



**COORDINATED CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION**



**State Plan, 2012-2017**



**Coordinated Chronic Disease Prevention and Health Promotion  
State Plan  
August, 2013**

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## Executive Summary

As the communicable diseases of the past have been contained, chronic diseases such as heart disease, diabetes, cancer, and asthma have emerged as lead causes of sickness and death in the United States. Over the last half-century, the focus of public health has shifted to reducing risk factors for chronic disease and disparities in the health statuses of people of different races, ethnicities, and levels of income. And yet, disparities persist. Our rates of overweight and obesity are unprecedented, and in some cases, barriers to improving the health and safety of communities are larger than ever. For the first time in modern American history, the members of the generation to come will have a lower life expectancy than their parents.



How can this be? What are we doing incorrectly?

This Rhode Island Coordinated Chronic Disease Prevention and Health Promotion State Plan (State Plan) is a response to these disconcerting trends.

The State Plan includes cross-cutting, statewide goals, and objectives. Its recommendations include strategies that support healthy behaviors population-wide. It includes policies at the state and community levels that are related to tobacco-free living, healthy environments, healthy development, social equity and social cohesion, and chronic diseases and their associated risk factors. The State Plan is guided by a vision that aligns with U.S. Public Health Services and *Healthy People 2020* strategic directions and long-term objectives for community transformation, chronic disease prevention, and health promotion. The State Plan incorporates the Health Equity Framework, which addresses the social determinants of health, policy integration, environmental, programmatic, and infrastructure strategies, and strategy implementation for populations across the lifespan.

The State Plan is a concerted effort of the Division of Community, Family Health, and Equity within the Rhode Island Department of Health. The internal collaborative process is occurring in coordination with the work of an external group of more than 35 partners who comprise the Rhode Island Collaborative for Health Equity. This partnership will help Rhode Island significantly reduce and control chronic diseases and risk factors population-wide. Crosscutting strategies will be implemented in multiple settings. They will connect healthcare, workplaces, child and adult care settings, and schools, among other places. These strategies relate to the five goals of the State Plan:

- Enhance capacity in leadership, management, advocacy, communication, surveillance, evaluation, and community mobilization to promote a culture of collaboration and advance disease prevention and health promotion.
- Create an integrated surveillance system that provides information on health-related risk and protective factors across the lifespan.
- Advance environmental strategies to improve individual-level health behaviors.
- Enhance services and systems in place that expand access to and utilization of coordinated healthcare services and reduce morbidity and mortality of preventable chronic diseases and risk factors.
- Expand access to community-based preventive services and strengthen their linkages with clinical care.



# Introduction

## **The National Context**

To slow and reverse current trends in chronic disease, public health organizations across the country are looking to coordinate efforts to address multiple diseases and risk factors simultaneously. To assist in these efforts, the Centers for Disease Control and Prevention (CDC) funded the Coordinated Chronic Disease Prevention and Health Promotion Program. This initiative will help Rhode Island continue to work systematically to coordinate efforts across the Division of Community, Family Health, and Equity and, subsequently, have a greater impact on the health of all Rhode Islanders.

## **Integration at the Rhode Island Department of Health**

The Division of Community, Family Health, and Equity (Division) is the result of a 2006 realignment and reorganization within the Rhode Island Department of Health. The Division was developed to achieve better program synergy, coordination, and integration. Through integration and the leveraging of funds the Division works toward its goal of health equity through eliminating health disparities, ensuring healthy child development, preventing and controlling disease, preventing disability, and working to make our environment healthy. The Division's goals are aligned with the objectives and activities of Coordinated Chronic Disease Prevention and Health Promotion Program. This facilitates collaboration across many of the Rhode Island Department of Health's existing programs: Tobacco Control, Heart Disease and Stroke, Initiative for a Healthy Weight, Diabetes Prevention and Control, Asthma, Comprehensive Cancer Control, the Healthy Homes Collaborative, and Arthritis, among others. Integrated initiatives and healthier populations will reduce Rhode Island's healthcare expenditures.

The Division has developed and implemented an eight-part Core Competency Equity Training as the foundation for integration work. A Division-wide survey has been developed that assesses attitudes toward, and knowledge about, integration as part of the long-term commitment to a culture of collaboration and cross-program integration. Every 18 months, members of the 44 programs within the Division complete the survey.

