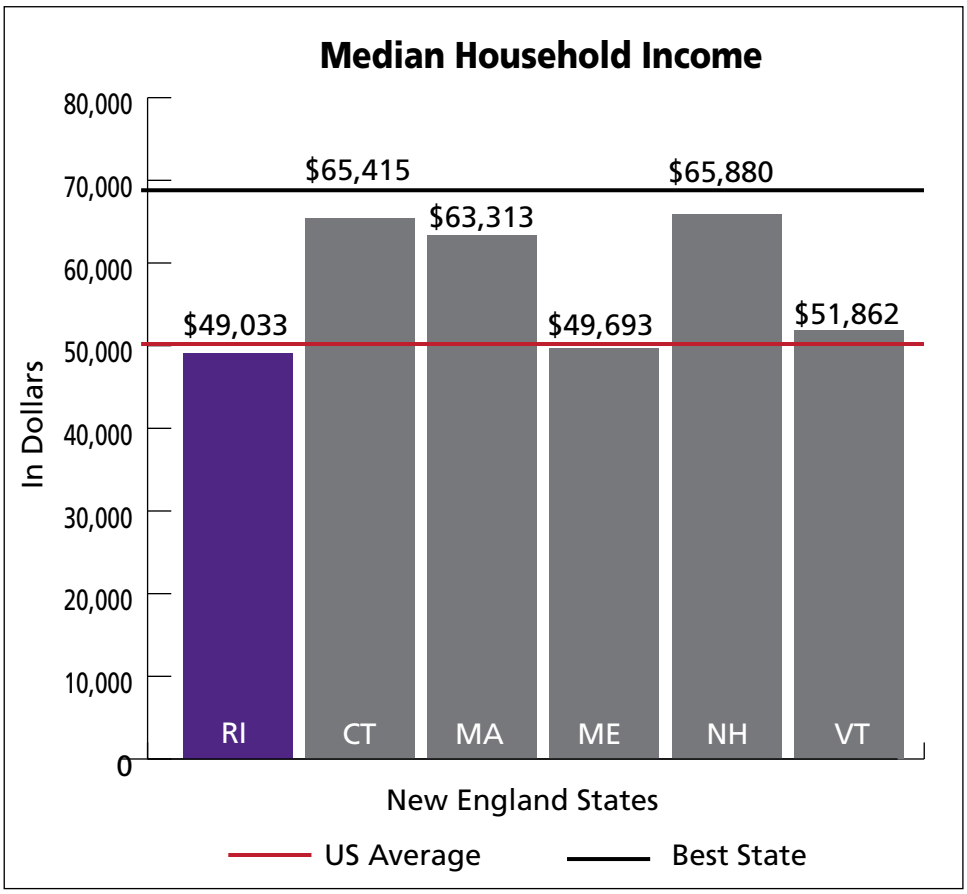
- Community centers
- Local gyms
- Smoking cessation programs
- Nutritionists and nutrition programs
- HEALTH's Tobacco Control Program
- HEALTH's Injury Prevention Program
- American Cancer Society
- American Lung Association

C. Supplemental Measures

1. Median Household Income
2. Unemployment Rate
3. Underemployment Rate
4. Hypertension
5. Colorectal Cancer Screening
6. Teen Births
7. Adolescents With Depression
8. Adolescents Smoking Cigarettes
9. Premature Birth Rate

MEDIAN HOUSEHOLD INCOME

Median household income is the amount of income that divides the income distribution into two equal groups: half with income above that amount and half with income below that amount. The median household income combines the incomes of all members of a household and is an indicator of the relative wealth of an area (higher median household income represents greater wealth). (Data Year: 2012)



Data Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

The Numbers at a Glance

- RI: $49,033
- U.S. Average: $50,054
- Best State: Maryland,$68,876
- No Healthy People 2020 Target

Why It's Important

Household income reflects the ability for that household to afford aspects of a healthy lifestyle including preventive medicine and curative care not provided to the individual through government, business, trade groups, or other sources (America's Health Rankings).

Strengths

- Rhode Island's median household income is nearly the same as that of the United States median household income.

Challenges

- Rhode Island has a high rate of unemployment and underemployment.
- National economic indicators impact the state's ability to increase job opportunities.

What Can Be Done

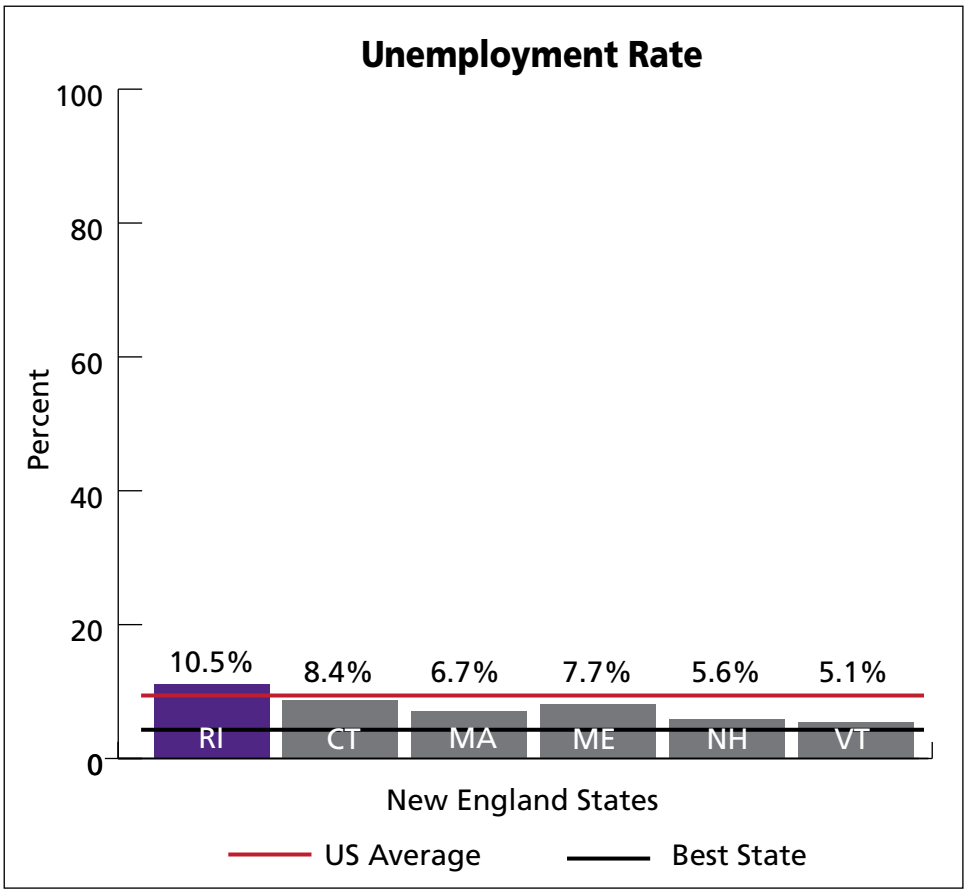
- Seek innovative approaches to increase job availability.
- Increase/expand job training and job seeking networks.

Resources

- Commerce RI
- Rhode Island Department of Labor and Training

UNEMPLOYMENT RATE

Total unemployed as a percentage of the civilian labor force (U-3 definition). (Data Year: 2012)



Data Source: U.S. Bureau of Labor Statistics

The Numbers at a Glance

- RI: 10.5%
- U.S. Average: 8.1%
- Best State: North Dakota, 3.2%
- No Healthy People 2020 Target

Why It's Important

Unemployment rate measures the total percentage of the civilian labor force that is unemployed. For most, employment is the source of income for sustaining a healthy lifestyle and for accessing healthcare. For many individuals, their employer is the source for their health insurance.

Employer-sponsored health insurance is the most common form of health insurance in the U.S., and the unemployment rate provides information about the number of uninsured. Unemployment also contributes to poverty, another cause of poor health.

Strengths

- The unemployment rate in Rhode Island has decreased from 11.1% in 2011 to 10.5% in 2012.

Challenges

- National unemployment rates are affected by national economic indicators.
- Unemployment has been associated with an increase in unhealthy behaviors such as poor diet, lack of exercise, tobacco use, and excessive alcohol consumption.

What Can Be Done

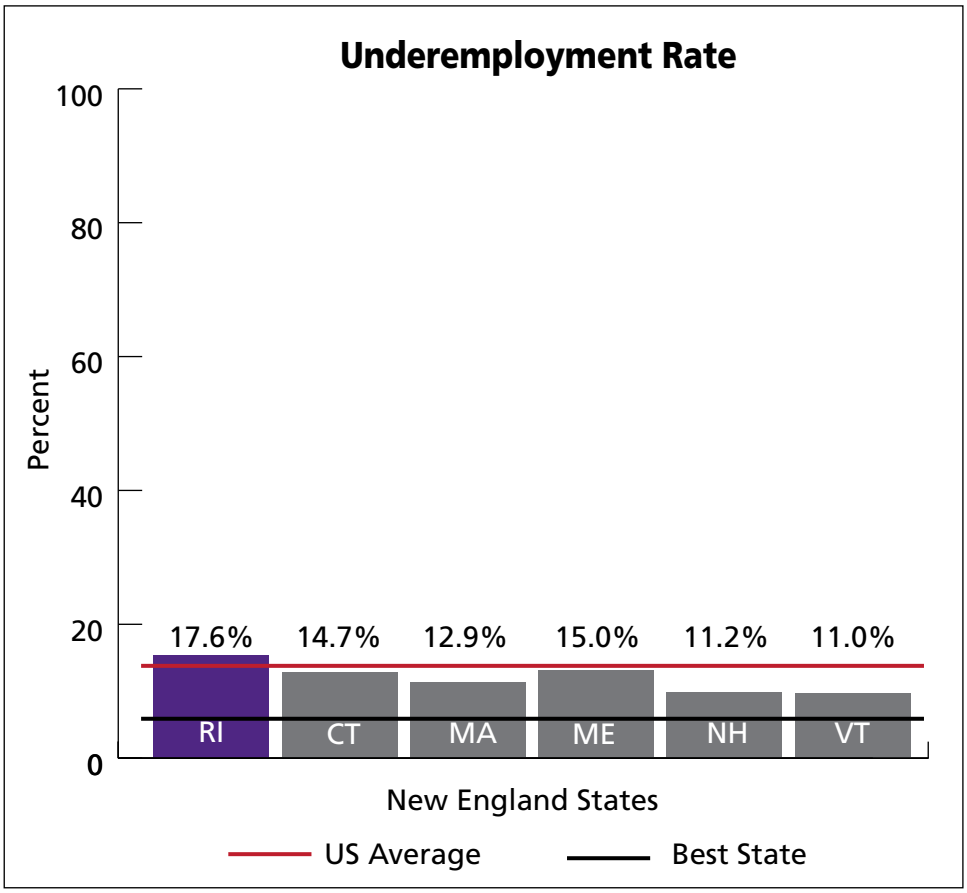
- Promote job training programs and job preparation programs.
- Expand and promote low-cost educational training programs.
- Increase access to educational loans.
- Improve the job-seeking system in the state to better connect employers to potential employees.

Resources

- Commerce RI
- Rhode Island Department of Labor and Training

UNDEREMPLOYMENT RATE

Total unemployed plus all marginally attached workers, plus those employed part-time for economic reasons, as a percent of the civilian labor force (U-6 definition) (Data Year: 2012)



Data Source: U.S. Bureau of Labor Statistics

The Numbers at a Glance

- RI: 17.6%
- U.S. Average: 14.7%
- Best State: North Dakota, 6.1%
- No Healthy People 2020 Target

Why It's Important

Underemployment rate measures the percentage of the civilian labor force that are unemployed, all marginally attached workers, plus those employed part-time for economic reasons. The connection between underemployment and health has been studied far less than that between unemployment and health; however, the existing evidence suggests underemployment is also associated with poor health. Underemployment leads to decreased earnings, which limits access to healthcare. Persons who are underemployed are more likely than other individuals to report lower levels of general well-being.

Strengths

- Rhode Island's annual underemployment rate is lower than the US average of 14.7%, but the highest of all the states in the northeast.

Challenges

- Underemployment is associated with a lack of health insurance.
- Workers who become hours- or income-underemployed after leaving high school report lower self-esteem than those who become adequately employed (Friedland, 2003).
- The risk of alcohol and drug abuse increases in cases of chronic underemployment (Friedland, 2003).
- Underemployed workers are at a greater risk of depression.

What Can Be Done

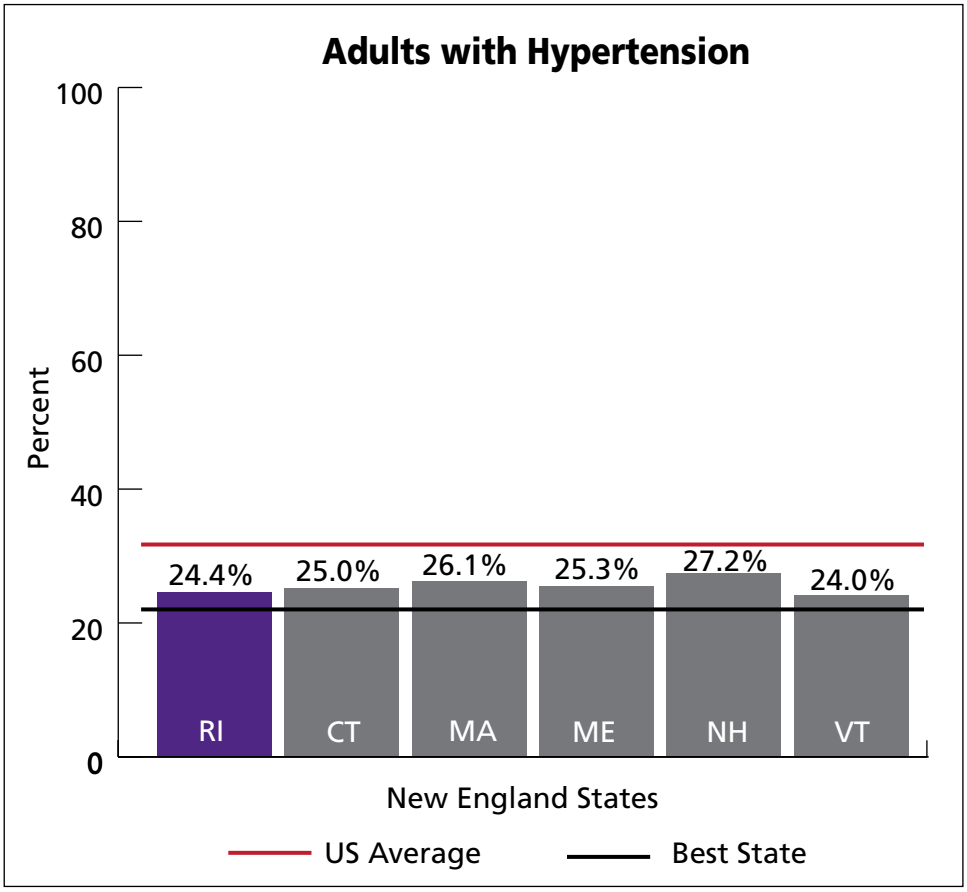
- Identify key partnerships and ways public health can promote healthy lifestyle changes.
- Develop relationship with the Rhode Island Department of Labor and Training to connect users with resources such as childcare and public transportation.

Resources

- Commerce RI
- Rhode Island Department of Labor and Training

HYPERTENSION

Percent of adults age 18 and older who have been told by a health professional that they have high blood pressure. (Data Year: 2011)



Data Source: Behavioral Risk Factor Surveillance System (BRFSS) (Centers for Disease Control and Prevention; Public Health Surveillance Program Office CDC, PHSPO)

The Numbers at a Glance

- RI: 24.4%
- U.S. Average: 31.0%
- Best State: Minnesota, 21.8%
- Healthy People 2020 Target: 26.9%

Why It's Important

The prevalence of high blood pressure in Rhode Island has increased. The age-adjusted prevalence of self-reported hypertension among Rhode Island adults was 25.5%, 27.1%, 28.7%, and 31.0% for the years 2005, 2007, 2009 and 2011, respectively.

Strengths

- Patient-Centered Medical Homes (PCMH) are being implemented statewide in 100 practices serving 250,000 patients.
- Apply lessons learned to practices that are not PCMHs and have more than 35% of patients with high blood pressure (HBP).
- HEALTH established centralized clinic-community referral system that links clinicians to community lifestyle modification and disease self-management programs for their patients.
- Opportunities exist for integration of HEALTH programs such as Chronic Care, Health Promotion and Emergency Medical Services (EMS).

Challenges

- Funding for practices not PCMHs to conduct Quality Improvement/Quality Assurance for HBP.
- Health plan reimbursement of evidence-based disease and self-management programs to motivate patients.
- Innovative approaches to address patients with undiagnosed HBP.
- Incentives built into health plans and the Affordable Care Act for patients to address healthy behavior changes to reduce HBP.

What Can Be Done

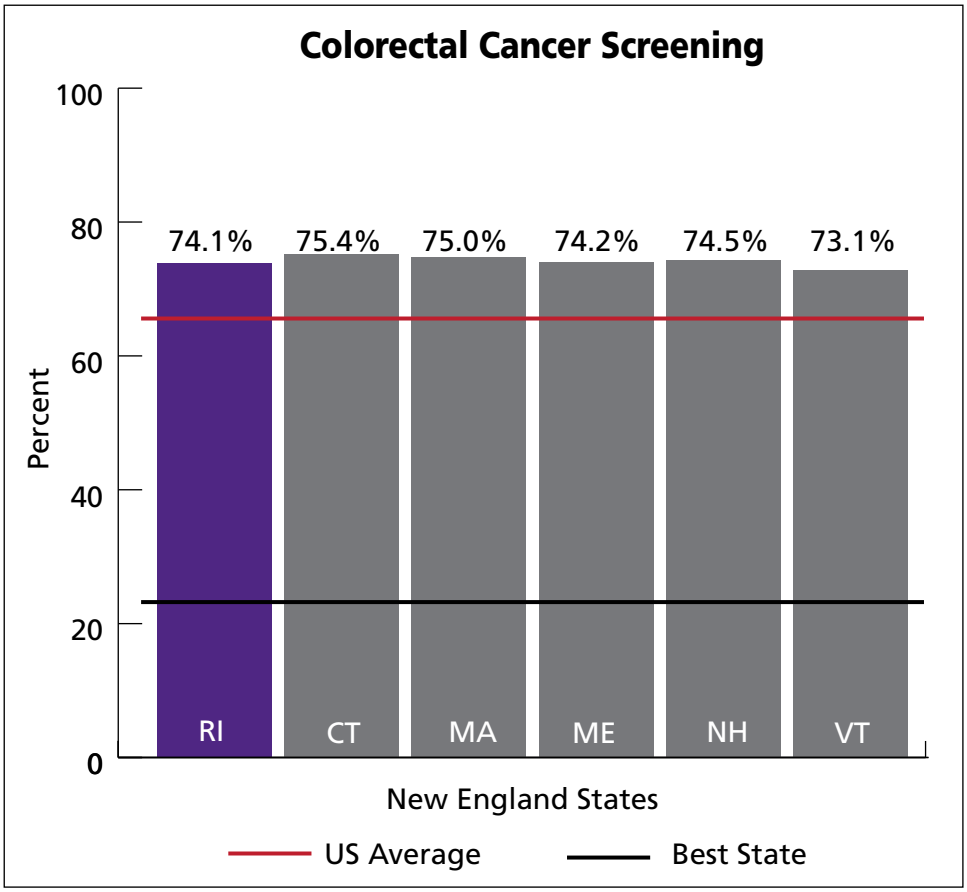
- Use aggregated National Quality Forum 18 data to improve population health outcomes by providing feedback to health system and community.
- Use Health Information Exchange (e.g. patient lists to identify undiagnosed persons with HBP) to manage patient panels and identify high risk patients.
- Use self-measured blood pressure monitoring programs accompanied by clinical support.
- Engage non-physician team members in HBP management in healthcare systems.
- Implement policy or systems in healthcare settings that encourage a multidisciplinary approach to HBP.
- Expand the role of the clinical team members to include focus on population management.
- Provide easily accessible evidence-based programs for HBP/chronic disease self management.

Resources

- American Heart Association
- Health plans (public/private)
- Primary care healthcare providers
- Specialty groups and organizations including federally qualified health centers, HEALTH's Community Health Network including the Young Men's Christian Association (YMCA) and Young Women's Christian Association (YWCA), self insured business and health entities, community based organizations, faith groups, Quality Improvement Organizations (QIO), hospitals/hospital systems, visiting nurse associations, home care providers, senior services-POINTs, senior centers, subsidized housing, independent living, American Association of Retired Persons (AARP), Emergency Medical Services (EMS)

COLORECTAL CANCER SCREENING

Sample respondents age 50+ who report ever having a sigmoidoscopy or colonoscopy. (Data Year: 2010)



Data Source: Centers for Disease Control and Prevention; Behavioral Risk Factor Surveillance System (BRFSS)

The Numbers at a Glance

- RI: 74.1%
- U.S. Average: 65.2%
- No Healthy People 2020 Target

Why It's Important

The vast majority of colorectal cancers are avoidable by following guidelines for screening colonoscopy. The procedure costs about $1,000, and for most adults older than age 50, needs to be repeated once every 7-10 years. The procedure allows for simultaneous (one-step) screening and removal of most precancerous lesions. In contrast, in the absence of screening, if a cancer of the colon or rectum is detected symptomatically, the resulting hospitalization and treatment, on average, costs $30,000. About 525 of these avoidable cancers are detected annually in Rhode Island, at a total cost of approximately $15.8 million.

Strengths

- A 76% increase in screening was seen within last 15 years.
- A 50% decline in colorectal cancer incidence was seen within the last 25 years.
- A 50% decline in colorectal cancer mortality was seen within the last 25 years.

Challenges

- 25% of eligible Rhode Islanders have never been screened for colorectal cancer.
- 12% of eligible Rhode Islanders have no health insurance

What Can Be Done

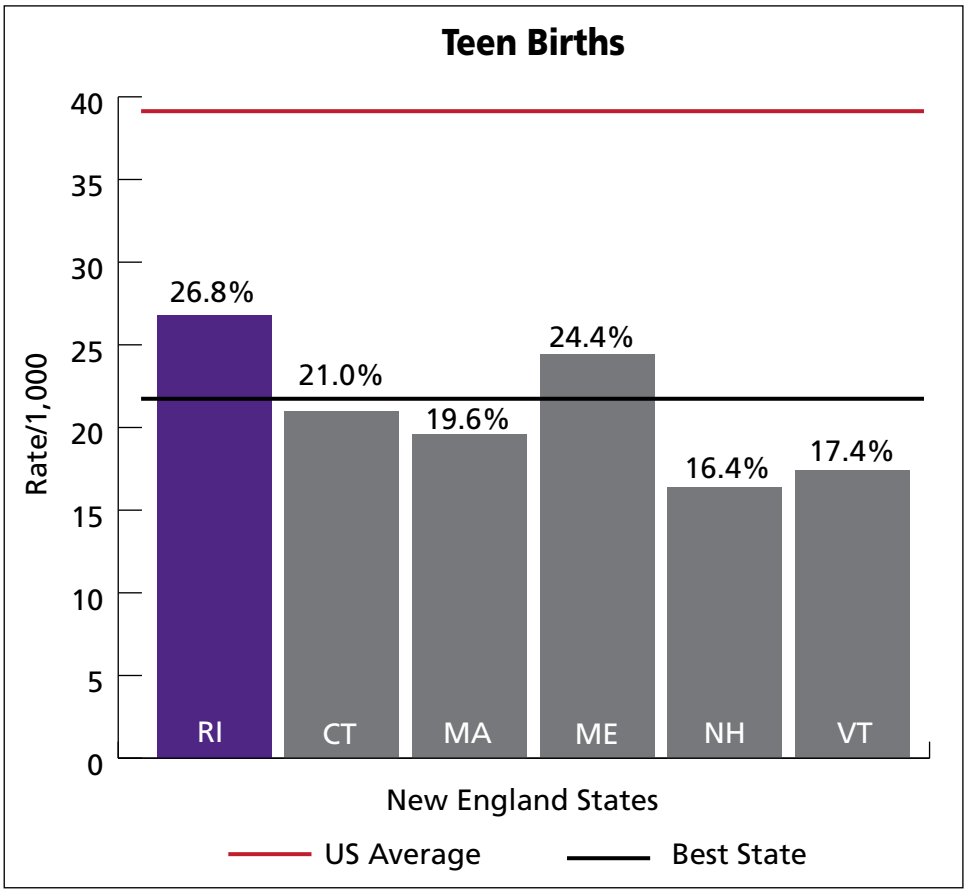
- Screen eligible adults age 50 and older who have health insurance.
- Subsidize the screening cost of eligible adults ages 50-64 who do not have health insurance.

Resources

- The Rhode Island Partnership to Reduce Cancer
- American Cancer Society

TEEN BIRTHS

Number of births to 1,000 female mothers age 15-19 (Data Year: 2009)



Data Source: National Vital Statistics System-Natality (NVSS-N) (Centers for Disease Control and Prevention, National Center for Health Statistics), Bridged-Race Population Estimates (CDC, Census)

The Numbers at a Glance

- RI: 26.8 %
- U.S. Average: 39.1%
- No Healthy People 2020 Target

Why It's Important

Teen pregnancy affects the long-term well-being of families and communities. Teen pregnancy and parenting also contribute to higher high school drop-out rates and lower income and educational attainment. For fathers, education statistics are similar; between 2002 and 2006, 40% of infants born to teens had fathers with a high-school diploma or less. Children of teen parents are more likely to have lower school achievement and drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teen, and face unemployment as a young adult. In 2008, Rhode Island public sector costs associated with teen childbearing were estimated at nearly $49 million.

Strengths

- Rhode Island is ranked ninth in the country for teen birth rates.
- Research and Data Analysis: RI Department of Health, RI KIDS COUNT and the Providence Plan that consistently collect and analysis data related to teen pregnancy and social health determinants
- Community Organizations: Fatherhood Initiatives, Parent Education and Support, Case Management, Youth empowerment, Job readiness, GED Education, After school enrichment, Nurse-Family Partnerships
- Health Care: Title X Family Planning Clinics offering services at free or reduced cost. College health centers offering free oral contraceptives and condoms. Two school-based health centers in the state that provide a range of primary care, behavioral, and oral health services that are available to students.

Challenges

- Rhode Island is ranked eighth highest percentage of repeat teen births.
- Minor consent to care and confidentiality laws are necessary for adolescents to seek healthcare, especially pertaining to sensitive information.
- Disparities exist among racial/ethnic groups and geographical locations.
- Transition from adolescent to adult services is an ongoing issue.
- Ensuring high-quality medical homes for adolescents, including enrolling adolescents with appropriate primary care providers.

What Can Be Done

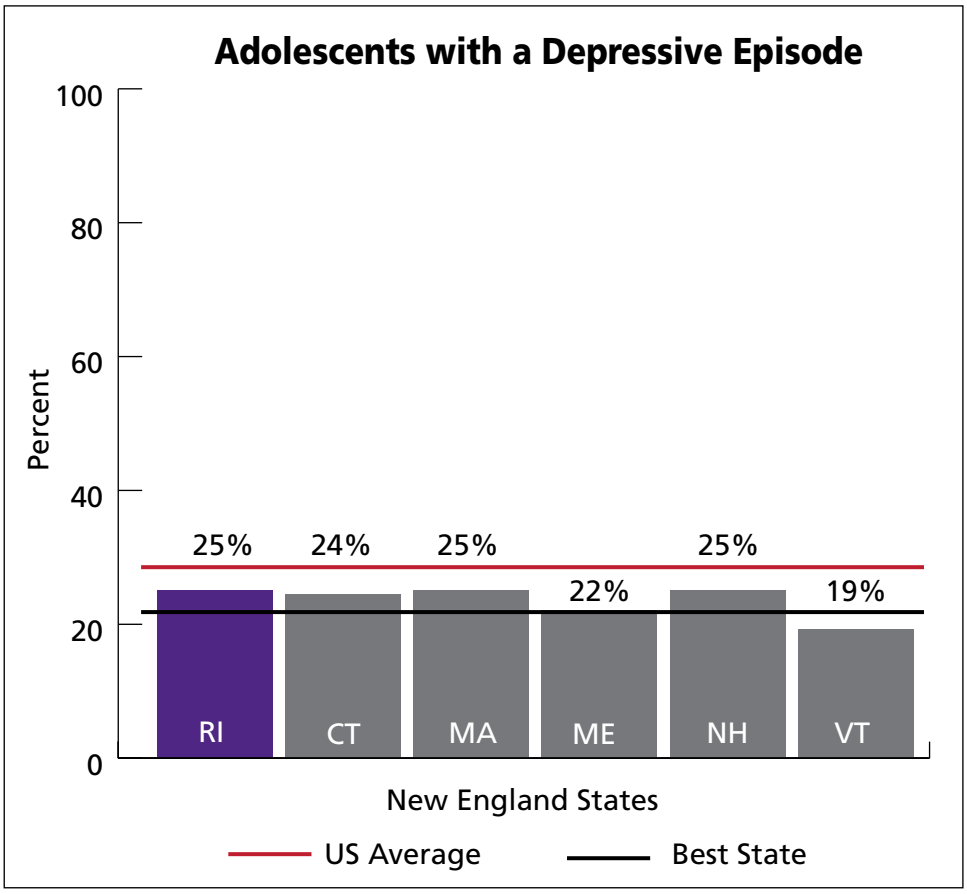
- Engage and support providers in quality improvement for medical homes.
- Require a physical exam for all Rhode Island high school students that coincides with the last required dose of meningococcal vaccine.
- Ensure comprehensive consent and confidentiality laws to support access to care.
- Develop family-community partnerships for prevention and community-based services including, physical, behavioral and oral healthcare.
- Invest in an analysis of where adolescents receive their care and what are the barriers to care.
- Plan for youth transitioning out of foster care; begin transition planning in middle school.
- Strengthen relationships among school and community providers related to physical and behavioral health services.
- Engage systems that serve families and youth at particularly high risk of pregnancy (Juvenile Justice, Foster Care, Domestic Violence, Homeless Youth and Community Behavioral Health).
- Cultivate youth development approaches in schools and communities.
- Reinstate school-based health centers with no limitations on health services provided.

Resources

- Personal Responsibility Education Program (Teen Outreach Program Curriculum) combines a comprehensive sexuality education curriculum with a youth-development approach in the form of a community service component that has proven effective in both school and community-based settings that are located statewide.
- Maternal and Child Home Visiting provides short- or long-term home visiting services to pregnant or parenting teens, including fathers.
- Home visitors help their clients find appropriate prenatal care, engage in preventive health practices, connect with community resources, become more confident parents, and set and achieve personal goals.
- Federally Funded Title X Family Planning Clinics provides confidential family planning services at low or no cost based on income.
- Teens can receive confidential birth control visits or HIV/STD testing without parental notification or consent.
- School-Based Health Centers (Two school-based health centers in the state provide a range of primary care, behavioral, and oral health services that are available to students.)

ADOLESCENTS WITH DEPRESSION

Percent of adolescents aged 12 to 17 years experienced a major depressive episode in past year. (Data Year: 2011)



Data Source: Youth Risk Behavioral Surveillance System (YRBSS), CDC National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

The Numbers at a Glance

- RI: 25%
- U.S. Average: 28.5%
- Healthy People 2020 Target: Decrease to 7.4%

Why It's Important

Major depressive disorders are the leading cause of disability among Americans ages 15 to 44 and about 11 percent of adolescents have a depressive disorder by age 18 according to the National Co-morbidity Survey-Adolescent Supplement (NCS-A).

Strengths

- Rhode Island is below the national average for adolescents with a depressive episode.

Challenges

- Adolescents who suffer from depression are especially vulnerable to falling behind in school, may lack in participation in social or school activities, and miss on growth/mastery activities.
- Adolescents that are depressed, and/or irritable, do not form the supportive relationships they need with family, peers, and teachers.
- Adolescents are often on long waiting lists for treatment, and the majority of visits to mental health care clinicians are for medication management.
- Stigma, cost, time, and location of clinics are common barriers to teens' treatment.

What can be done

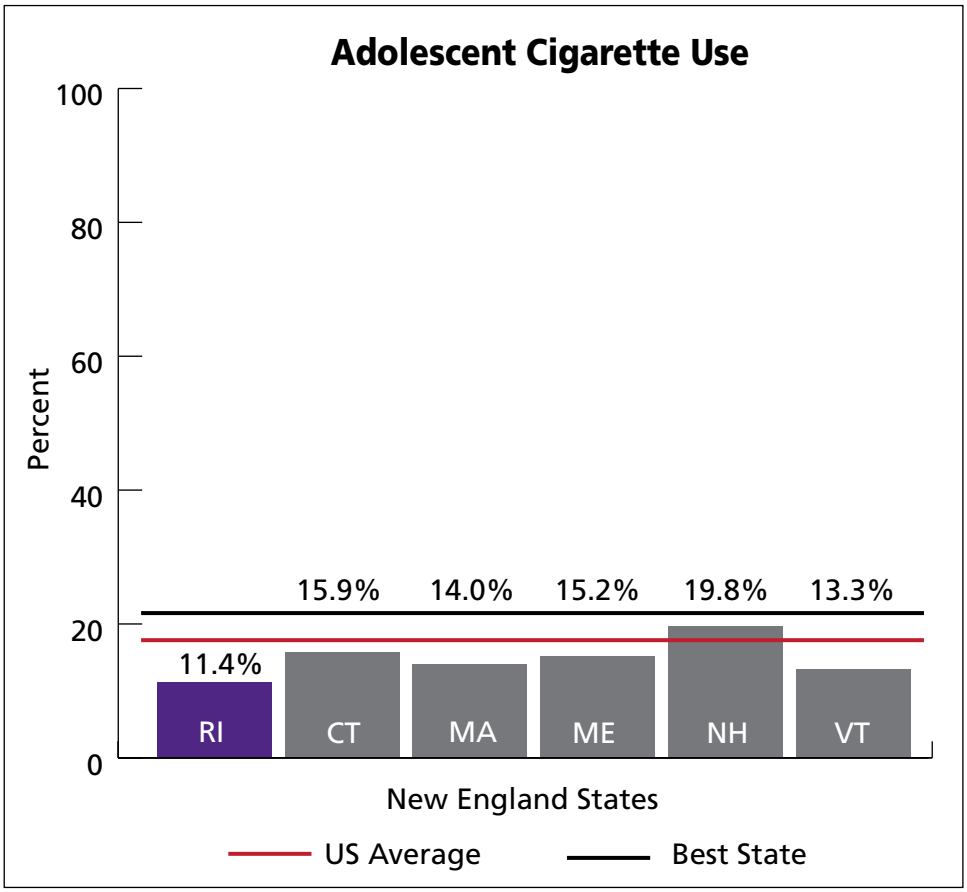
- Use trained, professional therapists and psychologists to help teens learn to cope with the negative in their lives so the depression can no longer be an overwhelming presence in their life.
- Weekly therapy sessions are a good place to start for many depressed teens.
- Some teens might find out they need more help in coping with their emotions and will need to be placed on an antidepressant medication to help them heal.
- Use a combination of medication, psychotherapy, or combined treatment.

Resources

- Bradley Hospital Parenting Guide: Depression in Children and Teens
- http://www.rhodeislandhospital.org/parenting-resources/depression-and-suicide/
- Rhode Island Youth Suicide Prevention Project
- http://riyouthsuicidepreventionproject.org/
- The Samaritans of Rhode Island
- http://samaritansri.org/youth-resources/parents-perspective/what-to-do/talk-with-your-teen
- HEALTH's Injury Prevention Program
- Butler Hospital

ADOLESCENTS SMOKING CIGARETTES

Number of students in grades 9 through 12 who reported having smoked cigarettes on one or more of the 30 days preceding the survey. (Data Year: 2011)



Data Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

The Numbers at a Glance

- RI: 11.4%
- U.S. Average: 18.1%
- Healthy People 2020 Target: 16% (Nationally)

Why It's Important

Most smokers begin before the age of 18. Rhode Island youth smoke cigarettes at a rate of 11.4%. Of the youth who currently smoke, 23,000 will eventually die early due to their smoking. For every person who dies from tobacco use, 20 more people suffer from serious tobacco-related illnesses, including cancer, heart disease, and respiratory illnesses. Smoking in Rhode Island costs $506 million annually in healthcare costs, $179 million in Medicaid expenditures, and nearly $379 million in lost productivity. Tobacco use disproportionately affects a few minority youth populations in Rhode Island: African American, Hispanic/Latino, lesbian, gay, bisexual, and youth unsure of their sexual identity (LGBU), and youth with physical or emotional disabilities.

Strengths

- The youth smoking rate in Rhode Island declined by five percent between 2004 and 2010.
- Fifty-two percent (52%) of Rhode Island high school students who currently smoke cigarettes daily have tried to quit smoking cigarettes.
- Tobacco Free Providence wrote and gained passage of multiple new city ordinances restricting tobacco marketing to youth, tobacco vendor marketing, and point of sale practices and zoning governing tobacco vendor density and proximity to schools.
- The City of Woonsocket bans the sale of tobacco and illicit drug paraphernalia within 200 feet of schools, child care centers, parks, and venues where youth recreate.

Challenges

- The younger the youth are when they start using tobacco, the more likely they will be addicted to nicotine, which prolongs tobacco use and can lead to severe health issues.
- Centers for Disease Control and Prevention best practices recommended funding level for a comprehensive tobacco control program is $15 million. Actual funding is approximately $1.5 million for the 2014 fiscal year.
- Rhode Island youth populations bear a greater tobacco burden:
- Current cigarette use is higher among Hispanic middle school students (6.7%) than among non-Hispanic white middle school students (3.9%).
- Current cigarette smoking is nearly three times higher (31% vs. 12%) among LGBU high school students.
- Youth with physical disabilities and high school students with emotional/learning disabilities are more likely than those without these disabilities to currently smoke cigarettes (20.3% vs. 12.3%)
- The tobacco industry creates new tobacco and nicotine products, maintaining smokers' addiction and often circumventing existing best practice tobacco control policies and pricing standards. Many of these products are used in conjunction with smoking cigarettes to maintain smokers' nicotine addiction when smoking a cigarette is not available to them.

What Can Be Done

Five evidence-based strategies supported by the CDC combine to produce significant gains in tobacco control efforts by changing community environments:

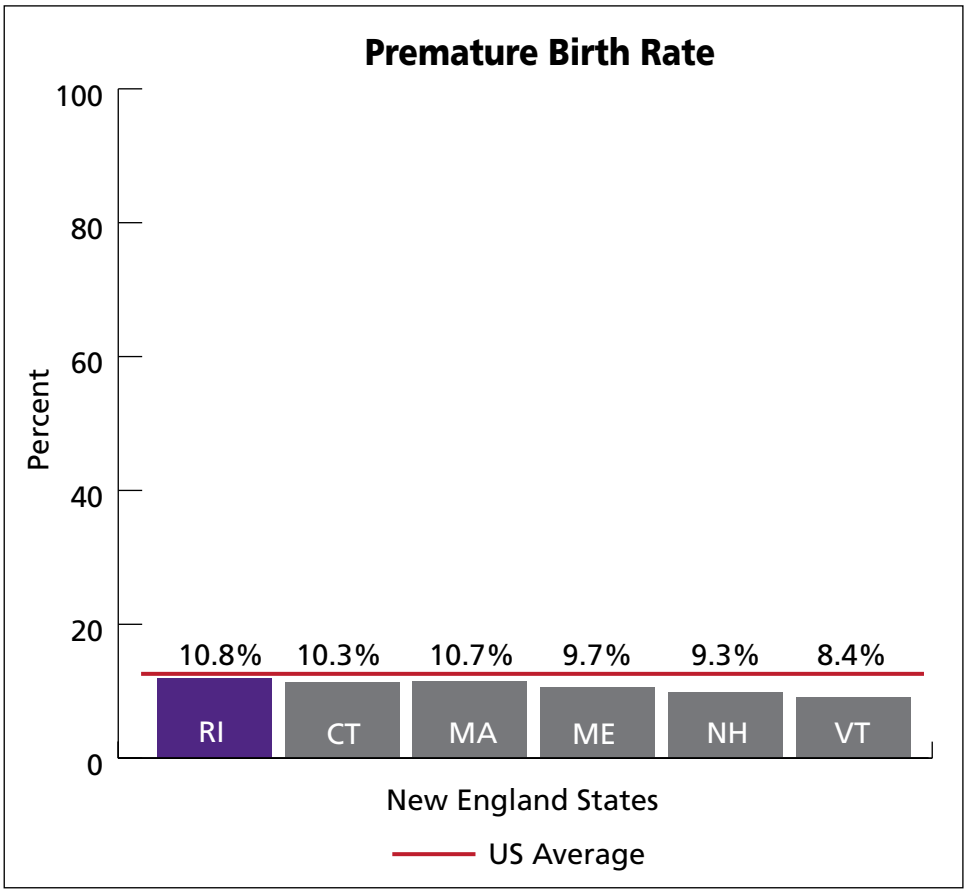
- Media: Hard-hitting counter-advertising campaigns are effective at prompting cessation attempts.
- Price: Increase the price of tobacco. Raising the Rhode Island cigarette tax, currently $3.50, will further reduce smoking rates.
- Access: Establish smoke-free public space limiting access to tobacco.
- Point of Purchase/Promotion: Establish municipal tobacco retailer licenses to assist communities in restricting tobacco retail in their community.
- Social Support & Services: Promote quitting among youth through outreach to healthcare providers via the QuitWorks-RI to provide a health-system wide cessation support to assist youth smokers in quitting.