Through federal funding, there is a Division-wide commitment to expanding Rhode Island's Healthy Communities by Design Program and establishing the Healthy Communities Designation Program for Rhode Island cities and towns. The Division has an integrated workforce in the Community Health Network. The workforce has drafted a business plan for health plan reimbursement of evidence-based chronic disease prevention and health promotion programs that are delivered in the community. An initial surveillance framework to advance data-driven integration efforts has been drafted. Communication staff is working effectively with multiple programs to better coordinate messages. The evaluator with the assistance of Evaluation Advisory Groups has developed an evaluation plan and logic model for the Coordinated Chronic Disease Prevention and Health Promotion Program. The Division continues to expand a shared health equity agenda across the state, implement a community development framework, transform the service delivery model and culture of service delivery, and build capacity to collaborate both internally and externally.

## **Moving Forward – Expanding Integration to Include External Partners**

A Rhode Island Collaborative for Health Equity is in place (formerly known as the Rhode Island Coalition for Health). The Division hired Community Initiatives, a consulting group and network of professionals and partner organizations dedicated to building healthy and whole communities. Community Initiatives worked with internal staff and external partners to understand their roles in facilitating more authentic communication, partnerships, and learning. They also laid the groundwork for structures and processes for developing broader community partnerships. The technical assistance of Community Initiatives helped shape collaborative approaches that will advance the integration of chronic disease prevention and health promotion work, as well as the work of other programs at the Rhode Island Department of Health and community-based agencies.

The Rhode Island Collaborative for Health Equity is building community capacity and knowledge and further developing leadership and advocacy skills. It is comprised of organizations that work with families and consumers through the implementation of community engagement strategies, program plans, and needs assessments. These coordinated strategies and plans are improving health outcomes. The purpose of the Rhode Island Collaborative for Health Equity is to build state and community capacity to respond in a coordinated manner to chronic disease. Many of the more than 35 partners in the Rhode Island Collaborative for Health Equity worked with the Rhode Island Department of Health to develop this State Plan.

The Rhode Island Collaborative for Health Equity is comprised of three Action Teams:

- The Online Resource Action Team is developing an electronic network of organizations (public, private, state/local government, and others) to better connect agencies and the work they do to serve Rhode Islanders.
- The Networking Action Team is creating opportunities on a quarterly basis that bring people together to enhance communication and strengthen relationships to promote health and well-being.
- The Healthy Places Learning Collaborative coordinates workshops and other training opportunities monthly. The events of this Action Team focus on the connections between neighborhoods and the health of their residents.

## **The Rhode Island Primary Care Trust**

The Rhode Island Primary Care Trust is a proposed funding mechanism for a robust network of Neighborhood Health Stations that will fundamentally change the way healthcare is delivered in Rhode Island. If the Primary Care Trust proposal is adopted and implemented, each community of 10,000 Rhode Islanders will have its own Neighborhood Health Station that serves as a “medical home” for that community. Open during hours that are convenient for patients on both weekdays and weekends, each Neighborhood Health Station will see patients the same day they are sick, offering services such as wellness visits, sick visits, dental care, physical therapy, behavioral health counseling, and home health services. Simply put, Neighborhood Health Stations will bring Rhode Islanders the healthcare they need, when and where they need it.

## **Why an Integrated State Plan is Needed**

The State Plan is a tool that will be used by the Rhode Island Department of Health and its partners to:

- Provide integrated leadership for chronic disease prevention and control.
- Enhance the implementation of cross-cutting strategies, communications, epidemiology, surveillance, and evaluation activities to support categorical chronic disease prevention programs.
- Increase collaboration and efficient use of resources across all categorical programs addressing chronic diseases and their associated risk factors, across the lifespan.
- Leverage resources to ensure achievement of population-level change in proposed chronic disease and risk factor outcomes, across the lifespan.
- Address gaps in health status between population subgroups and ensure the achievement of health equity for all Rhode Islanders.
- Align with and leverage the initiatives being proposed in federal and state grants to transform communities, ensuring that integration incorporates schools, worksites, child and adult care programs, and sectors such as transportation and agriculture.

## **Purpose of the State Plan**

The State Plan describes the approach and milestones to be achieved over the coming years that will reduce the burden of chronic disease in Rhode Island. The State Plan is a living document that identifies strategies that will be led by programs and partners from many sectors. The State Plan aims to guide Rhode Island in most effectively improving health and well-being.

## **Collaborative Process**

The State Plan reflects categorical chronic disease state plans in Rhode Island, as well as national data and national plans. These categorical chronic disease state plans are the result of stakeholder-driven input processes and include best and proven practices. The integrated State Plan aligns with individual program plans while maintaining program integrity and including opportunities for large-scale systems changes.

The collaborative process began with the Division's Senior Management Team, the internal leadership group of the Division. The Senior Management Team engaged a strategic planner, M+R Strategic Services, to assist in the development of the State Plan through the establishment of the Rhode Island Collaborative for Health Equity. (See Appendix 2 for a list of partners.)

The State Plan is a living document. It will evolve as progress is made towards achieving objectives and as lessons are learned.



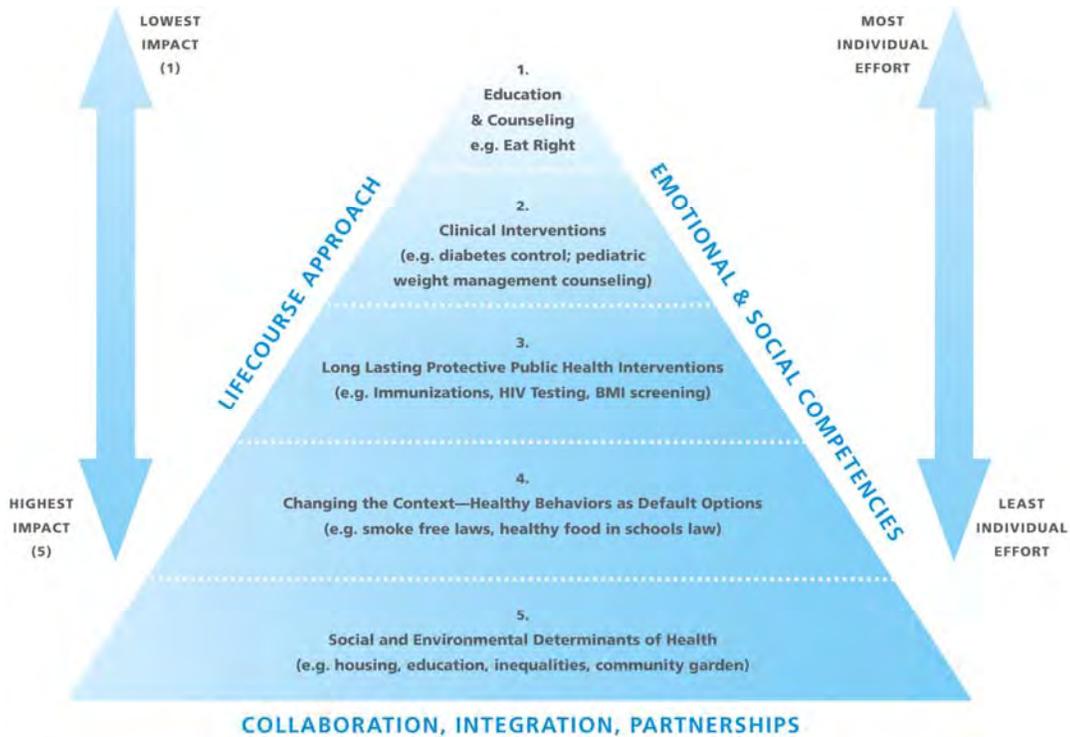
## Health Equity Framework

The Division's integration efforts are informed by a Health Equity Framework. The Health Equity Framework consists of four elements:

- **Social Determinants of Health**, discrimination and social inequities.
- **Life Course Approach**, which looks at the integrated continuum of changing developmental needs across the lifespan, and their impacts on individual and community health.
- **Social and Emotional Well-being**, which reflects quality of life, and the ability to manage stress and to thrive in an interactive environment.
- **Integration** of environmental and behavioral risk factor prevention, health promotion, disease management, and community practice work.