Resources

- Tobacco Free Rhode Island
- Tobacco-free policies through local community organizations engaging youth
- Annual Youth Conference for youth with disabilities
- QUITWORKS-RI
- American Cancer Society

PREMATURE BIRTH RATE

Number of infants born before 37 completed weeks of gestation. (Data Year: 2010)



Data Source: National Vital Statistics System-Natality (Centers for Disease Control, National Center for Health Statistics)

The Numbers at a Glance

- RI: 10.8%
- U.S. Average: 12.0%
- Best State: Vermont, 9%
- Healthy People 2020 Target: 11.4%

Why It's Important

Premature birth is a major determinant of infant mortality and morbidity in the U.S. Infants born before 37 weeks gestation are at higher risk than full-term infants for neurodevelopment, respiratory, and gastrointestinal problems. Children who were born prematurely may experience physical disabilities, learning difficulties, and behavioral problems later in life.

Strengths

- Rhode Island lowered its premature birth rate by more than eight percent since 2009.
- Rhode Island completed a Preconception Strategic Plan.
- Rhode Island continues to support and implement the Healthy Babies Are Worth the Wait Campaign.
- Rhode Island continues to support the Task Force on Premature Births.

Challenges

- The rate of premature births among teen girls younger than age 20 was higher than the state rate.
- Premature rates are highest among women with public health insurance.
- Develop state policies and programs that ensure access to primary and preventive healthcare for women.
- Educating providers and patients addressing previous premature birth.
- Promoting the use of tobacco cessation services by pregnant women who smoke.

What Can Be Done

- Implement Recommendations in Preconception Plan.
- Continue to implement prenatal, evidence-based home visiting.
- Continue to implement efforts to reduce non-medically indicated inductions or Cesarean sections prior to 39 weeks gestation.
- Continue to support the work of the Prematurity Task Force.
- Continue to support efforts around Sudden Infant Death Syndrome (SIDS).
- Continue to support the range of services provided at Title X sites to include women's health services before and between pregnancies.
- Continue to support local community coalitions.

Resources

- Rhode Island Department of Health
- Rhode Island Chapter of the March of Dimes
- Home Visiting Programs
- Preconception Strategic Plan
- Rhode Island Department of Human Services
- Hospital Association of Rhode Island

D. Minority Health Facts

Non-whites make up an estimated 14% of the Rhode Island population , compared to 22% nationwide. Note that Hispanics/Latinos are not included in this table because being of Hispanic/Latino origin is an ethnicity, which can be from any race.

	Total Population	White	Black or African American	American Indian And Alaska Native	Asian	Native Hawaiian And other Pacific Islander	Two or More races
RI	1,052,567	910,253	75,073	9,173	31,768	1,602	24,698
US	308,745,538	241,937,061	40,250,635	3,739,506	15,159,516	674,625	6,984,195

Table 8. Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin: April 1, 2010 to July 1, 2012

There is abundance of data and information about minority groups, including a group-specific fact sheet published by the Department of Health in 2011 and also available on the website, at http://health.ri.gov/programs/minorityhealthpromotion/

MINORITY HEALTH FACTS

African Americans

IN RHODE ISLAND

Introduction

This report provides information about major health indicators in the African American/Black population of Rhode Island. An African American/Black is defined by the Office of Management and Budget (Directive 15, rev 1997) as a person having origins in areas of the Black racial groups of Africa. A White person is a defined as a person having origins in any of the original peoples of Europe, the Middle East, and North Africa.

This report presents data on socio-economic characteristics, morbidity and mortality, behavioral risks, infectious diseases, maternal and child health, and access to care among African American/Black Rhode Islanders in comparison to the White and the overall state populations. Please note that race and ethnic status for some Department of Health data sets are based on self-identification. All groups reported in this fact sheet are non-Hispanic unless otherwise indicated. The tables present point estimates which should not be used to imply statistical significance.

Population Demographics

According to the US Bureau of the Census, 2010 Census, there are 51,560 African Americans in Rhode Island, making this group the second largest minority population in the state (4.9%). Nearly 99% of African Americans in the state live in urban areas. Estimates from the 2007-2009 American Community Survey data indicate that the median age for the African American population is 29.0 years whereas the total state median age is 39.4 years. Nearly 93% of the African American population is age 65 or younger, while 86% of the state population is age 65 or younger.

Socio-Economic Characteristics

The following are socio-economic characteristics of Rhode Island's African American/Black population. These characteristics may affect the health of the African American/Black population living in Rhode Island. Except for the high school graduate rate, the socioeconomic data source for the African American/Black, White, and overall state populations is based on the 2007–2009 American Community Survey 3-Year Estimates.

- The percentage of African Americans living below the poverty level is about two times that of the overall state population and almost three times that of the White population.
- The median household income for African Americans is $38,500. That is $16,200 less than the state median and about $21,000 less than that for the White population.
- A lower percentage of African Americans graduate from high school than that for the White and overall state populations.
- The percentage of African Americans who are unemployed is almost two times the percentage unemployed in the White and overall state populations.

TABLE A: SOCIO-ECONOMIC DATA

	AFRICAN AMERICAN[1]	WHITE[1]	STATE[1]
Percentage of population living in poverty*	23.0%	8.2%	11.9%
Percentage of population that is unemployed	7.2%	4.4%	5.2%
Median household income**	$38.5K	$59.5K	$54.7K
High school graduation rate[2]	86%	91%	89%

Sources: 1. US Bureau of the Census, 2007–2009 American Community Survey 3-Year Estimates
2. Rhode Island Department of Elementary and Secondary Education, 2006–2007 School Year

**The 100% federal poverty level for a family of 4 in 2008 was $21,200.*

***The median income is the middlemost amount which divides the incomes into two equal groups, half having incomes above the median and half having incomes below the median. Household income takes into account any wage earners who share a household regardless of relation.*

Behavioral Risk Factors

The percentage of African Americans who participate in physical activity is less than that of the White and the overall state populations.

Fewer African Americans engage in binge drinking compared to Whites and the overall state population.

Mortality

African Americans, Whites, and the overall state population share heart disease, cancer, stroke, and unintentional injuries as four of the top five causes of death. While diabetes mellitus ranks as the third leading cause of death in the African American population, this cause of death is not ranked among the top five for the overall state or the White populations.

Chronic Diseases

Racial and ethnic disparities exist in health outcomes related to chronic diseases such as asthma, diabetes, heart disease, and stroke. For detailed reports of the burden of these chronic diseases on the health of Rhode Island residents and the disproportionate impact on the state's minority residents, visit the Rhode Island Department of Health website at www.health.ri.gov

Infectious Diseases

The rate of gonorrhea is nearly eight times higher in the African American population than in the overall state population and almost 15 times higher than in the White population.

The rate of chlamydia is five times higher in the African American population than in the overall state population and about 10 times higher than in the White population.

From 2005 to 2007, the rate of tuberculosis cases was about four times higher for African Americans than for the overall state population and about 11 times higher than for the White population.

HIV rates are almost five times higher for African Americans than for the overall state population and about eight times higher than for the White population.

TABLE B: BEHAVIORAL RISK FACTOR INDICATORS (ADULTS 18 YEARS AND OLDER)

	AFRICAN AMERICAN	WHITE	STATE
Percentage of adult population who participates in light to moderate physical activity for at least 30 minutes per day (2003, 2005, 2007)	45.7	51.9	50.3
Percentage of adult population (20 yrs+) who is overweight/obese[1] (2005–2008)	69.2	61.2	61.4
Percentage of adult population (20 yrs+) who is obese[2] (2005–2008)	30.1	21.6	22.2
Percentage of adult population who consumes at least 5 daily servings of fruits and vegetables (2003, 2005, 2007)	30.0	28.9	28.5
Percentage of adult population who smokes cigarettes (2005–2008)	17.8	18.6	18.4
Percentage of adult population who consumed 5+ drinks on one or more occasions in past month (binge-drinking) (2005–2008)	10.1	18.2	17.3

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

1. Overweight/obesity defined by the Centers for Disease Control and Prevention (CDC) as body mass index (BMI) ≥ 25
2. Obesity defined by CDC as BMI ≥ 30

According to the 2010 Census, there are 51,560 African Americans living in Rhode Island, making this group the second largest minority population in the state.

TABLE C: LEADING CAUSE OF DEATH

RANK	AFRICAN AMERICAN	WHITE	STATE
1	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer
3	Diabetes Mellitus	Chronic Respiratory Diseases	Chronic Respiratory Diseases
4	Stroke	Stroke	Stroke
5	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries

Source: Rhode Island Department of Health, Office of Vital Records, RI Resident Deaths, ICD-10 Codes, 2005-2009

TABLE D: SELECTED INCIDENCE RATES OF INFECTIOUS DISEASES: CASES PER 100,000 POPULATION

DISEASE	AFRICAN AMERICAN	WHITE	STATE
Gonorrhea[1]	290.8	19.7	38.0
Chlamydia[1]	1525	146	300
Tuberculosis[2]	14.6	1.3	3.7
HIV/AIDS[3]	86.9	11.0	17.9

Sources: Rhode Island Department of Health, Division of Infectious Disease and Epidemiology
1. Sexually Transmitted Diseases (STD) Surveillance Data, 2007
2. Tuberculosis Database, 2005–2007
3. HIV/AIDS Surveillance Data, 2007

TABLE E: MATERNAL AND CHILD HEALTH INDICATORS

	AFRICAN AMERICAN	WHITE	STATE
Percentage of pregnant women with delayed prenatal care[1,~]	24.1	13.5	15.5
Rate of births to teens ages 15–19 (per 1000 teens)[1*]	63.5	27.1	28.3
Percentage of births to mothers with less than 12 years of education[1]	23.2	14.2	16.6
Percentage of infants with low birth weight (<5.5 lbs)[1]	10.6	7.4	8.0
Infant mortality rate (per 1000 live births)[2]	12.8	5.5	6.3
Percentage of children in poverty (<18 years old)[3]	31.5	9.1	17.1

Sources: 1. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009
2. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009 (births to mothers who are Rhode Island residents)
3. US Bureau of the Census, 2007–2009 American Community Survey 3-Year Estimates

** Note: Teens aged 15–19: Rates are calculated using 2006–2008 American Community Survey Estimates; all race categories, excluding Whites, include Hispanic ethnicity.*

~ Delayed prenatal care is defined as beginning prenatal care in the second or third trimester or receiving no prenatal care at all.

TABLE F: ACCESS TO HEALTHCARE INDICATORS (ADULTS 18 YEARS AND OLDER)

	AFRICAN AMERICAN	WHITE	STATE
Percentage of adults younger than 65 years old who reported having no health insurance (2005–2008)	12.5	6.4	9.3
Percentage of adults who reported having no specific source of ongoing healthcare (2001, 2006)	13.2	10.0	10.9
Percentage of adults who had no routine checkup within the past year (2005–2008)	17.8	19.5	20.2
Percentage of women aged 40+ who reported not receiving a mammogram in the past 2 years (2006, 2008)	15.8	16.4	16.7
Percentage of women who reported not having a pap test in the past 3 years (2006, 2008)	13.1	12.7	12.9
Percentage of adults who reported being unable to afford to see a doctor at least once in the past year (2005–2008)	13.3	7.8	10.0

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

TABLE G: YOUTH RISK BEHAVIOR INDICATORS (YOUTH IN GRADES 9–12)

	AFRICAN AMERICAN	WHITE	STATE
Percentage of youth who reported using marijuana one or more times during the past 30 days (2007, 2009)	22.5	26.8	24.9
Percentage of youth who reported engaging in binge drinking one or more days in the past 30 days (2007, 2009)	25.5	40.6	38.6
Percentage of youth who reported having engaged in sexual intercourse (2007, 2009)	54.7	42.3	45.0
Percentage of youth who reported smoking cigarettes or cigars or using smokeless tobacco (2007, 2009)	+	12.3	11.4
Percentage of youth who reported not engaging in physical activity for 60 minutes or more on 5 or more days in the past 7 days (2007, 2009)	59.0	53.5	56.9
Percentage of youth who reported never or rarely wearing a seatbelt when in a vehicle driven by someone else (2007, 2009)	19.1	10.5	13.2

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

+ Sample too small for meaningful analysis

Maternal and Child Health

The overall state and the White populations have more favorable maternal and child health outcomes than the African American population in Rhode Island.

A larger percentage of African Americans have delayed prenatal care, and the rate of teen births for African Americans is more than twice that of the overall state and the White teen populations.

The rate of death of African American infants before their first birthday is more than twice that of the overall state and the White populations.

The percentage of African American children who grow up in poverty is nearly twice that of the overall state population of children, and more than three times that of White children.

Access To Healthcare

A higher percentage of African Americans report having no health insurance and no specific source of ongoing healthcare compared to the overall state and the White populations.

A higher percentage of African Americans also report being unable to afford a doctor at some point in time than of the overall state and the White populations.

A lower percentage of African American women aged 40+ report not having a mammogram in the past two years compared to women in all other populations.

Youth Risk Behavior

A lower percentage of African American youth appear to engage in sufficient physical activity compared to the White and overall state populations.

African American youth are less likely to engage in binge drinking than their peers in the White and overall state populations.

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Infectious Diseases	Division of Infectious Disease and Epidemiology	401-222-2577
Maternal and Child Health	Division of Community, Family Health, and Equity	401-222-5115

www.health.ri.gov/programs/minorityhealth

SEPTEMBER 2011

MINORITY HEALTH FACTS

Asians & Pacific Islanders

IN RHODE ISLAND

Introduction

This report provides information about major health indicators for the Asian and Pacific Islander populations living in Rhode Island. An Asian or Pacific Islander (API) is defined by the Office of Management and Budget (Directive 15, rev 1997) as a person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Laos, Vietnam, and Samoa. A White person is a defined as a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

This report presents data on socio-economic characteristics, morbidity and mortality, behavioral risks, infectious diseases, maternal and child health, and access to care among Asian and Pacific Islander residents in comparison to the White and the overall state populations. Please note that race and ethnic status for some Department of Health data sets are based on self-identification. Due to the nature in which data are collected, some statistics may be reported only for Asians rather than both Asians and Pacific Islanders. All groups reported in this fact sheet are non-Hispanic unless otherwise indicated. The tables present point estimates which should not be used to imply statistical significance.

Population Demographics

According to the US Bureau of the Census, 2010 Census, there are 30,293 Asians and Pacific Islanders living in Rhode Island. Approximately 2.7% of the Rhode Island population is of Asian descent, and about 0.03% is of Pacific Islander descent. 61.9% of the Asian and Pacific Islander population in RI was born in a foreign country. Estimates from the 2007–2009 American Community Survey data indicate that the median age for the Asian population is 30.3 years whereas the overall state median age is 39.4 years. About 94% of the Asian population is age 65 or younger, while 86% of the overall state population is age 65 or younger.

Socio-Economic Characteristics

The following are socio-economic characteristics of Rhode Island's Asian and Pacific Islander population. These characteristics may affect the health of the Asian and Pacific Islander residents living in Rhode Island. Except for the high school graduation rate, the socio-economic data source for Asian and Pacific Islander, White, and overall state populations is based on the 2007–2009 American Community Survey 3-Year Estimates.

- The percentage of Asians and Pacific Islanders living below the poverty level is slightly higher than that of the overall state population and almost two times that of the White population.
- The Asian population has a lower unemployment rate than all other minority groups and the overall state population.
- The median household income for Asians and Pacific Islanders is about $56,700. That is $2,000 above the state median and about $2,800 less than that for the White population.

TABLE A: SOCIO-ECONOMIC DATA

	ASIAN & PACIFIC ISLANDER[1]	WHITE[1]	STATE[1]
Percentage of population living in poverty*	15.9%	8.2%	11.9%
Percentage of population that is unemployed	4.7%	4.4%	5.2%
Median household income**	$56.7K	$59.5K	$54.7K
High school graduation rate[2]	89%	91%	89%

Sources: 1. US Bureau of the Census, 2007–2009 American Community Survey 3-Year Estimates
2. Rhode Island Department of Elementary and Secondary Education, 2006–2007 School Year

**The 100% federal poverty level for a family of 4 in 2008 was $21,200.*

***The median income is the middlemost amount which divides the incomes into two equal groups, half having incomes above the median and half having incomes below the median. Household income takes into account any wage earners who share a household regardless of relation.*

Behavioral Risk Factors

The percentage of the Asian and Pacific Islander population that is overweight is substantially lower than that of the White and the overall state populations.

The percentage of Asians and Pacific Islanders who participate in light to moderate physical activity for at least 30 minutes a day is less than that of the White or the overall state populations.

Mortality

For the period of 2005–2009, cancer, heart disease, stroke, and unintentional injuries were among the four leading causes of death for the Asian and Pacific Islander and the overall state populations.

Chronic Diseases

Racial and ethnic disparities exist in health outcomes related to chronic diseases such as asthma, diabetes, heart disease, and stroke. For detailed reports of the burden of these chronic diseases on the health of Rhode Island residents and the disproportionate impact on the state's minority residents, visit the Rhode Island Department of Health website at www.health.ri.gov

Infectious Diseases

The rate of chlamydia is approximately 2.5 times higher in the Asian and Pacific Islander population than in the White population.

Between 2005 and 2007, the rate of tuberculosis cases was six times higher for Asians than it was for the overall state population and 17 times higher than for the White population.

There were no known cases of tuberculosis in the Pacific Islander population.

TABLE B: BEHAVIORAL RISK FACTOR INDICATORS (ADULTS 18 YEARS AND OLDER)

	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Percentage of adult population who participates in light to moderate physical activity for at least 30 minutes per day (2003, 2005, 2007)	38.1	51.9	50.3
Percentage of adult population (20 yrs+) who is overweight/obese[1] (2005–2008)	36.4	61.2	61.4
Percentage of adult population (20 yrs+) who is obese[2] (200–2008)	12.2	21.6	22.2
Percentage of adult population who consumes at least 5 daily servings of fruits and vegetables (2003, 2005, 2007)	27.6	28.9	28.5
Percentage of adult population who smokes cigarettes (2005–2008)	12.4	18.6	18.4
Percentage of adult population who consumed 5+ drinks on one or more occasions in past month (binge-drinking) (2005–2008)	7.4	18.2	17.3

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

1. Overweight/obesity defined by the Centers for Disease Control and Prevention (CDC) as body mass index (BMI) ≥ 25
2. Obesity defined by CDC as BMI ≥ 30

According to the 2010 Census, there are 30,293 Asians and Pacific Islanders living in Rhode Island.

TABLE C: LEADING CAUSE OF DEATH

DISEASE	ASIAN & PACIFIC ISLANDER	WHITE	STATE
1	Cancer	Heart Disease	Heart Disease
2	Heart Disease	Cancer	Cancer
3	Stroke	Chronic Respiratory Diseases	Chronic Respiratory Diseases
4	Unintentional Injuries	Stroke	Stroke
5	+	Unintentional Injuries	Unintentional Injuries

Source: Rhode Island Department of Health, Office of Vital Records, RI Resident Deaths, ICD-10 Codes, 2005–2009

+ Data too small for meaningful analysis

TABLE D: SELECTED INCIDENCE RATES OF INFECTIOUS DISEASES: CASES PER 100,000 POPULATION

DISEASE	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Gonorrhea[1]	24.8	19.7	38.0
Chlamydia[1]	368	146	300
Tuberculosis[2]	22.4	1.3	3.7
HIV/AIDS[3]	+	11.0	17.9

Sources: Rhode Island Department of Health, Division of Infectious Disease and Epidemiology
1. Sexually Transmitted Diseases (STD) Surveillance Data, 2007
2. Tuberculosis Database, 2005–2007
3. HIV/AIDS Surveillance Data, 2007

+ Data too small for meaningful analysis

TABLE E: MATERNAL AND CHILD HEALTH INDICATORS

	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Percentage of pregnant women with delayed prenatal care[1,~]	25.4	13.5	15.5
Rate of births to teens ages 15-19 (per 1000 teens)[1*]	22.9	27.1	28.3
Percentage of births to mothers with less than 12 years of education[1]	14.3	14.2	16.6
Percentage of infants with low birth weight (<5.5 lbs)[1]	9.0	7.4	8.0
Infant mortality rate (per 1000 live births)[2]	10.4	5.5	6.3
Percentage of children in poverty (<18 years old)[3]	17.1	9.1	17.1

Sources: 1. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009
2. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009 (births to mothers who are Rhode Island residents)
3. US Bureau of the Census, 2007–2009 American Community Survey 3-Year Estimates

** Note: Teens aged 15-19: Rates are calculated using 2006–2008 American Community Survey Estimates; all race categories, excluding Whites, include Hispanic ethnicity.*

~ Delayed prenatal care is defined as beginning prenatal care in the second or third trimester or receiving no prenatal care at all.

TABLE F: ACCESS TO HEALTHCARE INDICATORS (ADULTS 18 YEARS AND OLDER)

	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Percentage of adults younger than 65 years old who reported having no health insurance (2005–2008)	5.4	6.4	9.3
Percentage of adults who reported having no specific source of ongoing healthcare (2001, 2006)	+	10.0	10.9
Percentage of adults who had no routine checkup within the past year (2005-2008)	31.5	19.5	20.2
Percentage of women aged 40+ who reported not receiving a mammogram in the past 2 years (2006, 2008)	+	16.4	16.7
Percentage of women who reported not having a pap test in the past 3 years (2006, 2008)	+	12.7	12.9
Percentage of adults who reported being unable to afford to see a doctor at least once in the past year (2005–2008)	16.5	7.8	10.0

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

+ Sample too small for meaningful analysis

TABLE G: YOUTH RISK BEHAVIOR INDICATORS (YOUTH IN GRADES 9–12)

	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Percentage of youth who reported using marijuana one or more times during the past 30 days (2007, 2009)	+	26.8	24.9
Percentage of youth who reported engaging in binge drinking one or more days in the past 30 days (2007, 2009)	28.0	40.6	38.6
Percentage of youth who reported having engaged in sexual intercourse (2007, 2009)	35.4	42.3	45.0
Percentage of youth who reported smoking cigarettes or cigars or using smokeless tobacco (2007, 2009)	+	12.3	11.4
Percentage of youth who reported not engaging in physical activity for 60 minutes or more on 5 or more days in the past 7 days (2007, 2009)	63.1	53.5	56.9
Percentage of youth who reported never or rarely wearing a seatbelt when in a vehicle driven by someone else (2007, 2009)	17.0	10.5	13.2

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

+ Sample too small for meaningful analysis

Maternal and Child Health

The overall state and the White populations have more favorable maternal and child health outcomes than the Asian and Pacific Islander populations.

The rate of births to teens for the Asian and Pacific Islander populations is lower than that for the White and overall state populations.

The percentage of Asian and Pacific Islander women who receive delayed prenatal care is almost two times greater than that of the White and the overall state populations.

Access To Healthcare

A higher percentage of Asians and Pacific Islanders report having no routine check-up within the past year compared to the White and the overall state populations.

Nearly twice as many Asian and Pacific Islanders report that they could not afford to see a doctor within the past year than the White population.

Youth Risk Behavior

A lower percentage of Asian and Pacific Islander youth engage in binge drinking than their peers in the White and overall state populations.

Nearly twice as many Asian and Pacific Islander youth report never or rarely wearing a seatbelt when in a car driven by someone else compared to the White population.

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Behavioral Risk Factors, Access to Healthcare, Youth Risk Behavior, and Census Data	Center for Health Data and Analysis	401-222-7628
Infectious Diseases	Division of Infectious Disease and Epidemiology	401-222-2577
Maternal and Child Health	Division of Community, Family Health, and Equity	401-222-5115

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SEPTEMBER 2011

MINORITY HEALTH FACTS

Hispanics/ Latinos

IN RHODE ISLAND

Introduction

This report provides information about major health indicators for the Hispanic/Latino population living in Rhode Island. A Hispanic/Latino is defined by the Office of Management and Budget (Directive 15, rev 1997) as a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. A White person is a defined as a person having origins in any of the original peoples of Europe, the Middle East, and North Africa.

This report presents data on socio-economic characteristics, morbidity and mortality, behavioral risks, infectious diseases, maternal and child health, and access to care among Hispanic/Latino Rhode Islanders in comparison to the White non-Hispanic and overall state populations. Please note that race and ethnic status for some Department of Health data sets are based on self-identification. The tables present point estimates which should not be used to imply statistical significance.

Population Demographics

According to the US Bureau of the Census, 2010 Census, there are 130,655 Hispanics/Latinos living in Rhode Island, making this group the largest and one of the most diverse minority populations in the state (12.4%). Persons of Puerto Rican origin form the largest Hispanic/Latino population in Rhode Island, followed by Dominicans and Colombians. Nearly 98% of Hispanics/Latinos live in urban areas with the largest concentration of Hispanics/Latinos living in Providence, Pawtucket, and Central Falls. Estimates from the 2007-2009 American Community Survey data indicate that approximately 85% of Hispanics/Latinos in Rhode Island older than the age of five speak a language other than English in their homes (usually Spanish). The median age for the Hispanic/Latino population is 26.0 years whereas the overall state median is 39.4 years. About 96% of the Hispanic/Latino population is age 65 or younger, while 86% of the overall state population is age 65 or younger.

Socio-Economic Characteristics

The following are socio-economic characteristics of Rhode Island's Hispanic/Latino population. These characteristics may affect the health of the Hispanic/Latino population living in Rhode Island. Except for the high school graduate rate, the socio-economic data for the Hispanic/Latino, White, and overall state populations are based on the 2007–2009 American Community Survey 3-Year Estimates.

- The percentage of Hispanics/Latinos living below the poverty level is more than three times that of the White and more than two and a half times that of the overall state populations.
- The median household income for Hispanic/Latinos is $33,900. That is $20,800 less than the state median and $25,600 less than that for the White population.
- A lower percentage of Hispanics/Latinos graduate from high school, and a higher percentage of Hispanics/Latinos are unemployed, than those of the White and the overall state populations.

TABLE A: SOCIO-ECONOMIC DATA

	HISPANIC/ LATINO[1]	WHITE (NON-HISPANIC)[1]	STATE[1]
Percentage of population living in poverty*	29.5%	8.2%	11.9%
Percentage of population that is unemployed	10.0%	4.4%	5.2%
Median household income**	$33.9K	59.5K	54.7K
High school graduation rate[2]	82%	91%	89%

Sources: 1. US Bureau of the Census, 2007–2009 American Community Survey 3-Year Estimates
2. Rhode Island Department of Elementary and Secondary Education, 2006–2007 School Year

**The 100% federal poverty level for a family of 4 in 2008 was $21,200.*

***The median income is the middlemost amount which divides the incomes into two equal groups, half having incomes above the median and half having incomes below the median. Household income takes into account any wage earners who share a household regardless of relation.*

Behavioral Risk Factors

The Hispanic/Latino population has the lowest percentage of adults participating in physical activity compared to the White and the overall state populations.

The percentage of Hispanic/Latinos who are obese is higher than that of the White and the overall state populations.

The percentage of Hispanics/Latinos who smoke cigarettes is lower than that of the White and the overall state populations.

Mortality

The top two causes of death for the Hispanic/Latino, White, and overall state populations are heart disease and cancer. Perinatal conditions are the fourth top cause of death in the Hispanic/Latino population. However, this cause of death is not ranked among the top five for the White or overall state populations.

Chronic Diseases

Racial and ethnic disparities exist in health outcomes related to chronic diseases such as asthma, diabetes, heart disease, and stroke. For detailed reports of the burden of these chronic diseases on the health of Rhode Island residents and the disproportionate impact on the state's minority residents, visit the Rhode Island Department of Health website at www.health.ri.gov

Infectious Diseases

The rate of gonorrhea is almost two times higher in the Hispanic/Latino population than in the overall state population and more than three times higher than in the White population.

The rate of chlamydia in Rhode Island's Hispanic/Latino population is nearly three times higher than in the overall state population and six times higher than in the White population.

Between 2005 and 2007, the HIV rate was slightly more than two times higher for Hispanic/Latinos than it was for the overall state population. Hispanic/Latino tuberculosis rates are nine times higher, and HIV rates nearly four times higher, than those for the White population.

TABLE B: BEHAVIORAL RISK FACTOR INDICATORS (ADULTS 18 YEARS AND OLDER)

	HISPANIC/ LATINO	WHITE (NON-HISPANIC)	STATE
Percentage of adult population who participates in light to moderate physical activity for at least 30 minutes per day (2003, 2005, 2007)	35.8	51.9	50.3
Percentage of adult population (20 yrs+) who is overweight/obese[1] (2005–2008)	65.3	61.2	61.4
Percentage of adult population (20 yrs+) who is obese[2] (2005–2008)	26.0	21.6	22.2
Percentage of adult population who consumes at least 5 daily servings of fruits and vegetables (2003, 2005, 2007)	25.2	28.9	28.5
Percentage of adult population who smokes cigarettes (2005–2008)	14.6	18.6	18.4
Percentage of adult population who consumed 5+ drinks on one or more occasions in past month (binge-drinking) (2005–2008)	13.1	18.2	17.3

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

1. Overweight/obesity defined by the Centers for Disease Control and Prevention (CDC) as body mass index (BMI) ≥ 25
2. Obesity defined by CDC as BMI ≥ 30

According to the 2010 Census, there are 130,655 Hispanics/Latinos living in Rhode Island, making this group the largest and one of the most diverse minority populations in the state.

TABLE C: LEADING CAUSE OF DEATH

DISEASE	HISPANIC/LATINO	WHITE (NON-HISPANIC)	STATE
1	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer
3	Stroke	Chronic Respiratory Diseases	Chronic Respiratory Diseases
4	Perinatal Conditions	Stroke	Stroke
5	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries

Source: Rhode Island Department of Health, Office of Vital Records, RI Resident Deaths, ICD-10 Codes, 2005–2009

TABLE D: SELECTED INCIDENCE RATES OF INFECTIOUS DISEASES: CASES PER 100,000 POPULATION

DISEASE	HISPANIC/LATINO	WHITE (NON-HISPANIC)	STATE
Gonorrhea[1]	63.9	19.7	38.0
Chlamydia[1]	865	146	300
Tuberculosis[2]	12.6	1.3	3.7
HIV/AIDS[3]	39.8	11.0	17.9

Sources: Rhode Island Department of Health, Division of Infectious Disease and Epidemiology
1. Sexually Transmitted Diseases (STD) Surveillance Data, 2007
2. Tuberculosis Database, 2005–2007
3. HIV/AIDS Surveillance Data, 2007

TABLE E: MATERNAL AND CHILD HEALTH INDICATORS

	HISPANIC/ LATINO	WHITE (NON-HISPANIC)	STATE
Percentage of pregnant women with delayed prenatal care[1,~]	21.6	13.5	15.5
Rate of births to teens ages 15–19 (per 1000 teens)[1*]	77.9	27.1	28.3
Percentage of births to mothers with less than 12 years of education[1]	36.5	14.2	16.6
Percentage of infants with low birth weight (<5.5 lbs)[1]	8.1	7.4	8.0
Infant mortality rate (per 1000 live births)[2]	7.7	5.5	6.3
Percentage of children in poverty (<18 years old)[3]	38.4	9.1	17.1

Sources: 1. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009
2. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009 (births to mothers who are Rhode Island residents)
3. US Bureau of the Census, 2007–2009 American Community Survey 3-Year Estimates

** Note: Teens aged 15–19: Rates are calculated using 2006–2008 American Community Survey Estimates; all race categories, excluding Whites, include Hispanic ethnicity.*

~ Delayed prenatal care is defined as beginning prenatal care in the second or third trimester or receiving no prenatal care at all.

TABLE F: ACCESS TO HEALTHCARE INDICATORS (ADULTS 18 YEARS AND OLDER)

	HISPANIC/ LATINO	WHITE (NON-HISPANIC)	STATE
Percentage of adults younger than 65 years old who reported having no health insurance (2005–2008)	31.1	6.4	9.3
Percentage of adults who reported having no specific source of ongoing healthcare (2001, 2006)	18.4	10.0	10.9
Percentage of adults who had no routine checkup within the past year (2005–2008)	25.1	19.5	20.2
Percentage of women aged 40+ who reported not receiving a mammogram in the past 2 years (2006, 2008)	18.0	16.4	16.7
Percentage of women who reported not having a pap test in the past 3 years (2006, 2008)	12.8	12.7	12.9
Percentage of adults who reported being unable to afford to see a doctor at least once in the past year (2005–2008)	27.1	7.8	10.0

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

TABLE G: YOUTH RISK BEHAVIOR INDICATORS (YOUTH IN GRADES 9–12)

	HISPANIC/ LATINO	WHITE (NON-HISPANIC)	STATE
Percentage of youth who reported using marijuana one or more times during the past 30 days (2007, 2009)	19.5	26.8	24.9
Percentage of youth who reported engaging in binge drinking one or more days in the past 30 days (2007, 2009)	37.5	40.6	38.6
Percentage of youth who reported having engaged in sexual intercourse (2007, 2009)	51.3	42.3	45.0
Percentage of youth who reported smoking cigarettes or cigars or using smokeless tobacco (2007, 2009)	9.0	12.3	11.4
Percentage of youth who reported not engaging in physical activity for 60 minutes or more on 5 or more days in the past 7 days (2007, 2009)	68.4	53.5	56.9
Percentage of youth who reported never or rarely wearing a seatbelt when in a vehicle driven by someone else (2007, 2009)	20.0	10.5	13.2

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

Maternal and Child Health

The overall state and the White populations have more favorable maternal and child health outcomes than the Hispanic/Latino population.

The percentage of Hispanics/Latinos who have delayed prenatal care is about two times that of the White and the overall state populations.

The percentage of Hispanic/Latino children who grow up in poverty is more than twice that of the overall state population and more than four times that of the White population.

Access To Healthcare

A higher percentage of Hispanic/Latino adults report having no health insurance compared to all other groups and the state population overall.

A higher percentage of Hispanics/Latinos report having no ongoing source of healthcare compared to all other groups and the state population overall.

A higher percentage of Hispanic/Latino women report not having a pap test in the past three years compared to women in every other population.

Youth Risk Behavior

The overall state and the White populations have more favorable youth risk behavior indicators than the Hispanic/Latino population.

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SEPTEMBER 2011

MINORITY HEALTH FACTS

Native Americans

IN RHODE ISLAND

Introduction

This report provides information about major health indicators for the American Indian/Alaska Native population in the state, hereafter referred to as Rhode Island's "Native American" population. An American Indian/Alaska Native is defined by the Office of Management and Budget (Directive 15) as a person having origin in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. A White person is defined as a person having origins in any of the original peoples of Europe, the Middle East, and North Africa.

This report presents data on socio-economic characteristics, morbidity and mortality, behavioral risks, infectious diseases, maternal and child health, and access to care among Native American Rhode Islanders in comparison to the White and the overall state populations. Please note that race and ethnic status for some Department of Health data sets are based on self-identification. All groups reported in this fact sheet are non-Hispanic unless otherwise indicated. The tables present point estimates which should not be used to imply statistical significance.

Population Demographics

According to the US Bureau of the Census, 2010 Census, there are about 4,020 Native Americans living in Rhode Island. Tribal affiliation is diverse, with more than ten tribes with more than 100 members and numerous others with fewer than 100 members. The Narragansett tribe holds the largest membership with over 2,000 people. Over 60% of the urban Native American population lives in Providence County. The median age for the Native American population is 26 years whereas the total state median age is 39.4 years. While 86% of the state population is age 65 or younger, 93% of the Native American population is age 65 or younger.

Socio-Economic Characteristics

The following are socio-economic characteristics of Rhode Island's Native American population. These characteristics may affect the health of the Native American population living in Rhode Island. Except for the high school graduation rate, the socio-economic data source for Native Americans is the 2000 Census, while the data source for Whites and the state overall is based on the 2007-2009 American Community Survey 3-Year Estimates.

- The percentage of Native American living below the poverty level is more than three times higher than that of the overall state population and almost five times higher than that of the White population.
- The median household income for Native Americans is $22,800. This is $31,900 less than the state median and $36,700 less than that for the White population.
- A lower percentage of Native Americans graduate from high school compared to the overall state and the White populations.
- A greater percentage of Native Americans are unemployed compared to the overall state and the White populations.

TABLE A: SOCIO-ECONOMIC DATA

	NATIVE AMERICAN[1]	WHITE[2]	STATE[2]
Percentage of population living in poverty*	39%	8.2%	11.9%
Percentage of population that is unemployed	6.5%	4.4%	5.2%
Median household income**	$22.8K	$59.5K	$54.7K
High school graduation rate[3]	69%	91%	89%

Sources: 1. US Bureau of the Census, 2000
2. US Bureau of the Census, 2007-2009 American Community Survey 3-Year Estimates
3. Rhode Island Department of Elementary and Secondary Education, 2006-2007 School Year

**The 100% federal poverty level for a family of 4 in 2008 was $21,200.*

***The median income is the middlemost amount which divides the incomes into two equal groups, half having incomes above the median and half having incomes below the median. Household income takes into account any wage earners who share a household regardless of relation.*

Behavioral Risk Factors

Native Americans have a slightly higher percentage of overweight or obese individuals compared to the White and the overall state populations. This trend is also seen when only the obese percentages are presented.

The percentage of Native Americans who smoke cigarettes is almost two times higher than that of the White and the overall state populations.

Native Americans have a lower percentage of adults who consume at least five daily servings of fruits and vegetables when compared to the White and overall state populations.

Chronic Diseases

Racial and ethnic disparities exist in health outcomes related to chronic diseases such as asthma, diabetes, heart disease, and stroke. For detailed reports of the burden of these chronic diseases on the health of Rhode Island residents and the disproportionate impact on the state's minority residents, visit the Rhode Island Department of Health website at www.health.ri.gov

Mortality

The two leading causes of death for the Native American, White, and overall state populations are heart disease and cancer.

Infectious Diseases

From 2005 to 2007, there were no known cases of tuberculosis among Native Americans in Rhode Island.

Due to the small population of Native Americans in Rhode Island, the available statistics on sexually transmitted diseases and HIV/AIDS are too limited to report reliably.