The Division’s six teams apply the Health Equity Framework to promote synergy, collaboration, and coordination in working toward the goal of health equity. These six teams are:

- Health Disparities and Access to Care
- Healthy Homes and Environment
- Chronic Care and Disease Management
- Health Promotion and Wellness
- Perinatal and Early Childhood Health
- Preventive Services and Community Practices



The Health Impact Pyramid, April 2010, Vol 100, No. 4, American Journal of Public Health. This pyramid is adapted from Thomas Frieden, MD, MPH presentation at the Weight of the Nation conference, Washington D.C., July 27, 2009

## The Burden of Chronic Disease in Rhode Island

Heart disease, stroke, diabetes, and arthritis are among the most common, costly, and preventable of all illnesses in Rhode Island and nationally.<sup>1,2,3</sup> The tolls that these chronic disease take on our state are staggering.

- An estimated 7.4% (62,000) of Rhode Island adults have diagnosed diabetes. People with diabetes have medical expenditures 2.4 times higher than they would if they did not have diabetes. In Rhode Island, direct healthcare costs for adults with diabetes amount to an estimated \$722 million annually.
- As of 2010, the annual mortality rate due to stroke in Rhode Island was 34 deaths per 100,000 population. Approximately a third of Rhode Island adults have diagnosed high blood pressure, a major cause of stroke.
- In Rhode Island, 29% adults have arthritis. Of these adults, 41% have activity limitation due to their arthritis.

As disconcerting as these figures are, these chronic diseases are largely preventable. Four modifiable risk factors—smoking, high blood pressure, overweight/obesity, and the lack of physical activity—are responsible for much of the illness and premature death related to these chronic diseases.<sup>4</sup> The higher prevalence of these risk factors among Rhode Island’s Hispanic and non-Hispanic black populations and those of lower socioeconomic status explains a significant proportion of disparities in life expectancy in Rhode Island. This same pattern is consistently observed in other states.<sup>5</sup>

These four modifiable risk factors also serve as indicators of possible unmet community health needs. Access to high-quality and affordable preventative healthcare may greatly reduce a person’s risk for developing chronic disease. Equally important is living in a neighborhood that is safe to walk in for individual and group exercise and where there is access to a high quality and affordable selection of fruits and vegetables and low fat foods.<sup>6</sup>

Monitoring the prevalence of preventable chronic conditions and their associated risk factors is part of a long-term strategy to track the health of Rhode Islanders and build the foundation for an integrated, statewide chronic disease surveillance system. (See Proposed Integrated Surveillance Framework” on page 13.)

**Table 1. Potentially Preventable Chronic Diseases and Associated Risk Factors in Rhode Island****Prevalence of Diagnosed Chronic Diseases Among Adults<sup>1</sup>**

## Heart Disease

Heart Attack (ever told) 4.4%

Angina or Coronary Heart Disease (ever told) 4.2%

Stroke (ever told) 2.4%

Diabetes (ever told)  
(Excludes pregnancy-related diabetes) 8.4%

Asthma – Lifetime (ever told) 16.3%

Asthma – Current (ever told) 11.9%

Arthritis (ever told)<sup>2</sup> 26.7%**Prevalence of Four Major Modifiable Risk Factors – Adults<sup>1</sup>**Overweight/obese<sup>3</sup> 62.5%

Hypertension (ever told) 32.9%

Current smoking 20.0%

No physical activity/exercise past 30 days<sup>4</sup> 26.2%**Hospital Discharges<sup>5</sup>**Age-adjusted hospitalization rate per **10,000** Rhode Islanders ages 18+

- Cardiovascular disease 1179.0

- Heart Disease 814.2

- Stroke 185.0

- Diabetes 90.1

- Osteoarthritis 147.0

**Mortality<sup>6</sup>**

## Age-adjusted mortality rate per 10,000 Rhode Islanders ages 18+

- Cardiovascular disease 202.2

- Heart Disease 165.6

- Stroke 27.4

- Diabetes 13.5

- Arthritis \*

<sup>1</sup> 2011 Rhode Island Behavioral Risk Factor Surveillance System weighted data.<sup>2</sup> Persons told by a doctor that they have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia.<sup>3</sup> In 2011, 37.1% of adults were overweight and 25.4% were obese.<sup>4</sup> Adults that reported doing no physical activity or exercise during the past 30 days, excluding their regular job.<sup>5</sup> 2005-2009 Rhode Island Hospital Discharge Data 5-year aggregated file for the principal (1<sup>st</sup>) diagnosis.<sup>6</sup> 2005-2009 Rhode Island Vital Record Death Certificate Data 5-year aggregated file for the underlying cause of death.