TABLE B: BEHAVIORAL RISK FACTOR INDICATORS (ADULTS 18 YEARS AND OLDER)

	NATIVE AMERICAN	WHITE	STATE
Percentage of adult population who participates in light to moderate physical activity for at least 30 minutes per day (2003, 2005, 2007)	59.1	51.9	50.3
Percentage of adult population (20 yrs+) who is overweight/obese[1] (2005-2008)	66.9	61.2	61.4
Percentage of adult population (20 yrs+) who is obese[2] (2005-2008)	29.1	21.6	22.2
Percentage of adult population who consumes at least 5 daily servings of fruits and vegetables (2003, 2005, 2007)	20.4	28.9	28.5
Percentage of adult population who smokes cigarettes (2005-2008)	34.0	18.6	18.4
Percentage of adult population who consumed 5+ drinks on one or more occasions in past month (binge-drinking) (2005-2008)	13.5	18.2	17.3

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

1. Overweight/obesity defined by the Centers for Disease Control and Prevention (CDC) as body mass index (BMI) ≥ 25
2. Obesity defined by CDC as BMI ≥ 30

TABLE C: LEADING CAUSE OF DEATH

DISEASE	NATIVE AMERICAN	WHITE	STATE
1	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer
3	+	Chronic Respiratory Diseases	Chronic Respiratory Diseases
4	+	Stroke	Stroke
5	+	Unintentional Injuries	Unintentional Injuries

Source: Rhode Island Department of Health, Office of Vital Records, RI Resident Deaths, ICD-10 Codes, 2005–2009

+ Data too small for meaningful analysis

TABLE D: SELECTED INCIDENCE RATES OF INFECTIOUS DISEASES: CASES PER 100,000 POPULATION

DISEASE	NATIVE AMERICAN	WHITE	STATE
Gonorrhea[1]	+	19.7	38.0
Chlamydia[1]	+	146	300
Tuberculosis[2]	0	1.3	3.7
HIV/AIDS[3]	+	11.0	17.9

Sources: Rhode Island Department of Health, Division of Infectious Disease and Epidemiology
1. Sexually Transmitted Diseases (STD) Surveillance Data, 2007
2. Tuberculosis Database, 2005–2007
3. HIV/AIDS Surveillance Data, 2007

+ Data too small for meaningful analysis

According to the 2010 Census, there are about 4,020 Native Americans who live in Rhode Island.

TABLE E: MATERNAL AND CHILD HEALTH INDICATORS

	NATIVE AMERICAN	WHITE	STATE
Percentage of pregnant women with delayed prenatal care[1,~]	23.9	13.5	15.5
Rate of births to teens ages 15–19 (per 1000 teens)[1*]	129.1	27.1	28.3
Percentage of births to mothers with less than 12 years of education[1]	35.7	14.2	16.6
Percentage of infants with low birth weight (<5.5 lbs)[1]	13.6	7.4	8.0
Infant mortality rate (per 1000 live births)[2]	+	5.5	6.3
Percentage of children in poverty (<18 years old)[3]	+	9.1	17.1

Sources: 1. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009
2. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009 (births to mothers who are Rhode Island residents)
3. US Bureau of the Census, 2007–2009 American Community Survey 3-Year Estimates

** Note: Teens aged 15–19: Rates are calculated using 2006–2008 American Community Survey Estimates; all race categories, excluding Whites, include Hispanic ethnicity.*

~ Delayed prenatal care is defined as beginning prenatal care in the second or third trimester or receiving no prenatal care at all.

+ Data too small for meaningful analysis

TABLE F: ACCESS TO HEALTHCARE INDICATORS (ADULTS 18 YEARS AND OLDER)

	NATIVE AMERICAN	WHITE	STATE
Percentage of adults younger than 65 years old who reported having no health insurance (2005–2008)	23.8	6.4	9.3
Percentage of adults who reported having no specific source of ongoing healthcare (2001, 2006)	+	10.0	10.9
Percentage of adults who had no routine checkup within the past year (2005–2008)	26.9	19.5	20.2
Percentage of women aged 40+ who reported not receiving a mammogram in the past 2 years (2006, 2008)	+	16.4	16.7
Percentage of women who reported not having a pap test in the past 3 years (2006, 2008)	+	12.7	12.9
Percentage of adults who reported being unable to afford to see a doctor at least once in the past year (2005–2008)	29.4	7.8	10.0

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

+ Data too small for meaningful analysis

Maternal and Child Health

The overall state and the White populations have more favorable maternal and child health outcomes than the Native American population in Rhode Island.

Native Americans are about twice as likely to receive delayed prenatal care compared to the White population.

The percentage of Native American teens (ages 15–19) who give birth is about four times greater than that of the White and overall state teen populations.

Native Americans have the highest percentage of infants with low birth weight of all racial and ethnic groups.

Access To Healthcare

Most samples are too small to draw reliable conclusions regarding Native Americans and access to healthcare.

A higher percentage of Native American adults report being unable to afford to see a doctor in the past year compared to adults in the White and the overall state populations.

The percentage of Native Americans having no health insurance is more than two times that of the overall state population and nearly four times that of the White population.


Photo by Gerald L. Edmonds

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Infectious Diseases	Division of Infectious Disease and Epidemiology	401-222-2577
Maternal and Child Health	Division of Community, Family Health, and Equity	401-222-5115

www.health.ri.gov/programs/minorityhealth

SEPTEMBER 2011

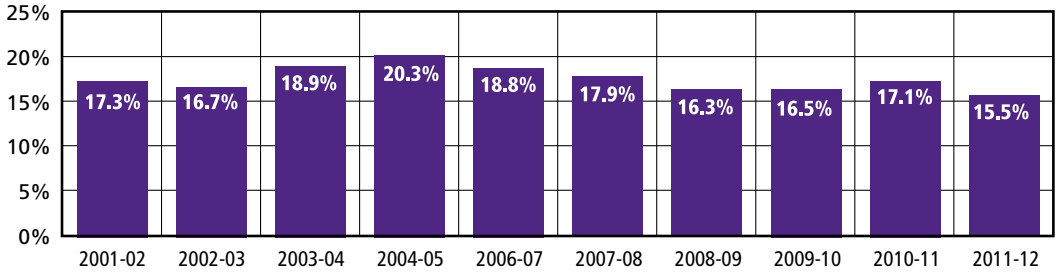
E. Other Communities and Population Groups

Rhode Island has many needs for its people. There are multiple, reliable data sources to learn more about what is affecting children, adults, the homeless, and people with disabilities. We strongly encourage you to learn more about each one of these groups that are part of our community.

1. Children

HEALTH collects and shares data on the health of children from pregnancy through birth, immunizations, lead poisoning, children with asthma and more. These data can be found in the annual publication Rhode Island KIDS COUNT Factbook, which includes data by city and town.

Visit: www.rikidscount.org/matriarch/MultiPiecePage.asp_Q_PageID_464_A_PageName_E_dataindicators



Source: Rhode Island Department of Health, Center for Child and Family Health, Immunization Program, School Years 2001-2002 through 2011-2012. *There are no data available for the 2005-2006 school year. Data are based on a sample of recorded heights and weights at kindergarten entry.

- Nearly one in six (15.5%) Rhode Island children entering kindergarten during the 2011-2012 school year were obese, down from a high of 20.3% in the 2004-2005 school year, and the lowest prevalence measured in 10 years.

- Excessive weight gain during pregnancy and gestational diabetes can put children at risk for obesity early in life. Having been breastfed is associated with long-term maintenance of lower BMI among children. Nationwide, one in seven (14.9%) low-income, preschool-aged children were obese in 2010.

Figure 8. Obesity among children entering Kindergarten.

2. Youth

HEALTH participates in Rhode Island's Youth Risk Behavior Survey (YRBS), part of a biennial national survey of public high school students on the major causes of disease and injury morbidity and mortality. In Rhode Island, nearly eight out of 10 high school students reported that they don't wear a bike helmet, and one in four felt depressed, according to the most recent survey conducted in 2011.

Visit: www.health.ri.gov/data/youthriskbehaviorsurvey

HIGH SCHOOL HEALTH RISK DATA

			RI-2011			US-2011			RI-2007			RI-2011			RI-2011			RI-2011		
	Measure	Description	Values	95% CIs		Values	95% CIs		Values	95% CIs		MALE	95% CIs		FEMALE	95% CIs		9th GRADE	95% CIs		12th GRADE	95% CIs	
DRUGS & ALCOHOL	Use Marijuana	1+ times, past mo.	26.3%	23.5%	29.4%	23.1%	21.5%	24.7%	23.2%	19.6%	27.3%	30.0%	26.7%	33.6%	22.7%	18.8%	27.2%	19.8%	16.3%	23.9%	34.0%	28.9%	39.6%
	Abused Rx/non-Rx Drugs	1+ times, ever	16.6%	15.3%	17.9%	n/a	n/a	n/a	n/a	n/a	n/a	18.9%	17.0%	20.8%	13.8%	12.0%	15.5%	13.0%	10.9%	15.0%	20.6%	17.4%	23.8%
	Drink Alcohol	1+ days, past mo.	34.0%	31.3%	36.8%	38.7%	37.2%	40.3%	42.9%	39.3%	46.6%	32.6%	29.2%	36.3%	35.2%	32.3%	38.3%	22.6%	18.8%	26.9%	44.8%	42.1%	47.5%
INJURY	No Bike Helmet	never/rarely wore, past yr.	77.5%	70.9%	82.9%	87.5%	85.0%	89.7%	80.4%	74.8%	84.9%	81.0%	75.4%	85.5%	72.7%	63.5%	80.3%	76.7%	67.9%	83.6%	79.8%	70.8%	86.5%
	No Seat Belt	never/rarely wore, past yr.	10.1%	7.7%	13.2%	7.7%	6.5%	9.1%	13.7%	11.1%	16.6%	12.4%	9.6%	15.9%	7.5%	5.4%	10.3%	10.5%	8.5%	13.0%	12.1%	7.7%	18.3%
	Drinking & Driving	1+ times, past mo.	6.5%	5.3%	7.9%	8.2%	7.6%	8.8%	9.8%	8.5%	11.4%	7.3%	5.9%	9.1%	5.5%	4.3%	6.9%	n/a	n/a	n/a	n/a	n/a	n/a
MENTAL HEALTH	Emotional Disability	for 6+ mos.	14.9%	13.3%	16.6%	n/a	n/a	n/a	12.9%	11.3%	14.7%	14.2%	12.6%	16.0%	15.6%	13.4%	18.2%	15.5%	12.3%	19.3%	14.3%	11.3%	17.8%
	Felt 'Depressed'	for 2+ wks., past yr.	24.6%	22.8%	26.5%	28.5%	27.2%	29.7%	23.6%	20.8%	26.7%	17.6%	15.7%	19.6%	31.5%	28.9%	34.2%	23.9%	20.6%	27.6%	25.2%	20.8%	30.3%
	Attempted Suicide	1+ times, past yr.	8.7%	7.3%	10.4%	7.8%	7.1%	8.5%	9.3%	7.8%	11.2%	9.1%	7.5%	11.0%	8.1%	6.5%	10.0%	8.5%	6.8%	10.6%	7.4%	5.3%	10.2%
SEX	Lesbian, Gay or Bisexual	sexual self-identity	7.7%	6.6%	9.0%	n/a	n/a	n/a	7.2%	5.5%	9.6%	4.7%	3.5%	6.3%	10.4%	9.0%	11.9%	6.7%	5.1%	8.6%	7.4%	5.2%	10.4%
	Sexually Active	1+ partner, past 3 mos.	29.8%	26.4%	33.4%	33.7%	31.8%	35.7%	33.1%	30.0%	36.4%	31.2%	27.3%	35.5%	28.4%	25.4%	31.7%	16.8%	13.4%	20.9%	45.2%	38.4%	52.1%
	Unprotected Sex	no protection, last encounter	11.6%	8.6%	15.6%	12.9%	11.6%	14.2%	12.2%	10.0%	14.8%	10.9%	9.1%	13.0%	12.5%	7.2%	20.7%	16.2%	11.2%	22.7%	10.8%	6.3%	18.1%
TOBACCO	Current Smoking	on 1+ days, past mo.	11.4%	9.0%	14.4%	18.1%	16.7%	19.5%	15.1%	11.7%	19.3%	13.3%	9.8%	17.7%	9.6%	7.6%	12.1%	9.4%	6.9%	12.6%	12.7%	9.8%	16.2%
	Heavy Smoking	10+ on days smoked, past mo.	8.6%	5.0%	14.6%	7.8%	6.3%	9.7%	12.0%	8.0%	17.6%	11.4%	6.0%	20.7%	4.7%	1.7%	11.9%	n/a	n/a	n/a	n/a	n/a	n/a
	Any Tobacco Use	cigs, cigars, smokeless past mo.	17.9%	14.6%	21.7%	23.4%	21.8%	25.1%	21.6%	17.5%	26.4%	23.3%	18.4%	29.1%	12.8%	10.5%	15.5%	13.0%	10.2%	16.4%	22.9%	17.8%	28.8%
VIOLENCE	Physical Fighting	1+ times, past yr.	23.5%	21.8%	25.3%	32.8%	31.5%	34.1%	26.3%	23.1%	29.8%	29.7%	27.0%	32.5%	17.3%	15.0%	19.9%	26.5%	23.5%	29.8%	18.0%	14.8%	21.7%
	Dating Violence	hit by boy/girlfriend, past yr.	8.2%	7.5%	8.9%	9.4%	8.6%	10.3%	14.0%	12.1%	16.2%	8.6%	7.0%	10.6%	7.6%	6.4%	8.9%	7.2%	6.0%	8.6%	8.1%	5.8%	11.2%
	Rape Victim	forced intercourse, ever	6.9%	6.0%	7.9%	8.0%	7.3%	8.8%	10.1%	8.6%	11.9%	5.2%	4.4%	6.2%	8.3%	7.1%	9.7%	5.4%	4.2%	6.9%	6.2%	4.6%	8.1%
WEIGHT	Obesity	> =95th percentile for BMI	10.8%	8.8%	13.3%	13.0%	11.7%	14.4%	10.6%	8.6%	12.9%	13.2%	10.1%	17.1%	8.4%	6.3%	11.1%	11.5%	8.9%	14.8%	10.9%	8.3%	14.3%
	Inadequate Exercise	not active for 60+ min., past wk.	12.1%	9.7%	14.9%	13.8%	12.8%	14.8%	13.3%	10.9%	16.1%	10.5%	8.4%	12.9%	13.8%	10.8%	17.4%	10.1%	7.5%	13.7%	13.0%	9.8%	17.0%
	Poor Nutrition	no fruit or veggies, past wk.	3.9%	3.2%	4.5%	n/a	n/a	n/a	3.6%	2.7%	4.4%	5.0%	4.0%	6.0%	2.7%	1.9%	3.5%	3.7%	2.6%	4.7%	3.3%	2.0%	4.7%

'n/a' not applicable/available, data were either not collected, the sample was too small to be statistically valid ('heavy smoking' by grade), or not a meaningful comparison ('drinking & driving' by grade)

Table 9. High School Health Risk Data

3. Non-Metro Communities

The non-metro areas are defined as all municipalities with a population density of 500 persons per square mile or less. By this definition, 16 cities and towns qualify as non-metropolitan areas: Burrillville, Charlestown, Coventry, Exeter, Foster, Glocester, Hopkinton, Jamestown, Little Compton, New Shoreham, Portsmouth, Richmond, Scituate, Tiverton, West Greenwich, and Westerly. In Rhode Island, a limited number of physicians practice outside the greater Providence area, and the public transportation is largely urban-oriented. As shown in the map below, non-metro Rhode Island has only seven medical facilities.

Visit: www.health.ri.gov/publications/reports/2012HealthOfRhodeIslandNonMetropolitanCommunities.pdf

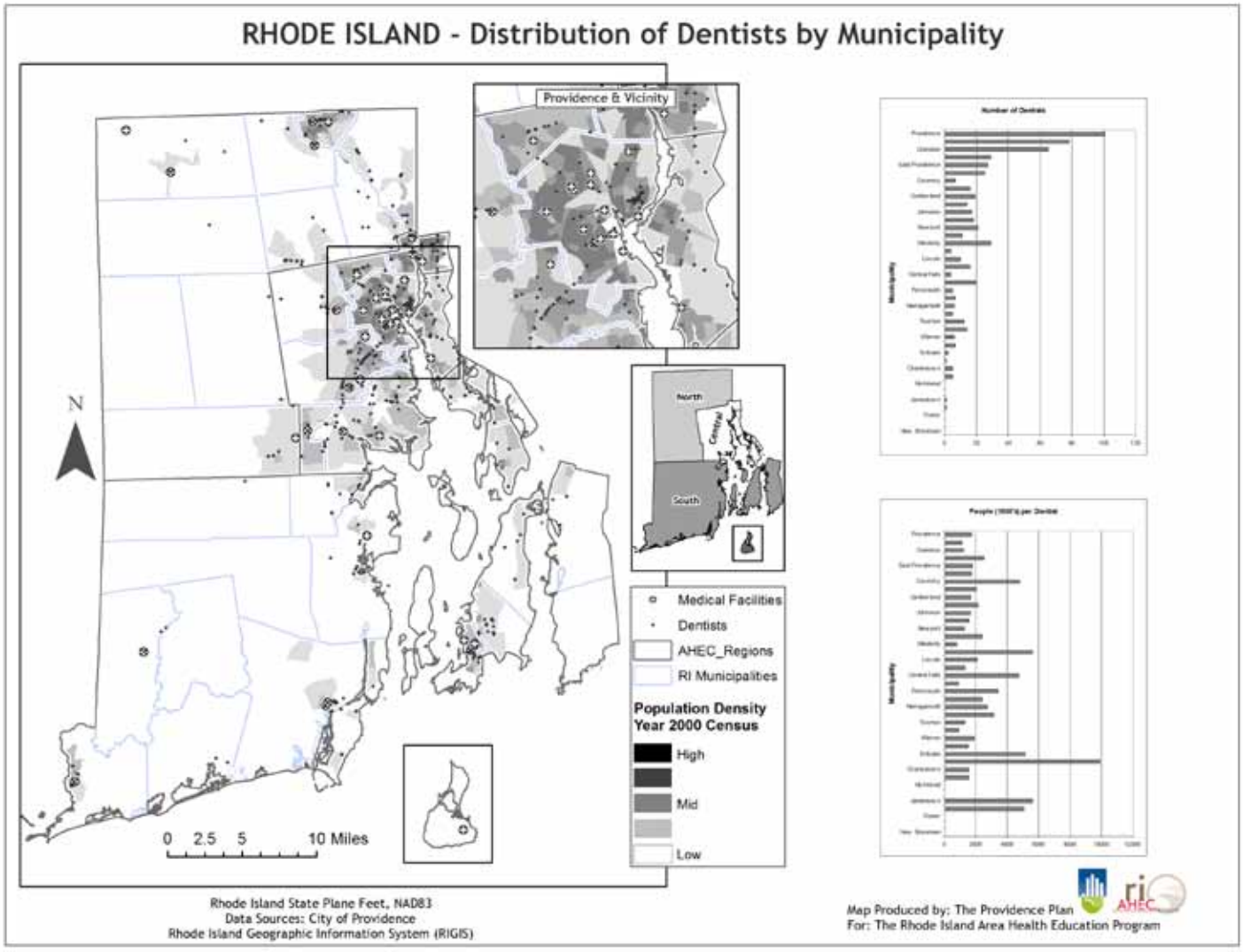


Figure 9. Distribution of Dentists by Municipality

4. Aging People

In Rhode Island, more than 363,000 people are age 50 or older, and the proportion of Rhode Island's population that is 60 and older is growing more rapidly than other segments of the population (see graph below).

A person's age can change how disease and other risk factors impact the individual. For example, tolerance of alcohol decreases as people get older, and so binge drinking, (three or more drinks in one event for women, and four or more for men), is a concern for this group. In Rhode Island, nearly 19% of men ages 50 and older engage in binge drinking, compared to nearly 13% of women age 40 and older.

In 2010, Rhode Island reported approximately 1,300 admissions to substance-abuse treatment among the 50 and older population, and nearly 20% of them reported their medical coverage was Medicaid or private insurance.

Visit: aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/docs2/Rhode%20Island%20Epi%20Profile%20Final.pdf

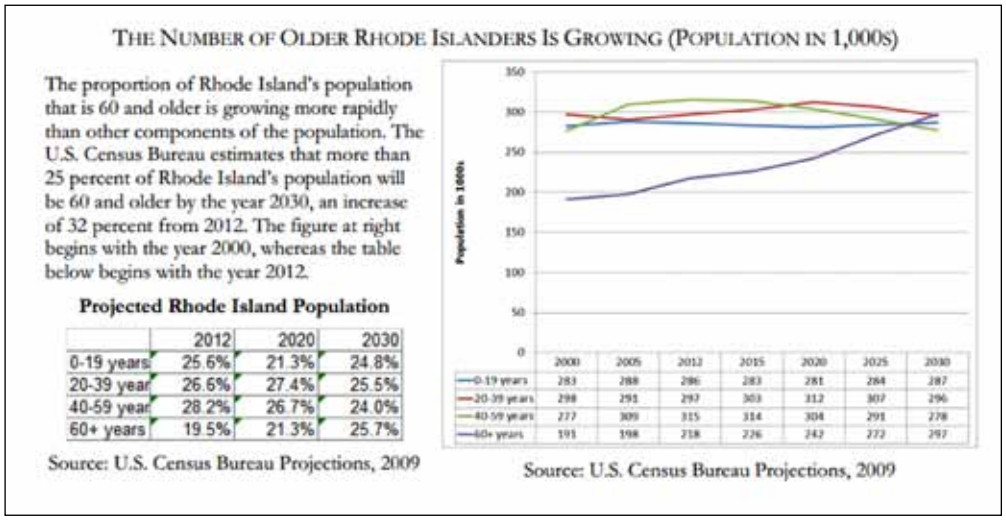


Figure 10. Number of older Rhode Islanders

5. People With Disabilities

In 2011, Rhode Island students with disabilities had significantly higher health risks on 20 of 24 measures than students without disabilities. However, from 2007-2011, four risk measures for students with disabilities improved significantly (current smoking, any tobacco use, current drinking, and early drinking before age 13).

Visit: health.ri.gov/programs/disabilityandhealth

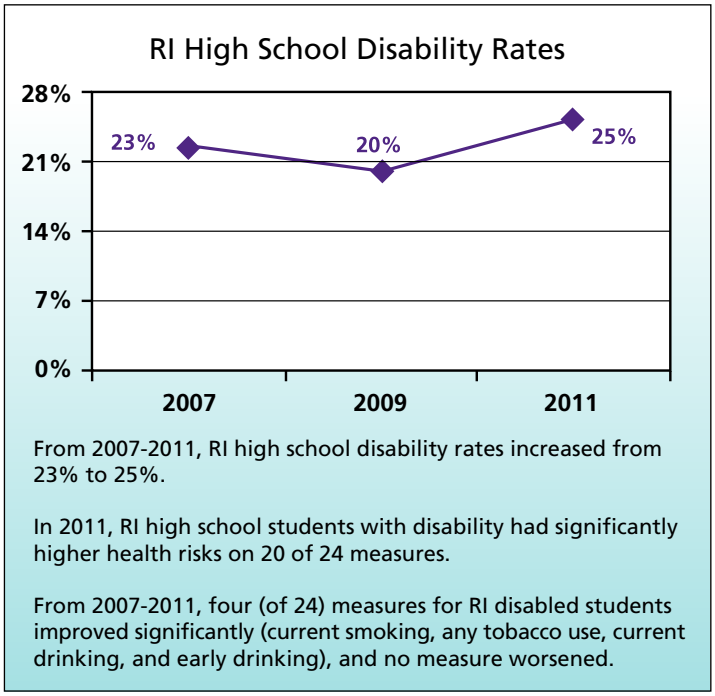


Figure 11. High School Disability Rates

6. Homelessness

In Rhode Island in 2010, about 4,400 people were homeless, living in shelters, on the streets, or in transitional housing for homeless people. On any given night, more than 1,100 Rhode Islanders had no home. Currently, Rhode Island has emergency, transitional, and permanent housing resources for the homeless that are reported to the Housing and Urban Development (HUD) agency. However, fewer units are available to families with children.

To end chronic and veterans homelessness in five years, as well as family homelessness in 10 years, it's estimated that more than 2,100 households will need housing assistance in the next four years.

Estimated needs for housing assistance, by type, among targeted households who will experience homelessness (unless prevented)	2012-2016			
	Families with Children	Chronically Homeless Adults without Children	Total Households	Veterans (included within other columns)
Prevention Strategies*	465		**465**	86
Rapid Re-Housing*	329		**329**	71
Deeply Affordable Housing**	350		**350**	40
Permanent Supportive Housing	251	724	**975**	178
Estimated need that could be met through turnover of existing supportive housing units	*-149*	*-277*	*-427*	*-98*
Need for new Supportive Housing	101	447	**548**	80
Estimated Total Target Households Needing Housing Assistance 2012-2016	**1,394**	**724**	**2,118**	**376**
Estimated Persons in these households	3,856	724	**4,580**	475

***Deeply affordable housing refers to subsidized rental housing that is affordable to persons living in deep poverty.*

Table 10. Estimated Needs for Housing Assistance

Affordable housing and permanent supportive housing options can take the form of scattered subsidized apartments or the development of buildings through new construction or rehabilitation. The affordable housing numbers presented here do not include rent subsidies needed to prevent homelessness or that may be used in conjunction with rapid re-housing or permanent supportive housing. These numbers also do not encompass the need for affordable housing among low income households who are not experiencing homelessness. Significantly increasing the availability of rental housing that is affordable to households with the lowest incomes would be the most effective strategy for preventing and ending homelessness. The need for affordable housing in Rhode Island is much larger than the number of affordable housing units needed to serve households who have become homeless.Visit: www.planning.ri.gov/documents/hmis/openingdoors.pdf

PROTECTING AND PROMOTING THE HEALTH OF ALL RHODE ISLANDERS IS THE MISSION OF THE DEPARTMENT OF HEALTH.

IV. Rhode Island's Health Improvement Plan

A. How we hear from our communities

Protecting and promoting the health of all Rhode Islanders is the mission of the Department of Health. Part of that work is done by collecting and analyzing data, and using those data to identify areas where we need more information to prioritize the health needs of Rhode Island communities. We have robust data to inform our decision making, and we use it to put together our Strategic Plan with the overall goals we set out to accomplish in the near future. In early 2012, HEALTH conducted a two-day retreat and discussed the priorities for the next five years, as included in the excerpt below.

HEALTH's Five-Year Strategic Focus

Rationale for Strategic Focus: Social factors are the dominant predictor of the health of Rhode Islanders. Evidence shows that the more we invest in education, housing, the environment and public safety, the healthier Rhode Islanders will become. But spending on medical services consumes the bulk of public spending – consuming one third of all state revenue dollars – and private spending on health services eclipses all Rhode Island, and is likely one and a half times the entire state budget. HEALTH is well positioned to build collaborations of all healthcare providers, following the instructions of the Governor and General Assembly, to help remodel the delivery system while practicing the best public health, so that system is focused on improving public health outcomes and lowering cost, so that the health of Rhode Islanders improves, our healthcare costs become affordable, and the economy of Rhode Island improves, and thus position the state to invest in education and housing and public safety, and thereby improve our health and well-being further.

HEALTH can also lead by improving the consumer experience in interactions with the Department. A reorganization of departmental resources and space can and will improve the business model of the Department while allowing us to focus on our core mission.

Strategic foci for the next five years:

- Focus on improving the measured health of all Rhode Islanders while containing health costs
- Reduce years of potential life lost and days of lost work, school, and leisure in Rhode Island
- Improve social capital in Rhode Island
- Improve economic status and resiliency in Rhode Island
- Assure equality and the ability to function at work, home and school, and participate in the civic life of Rhode Island

Strategic priorities:

- Redirect the Rhode Island healthcare delivery system so that it focuses on improving the measured health of all Rhode Islanders while containing health cost.
- Redirect HEALTH so that we focus on improving the measured health of all Rhode Islanders while containing health cost.

Communities as well as representatives from health and community organizations have multiple opportunities and mechanisms to provide input. Many of our programs convene Advisory Committees and/or are part of Coalitions (appendix 3) to comment and participate on the development of programs, activities and projects. Individuals and professionals communicate with the staff when receiving services we provide directly to the public, such as the issuance of death and birth certificates, or when applying for a professional license. Communities can also send comments via our website at www.health.ri.gov/contactus or by calling our Health Information Line at (401) 222-5960.

Consulting stakeholders and gathering community input is a robust, dynamic activity the HEALTH has conducted on a regular basis for many years, and for many purposes. Nearly all the programs in the Department have a community input component, whether it is required or considered key to program development. Most importantly, the input gathered by the communities is transformed into strategic goals and objectives for programmatic purposes, with the help and joint responsibility of those who are part of coalitions, committees, and workgroups. A condensed list of strategic goals and recommendations prepared by communities and coalitions is included in appendix 4.

To make this document a tool of easy use, we have selected only a few of the most representative community input processes the Department conducts, and describe them in the next paragraphs. We believe it is important to share the richness and diversity of the comments received, the places we visited, and the people who dedicated their time to talk to us. For this purpose, the next section of this document includes a brief summary of the largest and most relevant efforts conducted to hear our communities in general.

1. State Health Assessment Group

This group started in early 2012 through the efforts of Michael Fine, MD, Director of the Department of Health. Dr. Fine invited the Hospital Association of Rhode Island (HARI) to begin a dialogue about sharing efforts with all non-profit hospitals to prepare the Community Health Needs Assessment (CHNA) now required by the Internal Revenue Service (IRS) for all non-profit hospitals. With the same interests and needs, other agencies were invited as well, including the Rhode Island Public Health Institute and the Community Health Centers Association (CHCA). Over time, the group grew and diversified to include representatives from the healthcare industry, and from local agencies with experience in data analysis and mapping. (See membership list in appendix 2).

The group has steadily worked for almost two years. The first community meeting that was organized by the group took place in Central Falls in October 2013. Nearly 100 attendees came and provided substantive feedback (see Summary Report in appendix 5).

More meetings are being planned for 2014 and thereafter, and the group will continue to share in the knowledge and support implementation of key priorities.

2. Maternal and Child Health (MCH) Community Input Process

HEALTH administers federal funds to support programs that benefit pregnant women, infants, children, adolescents, children with special healthcare needs, as well as other services for women such as cancer screening, and sexually transmitted diseases. These funds come from the Maternal and Child Health (MCH) block grant (see the website https://mchdata.hrsa.gov/TVISReports/Snapshot/snapshot.aspx?statecode=RI for the complete Rhode Island Title V MCH Needs Assessment Report) also known as Title Five, and serve thousands of people every year.

There aren't enough funds to fulfill the needs of the community, and while the funding has been coming to our state every year for decades, existing funding must be prioritized. Thus, HEALTH makes significant effort to bring communities, parents, organizations, advocates and supporters together to open dialogue about programs that can support healthier behaviors and therefore healthier people.

Every five years the department conducts a robust analysis of data, and convenes community meetings throughout the state to help us identify the most pressing needs of women and children in the state. In 2010, nine community forums were facilitated, where more than 300 participants brought their ideas and opinions about what they think is important for their health (see appendix 5 for an excerpt of the community input and the overarching themes that were identified as a result).

3. Hospital Association of Rhode Island (HARI)

The health of Rhode Islanders depends largely upon the success of a multitude of partners collaborating with each other and sharing the knowledge, data, and resources. The collaborations include sharing information from other community events that are already taking place in the state with the same groups and representations. HARI has been a key partner in the success of the Health Assessment for the State of Rhode Island. HARI gladly agreed to be part of the Community Assessment group that was formed in early 2012. Most importantly, HARI purchased rihealthcarematters.org, a consumer-friendly software system that makes health indicators data easy to read and understand to a variety of audiences. HARI promptly invited HEALTH to join in the venture to own the software, released in May 2013. Since then, health indicators, best practices, news and more are available to the public.

HARI conducted a community health needs assessment to meet the IRS requirements for all non-profit hospitals, and like any other assessment, used data and community input to design their priorities. HARI conducted 49 key informant interviews, with key leaders from hospitals, elected officials, healthcare providers, human services experts and others. Through a contractor, HARI also conducted two focus groups to gather feedback specific to mental health issues, one of the priorities identified through the assessments (see appendix 6 for a summary report on the findings of both, key informant interviews and focus groups).

4. Assessing the Health of Rhode Island's Families

In 2011, HEALTH worked with the Rhode Island Public Health Institute and convened the support of leading community-based service organizations and conducted community health assessments in three small areas of the state. The small areas selected for this assessment were adult residents of the Constitution Hill community in Woonsocket, Southside Providence and the city of Central Falls.

The assessment was done in two parts. The first part consisted of a 2010 survey conducted in these neighborhoods, using the Active Neighborhood Checklist . The second part was interviewing randomly selected adults ages 18 and older in each of the neighborhoods, using the Neighborhood Health Check survey .

In Constitution Hill there were 106 in-person interviews with adults age 18 and older who live in the neighborhood. In the Southside of Providence, the survey identified 103 blocks within the neighborhoods of Upper and Lower South Providence, Elmwood, West End and parts of Federal Hill. In addition, there were 457 in-person interviews with adults ages 18 and older. In Central Falls, 311 randomly-selected adults 18 and older were interviewed in person.

The Community Health Reports of each of these assessments are included next, and are also available at http://health.ri.gov/data/communityhealthassessments/index.php.

COMMUNITY HEALTH REPORT • MARCH 2011

Southside Providence, Rhode Island

REPORT HIGHLIGHTS

- Two out of three adults report excellent, very good, or good health. One out of three reports fair or poor health.
- Many adults report health behaviors that put them at risk of poor health or disease.
- Most adults have been screened for cancer, high blood pressure, diabetes, and high cholesterol, but some still have trouble getting preventive care.
- The neighborhoods need more safe areas for physical activity.

About this report

This report is based on two surveys completed from 2008 to 2010 in Upper and Lower South Providence, Elmwood, West End, and parts of Federal Hill. These neighborhoods have relatively low income and are racially and ethnically diverse. The first survey was a walk through these five neighborhoods. We randomly chose 103 blocks and looked at how well they support physical activity, like walking or bicycling.[1]

In the second survey, we did in-person interviews with 547 Southside Providence adults 18 and older.[2] Interviewing an adult in about one out of every nine households, we asked about their health, health behaviors, thoughts about their neighborhood, and specific diseases they may have.

Together, these survey findings represent five neighborhoods with 29,000 adults. Southside Providence is the first of three Rhode Island communities we will learn about. The other two communities are Woonsocket's Constitution Hill and Central Falls.

1 We used the Active Neighborhood Checklist developed by Ross Brownson and Christine Hoehner at Washington University in St. Louis to look at the neighborhoods.

2 We used the Neighborhood Health✓Check Survey developed by the Rhode Island Public Health Institute to talk with residents. This survey is based on the statewide Behavioral Risk Factor Surveillance Survey (BRFSS) conducted annually by the Department of Health.

What we do

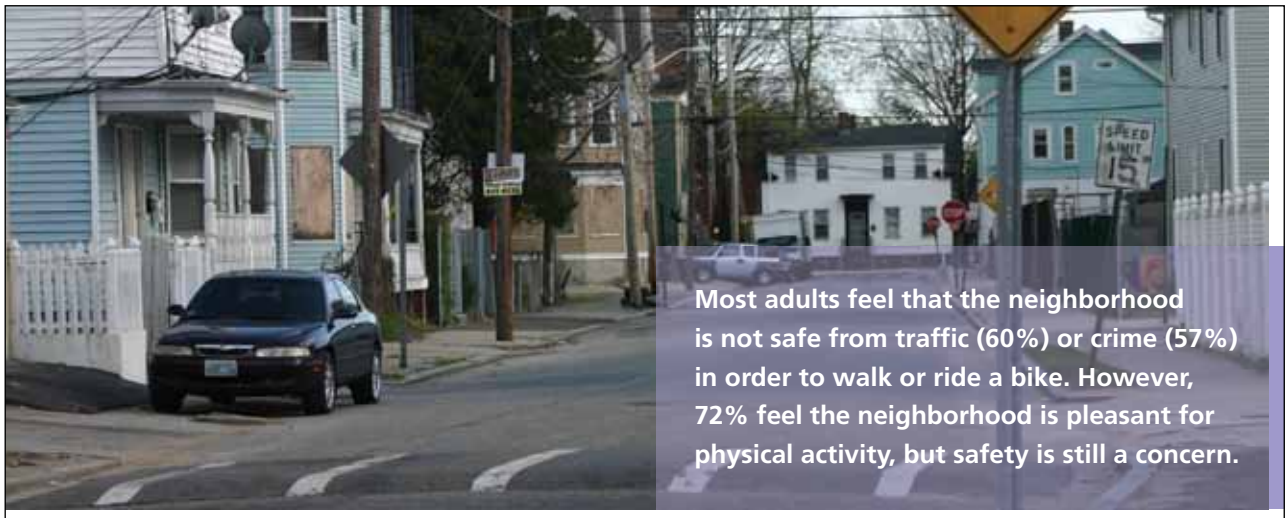
We go door-to-door in neighborhoods, talking to people about their health. We ask about:

- Cancer
- Diabetes
- High blood pressure
- Nutrition
- Physical activity
- Cholesterol
- Heart disease and stroke
- Neighborhood conditions
- Obesity
- Tobacco use

We also go street-by-street in neighborhoods to look at things like places to be physically active, types of buildings (e.g. houses, stores, boarded up buildings), safety of sidewalks, and whether or not there are walk signals and crosswalks.

Why we do it

The opportunities for better health begin where people live, learn, work, and play. National and state health data are important, but they can only tell us so much. By talking to people about their health and learning from them about their neighborhoods, we can build understanding of what affects health in their communities. Residents can use the information to work together to make changes. Community-based agencies and the Rhode Island Department of Health (HEALTH) can use the data to design programs and services and seek funding. Policy makers and advocates can develop new policies based on clearer understanding



Most adults feel that the neighborhood is not safe from traffic (60%) or crime (57%) in order to walk or ride a bike. However, 72% feel the neighborhood is pleasant for physical activity, but safety is still a concern.

of neighborhood issues. Working together and sharing data, we can build healthier neighborhoods and improve community health. We can also evaluate the impact of our efforts.

Who we are

HEALTH funds this effort through the Centers for Disease Control and Prevention (CDC) Preventive Health and Health Services Block Grant. The project's lead partner is the Rhode Island Public Health Institute (the Institute), an independent, not-for-profit organization established in 1993 to promote health and wellness by partnering with local community-based organizations, academic institutions, government agencies, and the business community. The Institute and HEALTH work together to support projects that improve the health of people and their communities.

Who we work with

Community partners working closely with HEALTH and the Institute include the African Alliance of Rhode Island, the Center for Hispanic Policy & Advocacy, John Hope Settlement House, St. Joseph Health Services of Rhode Island, and the Urban League of Rhode Island. Progreso Latino, Inc. in Central Falls and YWCA Northern Rhode Island in Woonsocket advised on this work and on work in their own communities. Many other organizations and residents helped.

Who we talked to

We talked to 547 adult residents, age 18 and older, living on 49 blocks. The information they shared represents the 29,000 adults living in the five surveyed neighborhoods.

- **Language:** 32% of adults prefer to be interviewed in Spanish.
- **Gender:** 47% of adults are male, and 53% are female.
- **Race/Ethnicity:** 49% of adults are Hispanic. 21% are Black, 18% are White, and 13% identify with another race.
- **Age:** 62% of adults are 18-44 years old. 38% are 45 years or older.
- **Income:** 44% of adults have a household income of less than $25,000 per year. 18% make between $25,000 and $50,000 per year, and 13% make $50,000 or more per year. The household income of 25% of the population is unknown.
- **Employment:** 49% of adults are employed, and 51% are not employed.
- **Education:** 27% of adults have less than a high school education, and 30% have finished high school only. 42% have completed some college or are college graduates.

What people told us about their health

Many adults have poor health and serious health conditions.

- Two out of three adults report excellent, very good, or good health. One out of three reports fair or poor health.
- One out of three adults says they have been unable to carry out daily activities on some days because of poor mental or physical health.
- 39% of adults are overweight, and 26% are obese.
- 34% of adults have high blood pressure.
- 11% of adults have diabetes.
- 10% of adults have heart disease or have had a stroke.
- 8% of adults have a history of cancer.

Many adults report health behaviors that put them at risk of poor health or disease.

- Seven out of ten adults do not eat the recommended five servings of fruits and vegetables per day.
- A little more than half (51%) of adults do not get recommended minimum amounts of physical activity.
- 19% of adults are current smokers, but eight out of ten smokers have tried to quit.

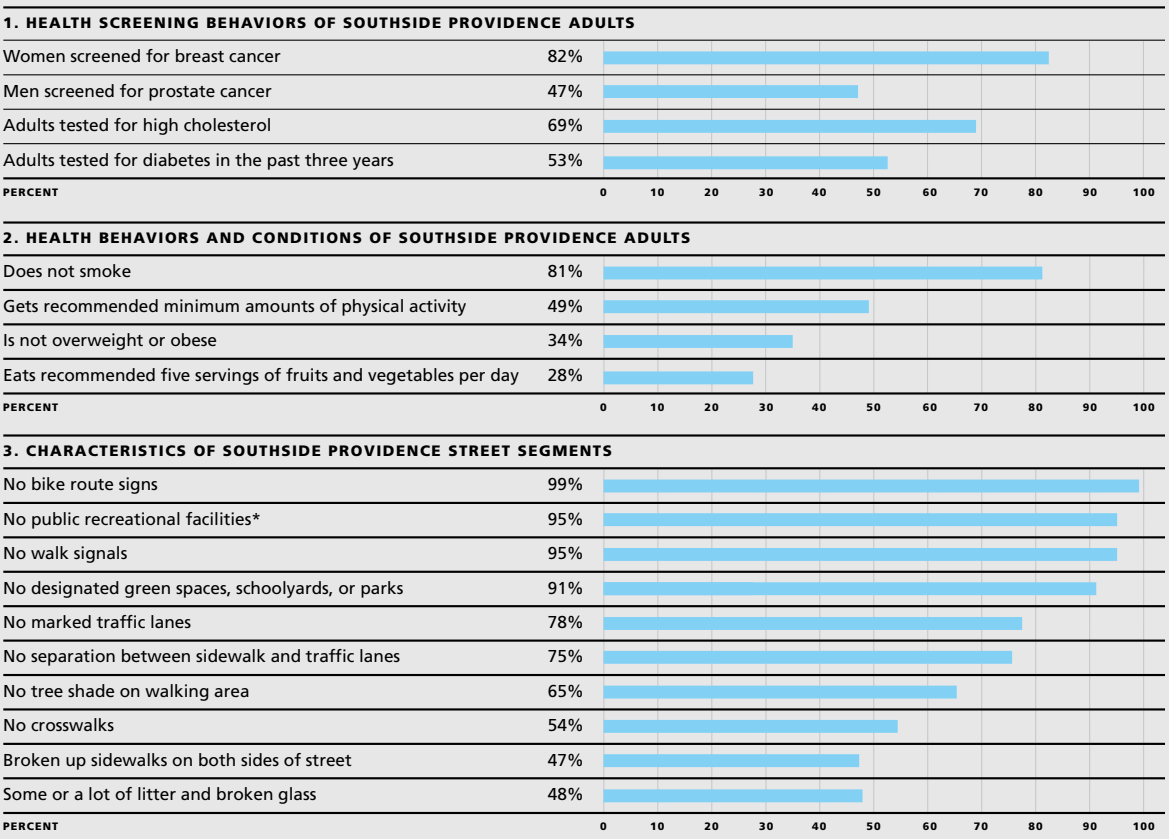


CHART NOTES
* Parks, off-road walking/biking trails, sports/playing fields, basketball/tennis/volleyball courts, playgrounds, outdoor pool
Charts 1-2 source: Neighborhood Health✓Check, 2009. Chart 3 source: Active Neighborhood Checklist, 2008

Most adults are screened for health conditions, but some still have trouble getting preventive care. The data suggest that:

- Women have more access to medical care that includes cancer screening than men.
  - » 82% of women have been screened for breast cancer.
  - » Only 47% of men have been screened for prostate cancer.
- Seven out of ten adults have been screened for high cholesterol.
- More screening for diabetes is needed to help identify this health condition before adults have symptoms.

What we heard about your neighborhoods

Is the glass half empty or half full?

- A little more than half (55%) of adults feel that the neighborhood is well maintained.
- A little more than half (54%) of adults feel that the neighborhood is not free from garbage, litter, and broken glass.
- Most adults feel that the neighborhood is not safe from traffic (60%) or crime (57%) in order to walk or ride a bike.
- Nearly three out of four adults (72%) feel the neighborhood is pleasant for physical activity, but safety is still a concern.

What we saw in your neighborhoods

The neighborhoods need more safe areas for physical activity. Trained observers saw:

- Few green spaces (parks and playgrounds), gyms, and safe places
- Poor sidewalk conditions
- Little shade
- A lot of broken glass and litter
- Few marked crosswalks
- Few bicycle lanes
- No traffic lane markings on most streets

NEXT STEPS

The Institute is available to help communities and community-based organizations use the data from the Southside neighborhood surveys. Contact the Institute at info@riphi.org to discuss your needs.

Community partners are planning forums and other activities to address the findings of these surveys. To learn more or get involved, contact:

COMMUNITY PARTNER	CONTACT	TELEPHONE
African Alliance of Rhode Island	Julius Kolawole and Susan Rezendes	401-331-5535
St. Joseph Health Services of Rhode Island	Adrienne Nicoloro	401-456-3027
Urban League of Rhode Island	Lynn August	401-351-5000 x140

For more information

Rhode Island Public Health Institute
Patricia A. Nolan, MD, MPH, 401-863-6416, info@riphi.org, www.riphi.org

Web-based access to statewide health data
www.health.ri.gov/programs/assessmentinitiativefordatadissemination

Comprehensive Southside Providence Neighborhood Health and Environmental Assessment
www.health.ri.gov/publichealth/about/communityassessments

Southside Project or the Preventive Health and Health Services Block Grant
Carol Hall-Walker, MPA, 401-222-5935, carol.hall-walker@health.ri.gov

Rhode Island Department of Health
HEALTH Information Line, 401-222-5960 / RI Relay 711, www.health.ri.gov

Funding for this project was provided through a cooperative agreement with HEALTH and supported by the CDC Preventive Health and Health Services Block Grant. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HEALTH or CDC.

COMMUNITY HEALTH REPORT • SEPTEMBER 2011

Central Falls, Rhode Island

REPORT HIGHLIGHTS

- Observers found signs of civic pride and community organization support to help residents stay healthy.
- The adult smoking rate is relatively high, but nearly half of current smokers have tried to quit.
- Many adults report health behaviors that put them at risk of poor health or disease.
- Many adults report poor health and serious health conditions.
- The things we heard about residents' health suggest that many opportunities exist to improve community health.



About this report

This report is based on two surveys completed in 2011 in Central Falls neighborhoods. This lower-income community is racially and ethnically diverse. In the first survey, we walked through the neighborhoods to look at how well they support physical activity, like walking or bicycling[1]. In the second survey, we did in-person interviews with 311 randomly-selected adults 18 and older[2] living in these neighborhoods. We asked about their health, their health behaviors, specific diseases they may have, and how their neighborhoods support healthy living.

Together, these survey findings represent about 3,876 adult residents living in a 40-block section of Central Falls. Central Falls is one of three Rhode Island communities we have learned about. The other two communities are Southside Providence and Woonsocket's Constitution Hill[3].

1 We used the Active Neighborhood Checklist developed by Ross Brownson and Christine Hoehner at Washington University in St. Louis to look at the neighborhoods.

2 We used the Neighborhood Health✓Check Survey developed by the Rhode Island Public Health Institute to talk with residents. This survey is based on the statewide Behavioral Risk Factor Surveillance Survey (BRFSS) conducted annually by the Department of Health.

3 See www.health.ri.gov/publichealth/about/communityassessments or www.riphi.org to view community health reports for Southside Providence and Constitution Hill.

What we do

We go door-to-door in neighborhoods, talking to people about their health. We ask about:

- Cancer
- Diabetes
- High blood pressure
- Nutrition
- Physical activity
- Cholesterol
- Heart disease and stroke
- Neighborhood conditions
- Obesity
- Tobacco use

We also go street-by-street in neighborhoods to look at things like places to be physically active, types of buildings (e.g. houses, stores, boarded up buildings), safety of sidewalks, and whether or not there are walk signals and crosswalks.

Why we do it

The opportunities for better health begin where people live, learn, work, and play. National and state health data are important, but they can only tell us so much. By talking to people about their health and learning from them about their neighborhoods, we can build understanding of what affects health in their communities. Residents can use the information to work together to make changes. Community-based agencies and the Rhode Island Department of Health (HEALTH) can use the data to design programs and services and seek funding. Policy makers and advocates can develop new policies based on clearer understanding

of neighborhood issues. Working together and sharing data, we can build healthier neighborhoods and improve community health. We can also evaluate the impact of our efforts.

Who we are

HEALTH funds this effort through the Centers for Disease Control and Prevention (CDC) Preventive Health and Health Services Block Grant. The project's lead partner is the Rhode Island Public Health Institute (the Institute), an independent, not-for-profit organization established in 1993 to promote health and wellness by partnering with local community-based organizations, academic institutions, government agencies, and the business community. The Institute and HEALTH work together to support projects that improve the health of people and their communities.

What the health data suggest

The things we heard about residents' health suggest that opportunities exist to:

Keep adults from smoking or help them quit.
The health benefits of quitting tobacco begin immediately, even for people who have smoked for a long time. Non-smokers are more likely to live longer and prevent serious diseases than smokers. Neighborhoods may want to look at ways to keep young adults from starting to smoke or reduce exposure to second-hand smoke. By looking more closely at adults who have tried to quit, community organizations and policy-makers may be able to identify ways to help them succeed.

Help adults achieve a healthy weight and prevent chronic diseases.
Adults who eat at least five servings of fruits and vegetables per day and who participate in moderate physical activity on most days can feel better and lower their risk of many diseases. Nutrition and physical activity levels in Central Falls are not very different from those of the rest of the state, but the reasons people struggle to stay healthy may vary. Looking at how neighborhoods support healthy choices or at the health behaviors of specific groups may offer clues to potential community health improvements.

Help more adults (especially men) get screened for health conditions before they start having symptoms.

- 74% of women have been screened for breast cancer, but only 40% of men age 50 or older have received a PSA test to screen for prostate cancer.
- 73% of adults have been screened for high cholesterol[4].
- 59% of adults have been tested for diabetes in the past three years.

Who we work with

HEALTH and the Institute work closely with Progreso Latino, Inc. in Central Falls. Progreso Latino helped define the neighborhoods and recruit interviewers. YWCA Northern Rhode Island in Woonsocket and the African Alliance of Rhode Island, the Center for Hispanic Policy and Advocacy, John Hope Settlement House, St. Joseph Health Services of Rhode Island, and the Urban League of Rhode Island in Southside Providence advised on this work and on work in their own communities. Many other organizations and residents helped.

Who we talked to

We talked to 311 adult residents, age 18 and older, living on 40 blocks. The information they shared represents about 3,876 adults living in the surveyed neighborhoods.

- **Language:** 50% of adults prefer to be interviewed in Spanish.
- **Gender:** 46% of adults are male, and 54% are female.
- **Race/Ethnicity:** 67% of adults are Hispanic. 5% are Black, 20% are White, and 8% identify with another race.
- **Age:** 58% of adults are 18-44 years old. 42% are 45 years or older.
- **Income:** 43% of adults have a household income of less than $25,000 per year. 23% make between $25,000 and $49,999 per year, and 13% make $50,000 or more per year. The household income of 21% of the population is unknown.
- **Employment:** 50% of adults are employed, and 50% are not employed.
- **Education:** 39% of adults have less than a high school education, and 35% have finished high school only. 25% have completed some college or are college graduates. The education level of 1% of the population is unknown.

What people told us about their health

Key finding: The adult smoking rate is relatively high, but nearly half of current smokers have tried to quit.

- 20% of adults are current smokers, compared to 18% across Rhode Island's core cities[5].
- 44% of current smokers have tried to quit for at least one day over the past 12 months.

Key finding: Many adults report health behaviors that put them at risk of poor health or disease.

- 75% of adults do not eat the recommended five servings of fruits and vegetables per day.
- 52% of adults do not get recommended minimum amounts of physical activity.

4 Among those screened, more than one third has been diagnosed with high cholesterol.

5 Core cities are those with more than 15% of children in families living below the federal poverty level. In Rhode Island, they include: Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

1. HEALTH SCREENING BEHAVIORS OF CENTRAL FALLS ADULTS

Women screened for breast cancer	74%
Men screened for prostate cancer	40%
Adults tested for high cholesterol	73%
Adults tested for diabetes in the past three years	59%

PERCENT 0 10 20 30 40 50 60 70 80 90 100

2. HEALTH BEHAVIORS AND CONDITIONS OF CENTRAL FALLS ADULTS

Don't eat recommended five servings of fruits and vegetables per day	75%
Don't maintain a healthy weight	68%
Don't get recommended minimum amounts of physical activity	52%
Do Smoke	20%

PERCENT 0 10 20 30 40 50 60 70 80 90 100

3. CHARACTERISTICS OF CENTRAL FALLS STREET SEGMENTS

No bike route signs	100%
No separation between sidewalk and traffic lanes	100%
No public recreational facilities*	94%
No walk signals	93%
No designated green spaces, schoolyards, or parks	92%
No marked traffic lanes	83%
Some or a lot of litter and broken glass	78%
No crosswalks	72%

PERCENT 0 10 20 30 40 50 60 70 80 90 100

CHART NOTES
* Parks, off-road walking/biking trails, sports/playing fields, basketball/tennis/volleyball courts, playgrounds, outdoor pool
Charts 1-2 source: Neighborhood Health✓Check, 2011. Chart 3 source: Active Neighborhood Checklist, 2011

Key finding: Many adults report poor health and serious health conditions.

- 30% of adults report fair or poor health, compared to 11.5% across Rhode Island's core cities.
- 35% of adults have high blood pressure.
- 32% of adults have a healthy weight. 37% are overweight, and 31% are obese.
- 15% of adults have diabetes.
- 11% of adults have heart disease or have had a stroke.
- 5% of adults have a history of cancer.

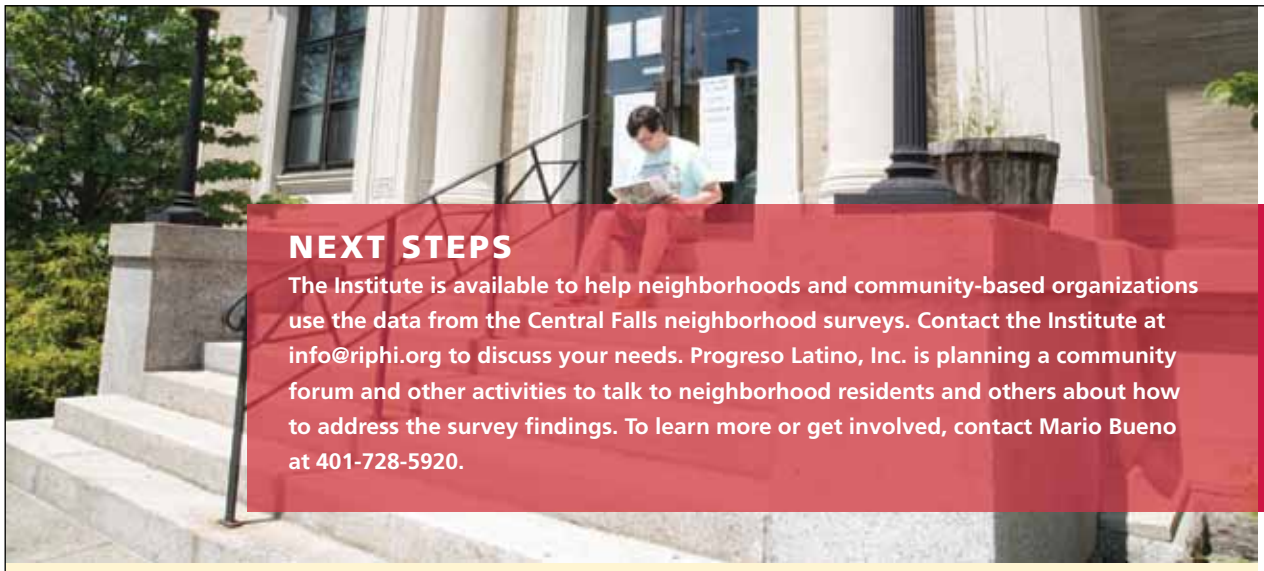
What we heard about your neighborhoods

Is the glass half empty or half full?

- A little more than half (58%) of adults feel that the neighborhood is well maintained.
- About half (48%) of adults feel that the neighborhood is not free from garbage, litter, and broken glass.
- About half of adults feel that the neighborhood is not safe from traffic (50%) or crime (46%) in order to walk or ride a bike.
- Nearly two out of three adults (66%) feel the neighborhood is pleasant for physical activity, but safety is still a concern.

What we saw in your neighborhoods

Physical activity is one of the best ways to improve health and reduce stress. It can be inexpensive and available to everyone—provided that the environment supports safe and healthy physical activity. An opportunity exists to improve this support in the south central section of Central Falls. Its largely residential neighborhoods have few marked traffic lanes or crosswalks, but almost every street has sidewalks. While green spaces, playgrounds, and gyms are limited, a large park (Jenks Park) at the southern end of the community offers space for exercise and community events.



NEXT STEPS

The Institute is available to help neighborhoods and community-based organizations use the data from the Central Falls neighborhood surveys. Contact the Institute at info@riphi.org to discuss your needs. Progreso Latino, Inc. is planning a community forum and other activities to talk to neighborhood residents and others about how to address the survey findings. To learn more or get involved, contact Mario Bueno at 401-728-5920.

Community work under way

Civic pride and ways to connect with the community are resources in this part of Central Falls. Local organizations have taken several actions[6] to help residents stay healthy. For example:

- The community recently cleaned up Jenks Park, making it a nicer and safer space to exercise and gather.
- Progreso Latino collaborates with the Women and Infants Family Van to hold a health clinic the first two Wednesdays of the month. At this clinic, uninsured residents can get glucose, cholesterol, blood pressure, and HIV testing. They can also get vaccinated against Hepatitis A, Hepatitis B, and other diseases.
- Progreso Latino, Inc. has worked to boost the participation of small food stores in the state's Women, Infants, and Children (WIC) Program[7].

Residents and community leaders can build on the success of existing efforts. Opportunities to increase safe places for physical activity and access to affordable and healthy foods have the potential to improve community health.

For more information

Rhode Island Public Health Institute: Patricia A. Nolan, MD, MPH, 401-863-6416, info@riphi.org, www.riphi.org

Web-based access to statewide health data: Karine Monteiro, MPH, 401-222-3395
www.health.ri.gov/programs/assessmentinitiativefordatadissemination

Neighborhood Health✓Check and Environmental Assessment: Central Falls 2011 Final Report to the Community
www.health.ri.gov/publichealth/about/communityassessments

Central Falls Project or the Preventive Health and Health Services Block Grant
Carol Hall-Walker, MPA, 401-222-5935, carol.hall-walker@health.ri.gov

Rhode Island Department of Health: HEALTH Information Line, 401-222-5960 / RI Relay 711, www.health.ri.gov

Progreso Latino, Inc: Mario Bueno, MA, Executive Director, 401-728-5920; Vinnie Velazquez, MS, Wellness Director, 401-617-8489

6 The Preventive Health and Health Services Block Grant did not fund the activities described in this section.

7 Children's Friend and Service has helped link WIC clients to a winter farmers' market in nearby Pawtucket, but at this time, there are no farmers' markets in Central Falls.

Funding for this project was provided through a cooperative agreement with HEALTH and supported by the CDC Preventive Health and Health Services Block Grant. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HEALTH and CDC.

COMMUNITY HEALTH REPORT • MAY 2011

Constitution Hill Neighborhood
Woonsocket, Rhode Island

REPORT HIGHLIGHTS

- **Many adults have poor health and serious health conditions.**
- **The adult smoking rate (32%) is very high.**
- **Rates of overweight (44%) and obesity (32%) are of concern.**
- **More screening for health conditions would be useful to identify affected adults before they start having symptoms.**



About this report

This report is based on a 2010 survey in Woonsocket's Constitution Hill neighborhood. This lower income neighborhood is racially and ethnically diverse, with some subsidized housing and shelters. We completed in-person interviews with 106 randomly selected adults 18 and older[1] living in this neighborhood. We asked them about their health, their health behaviors, specific diseases they may have, and how their neighborhood supports healthy living. The survey findings represent the 777 adults[2] living in the 20-block neighborhood.

Constitution Hill is one of three Rhode Island communities we are learning about. The other two communities are Southside Providence[4] and Central Falls (in progress in 2011).

1 We used the Neighborhood Health✓Check Survey developed by the Rhode Island Public Health Institute to talk with residents. This survey is based on the statewide Behavioral Risk Factor Surveillance System (BRFSS) survey conducted annually by the Rhode Island Department of Health.

2 Adults living in shelters were not eligible for the interviews and are not represented in these findings.

3 We did not complete an environmental survey in Constitution Hill, because this neighborhood was evaluated by a recent community development process organized by the Rhode Island Local Initiatives Support Corporation. (See www.rilisc.org/Portals/0/Uploads/Documents/LISC_ConstHi_Fairmt_SC_final.pdf for more information.) Going street-by-street through the neighborhood, we did an informal assessment of environmental support for physical activity, such as places to be physically active, safety of sidewalks and streets, and whether or not there are certain destinations (e.g. grocery stores, fast food stores, libraries, and schools) within walking distance.

4 See health.ri.gov/publications/datareports/2011SouthsideCommunityHealth.pdf for more information.

What we do

We go door-to-door in neighborhoods, talking to people about their health.[3] We ask about:

- Cancer
- Diabetes
- High blood pressure
- Nutrition
- Physical activity
- Cholesterol
- Heart disease and stroke
- Neighborhood conditions
- Obesity
- Tobacco use

Why we do it

The opportunities for better health begin where people live, learn, work, and play. National and state health data are important, but they can only tell us so much. By talking to people about their health and learning from them about their neighborhoods, we can build understanding of what affects health in their communities. Residents can use the information to work together to make changes. Community-based agencies and the Rhode Island Department of Health (HEALTH) can use the data to design programs and services and seek funding. Policy makers and advocates can develop new policies based on clearer understanding of neighborhood issues. Working together and sharing data, we can build healthier neighborhoods and improve community health. We can also evaluate the impact of our efforts.

Many adults have health behaviors that put them at risk of overweight, obesity, and poor health. Most adults (65%) do not eat the recommended five servings of fruits and vegetables per day.

Who we are

HEALTH funds this effort through the Centers for Disease Control and Prevention (CDC) Preventive Health and Health Services Block Grant. The project's lead partner is the Rhode Island Public Health Institute (the Institute), an independent, not-for-profit organization established in 1993 to promote health and wellness by partnering with local community-based organizations, academic institutions, government agencies, and the business community. The Institute and HEALTH work together to support projects that improve the health of people and their communities.

Who we work with

HEALTH and the Institute work closely with YWCA Northern Rhode Island in Woonsocket. The African Alliance of Rhode Island, the Center for Hispanic Policy and Advocacy, John Hope Settlement House, Progreso Latino, Inc., St. Joseph Health Services of Rhode Island, and the Urban League of Rhode Island advised on this work and on work in their own communities. Many other organizations and residents helped.

Who we talked to

We talked to 106 adult residents, age 18 and older, living on 20 blocks. The information they shared represents the 777 adults living in the 20-block neighborhood.

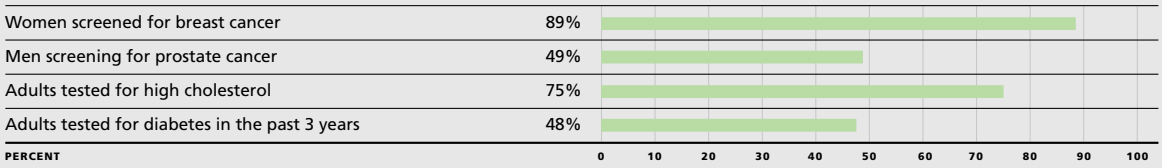
- **Language:** 26% of adults prefer to be interviewed in Spanish.
- **Gender:** 46% of adults are male, and 54% are female.
- **Race/Ethnicity:** 36% of adults are Hispanic. 25% are Black, 24% are White, and 15% identify with another race.
- **Age:** 67% of adults are 18-44 years old. 32% are 45 years or older.
- **Income:** 43% of adults have a household income of less than $25,000 per year. 22% make between $25,000 and $50,000 per year, 21% make $50,000 or more per year. The household income of 15% of the population is unknown.
- **Employment:** 57% of adults are employed, and 43% are not employed.
- **Education:** 26% of adults have less than a high school education, and 43% have finished high school only. 31% have completed some college or are college graduates.

What people told us about their health

Key Finding: Many adults have poor health and serious health conditions.

- Four out of ten adults have excellent or very good health. Roughly one out of four has fair or poor health.
- Almost half of adults are unable to carry out daily activities on some days because of poor mental or physical health.
- 44% of adults are overweight, and 32% are obese.
- 32% of adults have high blood pressure.
- 13% of adults have diabetes.
- 11% of adults have heart disease or have had a stroke.
- 2% of adults have a history of cancer.

1. HEALTH SCREENING BEHAVIORS OF CONSTITUTION HILL ADULTS



2. HEALTH BEHAVIORS AND CONDITIONS OF CONSTITUTION HILL ADULTS

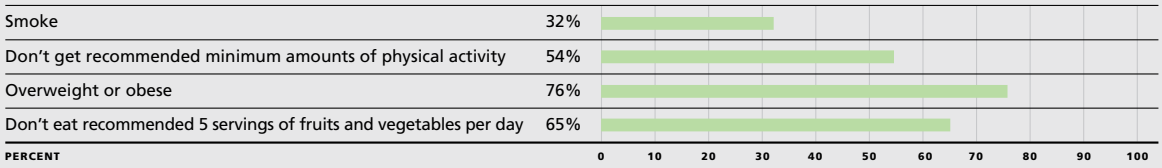


CHART NOTES
Charts 1 and 2 source: Neighborhood Health√Check, 2009

Key finding: The adult smoking rate is very high.

- 32% of adults are current smokers, compared to 19% in Southside Providence and 18% across Rhode Island's urban core cities[5].
- Eight out of ten current smokers have tried to quit at least once.
- Many adults may have high risks of cancer, heart disease, stroke, chronic lung disease, and asthma from smoking.
- In a neighborhood where many people live in multi-family buildings, the risk of exposure to second hand tobacco smoke is also high.

Key finding: Rates of overweight and obesity are troubling.

- 32% of adults are obese, compared to 26% in Southside Providence and 22% across Rhode Island's urban core cities[6].
- 44% of adults are overweight.
- Many adults have health behaviors that put them at risk of overweight, obesity, and poor health:
  - » 65% of adults do not eat the recommended five servings of fruits and vegetables per day.
  - » 54% of adults do not get recommended minimum amounts of physical activity.

The data suggest that: More screening for health conditions in this community would be useful to identify affected adults before they start having symptoms—especially in light of the neighborhood's high rates of smoking, overweight, and obesity.

- 48% of adults have been tested for diabetes in the past three years, but some still have trouble getting preventative care.
- Women have more access to medical care that includes cancer screening than men.
  - » 89% of women have been screened for breast cancer.
  - » Only 49% of men have been screened for prostate cancer.
- There is reasonable access to cholesterol screening in the community; however we could do better.
  - » Three out of four adults have been screened for high cholesterol.

What we heard about your neighborhood

Is the glass half empty or half full?

- 72% of adults feel that the neighborhood is well maintained.
- Half of adults feel that the neighborhood is not free from garbage, litter, and broken glass.
- Nearly three out of four adults (72%) feel the neighborhood is pleasant for physical activity, but safety is still a concern.
- About one out of three adults feels that the neighborhood is not safe from traffic (31%) or crime (39%) in order to walk or ride a bike.

5 Core cities are those with more than 15% of children living in families below the federal poverty level. In Rhode Island, they include: Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

6 Data source: HEALTH Web Data Query System
www.health.ri.gov/programs/assessmentinitiativefordatadissemination

NEXT STEPS

The Institute is available to help communities and community-based organizations use the data from the Constitution Hill neighborhood surveys. Contact the Institute at info@riphi.org to discuss your needs.

YWCA Northern Rhode Island is planning a community forum and other activities to talk to neighborhood residents and others about how to address survey findings. To learn more or get involved, contact Deborah Perry at 401-769-7450.

For more information

Rhode Island Public Health Institute
Patricia A. Nolan, MD, MPH, 401-863-6416, info@riphi.org, www.riphi.org

Web-based access to statewide health data
Karine Monteiro, MPH, 401-222-3395
www.health.ri.gov/programs/assessmentinitiativefordatadissemination

Comprehensive Constitution Hill Neighborhood Health Assessment
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Constitution Hill Project or the Preventive Health and Health Services Block Grant
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Rhode Island Department of Health
HEALTH Information Line, 401-222-5960 / RI Relay 711, www.health.ri.gov

Funding for this project was provided through a cooperative agreement with HEALTH and supported by the CDC Preventive Health and Health Services Block Grant. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HEALTH or CDC.

5. Olneyville Health Assessment

HEALTH partnered with the Olneyville Housing Corporation and other community decision-makers to conduct a community assessment. This effort involved talking to 175 residents through groups and interviews to learn about what is important to them for their neighborhood. The brief report on the results of the assessment is included next.

OLNEYVILLE:

ACTION FOR A HEALTHIER COMMUNITY

RHODE ISLAND DEPARTMENT OF HEALTH

olneyville
housing corporation

ASSESSING THE HEALTH OF OLNEYVILLE

The purpose of this assessment was to examine community factors that influence the health of residents and look for opportunities for improvement.

It is a fact that where you live impacts your health. Whether or not you have access to healthy foods, affordable quality healthcare, safe and attractive places to play and exercise, well-maintained streets, and social activities to engage in all affect your overall health and well-being.

From 2010 to 2011, Olneyville Housing Corporation and the Rhode Island Department of Health conducted a community assessment in partnership with local residents and community decision-makers. The assessment builds on years of community-based development in Olneyville and expands on the Rhode Island Local Initiatives Support Corporation (LISC) Olneyville Community Contract, a grassroots community improvement plan.

Our assessment looked at factors that influence the health of residents and opportunities for improvement. We talked to 175 residents through groups and interviews with adult residents, youth, and community leaders. We also looked at the physical environment of the community.

Please note that for the purposes of this report, we use the term "residents" to refer to residents of Olneyville who participated in the community assessment. Given the small sample size, the results of this community assessment do not necessarily apply to all residents of Olneyville. In addition, our data on "children" was reported by parents who participated in the assessment, rather than the children themselves, with the exception of the data on "youth" which comes from a youth discussion group.

WHAT WE FOUND

While Olneyville is a neighborhood ready for change, residents said they currently face a number of challenges to making healthy choices—cost, safety concerns, not enough local health-related programs, and unsafe streets.

While most residents reported being physically active, they also said that they need more organized, age-specific, year-round opportunities for exercise.

Almost half of residents said they eat fruits and vegetables everyday, but most people also face a variety of barriers to doing so including cost, transportation, quality of local produce, and lack of choice.

OLNEYVILLE FACTS*

LOCATION: On the west side of Providence; its boundaries are Atwells Avenue to the north, the AMTRAK railway line and Route 10 to the east, the Woonasquatucket River and Route 6 to the south, and Glenbridge Avenue to the west.

SIZE: About ½ square mile (2009 Providence GIS data)

RESIDENTS: 6,495 (US Census 2000)

HOUSEHOLDS: 2,228 (US Census 2000)

MEDIAN HOUSEHOLD INCOME: $17,538 (US Census 2000)

FAMILIES BELOW POVERTY LEVEL: 41%, compared with 24% Providence overall (US Census 2000)

RACIAL AND ETHNIC BREAKDOWN: 61% Hispanic; 16% White; 13% Black or African American; 4% Asian; 6% Other (US Census 2010)

HOUSING STOCK: 18% owner-occupied and 12% single-family housing units, compared with 35% and 26%, respectively, for Providence overall (US Census 2000)

RATES OF LEAD POISONING: 14% of children younger than age 6 had elevated blood lead levels, some of the highest in Providence (2004–2008 RI Department of Health, KIDSNET data)

TRANSPORTATION: 41% of households report not owning a car (US Census 2000)

LOW BIRTH WEIGHT: Only 3% of total births were less than 2500g, one of the best rates in Providence (2007 RI Department of Health, KIDSNET data)

BIRTHS TO MOTHERS WITH PUBLIC INSURANCE: 88% of total births from 2006–2008, consistently one of the highest rates in Providence (1997–2008 RI Department of Health, KIDSNET data)

PARKS: Three parks, two are linked together by the Woonasquatucket River Greenway Bike Path (2010 RIGIS data)

PLAYGROUNDS: Two community centers and three playgrounds (one in each park) (2010 The Providence Plan data)

FOOD: 22 fast food establishments, 13 convenience stores, and 6 restaurants (2009 RI Department of Health, Food Licensing data)

GARDENS: Three community gardens, one school garden, and no farmers' markets (2010 Farm Fresh Rhode Island data)

TOBACCO: 24 vendors selling tobacco products and 52 outdoor advertisements for tobacco products (2009 RI Department of Health, Tobacco Control Program Survey)

*Additional data are available at www.provplan.org

Residents agreed that tobacco use is a problem in Olneyville, and specific concerns included widespread advertising and easy access to tobacco for youth.

Residents said obesity is a common health issue, and 41% of residents have a diagnosed chronic disease or have someone in their family who has one. There is a need for more local supports that help people manage their chronic conditions.

There is a strong will in the community to get involved in making Olneyville a healthier and more attractive place to live.

NEIGHBORHOOD DESIGN

"I'm active but I'm discouraged by the way the neighborhood is dirty...I'd be interested in doing [something] to clean up the neighborhood..."

The small size of Olneyville could make it a very "walkable" community. The community has many popular destinations, such as parks, playgrounds, stores, community centers, and a library within walking distance. In order to lead active lives, residents need to have access to well-maintained sidewalks, bike routes, and parks:

- **Sidewalks:** While some residents thought that there were many sidewalks suitable for walking, others thought that the city could do a better job in keeping them unobstructed, well-maintained, and level.
- **Bike Path:** Residents overall had a better opinion about the bike path than the sidewalks, indicating that it was generally unobstructed, well-maintained, and easily identifiable. However, only "off-road" portions of the bike path are accessible for people with disabilities.
- **Parks:** Some residents indicated that the parks needed to be better maintained and improved. Residents indicated that the parks and open spaces were not well-linked together with a safe, easy way to get from one to the others. Accessibility for people with disabilities was also mentioned as a problem.

Overall, there was a sense that the community needs to be "cleaned up" to improve the condition of the neighborhood and make it feel more attractive and safe. Residents indicated that there is a lot of garbage, litter, and broken glass making the neighborhood visually displeasing.

RESIDENTS' SUGGESTIONS

Sponsor community service activities that could improve neighborhood cleanliness and appearance and, thus, encourage more outdoor activity.

Improve parks (for example develop a walking track) and ensure they are maintained.

Upgrade sidewalks to increase safety and walkability.

Provide better winter maintenance, like clearing sidewalks and fixing potholes.

Use empty lots to meet a variety of neighborhood needs, including community gardens, recreation, housing, etc.

Improve regulation and enforcement of laws related to upkeep of property.

Create spaces for both winter and summer activities.

NEIGHBORHOOD SAFETY

Residents were also concerned about unsafe drivers and bad traffic. Less than half of residents felt safe from traffic while walking or riding their bikes in the neighborhood.

Residents need to feel safe to "get out and about". While just over half of residents felt safe from crime while walking or riding their bikes in the neighborhood, residents mentioned concerns about personal and property crime, as well as drug dealings, particularly at night. Community leaders mentioned that there is a perception that the open spaces in the community, particularly the Bike Path, are dangerous. Community leaders also mentioned that safety concerns related to unsupervised teens and fear of strangers discourage people from getting out and being active. Residents reported that they learn to recognize unsafe parts of their community and adapt to avoid those places, indicating that there are not enough police patrols.

Residents were also concerned about unsafe drivers and bad traffic. Less than half of residents felt safe from traffic while walking or riding their bikes in the neighborhood. Parents of children under age 18 were particularly concerned about the unsafe road conditions for their children. Residents indicated that there is a lot of speeding and little enforcement. While crossing guards seem to be prevalent, the community is lacking in infrastructure, such as speed bumps to slow traffic and crosswalk counters to help residents cross busy streets. No Safe Routes to School and/or walking school bus programs to help children walk or bike safely to school were identified through the assessment.

On the other hand, residents have noticed recent neighborhood improvements, including improved street lighting, traffic, and sidewalks and additional community police, making some residents feel "more safe" in their community than they previously did. Most youth commented that they feel safe.

RESIDENTS' SUGGESTIONS

- Expand police presence and engagement
- Improve road safety through better streets and sidewalks
- Upgrade infrastructure (road lines, crosswalks, lights, speed bumps, signs, etc.), especially for people with disabilities
- Create an environmental education center in Riverside Park to create more of a community presence

PHYSICAL ACTIVITY

"Look at the statistics…kids stay at home playing video games…When I was growing up, my parents kicked me outta the house all day…when they get older they're gonna have a lot of medical problems and not know how to take care of themselves."

In Olneyville, physical activity is valued for both adults and children. Residents associated physical activity with the idea of getting out of the house and staying active or exercising, with walking being a common form of exercise. In addition, Spanish-speaking residents related physical activity with working and being independent, responsible, and socially active. Over half of Olneyville adults and children reported being physically active* everyday, with daily physical activity being more prevalent among English-speakers and smokers**.

A majority of residents reported they are physically active in Olneyville. Popular places included sidewalks, roads, bike paths, school, and playgrounds or parks. Residents indicated that most areas/facilities for physical activities are easy to walk to, well-utilized, and open seven to nine months a year on average. More specifically, about a third of Olneyville residents indicated that they used the bike path and over half of Olneyville residents indicated that they used Riverside Park. Specifically, Latinos were more likely to use Riverside Park. Teens mentioned that they use the bike path as well.

However, about half of Olneyville residents face barriers to physical activity. Neighborhood crime/violence, cost, cold weather, and limited age-specific

programs all stand in the way of physical activity for adults and children, as well as lack of transportation and lack of time to a lesser extent. Community leaders noted specifically that there is a lack of organized sports programs for kids. Community leaders also noted that there are few opportunities for people to be active together. In addition, adults have health issues (illness, pain, and injuries) and tough economic times to contend with. Teens thought that exercise was important but indicated that they often have better things to do and/or were embarrassed about exercising. Youth specifically mentioned that they do not use the parks because they are "too old" for them. When asked about the barriers to using specific resources like the bike path or Riverside Park, residents mentioned individual issues (too tired, not enough time, sick, don't have a bike, can't or don't want to ride, etc.), as well as broader issues such as not being aware of these resources and safety issues. Only about half of the parks and recreation facilities have appropriate areas/facilities/programs for people of all ages and there are no indoor facilities or programs specifically for adults.

Over half of adults and children in Olneyville watch two or more hours of television every day, making television a barrier to physical activity as well. Residents aged 46 and older, residents without children under age 18, and smokers were all more likely to watch more television. Community leaders indicated that the "culture" of video games and television are barriers to physical activity.

RESIDENTS' SUGGESTIONS

- Improve neighborhood safety, such as increasing police officer presence, adding more cameras, and adding more lighting
- Design safer roads, including speed bumps
- Make programs more affordable
- Provide accessible after-school, community, and organized sports options for kids
- Create a directory of all the programs, facilities, and spaces for physical activity.