\* Too few deaths to report an age-adjusted rate.

## Clustering of Risk Factors

Although each of the four major modifiable risk factors cited above (smoking, high blood pressure, overweight/obesity, physical inactivity) alone could devastate the health of an individual, they often do not effect people in isolated manners. They tend to cluster and act synergistically to increase the risk of developing one or more chronic conditions.<sup>7,8,9,10</sup> The clustering of these health behaviors or risk factors determines not only the occurrence and severity of a chronic disease, but also has important implications for health promotion.<sup>11</sup>

- Overweight and obesity increase risks of heart disease, stroke, type 2-diabetes, and osteoarthritis.
- Smoking, physical inactivity and high blood pressure (hypertension) increase the risks of heart disease, stroke, type 2 diabetes, and rheumatoid arthritis.
- Diets high in saturated fats increase the risks of heart disease and stroke, while high blood glucose (sugar) and high cholesterol increase the risk of type 2 diabetes.

Recent Rhode Island Behavioral Risk Factor Surveillance System data found that more than one-third of adults 20 to 64 years of age had at least one modifiable risk factor associated with cardiovascular disease and diabetes (36.2%), and an additional 44% of adults in this age group had two or more modifiable factors. This means that 252,614 Rhode Islanders between the ages of 20 and 64 years are at high risk for diabetes and heart disease.<sup>12</sup> Clustering of two or more risk factors was more prevalent among Rhode Islanders in the 20 to 64 year age group with a high school diploma or less education or who had household incomes that were lower than \$25,000 per year. For example, low-income adults aged 20 to 64 years were more likely to report two or more modifiable risk factors than adults in this age group with household incomes of \$50,000 a year and higher (55.0% versus 35.9%).<sup>13</sup>

Personal income and level of education, however, only partly explain disparities. Individuals are also affected by the communities in which they live. Living in a high poverty neighborhood, as compared to a more economically affluent neighborhood, for example, has been shown to increase the risk of coronary heart disease in white residents by 70 to 90 percent and by 30 to 50 percent for African American residents.<sup>14</sup> Adults 55 years of age and older living in economically disadvantaged areas in the United States are at increased risk for developing heart problems and high blood pressure. Additionally, women in this age category in these communities are at increased risk for diabetes. Living in an area with higher levels of crime and more segregation increases the chances of developing cancer for women and men.<sup>15</sup>

These findings may be the result of greater exposure to environmental toxins, such as hazardous waste and low quality water. The effect of stress on the body's ability to fight disease, which may be greater for those living in poverty, could be another contributing factor.

## Rhode Island Statewide Surveillance of Social Capital Data

The Rhode Island Department of Health collects information on neighborhood-level quality of life through the statewide Behavioral Risk Factor Surveillance System. Questions ask about satisfaction with one's neighborhood as a place to live, participation in and volunteering for community events, interaction with other people in one's neighborhood, and believing that people can make a difference in one's community. Perceptions about neighborhood assets and liabilities varied with people's socioeconomic statuses. In 2009, the most recent year the module was implemented, college-educated adults (as opposed to those with a high school diploma or fewer years of education) were much more likely to have:

- Felt that they could make a difference in their community (68.2% vs. 47.9%).
- Felt that service organizations understood the needs of the people living in their community (83.4% vs. 70.6%).
- Felt that by working together, people in their community could influence decisions that affect the community (85.1% vs. 78.5%).

Adults who perceived their communities as having more social liabilities than assets were more likely to report being in poor health and being socially and emotionally isolated.



## Surveillance and Epidemiology

The projected increase in the prevalence of chronic diseases and associated healthcare costs is both cause for concern and an opportunity for enhancing current chronic disease and health promotion surveillance systems.<sup>16</sup> In Rhode Island, an inpatient hospital admission for a primary diagnosis of heart disease with a coexisting diagnosis of diabetes is common. Between 2008 and 2009 in Rhode Island, there were 12,925 admissions for patients 18 years of age and older where diabetes and/or heart disease were the diagnosis. For 25.9% of these admissions, heart disease was the primary diagnosis and diabetes was a coexisting diagnosis (n = 3,343).<sup>17</sup> This example, and the data presented in the Burden of Disease section (page 8), underscore the importance of developing an integrated surveillance system.