*defined as engaging in physical activity, such as running, walking, biking, playing sports, for at least 30 minutes

**defined as anyone who has smoked at least 100 cigarettes in his or her life, not necessarily current smokers.

TOBACCO USE

Seventy-six percent of residents think young people have an easy time getting cigarettes and other tobacco products.

Residents tended to see smoking as a problem in Olneyville. Residents commented on the negative aspects of smoking, such as the smell and the negative health effects.

Over a third of residents reported being "smokers" themselves, defined as someone who has smoked at least 100 cigarettes in their life, and 70% of those residents smoked every day. Males, residents aged 46 and older, and residents with a chronic disease and/or with a family member with a chronic disease were all more likely to be smokers. The majority of smokers (78%) were aware of where to get help to quit smoking, with 83% being aware of the 1-800-TRY-TO-QUIT line specifically.

While there seem to be fewer advertisements around the neighborhood than in the past, 71% of residents still think that tobacco products are advertised a lot in Olneyville (52 outdoor advertisements were identified through a 2009 Tobacco Control Program Survey). Youth commented that advertisements that make smoking look cool are everywhere. Some residents thought advertisements influenced smoking. One resident said, "With fewer advertisements, people would forget about smoking." Other residents did not see advertisements as the primary problem, particularly concerning youth smoking. Residents seemed to agree that the primary problem is easy access, with 76% thinking that young people have an easy time getting cigarettes and other tobacco products. Youth can buy cigarettes through merchants who do not card ("especially if they know you") or through adults/older friends who are willing to buy cigarettes for them. Cost still remains a large barrier, however, to youth smoking.

Almost all residents believe that second-hand smoke is dangerous to their health and/or their children's health. Seventy-eight percent would support an increase in taxes on cigarettes if that meant fewer people would smoke, with Latinos more likely to support the tax increase. Residents had mixed reactions to smoke-free policies in public housing, high-rises, and their own homes. Spanish-speakers tended to support these policies, while English-speakers tended to think that the policies would threaten people's personal freedoms. Overall, the majority of residents reported they would prefer to live in a house or apartment where no one smokes inside, with Spanish speakers being more likely to prefer non-smoking residences.

RESIDENTS' SUGGESTIONS

- Provide more programs and counseling to deal with addiction
- Ban smoking in public places
- Limit the sale and advertising of cigarettes
- Provide insurance coverage for the patch and other quit methods
- Give people more activities and other things to occupy their time
- Promote more anti-tobacco advertisements
- Provide programs that help people improve their lives and reduce stress
- Enforce no-smoking policies on school grounds

NUTRITION

Residents identified cost as the primary barrier to buying fruits and vegetables, and to healthy eating in general. Residents also indicated that high-quality, affordable fruits and vegetables, low-fat products, and whole grains are not available in local stores.

Residents of Olneyville associate good nutrition with eating fruits and vegetables, avoiding greasy/fried/processed food, picking foods low in calories and fat, and eating a variety/balance of foods. Just under half of Olneyville adults and about half of children reported eating five or more servings of fruits and vegetables every day, with Latinos being less likely to eat fruits and vegetables.

Roughly two-thirds of Olneyville residents face barriers to buying fruits and vegetables. Residents identified cost as the primary barrier to buying fruits and vegetables, and to healthy eating in general. Residents also indicated that high-quality, affordable fruits and vegetables, low-fat products, and whole grains are not available in local stores. Only PriceRite and Stop&Shop carry healthy foods, and while these were the two most popular stores identified for shopping, transportation is limited to these stores and there are few price incentives or healthy food promotions. Eighty-four percent of residents would volunteer their time to support efforts to increase the availability of healthy foods in corner stores.

Olneyville parents mentioned time as a barrier to healthy eating, and community leaders and Spanish-speaking residents mentioned culture and taste preference as barriers. Not liking or not knowing how to prepare fruits and vegetables did not seem to be major barriers; although some Spanish-speaking focus group participants did mention that they did not like vegetables. Community leaders also mentioned that while the school lunch program has gotten better, it is still lacking in healthy food choices. They noted that costs are the biggest barrier to providing nutritious meals.

During the community assessment, residents were asked to comment on specific topics related to healthy eating:

- **Farmers' Markets:** Parents seemed to have the most experience with farmers' markets, whereas youth knew very little about them. Residents thought that the food at farmers' markets was fresh,

RESIDENTS' SUGGESTIONS

- Lower prices on high-quality healthy foods
- Increase access to low-cost, high-quality healthy foods, particularly fruits and vegetables, in corner stores or local food stands/carts
- Set up farmers' markets that are affordable and easy to get to
- Provide more safe spaces to garden (and maybe even a greenhouse for year-round gardening)
- Eliminate unhealthy vending machine options and replace them with water
- Provide education on "decent-flavored" alternatives to sugar-sweetened beverages (beyond water)
- Work with fast food establishments to provide healthier options and/or implement menu labeling of healthy choices

high-quality, and tasty; however, they found the prices to be too high, the markets to be inaccessible, and were uncertain about the location and the use of food stamps.

- **Gardens:** Very few residents currently garden, but many residents either have done so in the past or would like to in the future. Residents don't necessarily associate gardening with healthy eating, but rather as an activity they enjoy doing. Barriers to gardening include not having space, not having enough time to keep it up, not knowing how to garden, health issues ("bad back"), and stolen vegetables.
- **Eating Out:** While the majority of adults and children report eating food prepared at home most of the time, 21% of adults and 16% of children said they ate fast food, takeout, or food at sit down restaurants three or more days a week. Youth, in particular, mentioned that they liked fast food, commenting that there is too much fast food in Olneyville and that they "grew up on it." Community leaders agreed that fast food is a prominent choice in the community. Residents indicated that "eating out" is convenient and easy, especially when they are too busy to go food shopping or "don't feel like cooking". They use it as a way to splurge, to change routine, and to be social with other families. While eating out can be more expensive than eating at home, they said that they can pick cheaper options, acknowledging that the cheaper options are often less healthy. Local restaurants tend not to carry healthy foods and rarely promote them if they do, and residents had mixed views on whether nutritional information at the point of purchase would influence decision-making and make them choose healthier options.
- **Sugar-Sweetened Beverages:** About a third of Olneyville adults and children said they drank one or more sugar-sweetened beverage every day, with Latinos and Spanish-speakers being less likely to drink sugar-sweetened beverages. The majority of residents saw drinking too many sugar-sweetened beverages, such as soda, juice, Kool Aid, and iced tea, as a health problem, with 88% agreeing that they are a major cause of obesity in children. They also mentioned long-term effects such as weight gain, diabetes, and dental problems and shorter-term effects such as sugar crashes, headaches, and hyperactivity. Residents had mixed views on the effect of raising prices of sugar-sweetened beverages: while the majority of focus group participants said that raising prices would not affect behavior, the majority of interview respondents said that they would purchase fewer sugar-sweetened beverages for themselves and their children. Similarly, while focus group participants had mixed reactions to a policy that would ban sugar-sweetened beverages at certain public places such a libraries, public parks, and governmental buildings, 76% of interview respondents would support such a policy.

OBESITY AND CHRONIC DISEASE

Residents agreed that obesity is a problem in Olneyville. Forty-one percent of residents were diagnosed with a chronic disease or had a family member diagnosed with a chronic disease, such as asthma, diabetes or heart disease. English-speakers, non-Hispanics, and smokers were all more likely to have a chronic disease and/or have a family member with a chronic disease.

RESIDENTS' SUGGESTIONS

- Increase opportunities for physical activity
- Increase education on how to eat right and how to read nutrition labels
- Teach young children about exercise
- Provide consultations for family members to become more aware and knowledgeable about a family member's chronic disease

While almost all residents dealing with chronic disease said that they have the necessary services to manage the disease, residents would still like the following to help their families better manage their diseases:

- Educational materials
- More time with doctors
- Transportation
- Support groups / workshops
- Appointment reminders
- Home visits from health aids
- Medication management
- Workshops/orientations

HEALTHCARE AND HEALTH INSURANCE

Seventy-one percent of residents had health insurance (from one or more sources). The major health insurance providers were RIte Care (44%), Medicaid (32%), Medicare (18%), and UnitedHealthcare (14%). Females reported higher numbers of insurance coverage.

Residents receive their current healthcare from community health centers (47%), hospitals (31%), free clinics (14%), and private doctors (11%). Females, non-smokers, residents aged 45 or younger, residents with children under 18, residents with a chronic disease and/or with a family member with a chronic disease, Latinos, and Spanish-speakers were all more likely to receive care from a community health center. Smokers were more likely to receive care at free clinics than non-smokers.

Community leaders indicated that there is a general lack of awareness of the available healthcare services and benefits and that there needs to be better outreach to get people connected to those programs. They also commented that cultural issues may play a role in a resident's ability to navigate the system, as people have different health systems, perspectives, and beliefs.

RESIDENTS' SUGGESTIONS

- Expand access to health insurance
- Increase access to clinics for people who don't have insurance
- Provide assistance in "navigating" the healthcare/social services system

HOW PEOPLE GET THEIR INFORMATION

Residents reported they obtained information about community happenings from television (47%), newspapers (29%), and family and friends (36%). For information on keeping their families healthy, they turned to television (42%), community organizations (24%) their physician or healthcare provider (23%), radio (20%), family and friends (19%), and the newspaper (18%). The following trends were apparent regarding how people obtained health information:

FAMILY AND FRIENDS: Latinos, non-smokers, those without a chronic disease and/or family member with a chronic disease were all more likely to rely on family and friends for health information.

HEALTHCARE PROVIDERS: Spanish-speakers and non-smokers were more likely to rely on their physicians or healthcare providers for health information.

TELEVISION: Smokers were more likely to rely on TV for health information.

INTERNET: Half of the respondents used the Internet, although the Internet was not identified as a primary source of information. Residents aged 45 and younger and residents with children under 18 were both more likely to use the Internet.
Of those who do use the Internet, most use it for surfing (74%), health information (42%) and Facebook/My Space (38%).

CELL PHONES: Most respondents (65%) would not be interested in receiving health information on their cell phones. However, residents aged 45 or younger and non-smokers were more likely to be interested in receiving health information in this way.

DATA SOURCES

This comprehensive community assessment included focus groups and interviews with adults, a discussion group with youth, and interviews with community leaders, as well as a look at the actual physical environment of the community. A total of 175 residents took part in the assessment.

RESIDENT FOCUS GROUPS: Five 90-minute focus groups were conducted with Olneyville residents. The groups targeted English and Spanish-speaking adults with children under 18 living at home; English and Spanish-speaking adults without children under 18 living at home; and elderly residents aged 65 years and older. A bilingual facilitator was hired and trained to administer a 35-question focus group guide.

RESIDENT INTERCEPT INTERVIEWS: Utilizing a 37-question survey tool, trained local residents conducted one-on-one interviews with 99 residents. Interviews took place at local community gathering spots, such as community centers, pharmacies, community health centers, and community events.

YOUTH DISCUSSION GROUP: Youth from A Sweet Creation Youth Organization and Olneyville Youth Group were brought together for a discussion. The group included 10 teens ages 13 to 18. A trained teen facilitator led the group at Manton Heights Recreation Center.

COMMUNITY LEADER INTERVIEWS: Olneyville Housing Corporation staff conducted 10 interviews with community organizations, elected representatives, and resident leaders.

PHYSICAL ENVIRONMENT ASSESSMENT: Olneyville Housing Corporation and the YMCA utilized the YMCA's Community Healthy Living Index (CHLI) tool to conduct an assessment of the physical condition of the neighborhood. Eight neighborhood stakeholders gathered over four sessions to discuss the condition of the streets, sidewalks, parks, and recreation facilities, as well as the availability of healthy food choices in neighborhood stores and restaurants. They concluded by coming up with a number of recommendations for improving the neighborhood.

MAKING A HEALTHIER OLNEYVILLE

"A [community] is a complex place that has everything we need to exercise, socialize, and interact."

Residents understand the issues in their community—they know its strengths and weaknesses—and are motivated to take action to make changes but they need support to make it happen. As seen throughout this summary, respondents had a lot of suggestions as to how to improve the health of their community. When asked what one thing would help most, residents put forth the following ideas:

- Increase community participation and communication between residents and community organizations by strengthening neighborhood associations
- Cut crime/drug use with more police and a neighborhood watch group
- Create cleaner environments and better places for community participation and recreation, including programs/activities for children
- Provide more free health and social services and resources, like the buses to get your blood pressure taken or sugar tested or places to go to get help with a variety of issues
- Involve younger people in all aspects of community development
- Improve the safety infrastructure, especially for people with disabilities

In addition to the themes mentioned above by residents, community leaders suggested providing education and workshops on exercise and nutrition. Specific suggested topics included selecting and cooking healthy foods and how food is related to chronic disease.

Residents, particularly Spanish-speaking residents, favored policy or system interventions, while others proposed more individual-level changes to improve health. While residents were likely to act around issues of neighborhood design, physical activity, and nutrition issues, they felt that the physical infrastructure (such as streets and sidewalks) was an area that they had little control over and would look to the city to step in.

Residents felt that other people would support these changes, and indicated that community members and community officials were key stakeholders, specifically mentioning politicians, churches, teachers, home owners, and business owners. In particular, community leaders mentioned the need to get kids involved in the effort, as ways to get kids physically active, involved in their community, and out of trouble. Residents thought there should first be "grassroots" organizing at the community level ("a petition from the community" or "a committee of neighbors") with a clear plan and tangible results. They could then involve community officials/politicians, using the community-level information to guide decision-making. Residents mentioned limited community resources, particularly in "this economy", and lack of interest from community members and officials themselves as potential barriers to change.

NEXT STEPS

Olneyville Housing Corporation will be holding community forums to bring together residents to discuss the results of this assessment and identify priorities for action. These discussions will be the starting point for an action plan to improve health in Olneyville.

We need your help! To get involved, call Johanna Walczak at Olneyville Housing Corporation at 401.351.8719 x109 or email walczak@olneyville.org

RHODE ISLAND DEPARTMENT OF HEALTH

olneyville housing corporation

HEALTH INFORMATION LINE
401-222-5960 / RI RELAY 711
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B. Rhode Island Health Improvement Plan (2013-2018)

Rhode Island's Health Improvement Plan includes three major objectives:

- Strategic objectives: Comprehensive long-term objectives that mirror the Strategic Plan and supports overall infrastructure of the Department of Health.
- Programmatic objectives: Disease-specific objectives that are part of our public health work in response to community needs, surveillance, data, and local priorities.
- Process objectives: Activities directed to construct the Health Assessment and Improvement Plan in a more consistent, synchronized way in the next cycle.

NOTE: HEALTH works with statewide partners in multiple efforts, on an ongoing basis to address these and many other health issues affecting the Rhode Island communities. Most of those efforts are described and/or included in our website, but new initiatives and partnerships are constantly being organized and developed. Similarly, many programs within the Department have designed their topic-specific strategic plan, plan of action or comprehensive plan. Some of our partners are also required to prepare their health improvement plans for their own organizations, consumers and governing bodies to meet government requirements. For all of these reasons, a select number of activities and measures are included in this Health Improvement Plan. We invite everyone to visit our website at www.health.ri.gov as well as the indicator's website at www.rihealthcarematters.org for additional information on health indicators, data, reports, efforts and partnerships. You can also contact our Health Information Line, at 401-222-5960.

1. Strategic Objectives: Improve the overall health of Rhode Islanders

Goal	Activity	Measure	Point of Contact
Make Rhode Island the # 1 state in the America's Health Rankings	▪ Develop a strategy and timeframe to address the selected priority areas	By 2014: ▪ Identify three or four top priorities ▪ Design and begin implementation of activities to improve the selected priorities By 2018: ▪ Annually measure and improve state's ranking in the selected priorities	HEALTH (Dr. Fine, Ana Novais)
Reduce years of potential life lost and days of lost work, school, and leisure in Rhode Island	▪ Maintain the statewide coalition created in 2012 to further engage providers in the use of patient education tools and other strategies and provide training and assistance to enforcement agencies to review and develop state policy	▪ Increase the prescribers utilizing the Prescription Monitoring Program (PMP) to review the system 90% of the time before prescribing schedule 2 or 3 medication ▪ Decrease the number of deaths due to drug overdose from 182 in 2012	HEALTH, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), Rhode Island State Police
Develop a culture of quality improvement in the work we do	▪ Promote the ongoing training and use of QI tools among staff ▪ Conduct customer satisfaction surveys in selected units/programs within the Department	▪ Conduct annual QI Fair in observance of National Public Health Week ▪ Increase customer satisfaction in the program-specific surveys	HEALTH

2. <u>Programmatic Objectives</u>: Improve health outcomes

Goal	Activity	Measure	Point of Contact
Promote initiatives that reduce obesity in patients with diabetes	▪ Improve awareness of healthy lifestyles and prevention of obesity through Community Education and Health Screening Programs	▪ Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day (BRFSS)	South County Hospital
	▪ Increase awareness of risk factors for diabetes	▪ Number of patients screened for diabetes	Care New England hospitals
	• Disseminate *American Diabetes Association (ADA) Guidelines* to providers for diabetes screening recommendations. ▪ Provide new tools and resources on the meaning of diabetes screening results, pre-diabetes, and prevention - especially those from ADA.	▪ By 2015, increase the percentage of adults in Rhode Island who report having had a diabetes screening test done in the past 3 years by at least 5%.	HEALTH's Diabetes Prevention & Control Program
	▪ Promote participation in the Statewide Diabetes Health System (SDHS) by decision makers. ▪ Support and acknowledge participation of decision makers with public recognition.	▪ By 2015, increase the number of decision makers (legislators, employers, healthcare administration) on the Rhode Island Diabetes Council.	
	▪ Cultivate partnerships with non-traditional partners, such as smart growth advocates, neighborhood revitalization groups, and environmental groups. ▪ Provide seed funding to core cities to coordinate communitywide efforts. ▪ Develop community action plans to maximize strengths and address gaps by leveraging existing resources for policy and environmental change.	▪ By December 30, 2015, six core city neighborhoods will make at least two documented improvements in community walkability, safety, access to recreation, and access to healthy foods.	HEALTH's Initiative for a Healthy Weight Program
	▪ Ensure widespread distribution of Rhode Island Chronic Care Collaborative (RICCC) sites to include	▪ By December 30, 2015, attain equity in diabetes care quality process	Quality Partners of Rhode Island,

Goal	Activity	Measure	Point of Contact
	facilities and practices serving the most underserved and at-risk populations. ▪ Expand the use of the Chronic Care Model with emphasis on racial/ethnic minorities. ▪ Support expansion of and replication of successful patient centered medical homes models across the state.	measures across demographic population groups using HEDIS measures of: percent with at least 2 A1C, percent with foot exam, percent with dilated eye exam in past 12 months	Rhode Island Chronic Care Collaborative, Chronic Care Sustainability Initiative
Reduce the percent of youth initiation tobacco use	▪ Increase the number of communities that pass local tobacco license ordinances. ▪ Promote a mass media campaign to discourage high school and incoming college students from starting smoke.	▪ Percent of youth initiating tobacco use decrease from 4.2 to 2.2 percent by 2018	The Partnership to Reduce Cancer in Rhode Island
Decrease the rate of adolescents (ages 15-19) who become pregnant	▪ Coordinate training and technical assistance for healthcare providers and allied professionals who provide direct services, especially home visits. ▪ Develop resources to educate populations (e.g., adolescents, parents) about preconception health. ▪ Develop a comprehensive website that serves as a clearinghouse for preconception health information and a networking source for healthcare providers and allied professionals.	▪ Reduce the adolescent pregnancy rate to 5 % of all pregnancies by 2020	HEALTH's Division of Community, Family Health and Equity
Enhance access to mental health and substance abuse services	▪ Increase the proportion of patients for Patient Centered Medical Community (PCMC) participants that have access to mental health clinicians onsite and measure referrals to other related services	▪ Number of primary care providers participating in the PCMC initiative that are providing mental health consultations or referrals on-site	South County Hospital
	▪ Provide free lectures statewide on issues related to mental health	▪ Number of free lectures offered statewide each year	The Miriam Hospital

Goal	Activity	Measure	Point of Contact
	▪ Number of cancer patients referred to the STAR program	▪ Number of families educated about risk factors for postpartum depression and the services available	Care New England hospitals
Reduce heart disease through early identification, and early and appropriate treatment and management	▪ Educate women about the benefits of healthy behavior, including exercise, diet, and not smoking	▪ Number of individuals that participate in programs	Care New England hospitals
	▪ Conduct Community Education Programs that are free to the public and offered by cardiology experts	▪ Number of education and screening programs and program participants	South County Hospital
Carry out a comprehensive approach to prevent cancer in Rhode Islanders for all age groups	▪ Reduce the percentage of adults who report being overweight or obese ▪ Reduce the percentage of high school students who report being overweight or obese to 24% ▪ Increase the percentage of women ages 21 - 29 who have had a Pap test in the past three years ▪ Increase the percentage of women ages 50 through 74 who have had a mammogram in the past two years	By 2018: ▪ Decrease the percentage of overweight or obese adults from 64% to 63% ▪ Decrease the percentage of high school students overweight or obese from 26% to 24% ▪ Increase the percentage of women ages 21 - 29 who have had a Pap test in the past three years from 73% to 89% ▪ Increase the percent of women ages 50-74 who have had a mammogram in the past two years from 88% to 94%	The Partnership to Reduce Cancer in Rhode Island
	▪ Build upon the foundation of the STAR (Survivorship Training And Rehabilitation) program to provide availability of and access to cancer support and survivorship services, including access to psychosocial services	▪ Number of cancer patients referred to the STAR program	South County Hospital

Goal	Activity	Measure	Point of Contact
Promote the health and wellness of all Rhode Islanders	▪ Foster state policy that reduces adverse effects of emergencies on individual with special needs ▪ Train first responders and emergency preparedness personnel on disability-specific strategies to communicate with persons with special needs	By 2018: ▪ Increase registration of Rhode Islanders with special needs in the RI Special Needs Emergency Registry (RISNER) ▪ Increased number of adopted emergency preparedness plans and exercises that include Rhode Islanders with special needs in all phases of preparedness	HEALTH's Disability Community Planning Group, Division of Community, Family Health and Equity, Center for Emergency Preparedness and Response
	▪ Require that all childcare facilities serve meals and snacks that comply with Dietary Guidelines for Americans. ▪ Develop a co-op program with Johnson and Wales University to place students in restaurants to provide additional training and technical assistance. ▪ Provide adult providers with tools and training to better address obesity prevention.	By 2016: ▪ 25% of licensed childcare facilities will provide menus consistent with the Dietary Guidelines for Americans. ▪ 30 restaurants will be publicly recognized for providing healthy food and beverage options. ▪ All Rhode Island Health Centers will integrate obesity prevention into routine primary care.	HEALTH's Initiative for a Healthy Weight Program
Prevent violence and injuries in Rhode Island	▪ Decrease or maintain the 2009 death rate due to unintentional falls among adults ages 65 and older ▪ Increase the percent of older adults who exercise on most days of the week ▪ Decrease the rate of hospitalizations due to unintentional motor vehicle injuries in Rhode Island ▪ Decrease the number of deaths due to suicide for 15-24-year-olds in the six core cities	By 2016: ▪ Decrease or maintain the death rate of adults ages 65 and older at 71 per 100,000 or less ▪ Increase the number of "A Matter of Balance" program offered to older adults ▪ Decrease rate of hospitalizations from 38 per 100,000 in 2009 to 54 per 100,000	HEALTH's Violence and Injury Prevention Program

Goal	Activity	Measure	Point of Contact
		▪ Decrease the number of deaths due to suicide for 15-24 year olds from 5 in 2009 to 4	
Mobilize statewide assets and partnerships to achieve significant reduction on key health issues affecting the Rhode Island community	▪ Conduct a statewide campaign to mobilize partnerships and efforts to get to zero new cases of HIV by 2016	By 2018: ▪ Eliminate HIV transmission in Rhode Island (from 78 cases in 2012)	HEALTH's Division of Infectious Disease and Epidemiology
	▪ Conduct a joint campaign regarding the impact of smoking and second-hand smoke on asthma, targeting high school students and adults.	By 2019: ▪ Decrease the percentage of students with asthma who report that they smoke from 15.0% in 2012 to 10%. ▪ Decrease the percentage of adults with asthma who report that they smoke from 24.8% in 2012 to 20%.	HEALTH's Asthma Control and Tobacco Control Programs
Increase and promote healthy environments for all Rhode Islanders	▪ Provide technical assistance to schools.	By 2018, increase the number of school districts that adopt the "High Performance Schools/Tools for Schools" regulation from 16 in 2012 to 30	HEALTH, RI Department of Education, Rhode Island Commission on Occupational Safety and Health
	• Create a Healthy Housing and Community Quality Standards (HHCQS) Guidance document that centralizes all relevant healthy housing and community quality standards to achieve health in all policies, programs and initiatives. Provide an electronic version of the HHCQS on HEALTH's website.	By 2017, establish policies and partnerships that will create systems-level changes to improve housing and neighborhood	HEALTH, the Rhode Island Healthy Housing Collaborative, and partners statewide

Goal	Activity	Measure	Point of Contact
	• Modify policy within the Rhode Island Building Commission and Housing Resource Commission to ensure that all properties are held to consistent and comprehensive healthy housing standards (including addressing mold and asbestos, and requiring new radon-resistant construction). • Establish guidelines/standards for certifying that a residence is safe and healthy prior to occupancy and develop a healthy homes certificate of occupancy. • Research and assess current incentive mechanisms such as tax incentives, rebates, low-interest loans, deposit loan programs, hospital community assessments, and insurance breaks for investing in healthy housing. • Explore developing a rating system, utilizing the Housing Locator, to create a market for healthy housing.		
Increase and promote healthy environments for all Rhode Islanders Increase and promote healthy environments for all Rhode Islanders	• Create a unified, systematic approach so that home visiting professionals use an approved healthy housing checklist as part of home assessments, and are trained on follow-up procedures and protocols. • Develop toolkit for all home visitors (including community health workers, nurses, etc.) to take on the road. • Develop list of healthy homes referral resources for clinicians (weatherization professionals; code enforcers, lead inspectors). • Develop a plan to educate	By 2017, develop an integrated and linked system of care across clinical, social and housing sectors to systematically achieve quality housing and neighborhoods standards.	

Goal	Activity	Measure	Point of Contact
	all providers on how to address home hazards as a health risk during preconception care.		
	• Criteria for awarding HEALTH requests for proposals, contracts and formal agreements will be evaluated for opportunities to include healthy homes/community standards or assessments as part of the selection process • Generate data through partnerships with health insurance plans to demonstrate cost/benefit and return-on-investment of fixing the health and safety of homes (e.g., asthma).	By 2017, institutionalize healthy homes priorities into existing activities and core functions of HEALTH	HEALTH, the Rhode Island Healthy Housing Collaborative, and partners statewide
	• Advocate for insurers to reimburse hospitals for testing asymptomatic individuals for carbon monoxide poisoning. • Advocate for insurers to improve access to low and no-cost, face-to-face smoking cessation programs. • Create Healthy Home/Communities Toolkits for agencies and organizations to use and disseminate.	By 2017, ensure the long-term sustainability of healthy homes and healthy communities efforts	

3. <u>Process Objective:</u> Establish an ongoing Health Assessment and Improvement Plan development process

Goal	Activity	Measure	Point of Contact
Promote the use of rihealthcarematters.org within communities and other partners	▪ Add health indicators at the city/town level ▪ Jointly maintain the site with HARI, with recent reports and publications ▪ Joint presentations and promotion of the software for use by researchers, students, municipalities, etc.	▪ Number of city/town level indicators added to the site ▪ Number of presentations made to other partners to promote the use of the site	HEALTH, HARI
Maintain the Community Health Assessment group to jointly formulate the state's Community Health Assessment and Health Improvement Plan	▪ Conduct 2-3 community engagement meetings per year ▪ Complete and make publicly available an annual progress report of community engagement activity ▪ Revise and report progress on the Health Improvement Plan every 3-5 years	▪ Two community meetings conducted each year ▪ Annual publication of a progress report on the Health Improvement Plan	HEALTH's Community Health Assessment Group
Assure resources and a structure that allows prompt use and access to health data maintained by HEALTH	▪ Maintain multiple mechanisms to make data accessible to the public via query systems, data requests, annual reports, websites, surveys and other mechanisms	▪ Number of data requests received by community partners in relation to the state's community health assessment and improvement plan	HEALTH's Center for Health Data and Analysis
Establish a coordinated process and structure to share health assessment and health improvement planning efforts in the state	▪ Inventory partners and efforts to conduct health assessment and health improvement plans ▪ Develop a schedule, format and methodology to leverage resources and results from community health assessments	▪ Completion of the inventory and agreement from the partners in the process to share resources and expertise in the completion of the Health Assessment and Health Improvement Plan process.	HEALTH

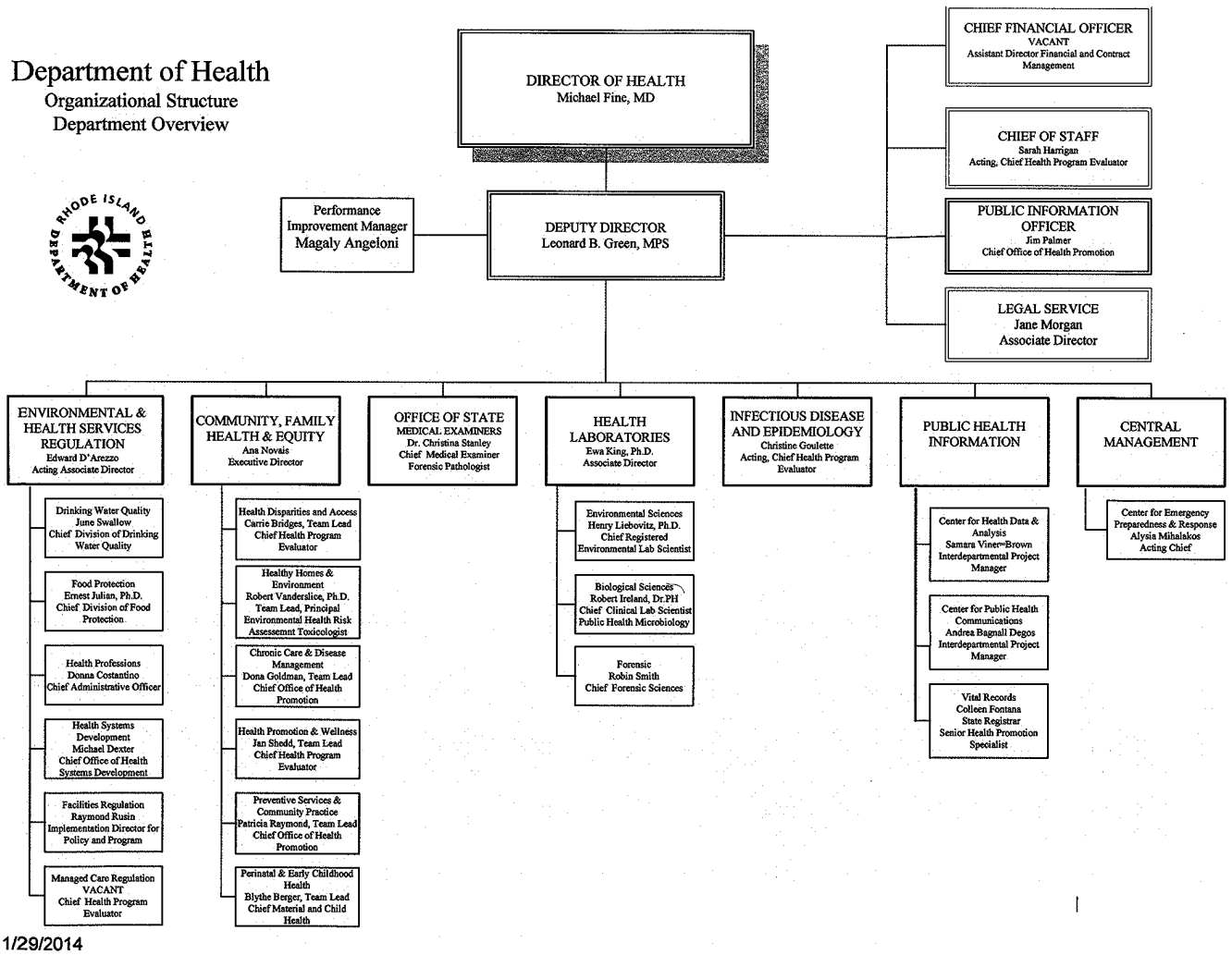
C. What's Next?

The implementation of a Health Improvement Plan is an ongoing activity, now largely structured as demonstrated throughout this document. Assessing the health needs and putting in place policies and programs to address those needs are the essence of HEALTH's mission. Assessments and improvements take place at all levels of the department, and this document contains a small fraction of the qualitative and quantitative data we collect and use for decision making.

Since this is a statewide activity, multiple partners from within and outside of HEALTH will continue to be involved. To keep the community at large informed about the Health Improvement Plan, the HEALTH will publish short summaries and synopsis of documents that may be of public interest. Examples of this include an annual report, announcements of upcoming community meetings, and summaries of meetings conducted throughout the year.

Please visit the HEALTH website often to learn more about what we are doing to help improve the health of all Rhode Islanders.

APPENDIX 1


Department of Health
Organizational Structure
Department Overview
RHODE ISLAND DEPARTMENT OF HEALTH
DIRECTOR OF HEALTH
Michael Fine, MD
Performance Improvement Manager
Magaly Angeloni
DEPUTY DIRECTOR
Leonard B. Green, MPS
CHIEF FINANCIAL OFFICER
VACANT
Assistant Director Financial and Contract Management
CHIEF OF STAFF
Sarah Harrigan
Acting, Chief Health Program Evaluator
PUBLIC INFORMATION OFFICER
Jim Palmer
Chief Office of Health Promotion
LEGAL SERVICE
Jane Morgan
Associate Director
ENVIRONMENTAL & HEALTH SERVICES REGULATION
Edward D'Arezzo
Acting Associate Director
Drinking Water Quality
June Swallow
Chief Division of Drinking Water Quality
Food Protection
Ernest Julian, Ph.D.
Chief Division of Food Protection
Health Professions
Donna Costantino
Chief Administrative Officer
Health Systems Development
Michael Dexter
Chief Office of Health Systems Development
Facilities Regulation
Raymond Rusin
Implementation Director for Policy and Program
Managed Care Regulation
VACANT
Chief Health Program Evaluator
COMMUNITY, FAMILY HEALTH & EQUITY
Ana Novais
Executive Director
Health Disparities and Access
Carrie Bridges, Team Lead
Chief Health Program Evaluator
Healthy Homes & Environment
Robert Vanderslice, Ph.D.
Team Lead, Principal Environmental Health Risk Assessemnt Toxicologist
Chronic Care & Disease Management
Dona Goldman, Team Lead
Chief Office of Health Promotion
Health Promotion & Wellness
Jan Shedd, Team Lead
Chief Health Program Evaluator
Preventive Services & Community Practice
Patricia Raymond, Team Lead
Chief Office of Health Promotion
Perinatal & Early Childhood Health
Blythe Berger, Team Lead
Chief Material and Child Health
OFFICE OF STATE MEDICAL EXAMINERS
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Chief Medical Examiner
Forensic Pathologist
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Chief Clinical Lab Scientist
Public Health Microbiology
Forensic
Robin Smith
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INFECTIOUS DISEASE AND EPIDEMIOLOGY
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State Registrar
Senior Health Promotion Specialist
CENTRAL MANAGEMENT
Center for Emergency Preparedness & Response
Alysia Mihalskos
Acting Chief
1/29/2014

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State Community Health Assessment Workgroup

Formed 2012

Blue Cross and Blue Shield of Rhode Island
Brown University
Hospital Association of Rhode Island (HARI)
Neighborhood Health Plan of Rhode Island (NHPRI)
Rhode Island Health Centers Association (RIHCA)
Rhode Island Department of Health (HEALTH)
Rhode Island Executive Office of Health and Human Services (EOHHS)
Rhode Island Kids Count
The Providence Plan
University of Rhode Island, Health Studies Program
UnitedHealthcare

3 APPENDIX

APPENDIX 3: HEALTH staff representation on Advisory Committees, Boards, Coalitions

This list is accurate as of December 2012

State level

ADAP Clinical Advisory Committee
AIDS Clinical Task Force
Americorp Inclusion Advisory Committee
APHL Newborn Screening Quality Indicators Workgroup
Autism Commission
Brown University Superfund Basic Research Program
CEDARR Interdepartmental Team
Child Death Review Team
Children's Trust Fund
Childhood Immunization Action Coalition
Community Health Worker Association of RI, Steering Committee
CSI/Beacon Advisory Committee
Coalition Against Domestic Violence
Children's Friends Early Head Start Health Advisory Board
Covering Kids
Cut 25 by 5 Committee
Department of Children, Youth, and Families (DCYF) System of Care Expansion Team
Developmental Disability Council
Department of Transportation Highway Safety Stakeholders Committee
Department of Transportation Traffic Records Coordinating Committee
Department of Transportation Advisory Committee
Department of Corrections Batterer's Intervention Oversight Committee
Executive Office of Health and Human Services (EOHHS) Grants Review Group
Executive Office of Health and Human Services (EOHHS) Policy Group
Emergency Food and Shelter Board, United Way
Early Hearing Detection Intervention Advisory Board
Environmental Justice League
Early Learning Council
Early Identification and Implementation of People Living with HIV/AIDS Committee
Education, Needle Exchange, Counseling, Outreach and Referral (ENCORE) Steering Committee
Family Voices Leadership Team
Full Service Community Schools
Global Waiver
Governor's Commission on Disabilities
Governor's Permanent Advisory Commission on Brain Injury
Governor's Council on Behavioral Health
Health Reform Commission

Healthcare Cultural and Linguistically Appropriate Services (CLAS) Workgroup
Heart Disease & Stroke Steering Committee
HIV Provision of Care Planning Body
Healthy Kids RI
Home Visiting Leadership Council
Home Asthma Response Program (HARP)
Housing Resources Commission
Interagency Coordinating Council (ICC)
Kids Count Factbook Advisory Committee
Kids Count Robert Wood Johnson Foundation (RWJF) Grant Advisory Committee
Latino Cancer Control Task Force
Leadership RI
Legislative Commission for Climate Change
Living Well RI
Local Wellness Council
LGBTQQ Task Force, Youth Pride
Minority Health Advisory Committee (Health Equity and Advocacy Commission)
Newborn Screening Advisory Council
New England Rural Health Round Table
New England Health Impact Assessment Conference Advisory Committee
Neighborhood Health Plan of Rhode Island Advisory Committee
Olneyville Community Action Team
Ocean State Adult Immunization Coalition (OSAIC)
Partnership to Reduce Cancer in Rhode Island
Pawtucket Cancer Control Task Force
Providence Center, Board of Directors
Providence Children's Initiative Advisory Committee
Providence Green and Healthy Housing Initiative Advisory Committee
Refugee Health Committee
POCC Consumer HIV Positive Committee
Rhode Island Childhood Immunization Coalition
Rhode Island Community Planning Group for HIV Prevention (RICPG)
Rhodes to Independence Advisory Committee
Rhode Island Diabetes Council
Rhode Island Special Education Advisory Committee (RI-SEA C)
Rhode Island Stroke Task Force
Rhode Island Task Force on Premature Births
Rhode Island Tobacco Cessation Committee
Rhode Island Tobacco Control Network
Rhode Island Transition Council
Rhode Island Traffic Safety Coalition

Rhode Island Council for Assistive Technology (RI-CAT)
Rhode Island Housing KeepSpace
RIte Safe Occupational Safety and Health Coalition
Rhode Island Healthy Housing Collaborative
Rhode Island Association of Certified Asthma Educators
Rhode Island Chronic Care Collaborative (RICCC)
Rhode Island Asthma Control Coalition
Rhode Island Department of Education, High Performance Schools Work Group
Rhode Island Department of Education HIV Curriculum and Policy Review Group
Rhode Island Public Health Institute
Rhode Island Alliance for Teen Pregnancy Prevention
RIASCD-Whole Child
Safety Alliance Furthering Educational Resources
Statewide Family Community Advisory Board (F-CAB)
Statewide Planning Technical Advisory Committee
Successful Start
Supporting Families with Cognitive Challenges
SNAP Advisory Committee
21st Century Schools
Viral Hepatitis Task Force
Women's Health Council
Woonsocket Cancer Control Task Force
YMCA of Greater Providence, Childhood Obesity Advisory Board

Regional and National Level
National Association of Chronic Disease Directors
National Association of Immunization Managers (AIM)
Region I Health and Human Services (HHS) Health Equity Council
Northeast Injury Prevention Network
National Association of Maternal and Child Health Programs
Region 1 Maternal and Child Health Network
Safe States Alliance State Injury Directors Special Interest Group
Director's of Health Promotion and Education
CityMatCH (National Organization of Maternal and Child Health Urban Leaders)
National Association of State Environmental Health Directors
CDC Asthma Reimbursement Workgroup
New England Asthma Program Collaborative
Asthma Regional Council of New England
CDC Health Equity Indicators Work Group
Region I Office of Minority Health State Directors Meetings
CDC Prevention Block Grant Planning Committee

4 APPENDIX

APPENDIX 4. Rhode Island Department Of Health's Excerpts From Action Plans And Strategic Plans Containing Community Representatives Participation In The Formulation Of Long Term Strategies

Heart Disease and Stroke Prevention, Rhode Island State Plan 2009

http://www.health.ri.gov/publications/plans/2009HeartDiseaseAndStrokePrevention.pdf

Steering Committee

American Heart Association/American Stroke Association
Blue Cross Blue Shield of Rhode Island
Brown University
Cardiovascular Research Center
Care New England Wellness Center
Chad Brown Health Center
Center for Hispanic Policy & Advocacy (CHisPA)
East Providence Fire Department
The Health & Wellness Institute
The Hospital Association of Rhode Island (HARI)
International Institute of Rhode Island
John Hope Settlement House
Kent Hospital
Lifespan Community Health Services
Johnston Fire Department
Memorial Hospital of Rhode Island
Mended Hearts Association
The Miriam Hospital
Narragansett Indian Health Center
Neighborhood Health Plan of Rhode Island
Newport Hospital
Newport Neurology
Quality Partners of Rhode Island
Rhode Island Department of Health (HEALTH)
Rhode Island Department of Administration
Rhode Island Free Clinic
Rhode Island General Assembly
Rhode Island Health Center Association (RIHCA)
Rhode Island Hospital
South County Hospital
St. Joseph's Health Services of Rhode Island
Warwick Fire Department
Women & Infants Hospital
Worksite Wellness Council of Rhode Island
YWCA of Northern Rhode Island

Preconception Health 2013-2015 Rhode Island Strategic Plan

http://www.health.ri.gov/publications/strategicplans/2013RhodeIslandPreconceptionHealth2015.pdf

Partners

American Academy of Pediatrics
Brown University
Comprehensive Community Action Program
Hasbro Children's Hospital
Kids Count
Lifespan
March of Dimes
Memorial Hospital
Neighborhood Health Plan of Rhode Island
Planned Parenthood of Southern New England
Providence Community Health Centers
Rhode Island College
Rhode Island Parent Information Network (RIPIN)
Rhode Island Prematurity Task Force
Tri-Town Health Center
Women & Infants Hospital
Women's Care
Women's Medical Center Rhode Island

Rhode Island Oral Health Plan, 2011-2016

http://www.health.ri.gov/publications/plans/2011OralHealth.pdf

Commission Members and Contributors

This list is accurate as of 2010.

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Dawn Wardyga, Family Voices at Rhode Island Parent Information Network
Joanne Wilbur, Rhode Island Dental Assistants Association
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Strategic Plan for Health and Wellness of Rhode Islanders with Special Needs, Disabilities and Chronic Conditions, 2013-2018

http://www.health.ri.gov/publications/strategicplans/2013-2018SpecialNeedsDisabilitiesAndChronicConditions.pdf

Disability Community Planning Group

Convened December 2012

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Laura Jones, Rhode Island Parent Information Network (RIPIN)
Kathy Kuiper, Rhode Island Parent Information Network (RIPIN)
Joanne Quinn, Autism Project
Lisa Schaffran, Rhode Island Parent Information Network (RIPIN)

State Agencies

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Carmen Boucher, Rhode Island Department of Health (HEALTH)
Paul Choquette, Executive Office of Health and Human Services (EOHHS)
Deborah Garneau, Rhode Island Department of Health (HEALTH)
Darren Kaw, Rhode Island Department of Health (HEALTH)
Laurie Leonard, Rhode Island Department of Health (HEALTH)
Barbara Mulligan, Rhode Island Department of Health (HEALTH)
Jo Ann Nannig, ORS
Colleen Polselli, Rhode Island Department of Health (HEALTH)
Corrina Roy, Rhode Island Department of Behavioral Health, Development Disabilities, and Hospitals (BHDDH)
Benvinda Santos, Rhode Island Department of Health (HEALTH)

Community agencies servicing people with disabilities

Dawn Brew
Kerry Burns, Serve Rhode Island
Janet M. Iovino, Sherlock Center

Rhode Island Cancer Prevention and Control, 2013-2018 Strategic Plan

http://www.health.ri.gov/publications/strategicplans/2013RhodeIslandCancerPreventionAndControl2018.pdf

Partnership To Reduce Cancer in Rhode Island

A Touch of Health Massage
AIDS Project Rhode Island
American Baptist Churches of Rhode Island
American Cancer Society
American Cancer Society Cancer Action Network (ACS-CAN RI)
American College of Surgeons
American Lung Association
Ann Porto, Psy.D. & Associates, Inc.
Blue Cross Blue Shield of Rhode Island
Body Kneads, Inc.
Caris Life Sciences
Community College of Rhode Island (CCRI) Therapeutic Massage Program
Chariho Task Force on Substance Abuse Prevention
CharterCare
City of Providence, Health Communities
Colors for a Cause
Connect CARRE
East Side Surgical Group
Eleanor Slater Hospital
Genral Dynamics – Electric Boat
Gloria Gemma Breast Cancer Resource Foundation
Governor's Commission on Disabilities
Hasbro Children's Hospital
Home and Hospice Care of Rhode Island
Hospital Association of Rhode Island (HARI)
Integrated Medical Weight Loss
Kent Hospital
Landmark Medical Center
Leukemia & Lymphoma Society
Lifespan
Lymph Care Rhode Island
Lymphoma Research Foundation
M.A.E. Foundation
Memorial Hospital of Rhode Island
The Miriam Hospital
National Ovarian Cancer Coalition

Neighborhood Health Plan of Rhode Island
Newport Hospital
Odyssey Hospice
Office of Rhode Island Senator Jack Reed
Our Lady of Fatima Hospital
Park View Counseling
Pawtucket Housing Authority
Pawtucket Prevention Coalition
Quality Partners of Rhode Island
Rhode Island Breast Cancer Coalition
Rhode Island Community Food Bank
Rhode Island Department of Health (HEALTH)
Rhode Island Department of Health, Tobacco Control Program
Rhode Island Department of Health, Women's Cancer Screening Program
Rhode Island Health Center Association
Rhode Island Hospital
Rhode Island Parent Information Network
Rhode Island Rehabilitation
Rhode Island State Nurses Association
Rhode Island Veterans Home
Rhode Island Department of Human Services Division of Elderly Affairs
Roger Williams Medical Center
Salgi Esophageal Cancer Research Foundation
Dierra Club
South County Hospital
Stella Amoah Cancer Foundation
Tobacco Free Rhode Island
UBS
University Dermatology
University of Rhode Island (URI)
Veteran's Administration Hospital
The Villa at St. Antoine
Visiting Angels
VNA of Rhode Island
Voices of Rhode Island – Colon Cancer Alliance
Westerly Hospital
Women & Infants Hospital
YMCA of Greater Providence
YWCA of Rhode Island

The Health of Rhode Island's Non-Metropolitan Communities

http://www.health.ri.gov/publications/reports/2012HealthOfRhodeIslandNonMetropolitanCommunities.pdf
November 2012

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Kim Pierson, the Providence Plan
Steve Sawyer, Rhode Island Department of Health (HEALTH)
Scituate Health Alliance
Kathy Taylor, Rhode Island Department of Health (HEALTH)
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Washington County Coalition for Children
YWCA Northern Rhode Island
VNS of Newport and Bristol Counties

Preventing Violence and injuries in Rhode Island, 2011-2016 Rhode Island Strategic Plan

http://www.health.ri.gov/publications/plans/2013InjuryPrevention.pdf

Injury Community Planning Group Steering Committee Structure

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Drug Overdose Prevention and Rescue Subcommittee Membership List

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Joseph Coffey, Warwick Police Department
Leslie Cohen, New England Addiction Technology Transfer Center (ATTC) Network
Cathy Cordy, Rhode Island Department of Health (HEALTH)
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Lori Dorsey, Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)
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Patrick Kelly, Rhode Island Department of Health (HEALTH)
Linda Mahoney, Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)
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Brandon Marshall, Brown University
Michelle McKenzie, The Miriam Hospital
Valeri Melekhov, Rhodes Technologies

Obad Papp, City of Providence
Beatriz Perez, Rhode Island Department of Health (HEALTH)
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Michael Rizzi, CODAC Behavioral Healthcare
George Stamatakos, Providence Police Department

The Falls Injury Prevention Subcommittee Membership List

This list is accurate as of October 2013.

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Shayne Donahue, Tri-town ElderCare
Susan Dugan, VNS of Newport and Bristol Counties
Jane Eskelund, Rebuilding Together
Catherine A. Gergora, Alliance for Better Long-Term Care
Cynthia Graves, West Bay Community Action Program/YMCA of Greater Providence
Celeste Harris, Coastal Medical, Inc.
Janice Hulme, University of Rhode Island Physical Therapy Program
Elaine Joyal, Memorial Hospital of Rhode Island
Edna Kurtzman, Bayside YMCA
Jennifer Lee, VNA of Care New England
Kelly Lockwood, Tamarisk Assisted Living Residence
Martha Machnik, YMCA of Greater Providence
Bob McManus, Providence Tai Chi
Amy Mochel, Federal Hill House Association
Beatriz Perez, Rhode Island Department of Health (HEALTH)
Lisa Piscatelli, YWCA Rhode Island
Gerry Plante, Safely Home
Vinny Quinterno, Office of the State Fire Marshall
Jennifer Reid, Executive Office of Health and Human Services (EOHHS)/Xerox State Healthcare, LLC
Rhonda Schwartz, Rhode Island Division of Elderly Affairs
Tara Treffry, Federal Hill House Association

TRAFFIC SAFETY COALITION

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Lloyd Albert, AAA Southern New England
Jennifer Andrade-Koziol, Rhode Island Department of Health (HEALTH)
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Sgt. Ann Assumpico, Rhode Island State Police (RISP)
James Barden, Rhode Island Department of Transportation (RIDOT)
Amanda Brezniak, Rhode Island State Police (RISP)
Sharon Brinkworth, Brain Injury Foundation
Gabe Cano, National Highway Traffic Safety Association
Col. Hugh Clements, Providence Police department
Nancy Devaney, Narragansett Prevention Partnership
Robert P Feltz, Volunteer
Mike Geraci, National Highway Traffic Safety Association
Kyle Girgan, Center for Southeast Asians
Sgt. Matthew Kite, Cranston Police Department
Joee Lindbeck, Office of the Attorney General
Francisco Lovera, Rhode Island Department of Transportation (RIDOT)
Mark Male, Independent Insurance Agents of Rhode Island
Despina Metakos, Rhode Island Department of Transportation (RIDOT)
Albert Milikian Jr., Community Advocate
Dina Morrissey, Injury Prevention Center
Anthony Napoli, Lifespan
Col. Steven O'Donnell, Rhode Island State Police (RISP)
Commissioner Steven Pare, Providence Public Safety Department,
Beatriz Perez, Rhode Island Department of Health (HEALTH)
Maj. Karen Pinch, Rhode Island State Police (RISP)
Steven Pristawa, Rhode Island Department of Transportation (RIDOT)
Dave Raposa, AAA Southern New England
Alison Riese, Lifespan
Bob Rocchio, Rhode Island Department of Transportation (RIDOT)
Jacinda Russell, Federal Highway Administration
Anthony Silva, Rhode Island Division of Motor Vehicles (DMV)
Gregory Smolan, Amica Insurance
Jay Sullivan, Office of the Attorney General
Richard Sullivan, Rhode Island Police Chief's Association
Sgt. Paul Zienowicz, Providence Police Department

Suicide Prevention Subcommittee Membership List

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Vernia Carter, Progreso Latino
Danielle Cote, Brown University
Chuck Cudworth, Rhode Island Student Assistance Services
Sarah Dinklage, Rhode Island Student Assistance Services
Christine Emond, Gateway Healthcare
Kimberly Gleason, American Foundation for Suicide Prevention
Jeffrey Hill, Rhode Island Department of Health (HEALTH)
Karyn Horowitz, Bradley Hospital
Elizabeth Kretchman, Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)
Faith LaMunyon, Rhode Island National Guard/Healthnet
Christine Miller, Beacon Hospice
Leigh Reposa, Rhode Island Student Assistance Services
Jean Russell, Johnson & Wales University
Rahila Saeed, Massachusetts and Rhode Island Poison Center
Sidra Scharff, The Samaritans of Rhode Island
Renee Shield, Brown University

Eat smart, Move more Rhode Island: A plan for Action 2010-2015

http://www.health.ri.gov/publications/actionplans/2010InitiativeForHealthyWeight.pdf

Eat Smart Move More Coalition

American Academy of Family Physicians, Rhode Island Chapter
American Academy of Pediatrics, Rhode Island Chapter
American Heart Association
Americhoice
Blue Cross Blue Shield of Rhode Island
Brown University
Channel One Central Falls and the Ralph J. Holden Community Center
Chad Brown Health Center
Chartwells Dining Services
Childspan
Farm Fresh Rhode Island
The Genesis Center
Governor's Commission on Disabilities
Harvard School of Public Health
Health and Wellness Institute
John Hope Settlement House
Johnson and Wales University
Kent Hospital, Kids Choose to Be Healthy
Kids First, Inc.
Lifespan
Local Initiatives Support Corporation
Memorial Hospital
Neighborhood Health Plan of Rhode Island
New England Coalition for Health Promotion and Disease Prevention
New England Dairy and Food Council
North Kingstown School Department
Office of Governor Lincoln Chafee
Physicians' Committee for Breastfeeding in Rhode Island
Primary Care Physicians' Corporation
Progreso Latino
Provant Health Solutions
The Providence Plan
Providence Community Health Centers
Rhode Island Association for Health, Physical Education, Recreation, and Dance
Rhode Island association of School Principals
Rhode Island Blueways Alliance

Rhode Island Breastfeeding Coalition
Rhode Island Association of Certified School Nurse Teachers
Rhode Island Community Food Bank
Rhode Island Department of Administration, Office of Statewide Planning
Rhode Island Department of Children, Youth, and Families (DCYF)
Rhode Island Department of Education (RIDE)
Rhode Island Department of Health (HEALTH)
Rhode Island Dietetic Association
Rhode Island Healthy Schools Coalition
Rhode Island Public Health Association
Rhode Island Public Transit Authority
Rhode Island State Nurses' Association
Shape Up Rhode Island
Southern Rhode Island Area Health Education Center
Southside Community Land Trust
University of Rhode Island (URI)
University of Rhode Island, USDA Food Stamp Education Program
United Healthcare of New England
Warwick Wellness Collaborative
Waterman Pediatrics
Wood River Health Services
Worksite Wellness Council of Rhode Island
YMCA of Greater Providence

5 APPENDIX

A Qualitative Assessment Of Community Health Needs and Concerns: Central Falls, Rhode Island

November 2013

In October, the Rhode Island Department of Health met with 96 residents and health care providers from the neighborhood of Central Falls to hear what their major public health concerns were. This meeting generated a wealth of commentary and concerns regarding the health and well being of their community. The following is an assessment of the content generated from this meeting. This report contains a summary of focus group commentary organized into general themes, followed by a closer look at each theme and the sub-topics within them. Accompanying each topic is a frequency measure, demonstrating the percentage of coverage each theme represents in the original focus group commentary.

As seen in Figure 1, a majority of responses focused on the need for more health services and increased access to health related education and information. These comments represent the community's desire for more health centers, health-related programs, and health education and information (Fig 2 & 3). The residents of Central Falls also expressed a desire for more community resources, specifically naming resources for physical activity, adult and youth activity programs, and projects or events involving the community as a whole (Fig. 4). Comments about health services, health education, and community resources stood out the most, particularly with ideas concerning an all-in-one type resource center. For example, many residents expressed interest in a community center where they could take exercise classes, get educational instruction on healthy cooking and eating, and collaborate in programs that educate on a wide variety of health topics.

Safety was another important theme represented in the commentary, with a majority of statements concerning safety in the general public and in schools, followed by safety concerns regarding drugs, alcohol, and cleanliness (Fig. 5). Comments about safety in schools were especially noticeable, possibly reflecting some of the violent events recently reported in the media. There were also expressed concerns for access to healthier foods, particularly regarding school lunches and increased access to farmers markets and community gardens (Fig. 6). Much of this commentary stood out as well, reflecting the community's desire for healthier and more affordable food options. Lastly, the least mentioned theme referenced concerns about employment and financial assistance (Fig. 7). The bulk of these comments reflected desires for more jobs and an increase in financial assistance and services for those in need.

Rhode Island is comprised of a variety of different communities, and each community differs in the needs and challenges they face. The overall health of a community profoundly relies on environmental, individual, and social conditions, and the voices of Central Falls reflected needs in each of these target areas. It is important to take into account the perceptions and concerns of a community's inhabitants in assessing their collective needs and areas of improvement. The people of Central Falls demonstrated this importance, providing a unified voice as to how and where their community could be improved.

Figure 1: General Themes

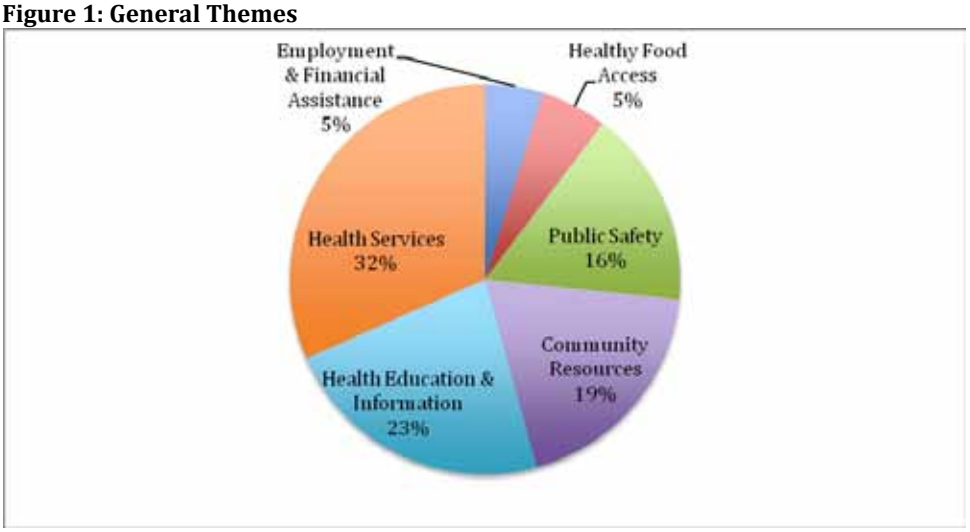


Fig. 2: Health Services Sub-Categories

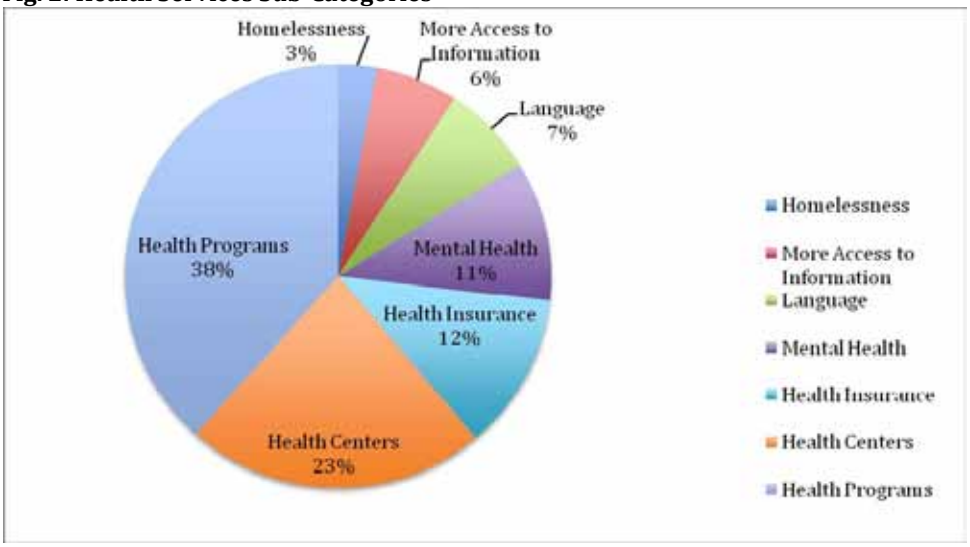


Figure 3: Health Education & Information Sub-Categories

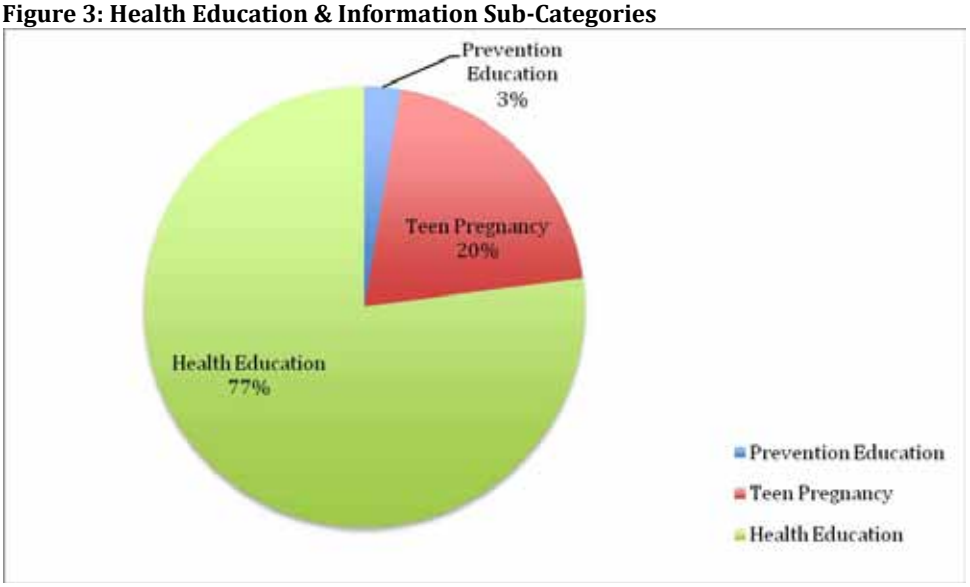


Figure 4: Community Resources Sub-Categories

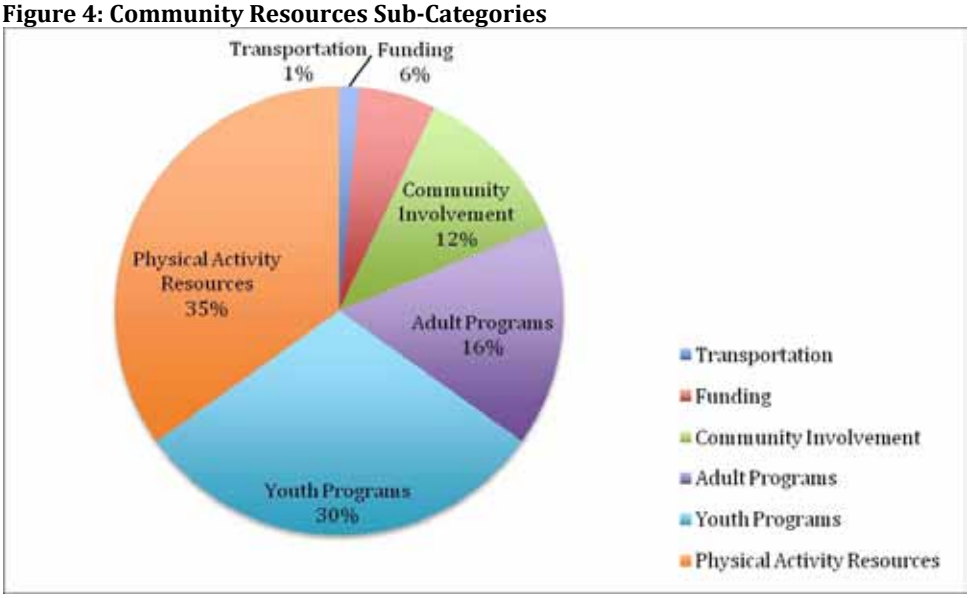


Fig 5: Safety Sub-Categories

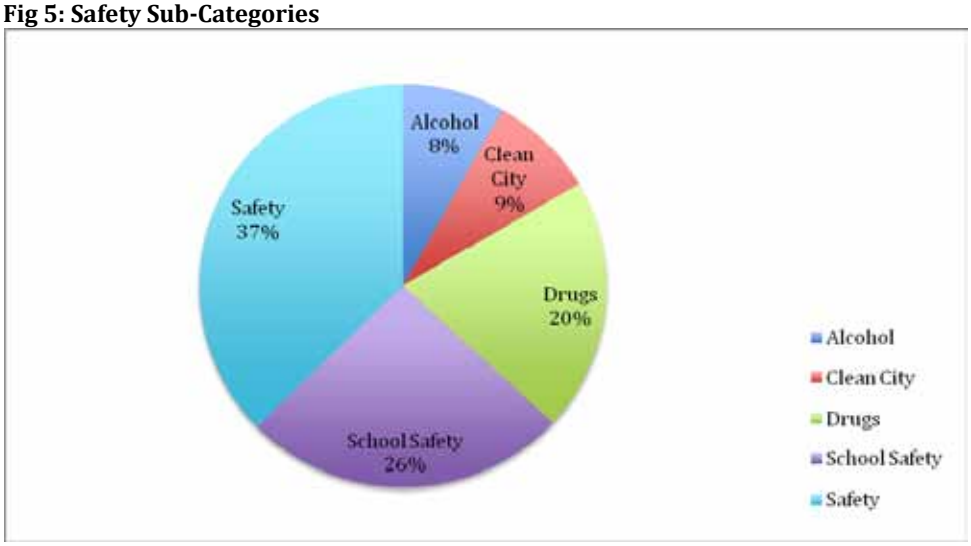


Figure 6: Healthy Food Access Sub-Categories:

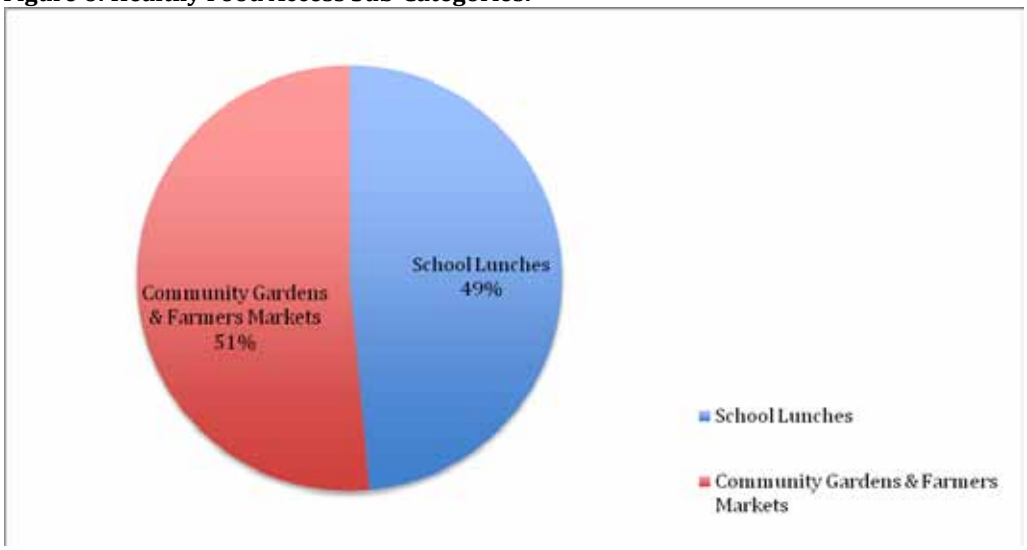
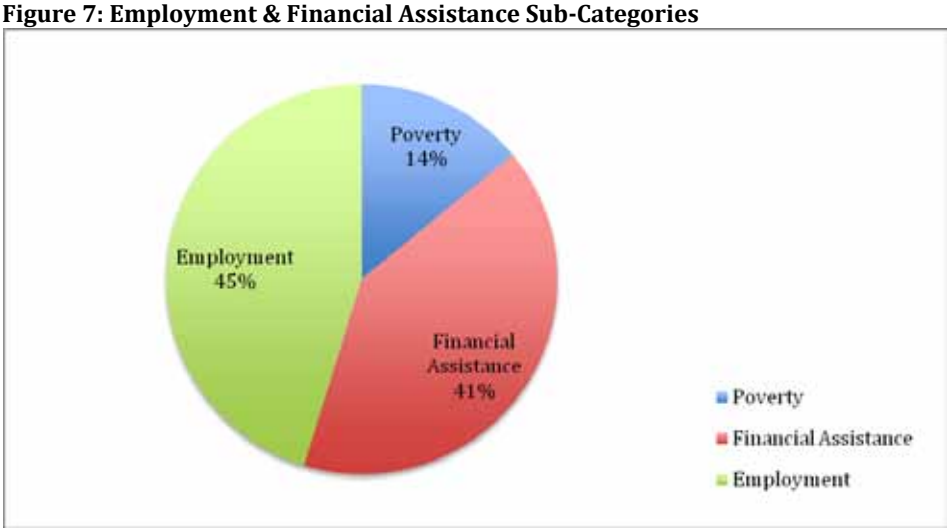


Figure 7: Employment & Financial Assistance Sub-Categories



6 APPENDIX

MAJOR HEALTH INDICATORS IN THE RACIAL AND ETHNIC MINORITY POPULATION OF RHODE ISLAND

Minority Health Facts




INTRODUCTION: This report provides information about major health indicators in the racial and ethnic minority population of Rhode Island, defined by the Office of Management and Budget* as:

- **American Indian or Alaska Native:** A person having origin in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Black or African American:** A person having origins in areas of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American".
- **Hispanic or Latino:** A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin", can be used in addition to "Hispanic or Latino".
- **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

This report presents data on socio-economic characteristics, morbidity and mortality, behavioral risks, infectious diseases, maternal and child health, and access to care among Rhode Island's racial and ethnic minority populations in comparison to the White and the overall state population. Please note that race and ethnic status for some Department of Health data sets are based on self-identification. Also, since the population of Native Hawaiian or Other Pacific Islanders is very small in Rhode Island, this group was combined with Asians for meaningful statistical analysis. All groups reported in this fact sheet are non-Hispanic unless otherwise indicated. The tables present point estimates which should not be used to imply statistical significance.

Directive 15, rev 1997

Population Demographics

The population of Rhode Island is becoming increasingly diverse. From 2000 to 2010, Rhode Island's minority population increased by 31.1% while the White (non-Hispanic) population decreased by 3.9%. Today, 23.6% of the state population is a racial or ethnic minority. The median age of Rhode Island's minority population (27.8 years) is lower than the median age for the overall state population (39.4 years). Also, a large percentage (93.9%) of the minority population is age 65 or younger as compared to 86% of the overall state population that is age 65 or younger.

From 2000 to 2010, Rhode Island's minority population increased by 31.1% while the White population decreased by 3.9%. Today, 23.6% of the state population is a racial or ethnic minority.

According to the US Bureau of the Census, 2010 Census:

» There are 130,655 Hispanics/Latinos living in Rhode Island, making this group the largest and one of the most diverse minority populations in the state (12.4%). Persons of Puerto Rican origin form the largest Hispanic/Latino population in Rhode Island, followed by Dominicans and Colombians. Nearly 98% of Hispanics/Latinos live in urban areas with the largest concentration of Hispanics/Latinos living in Providence, Pawtucket, and Central Falls. Approximately 85% of Hispanics/Latinos in Rhode Island older than the age of five speak a language other than English in their homes (usually Spanish). The median age for the Hispanic/Latino population is 26.0 years, and about 96% of the Hispanic/Latino population is age 65 or younger.

» There are 51,560 African Americans in Rhode Island, making this group the second largest minority population in the state (4.9%). Nearly 99% of African Americans in the state live in urban areas. The median age for the African American population is 29.0 years, and about 93% of the African American population is age 65 or younger.

» There are 30,293 Asians and Pacific Islanders living in Rhode Island. Approximately 2.9% of the Rhode Island population is of Asian descent, and about 0.03% is of Pacific Islander descent. 61.9% of the Asian and Pacific Islander population in RI was born in a foreign country. The median age for the Asian and Pacific Islander population is 30.3 years, and 94% of this population is age 65 or younger.

» About 4,020 Native Americans live in Rhode Island. Tribal affiliation is diverse, with more than ten tribes with more than 100 members and numerous others with fewer than 100 members. The Narragansett tribe holds the largest membership with over 2,000 people. Over 60% of the urban Native American population lives in Providence County. The median age for the Native American population is 26 years, and about 93% of the Native American population is age 65 or younger.

Socio-Economic Characteristics

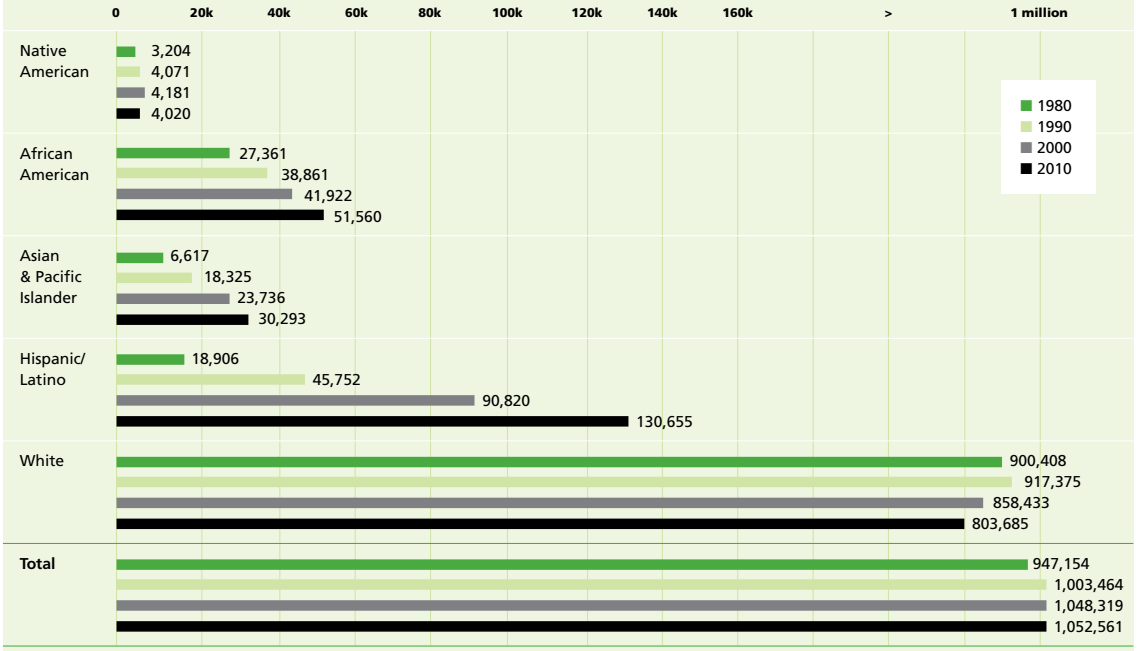
The following are socio-economic characteristics of Rhode Island's minority populations. These characteristics may affect the health of the minority populations living in Rhode Island. Except for the high school graduation rate, the socio-economic data source for Native Americans is the 2000 Census, while the data source for other ethnic groups and the state overall is the 2007-2009 American Community Survey 3-Year Estimates.

» The Asian population has a lower unemployment rate than all other minority groups and the overall state population.

» The Native American median household income and high school graduation rate are lower than those of all other minority groups and the state population overall.

» All minority groups have a higher percentage of their population living in poverty than the non-Hispanic White population or the state overall.

FIGURE 1. POPULATION OF MINORITY GROUPS, WHITES, AND STATE OVERALL IN 1980, 1990, 2000, AND 2010 IN RHODE ISLAND



Source: US Bureau of the Census, 2010

TABLE A: POPULATION DEMOGRAPHIC DATA

	HISPANIC/ LATINO[1]	AFRICAN AMERICAN[1]	NATIVE AMERICAN[2]	ASIAN & PACIFIC ISLANDER[1]	WHITE[1]	STATE[1]
Median age	26.0	29.0	26	30.3	42.6	38.9
Percentage of population younger than 18 years	35.8	30.7	36.7	25.5	18.5	21.8
Percentage of population age 65 years or older	4.3	6.8	7.1	6.0	16.6	14.1
Percentage of population born in another country	43.7	31.1	+	61.9	5.0	12.7
Percentage of population speaking only English at home	14.7	69.8	+	22.6	90.9	79.1

Sources: 1. US Bureau of the Census, 2007–2009 American Community Survey 3-Year Estimates
2. US Bureau of the Census, 2000
+ Data not available

TABLE B: SOCIO-ECONOMIC DATA

	HISPANIC/ LATINO[1]	AFRICAN AMERICAN[1]	NATIVE AMERICAN[2]	ASIAN & PACIFIC ISLANDER[1]	WHITE[1]	STATE[1]
Percentage of population living in poverty*	29.5%	23.0%	39%	15.9%	8.2%	11.9%
Percentage of population that is unemployed	10.0%	7.2%	6.5%	4.7%	4.4%	5.2%
Median household income**	$33.9K	$38.5K	$22.8K	$56.7K	$59.5K	$54.7K
High school graduation rate[3]	82%	86%	69%	89%	91%	89%

Sources: 1. US Bureau of the Census, 2007–2009 American Community Survey 3-Year Estimates
2. US Bureau of the Census, 2000
3. Rhode Island Department of Elementary and Secondary Education, 2006-2007 School Year

** The 100% federal poverty level for a family of 4 in 2008 was $21,200.*
***The median income is the middlemost amount which divides the incomes into two equal groups, half having incomes above the median and half having incomes below the median. Household income takes into account any wage earners who share a household regardless of relation.*

TABLE C: BEHAVIORAL RISK FACTOR INDICATORS (ADULTS 18 YEARS AND OLDER)

	HISPANIC/ LATINO	AFRICAN AMERICAN	NATIVE AMERICAN	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Percentage of adult population who participates in light to moderate physical activity for at least 30 minutes per day (2003, 2005, 2007)	35.8	45.7	59.1	38.1	51.9	50.3
Percentage of adult population (20 yrs+) who is overweight/obese[1] (2005–2008)	65.3	69.2	66.9	36.4	61.2	61.4
Percentage of adult population (20 yrs+) who is obese[2] (2005–2008)	26.0	30.1	29.1	12.2	21.6	22.2
Percentage of adult population who consumes at least 5 daily servings of fruits and vegetables (2003, 2005, 2007)	25.2	30.0	20.4	27.6	28.9	28.5
Percentage of adult population who smokes cigarettes (2005–2008)	14.6	17.8	34.0	12.4	18.6	18.4
Percentage of adult population who consumed 5+ drinks on one or more occasions in past month (binge-drinking) (2005–2008)	13.1	10.1	13.5	7.4	18.2	17.3

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

1. Overweight/obesity defined by the Centers for Disease Control and Prevention (CDC) as body mass index (BMI) ≥ 25
2. Obesity defined by CDC as BMI ≥ 30

TABLE D: LEADING CAUSE OF DEATH

RANK	HISPANIC/ LATINO	AFRICAN AMERICAN	NATIVE AMERICAN	ASIAN & PACIFIC ISLANDER	WHITE	STATE
1	Heart Disease	Heart Disease	Heart Disease	Cancer	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer	Heart Disease	Cancer	Cancer
3	Stroke	Diabetes Mellitus	+	Stroke	Chronic Respiratory Diseases	Chronic Respiratory Diseases
4	Perinatal Conditions	Stroke	+	Unintentional Injuries	Stroke	Stroke
5	Unintentional Injuries	Unintentional Injuries	+	+	Unintentional injuries Injuries	Unintentional Injuries

Source: Rhode Island Department of Health, Office of Vital Records, RI Resident Deaths, ICD-10 Codes, 2005-2009

+ Data too small for meaningful analysis

TABLE E: SELECTED INCIDENCE RATES OF INFECTIOUS DISEASES: CASES PER 100,000 POPULATION

	HISPANIC/ LATINO	AFRICAN AMERICAN	NATIVE AMERICAN	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Gonorrhea[1]	63.9	290.8	+	24.8	19.7	38.0
Chlamydia[1]	865	1525	+	368	146	300
Tuberculosis[2]	12.6	14.6	0	22.4	1.3	3.7
HIV/AIDS[3]	39.8	86.9	+	+	11.0	17.9

Sources: Rhode Island Department of Health, Division of Infectious Disease and Epidemiology
1. Sexually Transmitted Diseases (STD) Surveillance Data, 2007
2. Tuberculosis Database, 2005–2007
3. HIV/AIDS Surveillance Data, 2007

+ Data too small for meaningful analysis

Behavioral Risk Factors

The Hispanic/Latino population has the lowest percentage of adults participating in physical activity compared to all other minority groups and the overall state population.