### Proposed Integrated Surveillance Framework

A long-term goal of the Rhode Island Coordinated Chronic Disease Prevention and Health Promotion Program is the establishment of an integrated chronic disease surveillance system.

Currently, surveillance data housed in the Rhode Island Department of Health are collected from a variety of sources. Each data set, whether a population-based survey like the Behavioral Risk Factor Surveillance System, or a healthcare utilization database like the Hospital Discharge Data, provides a snapshot of the health of a population. Each is valuable, but it is critical that Rhode Island's public health surveillance system be transformed from one that meets the needs of individual categorical programs to one that is cross-cutting. Such a system would allow for the monitoring of risk factors that cluster, such as smoking and hypertension, which in turn increase the risk of preventable chronic diseases, such as heart disease and diabetes.

Additionally, such a system would improve data collection and analysis; streamline data reports of interest to those addressing multiple categorical chronic diseases; and provide timely data that would enhance collaborative work to reduce health disparities.<sup>18</sup>

Integrated chronic disease surveillance systems are being piloted nationally in the U.S.<sup>19</sup> and Canada,<sup>20,21</sup> but similar work at the state level is in its infancy. Therefore, the short-term goal in Rhode Island is to convene work groups that will develop action steps for improving the measurement and reporting of population-based health outcomes across the lifespan, health disparities, social determinants of health, and clustering of risk and protective factors. This effort is currently underway. The Rhode Island Department of Health has formed four internal working groups, each with a different mandate. The work of all four groups, however, will contribute to the long-term goal of building an integrated chronic disease surveillance system. (See the section "Building New Partnerships for Surveillance.")

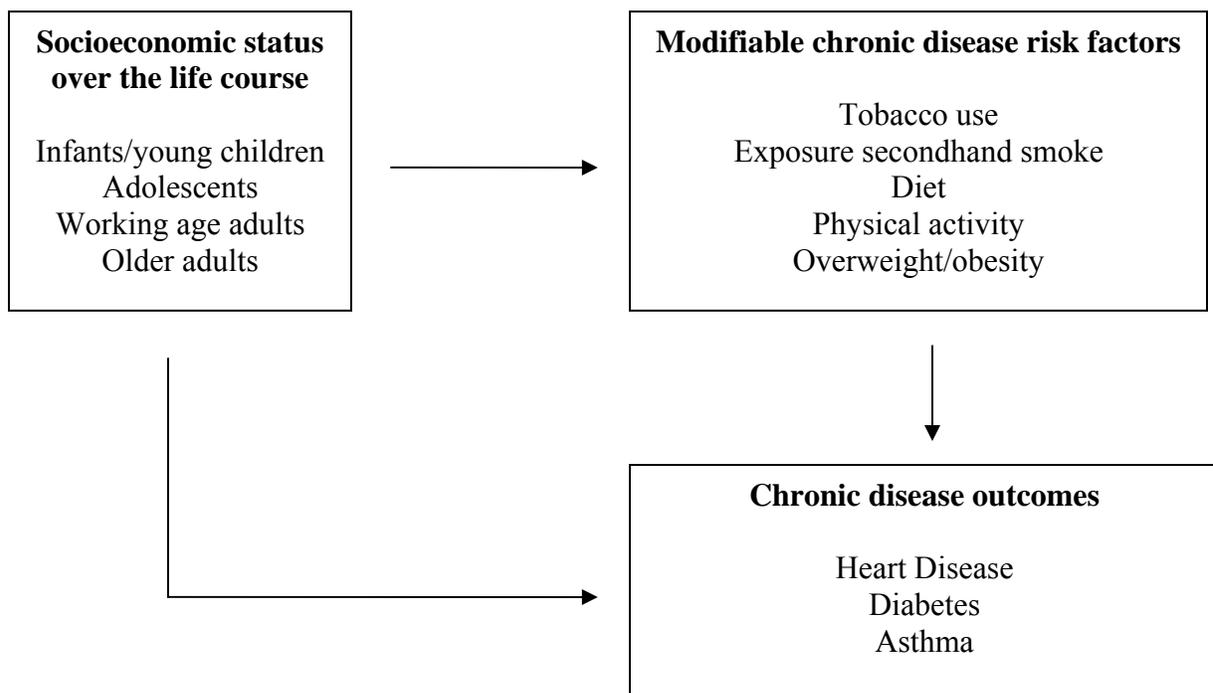
Figure 1 shows Rhode Island's Life Course Framework for chronic disease prevention and health promotion surveillance. As this framework displays, socioeconomic status over one's lifetime affects the likelihood of having one or more modifiable risk factors, and affects the likelihood of developing and dying from a preventable chronic disease. Socioeconomic status is often thought of as a non-modifiable risk factor in public health surveillance. But public health interventions

and policies can make a significant impact on disparities in health. Local and statewide initiatives can focus on the overlaps between housing, transportation, and neighborhood social and economic resources in order to reduce health disparities.<sup>22</sup>