Compared to the state and all other minority groups, Native Americans and African Americans have the highest percentage of adults who are overweight and obese. Asians and Pacific Islanders have the lowest percentages of overweight and obesity, lower than the overall state percentage.

African Americans have the highest percentage of fruit and vegetable consumption. Native Americans have the lowest percentage of the population that consumes at least five daily servings of fruits and vegetables.

The percentage of Native Americans who smoke cigarettes is the highest among minority populations and higher than the overall state population, while the percentages of Hispanics/Latinos and Asians and Pacific Islanders who smoke are lower than the state average.

All minority groups demonstrate lower percentages of binge-drinkers compared to the White population and the overall state population.

Mortality

The top five causes of death in the overall state population are heart disease, cancer, chronic respiratory diseases, stroke, and unintentional injuries. For some racial and ethnic minority populations, diabetes mellitus and perinatal conditions are ranked among the top five causes of death.

Chronic Diseases

Racial and ethnic disparities exist in health outcomes related to chronic diseases such as asthma, diabetes, heart disease, and stroke. For detailed reports of the burden of these chronic diseases on the health of Rhode Island residents and the disproportionate impact on the state's minority residents, visit the Rhode Island Department of Health website at www.health.ri.gov

Infectious Diseases

The rates of gonorrhea, chlamydia, and HIV/AIDS are significantly higher for African Americans than other minority groups and the overall state population. Note: This comparison excludes Native Americans in Rhode Island.

During 2005-2007, Asian and Pacific Islanders had the highest rate of tuberculosis. There were no known cases of tuberculosis among Native Americans from 2005 to 2007.

Maternal and Child Health

In general, both the White and the overall state populations have better maternal and child health outcomes than the racial and ethnic minority populations.

Higher percentages of all minority mothers receive delayed prenatal care compared to the White and the state populations overall.

Native American teens have the highest birth rates compared to all other groups.

Native Americans have the highest percentage of infants with low birth weight.

African American babies have the highest rate of infant mortality compared to all other groups.

African Americans and Hispanics/Latinos have the highest percentages of children living in poverty as compared to all other groups and the overall state population.

While we do not have data on the incidence of elevated blood lead levels for each minority group, the statewide incidence of elevated blood lead levels among children younger than age six decreased significantly from 2003 to 2008. Of note, the vast majority of lead poisoning occurs in core cities. (A core city is defined as any city where 15% or more of the children live in poverty. Current core cities are: Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.)

A higher percentage of Hispanic/Latino adults report having no health insurance compared to all other groups and the state population overall.

Access to Healthcare

A higher percentage of Hispanic/Latino adults report having no health insurance compared to all other groups and the state population overall.

A higher percentage of Hispanics/Latinos report having no ongoing source of healthcare compared to all other groups and the state population overall.

A higher percentage of Asians and Pacific Islanders report having no routine checkups within the past year compared to other minority populations and the overall state population.

A lower percentage of African American women aged 40+ report not having a mammogram in the past two years compared to women in all other populations.

A lower percentage of Hispanic/Latino women report not having a pap test in the past three years compared to women in the African American and overall state populations.

A higher percentage of Native American adults report being unable to see a doctor because of cost in the past year compared to adults in other minority populations and the overall state population.

Youth Risk Behavior

Hispanic youth are less likely to engage in marijuana use compared to the White and overall state populations.

Lower percentages of African American and Asian and Pacific Islander youth engage in binge drinking compared to the White and overall state populations.

Higher percentages of Hispanic and African American youth engage in sexual intercourse.

Minority youth are more likely to never or rarely use a seatbelt when in a vehicle driven by someone else.

TABLE F: MATERNAL AND CHILD HEALTH INDICATORS

	HISPANIC/ LATINO	AFRICAN AMERICAN	NATIVE AMERICAN	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Percentage of pregnant women with delayed prenatal care[1~]	21.6	24.1	23.9	25.4	13.5	15.5
Rate of births to teens ages 15-19 (per 1000 teens)[1]*	77.9	63.5	129.1	22.9	27.1	28.3
Percentage of births to mothers with less than 12 years of education[1]	36.5	23.2	35.7	14.3	14.2	16.6
Percentage of infants with low birth weight (<5.5 lbs)[1]	8.1	10.6	13.6	9.0	7.4	8.0
Infant mortality rate (per 1000 live births)[2]	7.7	12.8	+	10.4	5.5	6.3
Percentage of children in poverty (<18 years old)[3]	38.4	31.5	+	17.1	9.1	17.1

Sources: 1. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009
2. Rhode Island Department of Health, Center for Health Data and Analysis, 2005–2009 (births to mothers who are Rhode Island residents)
3. US Bureau of the Census, 2007-2009 American Community Survey 3-Year Estimates

+ Data too small for meaningful analysis

** Note: Rates of birth to teens aged 15–19 statewide are calculated using 2006-2008 American Community Survey Estimates; all race categories, excluding Whites, include Hispanic ethnicity.*

~ Delayed prenatal care is defined as beginning prenatal care in the second or third trimester or receiving no prenatal care at all.

TABLE G: ACCESS TO HEALTHCARE INDICATORS (ADULTS 18 YEARS AND OLDER)

	HISPANIC/ LATINO	AFRICAN AMERICAN	NATIVE AMERICAN	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Percentage of adults younger than 65 years old who reported having no health insurance (2005–2008)	31.1	12.5	23.8	5.4	6.4	9.3
Percentage of adults who reported having no specific source of ongoing healthcare (2001, 2006)	18.4	13.2	+	+	10.0	10.9
Percentage of adults who had no routine checkup within the past year (2005–2008)	25.1	17.8	26.9	31.5	19.5	20.2
Percentage of women aged 40+ who reported not receiving a mammogram in the past 2 years (2006, 2008)	18.0	15.8	+	+	16.4	16.7
Percentage of women who reported not having a pap test in the past 3 years (2006, 2008)	12.8	13.1	+	+	12.7	12.9
Percentage of adults who reported being unable to afford to see a doctor at least once in the past year (2005–2008)	27.1	13.3	29.4	16.5	7.8	10.0

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

+ Sample too small for meaningful analysis

TABLE H: YOUTH RISK BEHAVIOR INDICATORS (YOUTH IN GRADES 9–12)

	HISPANIC/ LATINO	AFRICAN AMERICAN	NATIVE AMERICAN	ASIAN & PACIFIC ISLANDER	WHITE	STATE
Percentage of youth who reported using marijuana one or more times during the past 30 days (2007, 2009)	19.5	22.5	+	+	26.8	24.9
Percentage of youth who reported engaging in binge drinking one or more days in the past 30 days (2007, 2009)	37.5	25.5	+	28.0	40.6	38.6
Percentage of youth who reported having engaged in sexual intercourse (2007, 2009)	51.3	54.7	+	35.4	42.3	45.0
Percentage of youth who reported smoking cigarettes or cigars or using smokeless tobacco (2007, 2009)	9.0	+	+	+	12.3	11.4
Percentage of youth who reported not engaging in physical activity for 60 minutes or more on 5 or more days in the past 7 days (2007, 2009)	68.4	59.0	+	63.1	53.5	56.9
Percentage of youth who reported never or rarely wearing a seatbelt when in a vehicle driven by someone else (2007, 2009)	20.0	19.1	+	17.0	10.5	13.2

Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System

+ Sample too small for meaningful analysis

2011 MINORITY HEALTH FACT SHEETS PREPARED BY:

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For more information regarding minority health and the statistics contained in this report, please contact:

TOPIC	CONTACT	TELEPHONE
Minority Health	Office of Minority Health	401-222-2901
Birth and Death Data	Office of Vital Records	401-222-2812
Behavioral Risk Factors, Access to Healthcare, Youth Risk Behavior, and Census Data	Center for Health Data and Analysis	401-222-7628
Infectious Diseases	Division of Infectious Disease and Epidemiology	401-222-2577
Maternal and Child Health	Division of Community, Family Health, and Equity	401-222-5115

www.health.ri.gov/programs/minorityhealth

SEPTEMBER 2011

7 APPENDIX

HOLLERAN
celebrating 20 years

HARI
Community Health Needs Assessment
Focus Groups Report:
Behavioral Health Issues

May 2013

BACKGROUND & METHODOLOGY

The Hospital Association of Rhode Island (HARI) and its member hospitals spearheaded a comprehensive Community Health Needs Assessment (CHNA) to better understand health issues impacting residents of Rhode Island. The CHNA included the following research methodologies:

1. Analysis of Rhode Island Department of Health BRFSS Household Survey Data
2. Secondary Data Profile
3. Key Informant Surveys
4. Focus Groups
5. Prioritization of Community Health Needs

Holleran, a research and consulting firm based in Lancaster, Pennsylvania and specializing in CHNAs, was contracted to conduct the research and reporting.

Holleran conducted two focus groups on March 26, 2013, with 21 Mental and Behavioral Health Care professionals. Both Focus Groups were held at Butler Hospital in Providence, Rhode Island. Focus Group participants were recruited by HARI and its member hospitals. A list of participants is included as Appendix A. The discussion guide is included as Appendix B.

The aim of the Focus Groups was to identify mental and behavioral health needs throughout Rhode Island. Focus group participants discussed Rhode Island's challenges and successes in providing care to residents with mental health needs. Special populations, access to care, community perception, emerging trends, and recommendations were discussed. The following report outlines specific responses and themes. A conclusion summarizes the findings.

SPECIAL POPULATIONS

Focus participants identified the following populations as being underserved with regard to receiving behavioral health services in Rhode Island:

- Children and Youth
- Older adolescents (18-21 year olds)
- Elderly
- LGBTQ community
- Homeless
- Underinsured/Uninsured
- Families with generational mental health needs Cambodian, Laos, Latino/Hispanic
- Post Incarcerated
- Non-English Speaking Individuals

Additionally, participants recognized that there were special populations, based on mental health diagnoses, which were in need:

- Individuals with co-occurring substance abuse and mental health issues
- Individuals with co-occurring chronic illness and mental health issues
- Youth with substance abuse issues
- Individuals with Developmental disorders
- Complex personality disorders in young people
- Individuals with PTSD or trauma histories
- Individuals diagnosed with disorders on the Autism Spectrum
- Deaf and hard of hearing individuals

Concerns mentioned with the above populations include the continued stigma associated with mental health issues and the hesitation and/or refusal to seek services; the denial that care is needed; the limited resources and number of providers who are specialize in treatment; and the high cost of receiving services.

Mental health concerns are among the top diagnosis codes for ED visits. Participants shared that homeless individuals make up "a disproportionate amount of ED admissions." Others added, "Many are repeat users;" "About 35% of the homeless are uninsured." "They are less likely to follow

up on care because they struggle to navigate the system." Transportation is a major barrier." "Seventy-five percent have substance abuse issues."

Respondents noted an increase in Post-Traumatic Stress Disorders (PTSD) and recognized that many residents have anxiety and depression related to socio-economic factors, including the economic downturn. A specific concern was that residents with these diagnoses were suffering in silence, and may be self-medicating with prescriptions, over the counter medications, or medications belonging to others.

The geriatric population was a population the informants saw as often overlooked in the community. Concerns existed about suicide rates with older individuals as well as "disguised drug overdoses," hoarding, and isolation. The elderly population with behavioral health needs may not be receiving the care they need in nursing homes. Behaviors can escalate to the point of needing to go to a hospital Emergency Department (ED). Once elderly patients are admitted to the ED for mental health needs, they may not be readmitted back to their nursing home.

Parents have particular challenges in finding behavioral health care for their children. When care is found, getting to appointments is a barrier based on socio-economic issues such as transportation, time off of from work, and finding child care for other family members. "In many instances, behavioral health needs are generational. The parents need help, too." Family therapy was seen as a gap in the available services.

Growth with substance abuse issues was also identified. Participants thought that mental health and substance abuse issues are intertwined. Participants observed that substance abuse among adolescents and young adults in Rhode Island has increased with the use of prescription medications and mixing multiple substances such as alcohol, pills, energy drinks, and herbal supplements.

"There is no system to treat children and adolescents with substance abuse issues."

Of particular concern was the increased use of "Bath Salts," a street drug made of a variety of unknown compositions and chemicals which produce amphetamine-like reactions, as well as psychotic behaviors. A shared concern was the legal sale and availability of these substances. "When one ingredient is deemed to be illegal by the FDA, they just replace that one and it is back on the shelves."

Due to the mass availability and popularity of the substance, an increase in overdose cases presenting at the ED was reported by focus group participants.

One respondent said, "When they present at the ED, we're not sure what was taken. Another added, "We can't screen for bath salts."

Traditional illicit/recreational drugs, such as marijuana, cocaine, opiates, and heroin, are also prevalent in the community. Participants agreed that there is often an underlying mental disorder that is "unmasked" by use of drugs or alcohol.

Some participants shared concerns about what was perceived as the "overprescribing of stimulants for youth with cognitive disorders." Specifically, the increase of primary care physicians prescribing Benzodiazepines and ADHD stimulant mediations. "At the risk of offending some of my colleagues, I don't think primary care providers should be prescribing [these drugs]." Participants were concerned that prescriptions were not always monitored. Others were concerned that thorough diagnostic screening and testing is not completed to justify the prescription need. Related, one participant noted that insurance does not cover other treatments for cognitive behavior treatment, resulting in broad use of prescription treatment.

ACCESS TO CARE

The focus group participants agreed that the barriers to accessing behavioral healthcare in Rhode Island are coordination of service, timeliness, availability of services, and cost of receiving treatment.

Coordination of Services

Residents receive information about available mental health services through a variety of sources. Primary care providers, social service agencies, and schools were the main referral sources, followed by friends and family.

The participants agreed that the community needed an up-to-date electronic system for resources. "There was a printed directory, but it is out of date as soon as it is printed." School representatives shared challenges with connecting students to community services. "We are required to provide a list of three providers. When no one on the list is accepting patients, parents get frustrated and give up." Another issue is "we never know if they actually get the care." The participant explained that in the past the school nurse would call and set up the appointment, but they can no longer do that.

Participants acknowledged that some "pockets of coordination exist" that we could use to build a better model.

Providers in hospital Emergency Departments have similar challenges referring patients to services. "The system is totally opaque to us. We should know who has 'beds' available. The system totally shuts down on the weekend. If someone comes to ED on Friday, you can bet they will be there until Monday morning when we can find them a bed."

Another said, "There is no progressive flow. Patients come in through ED, they are discharged to outpatient services, and then they go to a group home. If they end up back in the hospital, instead of going back to the group home, they start the process over. It's a perpetual cycle."

"The insurance companies authorize lowest level of care first." "They won't authorize detox until person has failed in other level of care." "People who need inpatient care are only authorized for outpatient." "Our hands are tied in knots."

One example of success that was given was an initiative at Women & Infants Hospital to address postpartum depression in new mothers. "We get referrals because we exist," said one representative. "Before we had this program, [physicians] were afraid to 'ask the question.' Now they know where to refer patients, so they do."

Time Factors

Focus group respondents saw timeliness as one of the key factors in delivery of mental health services. They described long lag times until some patients can get an appointment with a behavioral health provider. Lag time varied by specialty and geography.

When patients cannot get an appointment with a provider, they often use the ED for crisis situations, as well as prescription refills. Others go without the care they need.

Patients can remain in the ED for days "until a bed opens up for them." One respondent offered that, "A measure of success of the whole system is how long the ED is holding for referrals." Participants said that EDs can "hold" a patient for three to seven days before a program can be identified to transfer the patient to.

Another time factor is the duration of treatment. Many patients need treatment for years. Focus group participants noted that cost, insurance, and other "navigation" barriers prevent patients from receiving uninterrupted care to promote optimal health.

Providers also recognized that insurance standards reduced the number of days a patient can receive inpatient treatment. "Insurance moved from 10- to 12-day stay with proven success to a two- to three-day stay to cut costs."

Availability of Services

Respondents reported that there is a shortage of mental health professionals to meet the need. While the state physician ratios reflect adequate coverage and a decrease in utilization, participants thought those statistics may be misleading.

One participant described getting an initial appointment with a behavioral health professional as a "herculean effort." Another stated that, "You can't shoe-horn somebody into the hospital for inpatient if you tried."

Some participants thought that many psychiatrists "do not take a lot of the big insurances." "There's a lack of providers who accept the insurance people have." One participant blamed "bureaucracy" for the problem. "They changed the rules. I can't take Medicaid patients if I wanted to."

The need for more psychiatrists was seen as a particular challenge. "Follow-up appointments can be backlogged two to three months." "Patients go to hospital to get their meds filled because they can't get an appointment with a psychiatrist."

One participant suggested, "Reimbursement rates are low in Rhode Island. It makes it hard to recruit doctors, specialists, especially psychiatrists." Another added, "Psychiatrists in this area want to work in Boston." "It's difficult for outpatient providers to function out of the red"

Geography was seen as a determinant for availability of care. "The larger metro areas have better patient to physician ratios, and meet quotas, but the availability isn't appropriately disseminated." Providence, Newport, and Westerly were seen to have more availability of providers.

"If you live in South County, there are less providers and transportation is a barrier." Another added, "Even though it's a small state, 'you can't get there from here.'"

Other concerns with availability are the lack of care for children with substance abuse issues. "We will never have enough professionals to treat all the kids that need mental health."

Participants voiced concerns about the availability of supportive housing for patients. "There is a six to eight month's wait for a group home."

Cost

Cost is a barrier for many residents who need mental health services. Public assistance is available for some, "but not if you are diagnosed with a substance abuse disorder." If an individual has a serious and persistent mental illness (SMI), there is difference in their insurance coverage than those with a first-time diagnosis, or less severe mental illness.

Some thought it was easier for those who were uninsured to receive services. Copays for providers were seen as a barrier for those with private insurance. Residents are choosing to see only their counselor or their psychiatrist because they are unable to pay for both visits. Or, they schedule appointments less frequently than medically necessary. The ED remains a safety net for those that cannot afford care.

Due to cost, some varied and specific levels of care for mental health, such as residential treatment or partial hospitalization, have been reduced or cut. State funding for inpatient beds is "going away." "The ripple effect is there are limited uninsured beds to go around."

Specialty providers may not accept any insurance, and are only accessible to those with resources to pay out of pocket. Other providers who accept insurance may not be paneled to collect Medicare/ Medicaid reimbursement.

Providers in the group said they are seeing reductions in their reimbursements due to documentation issues and confusion. They shared that the coding for procedures recently changed. Documentation of care is more specific to receive the maximum reimbursement. The process is long, cumbersome, and not clearly defined by all payers. These procedures are seen as a burden and as taking time away from providing care to patients.

COMMUNITY PERCEPTION

Focus Group participants discussed the community's perception of mental health issues and the overall knowledge and understanding of the varied degrees of mental illness.

Respondents commented that many community residents and entities deny mental illness as existing or being their responsibility. Stigma continues to be prevalent among some residents, especially working class communities and older residents. "We had the benefit of Patrick Kennedy who helped break down stigma by discussing his personal battles but that only helped a little bit".

Community residents may not recognize the signs and symptoms of mental health conditions. Some participants shared that there was a community "expectation of stress and anxiety" due on personal circumstances such as unemployment or homelessness and perpetuating the misperception that "it is not a real problem."

Primary/ Secondary school systems were identified as a strength area for Rhode Island in helping to reduce stigma and improve mental health care. One respondent noted that there had been a successful program in the schools which taught students to identify if peers needed mental health interventions. "Students used to bring their friends to the nurse if they suspected a problem." The program was successful, but funding for the program was cut.

Participants reported that some colleges are "intolerant of mental health." The perception is "we don't have that here." Respondents thought that colleges' fears of mental health conditions leading to violence made them less tolerant. Some thought colleges may be more concerned with their reputation than student care.

EMERGING TRENDS AND RECOMMENDATIONS

Participants discussed emerging trends related to mental health. Tele-psychiatry and the integration of primary care and mental health care were seen as a positive direction to reduce barriers to identifying and providing care.

The group recognized the relationship between mental and physical health, noting the prevalence of mental health as a co-morbidity factor to chronic disease. "People with serious mental illness (SMI) die 25 years earlier than the rest of the population." A recommendation was made to automatically screen patients treated for heart disease, diabetes, and other chronic conditions for co-occurring mental health conditions.

Using technology to reduce paperwork and improve coordination of care was recommended. "We need electronic admissions. We still have to fax huge paper applications to get patients admitted to a program."

An electronic inventory for available programs and services, as well as inpatient beds was seen as a top priority. "We need to know what beds are available and have access to the system 24/7." "We need an 'Open Table' app for mental health programs."

Providing patient navigators, help with transportation to care, increased office hours, and community-based services was seen as a way to break down barriers to accessing care.

Respondents were pleased with past and current efforts in the schools and recommended the continuation of policies, training, education, and support services to meet the needs of students at school. School-based mental health professionals and expressive art therapies such as music therapy were seen as successful ways to identify and provide services to youth.

Participants thought that more advocacy is needed. "There is the perspective that there is waste in system." Successful programs are being cut because providers and families don't have time to do advocacy."

Another recommendation was to identify less costly ways to provide services. "The ED is the most expensive treatment option." One respondent cited the ANCHOR Recovery Community Center (specializing in substance abuse recovery) in Pawtucket. "Two inpatients for 365 days would fund 150,000 visits to Pawtucket."

Encouraged by the dialogue of the focus group, and opportunity to increase dialogue among health providers, referral sources, community agencies, and others, the participants suggested a state-wide mental health summit to further explore issues and opportunities.

CONCLUSIONS

Focus group participants discussed Rhode Island's challenges and successes in providing care to residents with mental health needs. Special populations, access to care, community perception, emerging trends, and recommendations were discussed.

Adolescents, the elderly, homeless individuals, and those who do not speak English were seen as some of the most underserved populations when it came to mental health needs. Of particular concern is increased substance abuse, especially among adolescents, and the co-occurring diagnosis of mental illness and substance abuse.

Challenges with accessing care included lack of insurance and ability to afford care, as well as provider reimbursement rates and acceptance of insurance. Coordination of services within the system needs to be improved to create a transparent system where providers can easily provide referrals to the appropriate level of care in an efficient and expedient manner.

Stigma, as well as the recognition of signs and symptoms of mental health conditions, continues to be a barrier to treatment. Recommendations were made to continue to explore the integration of primary care and mental health, as well as regular mental health screening of patients with chronic conditions.

Continued collaborations between schools and community-based services were seen as successful and in need of additional support. Advocacy to ensure continued funding successful programs is needed.

A shift from payer-led treatment plans to provider-led treatment plans would enable the appropriate level of care and likely cut costs in the end. Providers feel as though "their hands are tied" when it comes to providing the best treatment for patients.

Participants, encouraged by the dialogue with a cross-section of providers, referral sources, and community agencies, suggested a state-wide mental health summit to further explore issues and opportunities.

APPENDIX A: FOCUS GROUP PARTICIPANTS

Name	Title	Agency
Tom Allen	LICSW, Director, Outpatient Addiction Medicine & Behavioral Health Social Work	Roger Williams Medical Center
Fay Baker	LICSW, Director, Project Implementation and Acute Care Services	The Providence Center
Susan Bruce	LICSW	
Gary Bubly	MD, Director, Department of Emergency Medicine	The Miriam Hospital
Joseph Dziobek	President & CEO	Fellowship Health Resources
Charlene Elie	RN, Chief Nursing Officer	Landmark Medical Center
Peter Erickson	PhD	
Dr. Roberta Feather	Marriage and Family Counseling	Private practice
Diane Ferreira	RN, Director of Social Services	Butler Hospital
Robert Hamel	RN, Director of Psychiatric Partial Hospital Psychiatric Services	Butler Hospital
Margaret Howard	PhD, Director of Post-Partum Depression Day Hospital	Women & Infants Hospital
Sue Jameson		VNS Home Health Services
Dale K. Klatzker	President & CEO	The Providence Center
Rich Marwell		Eleanor Slater Hospital
Sally Mitchell	PsyD	
Caroline Obrecht	LICSW	
Deborah O'Brien	Vice President & COO	The Providence Center
Francis Paranzino	Vice President & COO	Newport County Community Mental Health Center
David Robinson	Office of Primary Care and Rural Health	Rhode Island Department of Health
Lisa Shea	MD, Deputy Medical Director	Butler Hospital
Curt Wilkins	Director of Social Services	Landmark Medical Center

APPENDIX B: FOCUS GROUP DISCUSSION GUIDE

DISCUSSION QUESTIONS

First, I want to learn about the infrastructure that supports Mental and Behavioral Health Services in Rhode Island.

1. What kinds of mental health and behavioral health issues do you see among Rhode Island adults? Among youth?

2. What kinds of substance abuse or addiction problems do you see among Rhode Island adults? Among youth?

3. How would you describe the community's attitude toward mental health and behavioral health services? Toward substance abuse or addiction problems?

4. How do people get connected to mental/behavioral health services? What/who are typical referral sources?

5. How do residents learn about services in the community? Are people aware of existing resources and services available to help them address mental and behavioral health needs?

6. Do some populations have a more difficult time accessing services? Why or why not?

Delivery of Services

7. In your opinion, are there enough mental and behavioral health providers in the state? *Probes: Are there differences between city center and rural locations? Do people have to travel to access services?*

8. What mental and behavioral health resources or services are missing in the community?

9. How can community referral sources and providers improve awareness of services, access to care, and care coordination?

10. What (other) recommendations do you have to improve the delivery of mental/behavioral health services?

Emerging Trends in Care/Needs

11. Are there new, emerging issues or trends in mental health that providers and community members should have on their radar?

12. Are you seeing a difference in the population(s) in need of services?

HARI

Community Health Needs Assessment

Key Informant Report

February 2013

HOLLERAN

BACKGROUND

Hospital Association of Rhode Island and its member hospitals (Care New England, CharterCARE, Kent Hospital, Landmark Medical Center, Memorial Hospital of Rhode Island, South County Hospital, Westerly Hospital) spearheaded a comprehensive Community Health Needs Assessment to evaluate the health needs of individuals living in the state of Rhode Island. The purpose of the assessment is to gather information about local health needs and health behaviors.

As part of the assessment, Hospital Association of Rhode Island contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct a Key Informant Study with community stakeholders. Holleran staff worked closely with Hospital Association of Rhode Island to identify key informant participants and to develop the online Key Informant Survey Tool. A copy of the questionnaire can be found in Appendix A. The questionnaire focused on gathering qualitative feedback regarding perceptions of community needs and strengths across 3 key domains:

- Key Health Issues
- Health Care Access
- Challenges & Solutions

A total of 49 interviews were conducted by Holleran's teleresearch center during December 2012 and January 2013. Study participants represented a variety of sectors including public health and medical services, non-profit and social organizations, children and youth agencies, faith-based organizations, and the business community. Select demographics for the key informants can be found in Appendix B. It is important to note that the number of completed surveys and limitations to the sampling method yield results that are directional in nature. Results reflect the perceptions of a sampling of community leaders in Rhode Island.

Hospital Association of Rhode Island and its partners will use the results of the Key Informant Study in conjunction with Behavioral Risk Factor Surveillance System (BRFSS) data and focus group discussions to identify key community health issues and ensure hospital community benefit initiatives are aligned with those needs.

Key Health Issues

The first section of the survey focused on the key health issues facing the community. Individuals were asked to select the top three health issues that they perceived as being the most significant. The three issues that were most frequently selected were:

- Access to Health Care/Uninsured/Underinsured
- Mental Health/Suicide
- Overweight/Obesity

The following table shows the breakdown of the percent of respondents who selected each health issue. Issues are ranked from top to bottom based on number of participants who selected the health issue as one of their top three issues. The first column depicts the total percentage of respondents that selected the health issue as one of their top three. Respondents were also asked of those health issues mentioned, which one issue is the most significant. The second column depicts the percentage of respondents that rated the issue as being the most significant health issue.

Table 1: Ranking of Key Health Issues

Rank	Health issue	Percent of respondents who selected the issue	Percent of respondents who selected the issue as the most significant
1	Access to Health Care/Uninsured	82%	41%
2	Mental Health/Suicide	47%	16%
3	Overweight/Obesity	39%	10%
4	Substance Abuse/Alcohol Abuse	29%	4%
5	Diabetes	24%	8%
6	Maternal/Infant Health	20%	2%
7	Heart Disease	12%	2%
8	Cancer	10%	2%
9	Aging & Caregiving Issues	8%	8%
10	Dental Health	8%	0%
11	Stroke	6%	0%
12	Sexually Transmitted Diseases	2%	0%
13	Tobacco	2%	0%

Figure 1 shows the key informant rankings of all the key health issues. The bar depicts the total percentage of respondents that ranked the issue in their top three.

"What are the top 3 health issues you see in your community?"

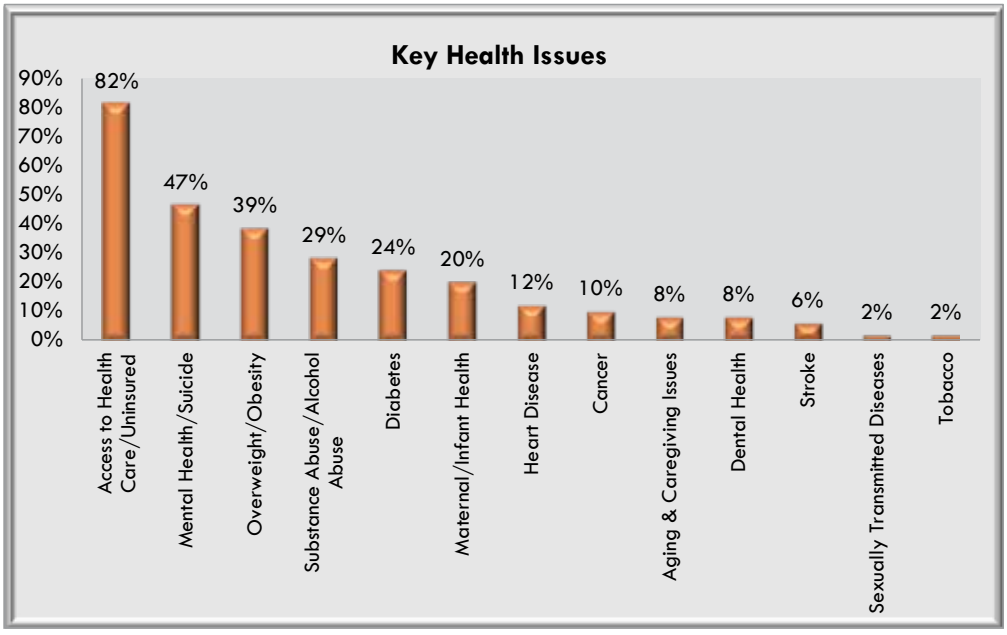


Figure 1: Ranking of key health issues

An 'other' option was provided to allow respondents to select an issue that was not on the list. Other key health issues that were specified include:

- Childhood Asthma
- Teenage Pregnancy
- Poverty/Health Disparities

After selecting the top three issues, respondents were asked to share any additional information regarding the health issues they selected and reasons for their selections. The following section provides a brief summary of the key health issues and highlights related comments.

Access to Health Care was the most frequently selected health issue with 82% of informants ranking it among the top three key health issues. 41% of informants ranked it as the most significant issue facing the community.

Select Comments related Access to Health Care Issues:

- *"Access is a priority because we have a significant number of people in Rhode Island who have no health care access and who are using the emergency room as a primary point of care."*
- *"We are confronted with overcrowding in our emergency rooms and it has to do with lack of access to primary care services or other services in the community."*
- *"We're a community health center that serves the underinsured and the uninsured. Almost 50% of our patient population is uninsured. We can only do so much for them, and inevitably they need specialty care. It could be a year for them to be seen. It's a system that's broken and really needs some work."*
- *"In Rhode Island, we have still have about 140,000 uninsured folks. Community health centers are seeing increasing numbers of uninsured people. These folks have incredible barriers to accessing Specialty Care."*
- *"Health care costs are rising across the spectrum and the cost of health care coverage has been increasing dramatically."*
- *"Access is a critical issue because families, children, and individuals cannot get the services they need especially when they don't know where to get information and when they don't meet the narrow criteria for assistance programs."*
- *"The gateway to all other health and wellness care is whether or not you have health coverage."*

Mental Health/Suicide was the second most frequently selected health issue with 47% of informants selecting it among the top three key health issues. 16% of respondents ranked mental health as the most significant issue facing the community. Respondents indicated that the resources available for the treatment of mental health issues are insufficient.

Select Comments related to Mental Health:

- *"A lot of the folks we see are in need of mental health services for depression and anxiety, but it's hard to make referrals to get people the services they need."*
- *"We see a number of people in Woonsocket who exhibit mental health concerns who are struggling with access to care and with substance abuse issues."*
- *"It's very difficult to get psychiatric or psychological care in the community so people with mental health issues end up presenting in the emergency room."*

- *"Rhode Island has been identified as the state with the highest incidence of admitted suicide idealization. We know that there are many mental health needs out there that need to be met, but the resources are very limited."*
- *"There are significant gaps in children's mental health services."*
- *"Mental health is incredibly important. There are far too many children and teenagers that have untreated mental health problems that lead to other problems with education, getting involved in crime, or harming themselves through suicide."*
- *"We see lots of uninsured people who have both serious mental health and substance abuse disorders. There are not a lot of places to go if you're uninsured. We have to try to do the best we can without any resources to see them."*

Overweight/Obesity was the third most frequently selected health issue with 39% of informants ranking it among the top three key health issues. 10% of informants ranked Overweight/Obesity as the most significant issue facing the community. Respondents feel that reducing obesity can lead to improvements in many of the other key health issues identified in Table 1.

Select Comments related to Overweight/Obesity:

- *"Nationally, we're headed for big trouble with obesity. We also have high obesity rates in our community."*
- *"We have a lot of obesity in Rhode Island. People eat a lot of processed foods, too much meat, and not enough vegetables and that leads to chronic diseases like Diabetes, Heart Disease, and Heart Attacks."*
- *"Obesity is a common denominator for many of the illnesses that we must address as care providers. It contributes to diabetes, heart disease, high blood pressure, and even some cancers. If we can make a difference there, we might be able to make a difference in with other health issues."*

Substance Abuse/Alcohol Abuse was the fourth most frequently selected health issue with approximately 29% of key informants ranking it among the top three key health issues. Many informants that people with mental health issues often have substance abuse issues as well.

Select Comments related to Substance Abuse/Alcohol Abuse:

- *"According to federal statistics from the Substance Abuse & Mental Health Services Administration, Rhode Island is number one in categories that we don't want to be number one in like use of illicit drugs."*
- *"Adolescent addiction is a growing concern. We have one of the highest rates of addiction among the teen population and younger people in the country."*
- *"Behavioral health and substance abuse drive a lot of unnecessary emergency room utilization in the communities we are in. There is a lack of capacity to treat those patients. We are overwhelmed and the community mental health organizations are not capable of meeting the demand."*
- *"Alcohol has permeated the culture here and I think it's really excessively used. I also see many people who are drug dependent on prescription medication and illicit drugs."*
- *"There's a high volume of people who have been touched by substance abuse directly or who have grown up in a substance abusing household. We operate a homeless shelter and child welfare services so we see it quite regularly there."*

ACCESS TO CARE

The focus group participants agreed that the barriers to accessing behavioral healthcare in Rhode Island are coordination of service, timeliness, availability of services, and cost of receiving treatment.

Coordination of Services

Residents receive information about available mental health services through a variety of sources. Primary care providers, social service agencies, and schools were the main referral sources, followed by friends and family.

The participants agreed that the community needed an up-to-date electronic system for resources. "There was a printed directory, but it is out of date as soon as it is printed." School representatives shared challenges with connecting students to community services. "We are required to provide a list of three providers. When no one on the list is accepting patients, parents get frustrated and give up." Another issue is "we never know if they actually get the care." The participant explained that in the past the school nurse would call and set up the appointment, but they can no longer do that.

Participants acknowledged that some "pockets of coordination exist" that we could use to build a better model.

Providers in hospital Emergency Departments have similar challenges referring patients to services. "The system is totally opaque to us. We should know who has 'beds' available. The system totally shuts down on the weekend. If someone comes to ED on Friday, you can bet they will be there until Monday morning when we can find them a bed."

Another said, "There is no progressive flow. Patients come in through ED, they are discharged to outpatient services, and then they go to a group home. If they end up back in the hospital, instead of going back to the group home, they start the process over. It's a perpetual cycle."

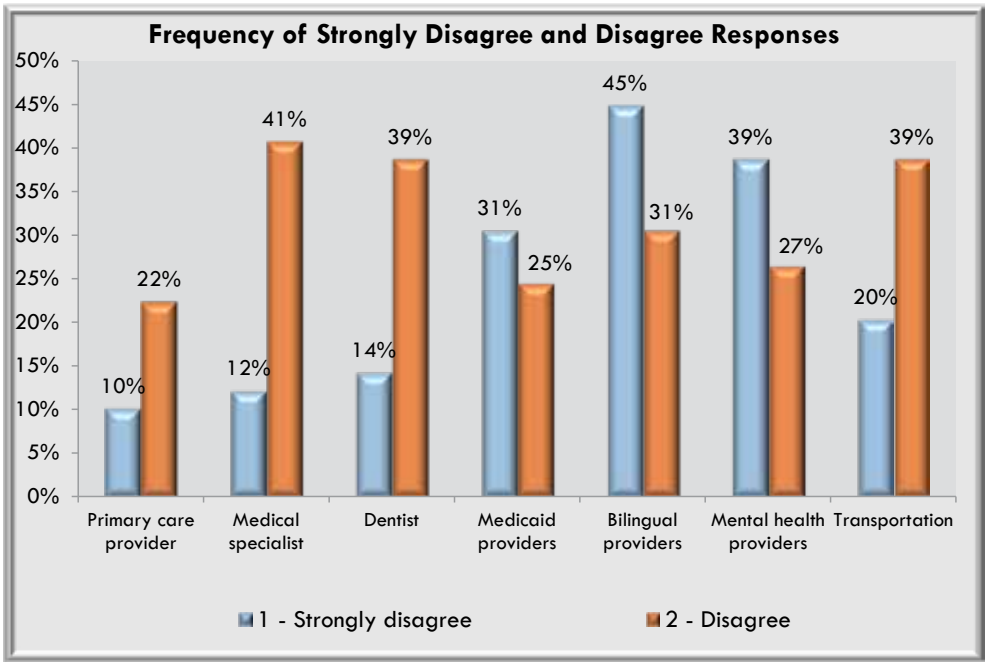


Figure 2: Frequency of disagree and strongly disagree responses for health care factors

Barriers to Health Care Access

After rating availability of health care services, the informants were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The barriers that were most frequently selected were:

- Lack of Health Insurance Coverage
- Lack of Transportation
- Inability to Pay Out of Pocket Expenses

Table 3 shows the breakdown of the number and percent of respondents who selected each barrier. Barriers are ranked from top to bottom based on the frequency of participants who selected the barrier. Figure 3 shows a graphical depiction of the frequency of selected barriers to health care access.

"What are the most significant barriers that keep people in the community from accessing health care when they need it?"

Table 3: Ranking of Barriers to Health Care Access

Rank	Barrier to Health Care Access	Number of respondents who selected the issue	Percent of respondents who selected the issue
1	Lack of Health Insurance Coverage	25	51%
2	Lack of Transportation	19	39%
3	Inability to Pay Out of Pocket Expenses	17	35%
4	Availability of Providers/Appointments	15	31%
5	Inability to Navigate Health Care System	10	20%
6	Language/Cultural Barriers	10	20%
7	Time Limitations	5	10%
8	Basic Needs Not Met	3	6%
9	Lack of Trust	3	6%

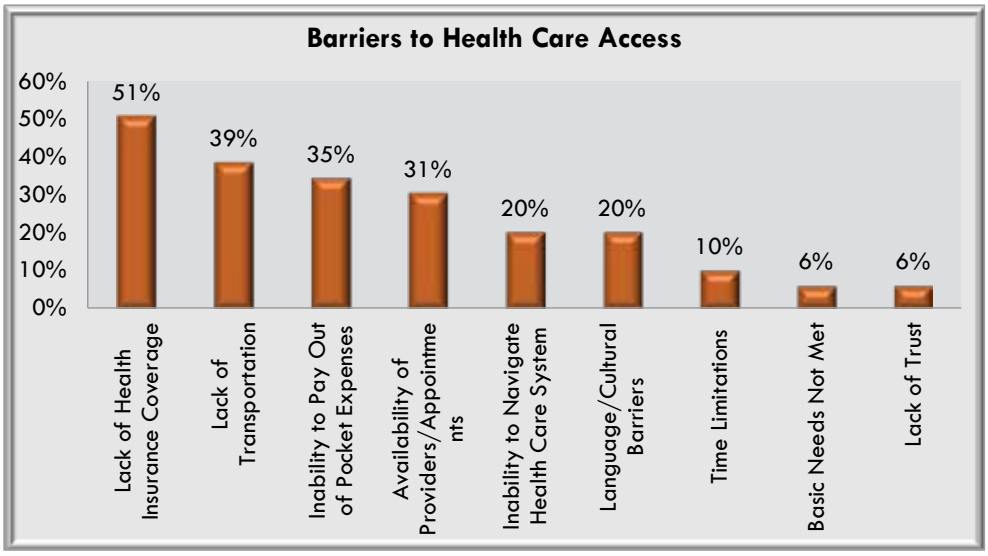


Figure 3: Ranking of barriers to health care access

After selecting the most significant barriers, informants were asked to share any additional information regarding the barriers to accessing health care.

Select Comments regarding Health Care Access & Barriers:

- *"High deductibles and copays are barriers for families."*
- *"Prescriptions are very expensive, especially if you're managing a chronic illness."*
- *"People who are working cannot get to a doctor's office during the day, and many do not have evening or weekend hours. A flexible schedule would allow people to get there when they need to."*
- *"Our public transportation system is awful, it is practically non-existent and not convenient for our residents and the services they need."*
- *"Unless you are disabled/elderly or have Medicaid, there is no free transportation to medical providers."*
- *"Transportation is a real struggle. We don't have bus service down here. We refer a lot of people to Wood River Health and that's a $60 cab fare down there and people just don't have that kind of money."*
- *"Transportation is a significant problem here in Woonsocket; we know that families particularly with young children have a problem getting them to appointments."*
- *"What would typically be a 15 minute drive takes approximately an hour and a half one way by bus. People have to go through the Providence Terminal and take several bus changes to get anywhere."*
- *"If you don't have a roof over your head, if you don't have a pay check, if you don't have resources to eat then you're going to have a hard time managing a chronic illness."*
- *"People are not sure how to access the system or whom to turn to in order to get referrals to the services they need. Often times they are unaware that certain services exist."*
- *"It's impossible to get an outpatient appointment in a reasonable period of time."*
- *"There are issues around child care sometimes, when one child is sick there has to be someone to watch the other children."*
- *"There need to be more bilingual providers in the area. We live in a community where the Spanish population is growing."*
- *"Undocumented patients are often afraid to fill out paperwork to apply for the sliding scale fee at community health centers because they think they will be turned in to Immigration. They end up using the emergency room for primary care."*
- *"Language, culture, and literacy are all barriers to health care."*
- *"We have a large population of immigrants here in Rhode Island from Africa, the Mid-East, Southeast Asia, from all over the world. We are lacking interpreters."*
- *"Many of the primary care providers are full and not accepting new patients."*
- *"Guatemalans, speak a different Spanish dialect and we don't have practitioners to serve them in this community."*
- *"There is limited bilingual health care access in our state and a tremendous need."*
- *"People who are deaf or hard of hearing have difficulty accessing health services. There is a lack of interpreters and more importantly, for clinicians who can sign or are able to deal with people with that disability."*

Underserved Populations

Informants were then asked whether they thought there were specific populations who are not being adequately served by local health services. As seen in Figure 4, the majority of respondents (88%) indicated that there are underserved populations in the community.

"Are there specific populations in this community that you think are not being adequately served by local health services?"

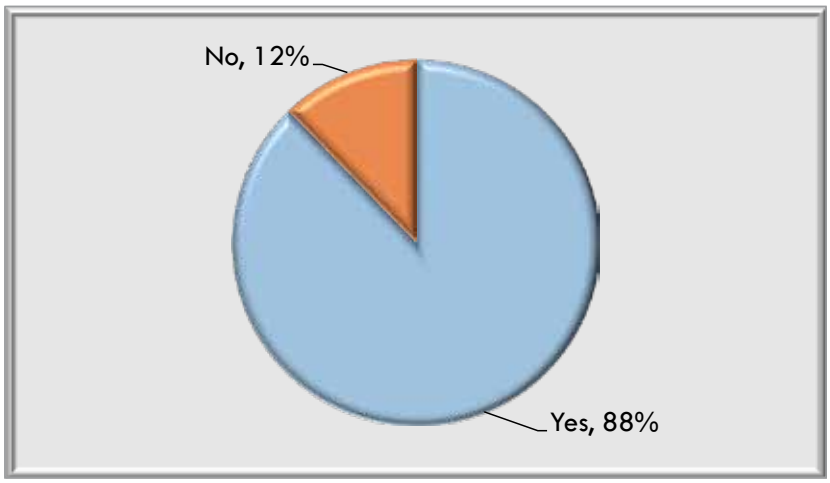


Figure 4: Key informant opinions regarding underserved populations

Those respondents were asked to identify which populations they thought were underserved. The results can be found in Table 4 below. Immigrant/refugee populations and racial/ethnic minorities such as Hispanic/Latino individuals were considered underserved populations. Low-income/poor individuals and uninsured/underinsured individuals were also considered underserved populations. In addition, several participants felt that individuals with mental health issues were underserved.

Table 4: Underserved Populations

	Underserved Populations	Number of respondents who selected population
1	Immigrant/Refugee	16
2	Low-income/Poor	15
3	Uninsured/Underinsured	13
4	Hispanic/Latino	10
5	Individuals with Mental Health Issues	8
6	Black/African-American	7
7	Seniors/Aging/Elderly	5
8	Young Adults	5
9	Disabled	5
10	Homeless	3
11	Children/Youth	2

Health Care for Uninsured/Underinsured

Next, the informants were asked to select where they think most uninsured and underinsured individuals go when they are in need of medical care. Table 5 and Figure 5 show the results. The majority of respondents (71%) indicated that most uninsured and underinsured individuals go to the Hospital Emergency Department for medical care. Approximately 22% of respondents indicated that uninsured and underinsured individuals use Health Clinics or Federally Qualified Health Clinics (FQHCs) for health care.

In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care?

Table 5: Ranking of Where Uninsured and Underinsured Individuals Receive Medical Care

Rank	Location	Number of respondents who selected location	Percent of respondents who selected location
1	Hospital Emergency Department	35	71%
2	Health Clinic/FQHC	11	22%
3	Walk-in/Urgent Care Center	2	4%
4	Don't Know	1	2%

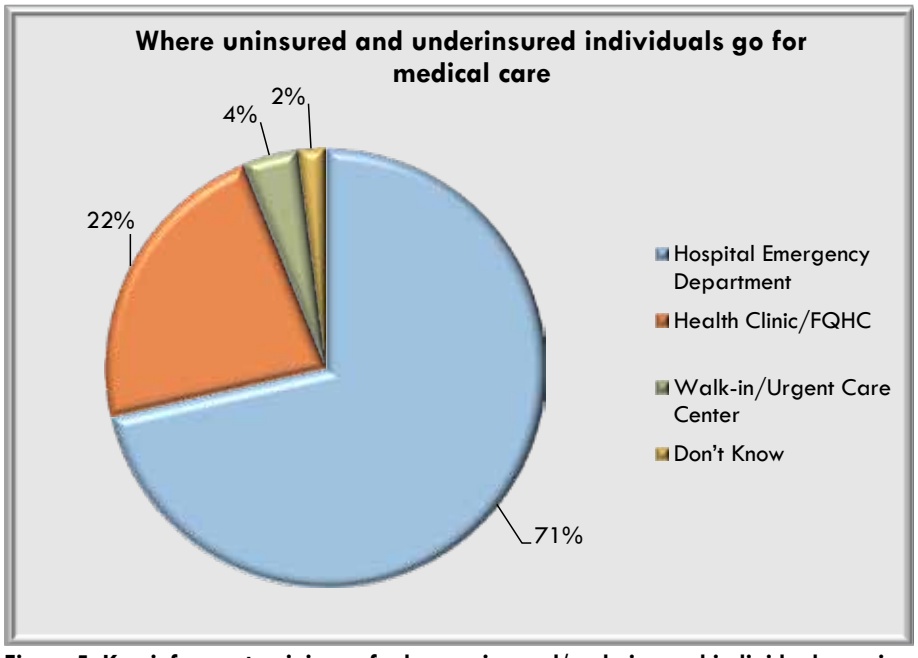


Figure 5: Key informant opinions of where uninsured/underinsured individuals receive medical care

Respondents stated that people use the Emergency Department for non-emergency care for a number of reasons: it is accessible and open 24/7, they will not be turned away, they will be seen that day, and/or they do not know where else to get care. Several informants mentioned that there is a need for education around appropriate use of emergency services and navigating the health care system.

Resources Needed to Improve Access

Respondents were asked to identify key resources or services they felt would be needed to improve access to health care for residents in the community. Table 6 includes a listing of the resources mentioned ranked in order of the number of mentions. Many Key Informants indicated that Mental Health Services were needed. Informants also felt there was a need for more Health Education, Information, and Outreach. In addition, respondents suggested that additional free and low cost medical and dental services would help improve access.

Table 6: Listing of Resources Needed in the Community

Rank	Resources Needed	Number of Mentions
1	Mental Health Services	23
2	Health Education/Information/Outreach	20
3	Free/Low Cost Medical Care	11
4	Free/Low Cost Dental Care	10
5	Transportation	9
6	Assistance with Basic Needs (Food/Housing)	8
7	Primary Care Providers	7
8	Bilingual Services	5
9	Prescription Assistance	4
10	Substance Abuse Services	5
11	Health Screenings	4
12	Geriatric Care/Aging Services	3
13	Medical Specialists	2
14	Free/Low Cost Recreation Facilities	2

Challenges & Solutions

The final section of the survey focused on challenges to maintaining healthy lifestyles, perceptions of current health initiatives, and recommendations for improving the health of the community.

When asked what challenges people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy, participants suggested the following common challenges:

- Cost/Access
- Motivation/Effort
- Time/Convenience
- Education/Knowledge

Several participants indicated that cost is a barrier. They explained that healthy foods like fresh fruits and vegetables can be expensive, and unhealthy food is often cheaper. Participants also mentioned that gym memberships and fitness programs can be expensive. In addition, informants expressed concerns about lack of awareness and education.

Select Comments regarding Challenges to Maintaining Healthy Lifestyles:

- *"There is lack of knowledge and education regarding nutrition."*
- *"Healthy eating, cooking and nutritional instruction need to be embedded again in the public schools curriculum."*
- *"At the north end of our town, there are no grocery stores. If you don't have transportation, it's really hard to get fresh fruits and vegetables.*
- *"When you don't have transportation, the only place you can get to is a corner store that sells potato chips and soda. You can't get buy fresh fruit and vegetables."*
- *"When people live in a food desert or a community where there is a lot of fast food, we shouldn't be surprised when people aren't eating healthy foods."*
- *"One of the challenges in staying healthy is that most of communities are not walkable. There is not a lot of natural exercise within the course of someone's day. They have to make time for it and that is challenging for people. People who live in walkable communities have an easier time managing their diseases and getting a lot of good exercise."*
- *"We don't have communities that are walkable. We don't have complete streets, and we don't have sidewalks that are intact."*
- *"There is a lack of access to safe outdoor spaces to exercise in the communities."*
- *"In the inner city, there are a lack of grocery stores and access to nutritious foods."*
- *"I think part of the issue is culture. Many people have been acculturated in a manner that doesn't re-enforce a healthy lifestyle."*
- *"People are working long hours and can't fit exercise into their routine. There is also a lack of facilities for low income people."*
- *"Healthy eating and exercise takes a lot of daily planning. If you don't plan, then you come up short and end up making poor choices."*

Respondents were asked "What is being done well in the community in terms of health and quality of life?" The following specific organizations and programs were regarded as important resources in the community: Local Hospitals, Health Departments, Community Health Centers/Federally Qualified Health Centers, Wood River Health Services, Rhode Island Free Clinic, RIte Care, Bright Smiles, Patient centered medical homes initiatives, Schools, Senior Centers, SNAP (Supplemental Nutrition Assistance Program), Tobacco prevention programs, YMCA, and United Way. Overall, there were many positive comments about programs in the community; however, it is important to note that some informants felt that not enough was being done and that there was still a lot of work needed to improve community health.

Select Comments regarding What is Being Done Well:

- *"Rhode Island is fortunate to have a high quality hospital network."*
- *"We have an excellent hospital system."*
- *"We have very high quality hospitals and nursing homes."*
- *"Both Wood River Health Services and Westerly Hospital work very hard on community education."*
- *"The Federally Qualified Health Centers provide medical care and dental care regardless of ability to pay."*
- *"Our community health centers and the Rhode Island Free Clinic are strengths."*
- *"Some of the work being done in health centers, particularly the new concepts of patient centered medical home, are not only improving access but are also improving overall coordinated treatment for patients."*
- *"Work that we are doing around patient center medical homes to improve our capacity to work with folks is a real significant asset to our state."*
- *"We have excellent access to prenatal care and obstetric services and a commitment in our community to providing those without the regard of the ability to pay."*
- *"We have made great progress through Bright Smiles and that progress needs to continue to make sure all children have access to dental care."*
- *"There are great groups out there doing work with farmer's markets and healthy corner store initiatives. They're trying to make the environment more healthy and friendly and providing access right at people's fingertips to good healthy foods."*
- *"Local communities are investing in creating local community spaces like parks and gardens."*
- *"The SNAP program works with people to increase their knowledge on how to eat better with less money."*
- *"There are many wonderful places close by where people can get outside. We have beautiful beaches, bike paths, community parks, and opportunities for exercise and stress reduction."*
- *"We have many farmers' markets with fresh local foods. Many of the farmers markets offer cooking demonstration and recipes and helpful tips for eating healthy."*
- *"There are programs that are reaching out to communities to engage them in the conversation of what their needs are particularly around access."*
- *"I think there's a significant effort made among community providers to work as a network and a system and try to coordinate care."*
- *"The non-profit sector in Woonsocket makes a very considerate effort in terms of trying to come together to coordinate services and care."*
- *"We have seen some successes in school-based clinics that have helped to work with young people particularly around the areas of teenage pregnancy."*
- *"The Health Department is making serious efforts and collaborations with Kids Count to remove unhealthy snacks from vending machines, remove sugary drinks from the schools, and improve the quality of food in the schools."*
- *"Most communities in Rhode Island have well developed senior programs."*

Next, key informants were asked "What recommendations or suggestions do you have to improve health and quality of life in the community?" Several major themes emerged from the comments including the following:

- Increased Awareness/Education/Community Outreach
- Increased Emphasis on Prevention & Chronic Disease Management
- Increased Collaboration/Coordination
- Improved Access to Affordable Recreational Opportunities & Healthy Food
- Improved Access to Affordable Medical & Dental Care
- Enhanced Mental Health & Substance Abuse Services
- Enhanced Senior/Aging Services

Select Comments regarding Recommendations to Improve Health:

- *"I think the hospitals have to rethink their roles and focus on educating the community, vaccinations, prevention, healthy lifestyles, and investing in ways to keep people well to prevent illness."*
- *"It comes down to education. Every patient visit is an opportunity for patient education about better nutrition, more exercise, and reducing blood pressure and A1C counts. People have to be more involved with their own health care and that message has got to get out there. It's all patient education."*
- *"There needs to be more health promotion. We don't do enough with schools and children to educate them and their families about the importance of health - physical and emotional health. If we started young and did more outreach with children and early care in education and day care facilities, we could go a long way in planting the seeds to good health."*
- *"We need to focus on creating communities that encourage residents of those communities to lead healthy lives. Not so much teach or tell or put up billboards, but create the infrastructure so people can safely and easily walk or bike to school or work.*
- *"I would encourage more funding to support programs that reach out to people and assist them with getting the help and information they need.*
- *"More education campaigning that reaches families with children."*
- *"Introduce more resources that assist people in changing their behavior, such as smoking cessation."*
- *"Increased use of community health workers and navigators to help spread the word about resources available in the community."*
- *"Embed Mental Health Services into the Primary Care system."*
- *"Integrate behavioral health and medicine with physical health and medicine."*
- *"Provide affordable community-based medical services that are locally accessible for a low income community like Woonsocket."*
- *"Create satellite treatment centers, walk in centers, and minute clinics that allow people to get treated for routine and preventive care in a convenient, low cost setting.*
- *"Bring health services, particularly specialty services much closer to the community, and set up transportation systems, perhaps specialized medical transportation systems.*
- *"Improve reimbursement for Primary Care and Specialty providers especially for Medicaid patients."*
- *"The hospitals should work with the primary care community to put together a plan that's helpful to both rather than working separately."*
- *"Working more closely with Primary Care Practices to coordinate care and ensure patients who are using the emergency room are referred to a Primary Care Provider.*

- *"We need to have an overall state plan that approaches the implementation of population health throughout the state. We need that sooner rather than later, and we need to continue the movement to invest in Primary Care Services."*
- *"Extending patient centered medical homes and nurse care managers to more patients."*
- *"The hospitals need to do more outreach in the community and work with community agencies to educate the public on how to appropriately access health care services."*
- *"There needs to be far greater coordination among the various institutions in the community. Government, education, health care, not for profits, and for profits really need to be on the same page toward correcting the issues. This is such a small state that it's difficult to believe that we can't address issues in a better way than we are."*
- *"Further communication and collaboration with the different sectors such as the education sector and health care sector. By working together, they can get the information to those people who need health care."*
- *"Improve access to safe places for the physical activity and access to high quality foods in urban and rural neighborhoods."*
- *"Greater coordination and communication between hospital, nursing homes, adult day centers and home and community providers to better serve the elderly population."*
- *"Expand the use of mid-level practitioners, nurse practitioners, and physician assistants and find new ways to involve allied health professionals, medical assistants, certified nursing assistants, and nurses in the provision of care that's appropriate for their level but make sure we are using everyone to their maximum ability so we can best place those very scarce resources in the roles that have them working at the top of their license as well."*
- *"Increase cultural competence and diversity of our health practitioner work force."*
- *"Individuals in hospitals need to be trained to work with older people and people with cognitive impairment. They need to know the signs of Dementia and how to deal with someone with Dementia."*
- *"Provide training to doctors to better serve the deaf and hard of hearing."*

Conclusions

Many of the key informants expressed appreciation for the opportunity to share their thoughts and experiences and indicated interest and support for efforts to improve community health. Based on the feedback from the key informants, access to health care is a significant health issue in the community. A number of barriers contribute to access issues including health insurance coverage, transportation, and inability to pay. The need for mental and behavioral health services were also repeatedly mentioned by informants. In addition, informants expressed concern about the growing problem of obesity and indicated that there are number of challenges that contribute to obesity including cost, accessibility, convenience, education, and motivation. Many respondents indicated the need for increased awareness, education, prevention, and outreach and encouraged more collaboration and coordination among health and human service providers.

Hospital Association of Rhode Island and its partners will use the results of the Key Informant Study in conjunction with Behavioral Risk Factor Surveillance System (BRFSS) data and focus group discussions to understand community health needs and prioritize public health endeavors.

APPENDIX A: QUESTIONNAIRE

INTRODUCTION: Good morning/afternoon, this is _____ with Holleran Consulting. I'm calling on behalf of Hospital Association of Rhode Island. You should have received a letter and/or email requesting your participation in a brief survey that is part of a community needs assessment.

Your perspective about the community is valuable in identifying ways to improve community health. The survey will take about 15 minutes to complete over the phone. If you have time, I could administer the survey now. Otherwise, I would be glad to schedule a time to talk later. Would you like to take the survey now, or schedule a more convenient time?

Holleran is an independent research firm. Your responses will only be used in a report of this study, which is part of a greater Community Health Needs Assessment. Please note that while your responses, including specific quotations, may be included in the report, your identity will be kept confidential.

KEY HEALTH ISSUES

1. What are the top **three health** issues you see in your community? (CHOOSE 3)

Caller: Do not read list unless prompt needed:

☐ Access to Care/Uninsured	☐ Overweight/Obesity
☐ Cancer	☐ Sexually Transmitted Diseases
☐ Dental Health	☐ Stroke
☐ Diabetes	☐ Substance Abuse/Alcohol Abuse
☐ Heart Disease	☐ Tobacco
☐ Maternal/Infant Health	☐ Other (specify):
☐ Mental Health/Suicide	

Probes: Why do you think that? What makes you say that? Can you give an example?

2. Of those issues mentioned, which **one** is the most significant? (CHOOSE 1)

☐ Access to Care/Uninsured	☐ Overweight/Obesity
☐ Cancer	☐ Sexually Transmitted Diseases
☐ Dental Health	☐ Stroke
☐ Diabetes	☐ Substance Abuse/Alcohol Abuse
☐ Heart Disease	☐ Tobacco
☐ Maternal/Infant Health	☐ Other (specify):
☐ Mental Health/Suicide	

Probes: Why do you think that? What makes you say that? Can you give an example?

ACCESS TO CARE

On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about **Health Care Access** in the area.

	Strongly disagree←→Strongly agree				
3. Residents in the area are able to access a primary care provider when needed. (Family Doctor, Pediatrician, General Practitioner)	☐1	☐2	☐3	☐4	☐5
4. Residents in the area are able to access a medical specialist when needed. (Cardiologist, Dermatologist, Neurologist, etc.)	☐1	☐2	☐3	☐4	☐5
5. Residents in the area are able to access a dentist when needed.	☐1	☐2	☐3	☐4	☐5
6. There is a sufficient number of providers accepting Medicaid and Medical Assistance in the area.	☐1	☐2	☐3	☐4	☐5
7. There is a sufficient number of bilingual providers in the area.	☐1	☐2	☐3	☐4	☐5
8. Transportation for medical appointments is available to area residents when needed.	☐1	☐2	☐3	☐4	☐5
9. There is a sufficient number of mental/behavioral health providers in the area.	☐1	☐2	☐3	☐4	☐5

10. What are the most significant barriers that keep people in the community from accessing health care when they need it?

Caller: Do not read list unless prompt needed:

☐ Availability of Providers/Appointments
☐ Basic Needs Not Met (Food/Shelter)
☐ Inability to Navigate Health Care System
☐ Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
☐ Lack of Child Care
☐ Lack of Health Insurance Coverage
☐ Lack of Transportation
☐ Lack of Trust
☐ Language/Cultural Barriers
☐ Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
☐ Other (specify):

Probes: Why do you think that is? Can you give an example of that? What are some ways we could minimize those barriers?

11. Are there specific populations in this community that you think are not being adequately served by local health services?

__ Yes __ No

12. **If yes**, which populations are underserved?

Do not read list unless prompt needed:

☐ Uninsured/Underinsured
☐ Low-income/Poor
☐ Hispanic/Latino
☐ Black/African-American
☐ Immigrant/Refugee
☐ Disabled
☐ Children/Youth
☐ Young Adults
☐ Seniors/Aging/Elderly
☐ Homeless
☐ Other (specify):

Probes: Why do you think that is? Can you give an example of how they are not being served?

13. In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care? (CHOOSE 1)

Do not read list unless prompt needed:

☐ Doctor's Office
☐ Health Clinic
☐ Hospital Emergency Department
☐ Walk-in/Urgent Care Center
☐ Don't Know
☐ Other (specify):

Probes: Why do you think they go there? How could we make other options more accessible?

14. Related to health and quality of life, what services or resources do you think are missing in the community?

Do not read list unless prompt needed:

☐ Free/Low Cost Medical Care
☐ Free/Low Cost Dental Care
☐ Primary Care Providers
☐ Medical Specialists
☐ Mental Health Services
☐ Substance Abuse Services
☐ Bilingual Services
☐ Transportation
☐ Prescription Assistance
☐ Health Education/Information/Outreach
☐ Health Screenings
☐ Other (specify):

15. What challenges do people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy?

    Probes: What makes it difficult for people to make healthy choices? What challenges do people face in trying to manage chronic conditions like diabetes or heart disease?

16. In your opinion, what is being done ***well*** in the community in terms of health and quality of life?

    Probes: What are some Community Assets/Strengths/Successes? Can you give an example?

17. What recommendations or suggestions do you have to improve health and quality of life in the community?

    Probe: Do you have any other suggestions/feedback for the hospital?

CLOSING

18. Please answer a few quick demographic questions.

Which one of these categories would you say BEST represents your community affiliation? (CHOOSE 1)

☐ Health Care/Public Health Organization
☐ Mental/Behavioral Health Organization
☐ Non-Profit/Social Services/Aging Services
☐ Faith-Based/Cultural Organization
☐ Education/Youth Services
☐ Government/Housing/Transportation Sector
☐ Business Sector
☐ Community Member
☐ Other (specify):

What is your gender? __ Male __ Female

What is your race/ethnicity? (CHOOSE 1 that best represents their race)

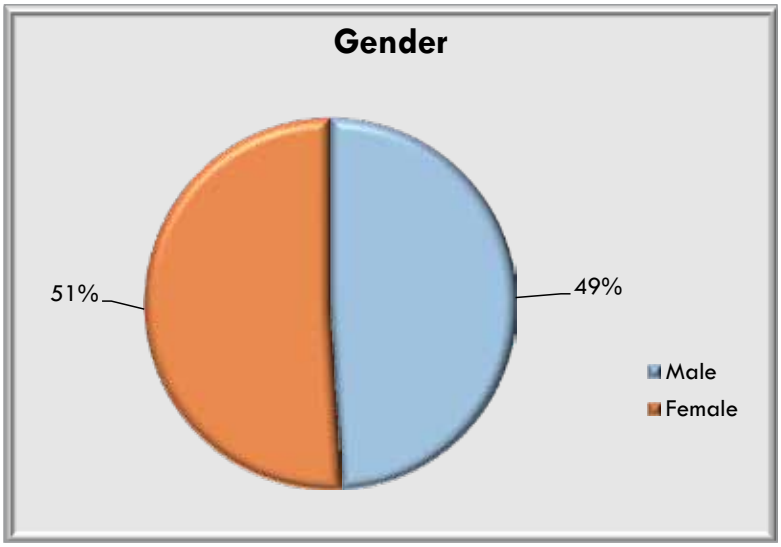
☐ White/Caucasian
☐ Black/African American
☐ Hispanic/Latino
☐ Asian/Pacific Islander
☐ Other (specify):

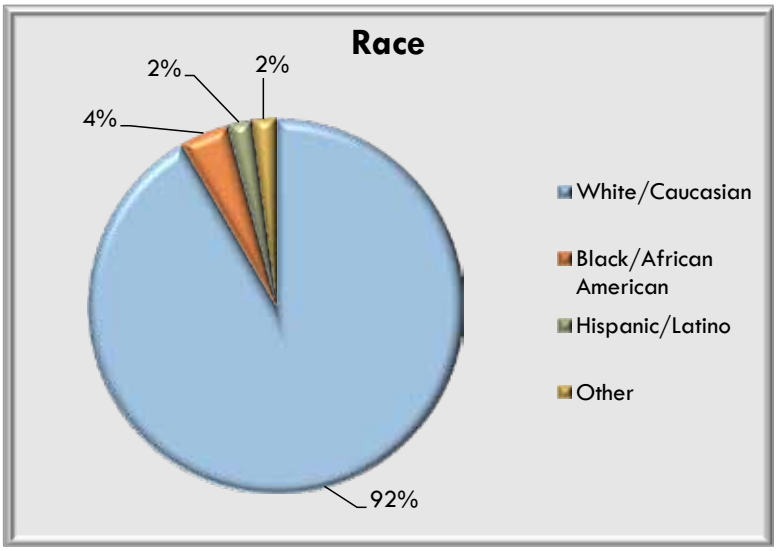
Hospital Association of Rhode Island will be using the information gathered through these surveys to develop a community health implementation plan. Your feedback is very valuable. I appreciate your participation.

Thank you! That concludes the survey.

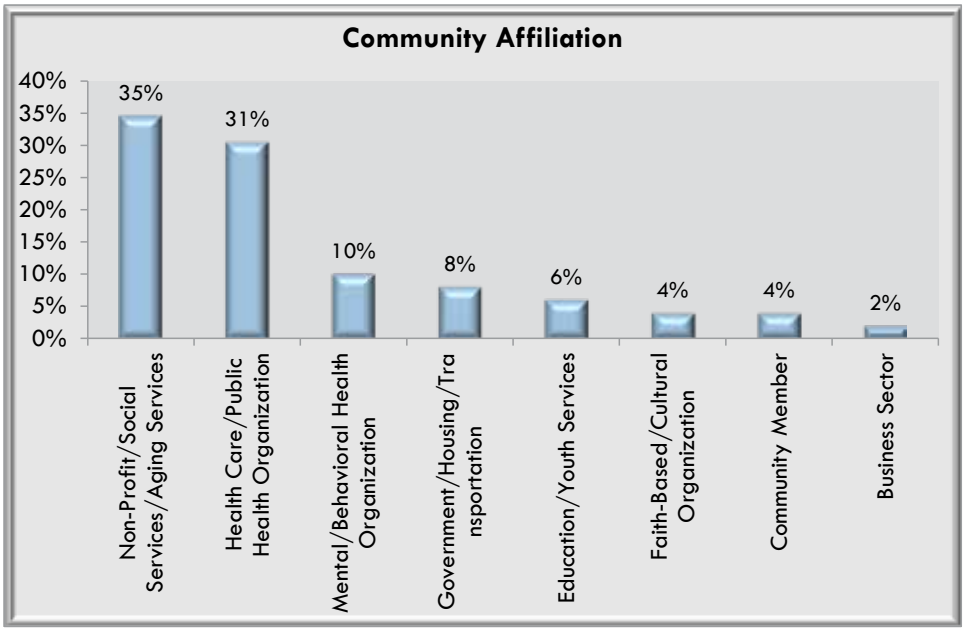
APPENDIX B: DEMOGRAPHICS

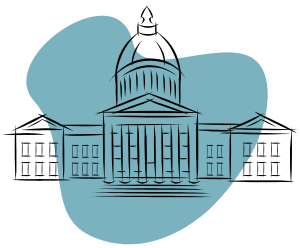
Respondents were asked to provide some demographic information including: gender, race, and community affiliation. The following figures provide a graphical depiction of these demographic characteristics.

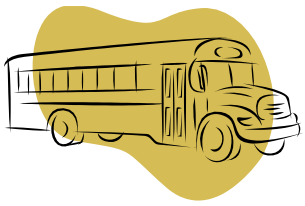




"Which one of these categories would you say <u>best</u> represents your community affiliation?"







8 APPENDIX

References

1. U.S. Census Bureau People Quickfacts. 2010 7/26/13]; Available from: http://quickfacts.Census.gov/qfd/states/44000.html.

2. Rhode Island Health Center Association, Health Center Facts. 2011.

3. Rhode Island Department of Education and Secondary Education. Public School Enrollment. 2013 07/26/13]; Available from: http://www.rikidscount.org/matriarch/documents/13_Factbook_Indicator_46.pdf

4. Rhode Island Department of Education and Secondary Education. Rhode Island Secondary Education. 2010 07/26/13]; Available from: http://www.rikidscount.org/matriarch/documents/Improving%20High%20School%20Graduation%20Rates%20in%20RI_June%202011_FINAL%281%29.pdf

5. Rhode Island Department of Education and Secondary Education. English Language Learners. 2010 2013 07/26/13]; Available from: http://www.rikidscount.org/matriarch/documents/13_Factbook_Indicator_56.pdf

6. Department of Labor. Bureau of Labor Statistics- Economy at a Glance. 2013 7/26/13]; Available from: http://stats.bls.gov/eag/eag.ri.htm.

7. Housing, R.I. 2010 Homes and Economy. 2012; Available from: http://www.rhodeislandhousing.org/sp.cfm?pageid=850.

8. Rhode Island Department of Health. Childhood Lead Poisoning Prevention Program. 2012 7/29/13]; Available from: http://www.health.ri.gov/healthrisks/poisoning/lead/.

9. Nesi, T., Rhode Island's median family of four makes $88,593, in WPRI2011. Available from: http://blogs.wpri.com/tag/households/

10. Shore, R.S., B. KIDS COUNT indicator brief: Reducing the high school dropout rate. . 2013 7/29/19]; Available from: . http://www.rikidscount.org/matriarch/documents/13_Factbook_Indicator_66.pdf

11. Rhode Island Economic Development Corporation (now called Commerce RI). Top Employers in Rhode Island. 2011 [cited 02/1/2012; Available from: http://www.www.riedc.com/files/Top%20Employers%20ranking%202011.pdf

12. Klepper, D., RI cities and towns seek state's help, but fiscal, political challenges may delay rescue, in Tribtown2012.

13. McGowan, D., Rhode Island Ranked Third Worst State in Country to Retire, in Go Local Prov2012.

14. Office of Health Insurance Commissioner. Assessment. 2011; Available from: http://www.ohic.ri.gov/.

15. The Burden of Overweight and Obesity in Rhode Island, 2011, Rhode Island Department of Health. p. 4-8. Available From: http://www.health.ri.gov/publications/burdendocuments/2011OverweightAndObesity.pdf

16. Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health DatabaseCited 2012; Available from: http://www.rikidscount.org/matriarch/documents/13_Factbook_Indicator_27.pdf

17. Rhode Island Department of Health. Rhode Island Youth Risk Behavior Survey 2009 [cited 2012; Available from: http:// www.rikidscount.org/matriarch/documents/10_Factbook_Indicator_33.pdf

18. Rhode Island Department of Health. Health Disparities and People with Disabilities- Annual Report 2012 [cited 2012; Available from: http://www.health.ri.gov/publications/annualreports/2012DisabilityAndHealth.pdf

19. Rhode Island Department of Health. The Burden of Diabetes in Rhode Island. 2010 [cited 2012; Available from: http://www.health.ri.gov/publications/burdendocuments/2010Diabetes.pdf.

20. Rhode Island Department of Health. Minority Health Facts. 2010 [cited 2012; Available from: http://www.health.ri.gov/publications/factsheets/minorityhealthfacts/Summary.pdf.

21. Rhode Island Department of Health. Acute Infectious Disease Program. 2011; Available from: http://www.health.ri.gov/programs/acuteinfectiousdisease/.

22. Rhode Island Department of Health. Rhode Island Comprehensive HIV Prevention Plan. 2010 [cited 2012; Available from: http://www.health.ri.gov/publications/plans/2010ComprehensiveHIVPrevention.pdf.

23. Rhode Island Department of Health. Suicide. 2010; Available from: http://www.health.ri.gov/violence/about/suicide/.

24. Rhode Island Department of Health. Cancer in Rhode Island: The Burden of Cancer. 2010 [cited 2012; Available from: http://www.health.ri.gov/publications/plans/2007ComprehensiveCancerControl.pdf.

25. Trust for America's Health, Prescription Drug Abuse: Strategies to Stop the Epidemic, 2013. Washington D.C. http://healthyamericans.org/assets/files/TFAH2013RxDrugAbuseRptFINAL.pdf

26. Rhode Island Department of Health, Center for Health Data and Analysis. Child Deaths. 2013 [cited 2013; Available from: http://www.rikidscount.org/matriarch/documents/13_Factbook_Indicator_34.pdf

End Notes

Viewed on October 15, 2013, at http://en.wikipedia.org/wiki/List_of_U.S._states_by_population_density.

Hispanic or Latino refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race, according to the U.S CensusCensus

Core cities are those that have child poverty levels greater than 15%

"Student engagement" for this purpose is defined by a number of variables, such as student interest in schoolwork, how hard a student works in school, and the extent to which a student enjoys school.

Source: the RI 21st Century Community Learning Center Initiative: Supporting student success for nearly a decade (2010), Providence, RI: Rhode Island Department of Elementary and Secondary Education. Retrieved January 26, 2011, from www.mypasa.org.

21st Century Community Learning Centers providing afterschool supports to communities nationwide (2009). Washington, DC: Afterschool Alliance, retrieved 1/25/2011 from www.afterschoolalliance.org.

Rhode Island Department of Elementary and Secondary Education, class of 2010 four-year and five-year cohort graduation rates.

In year 2012, it was estimated that the elderly, considered the group of 65 years of age and older are 15.1% of the population in the state.

According to data from the Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2007-2011. Data for 2011 is provisional.

As reported in the RI PRAMS Databook for 2012, these data reflect the proportion of mothers with a preterm birth, which differs from the proportion of preterm babies reported in Rhode Island Vital Records data. For example, a woman who delivers multiples (twins, triplets) is counted once in the PRAMS data file, and information on prematurity and other measures is collected for only one of her babies.

Rhode Island Youth Risk Behavior Survey, year 2011 data

Rates for Native Americans are not considered to be statistically reliable due to the relatively small population of Native American females aged 15-19 (n = 251).

Rhode Island's land area is 1,045 square miles, the smallest state in the United States according to an Internet source consulted on 10/29/2013 (http://www.worldatlas.com/aatlas/infopage/usabysiz.htm). The largest state is Alaska with an extension of 571,951 sq. mi.

According to the U.S. Census Bureau, consulted on 10/29/2013, at http://factfinder2.CensusCensus.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

OPCRH, The Health of Rhode Island Non-Metropolitan Communities, http://www.health.ri.gov/publications/reports/2011HealthOfRhodeIslandNonMetropolitanCommunities.pdf, (March 6, 2012).

The Neighborhood Health Checklist was developed by Ross Brownson and Christine Hoehner at Washington University in St. Louis.

The Neighborhood Health Check Survey was developed by the Rhode Island Public Health Institute to talk with residents, and the survey was based on the statewide Behavioral Risk Factor Surveillance Survey (BRFSS) conducted annually by the Department of Health.