### Review of Current Rhode Island Department of Health Data Sources

A newly compiled data inventory exists for the Rhode Island Department of Health’s population-based surveys. The inventory provides information on the availability of data to measure individual, family, and neighborhood economic well-being. It also provides information on modifiable chronic disease risk factors and the prevalence of chronic diseases that are termed “potentially preventable”.<sup>23</sup> By 2016, an interactive web-based data inventory with data sources organized by topic area and key search words will make the search of data and information more efficient. The inventory will also allow data to be used to better understand the relationships between chronic disease risk factors and conditions. Additionally, new data sources are being added to the data inventory. These can enrich our understanding of the health of Rhode Islanders. Clinical data from the Rhode Island Chronic Care Sustainability Initiative is currently being used to test one of the nation’s first multi-payer demonstrations of the patient-centered medical home. Should such data become publicly available, Rhode Island would, for the first time, have the capacity to compare health outcomes of patients enrolled in different healthcare settings, such as private physician practices and federally qualified health centers.

**Figure 1: Rhode Island’s Life Course Approach for chronic disease prevention and health promotion surveillance**



## **Building New Partnerships for Surveillance**

As described above, the investment to build an integrated chronic disease and health promotion surveillance system within the Rhode Island Department of Health is benefiting from the formation of four new internal work groups. Each work group is facilitating collaboration across health department divisions and centers and strengthening chronic disease and health promotion surveillance.

- *Epidemiology and Evaluator Work Group.* This group collaborates on epidemiology and evaluation activities across all programs and centers in the Rhode Island Department of Health.
- *Health Data Inventory Group.* This group is developing an interactive Health Data Inventory website for internal users and the public.
- *Life Course Performance Metrics Work Group.* This group is identifying a set of life course indicators from birth to old age to improve population health and advance integrative program planning and policy work.
- *Statistical Precision and Confidentiality in Public Health Reporting Work Group.* This group is conducting an in depth assessment of how health department data are used to inform program and policy interventions.

## **Interactive Query Systems**

The Center for Health Data and Analysis at the Rhode Island Department of Health has established, for public use, an online query system for the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, and Vital Record Birth and Death files.

## **Dissemination of Knowledge Using an Integrated Approach to Surveillance**

Rhode Island's Coordinated Chronic Disease Prevention and Health Promotion Program has published several briefs using an integrated approach to data analysis to address emerging issues in public health.<sup>24, 25</sup> Several burden of disease reports address the social and economic determinants of health, such as *The Burden of Asthma in Rhode Island, 2009*, and *2013 Tobacco Control Program Data Report, Adult Tobacco Use in Rhode Island*.

## **Evaluation of Surveillance Activities**

The evaluation of Rhode Island's surveillance activities will follow the steps outlined in the Coordinated Chronic Disease Prevention and Health Promotion Evaluation Plan. In particular, the evaluation will focus on answering the overarching data evaluation question: How were data collection, analysis, and dissemination influenced by coordination efforts?

Additional evaluation questions to be answered related to surveillance activities include:

- What datasets (both population and program specific) were available for measuring disease prevention and health promotion?
- How were datasets used for coordinated chronic disease and health promotion surveillance efforts?
- What were the individual level and community level markers available to measure disparities (e.g. race, education, income, etc.)?
- Which indicators (risk and resilience) were identified across the life course that affect quality of life?
- How were indicators prioritized?
- Was there consensus about how to measure/track chronic disease risk factors and collect demographic data associated with these risk factors? If not, what were the differences in ways risk factors were tracked and demographics measured?

Several data collection methods will be utilized to evaluate surveillance activities. Specific data collection methods will include interviews with the Coordinate Chronic Disease Prevention and Health Promotion Program epidemiologist, workgroup members, and epidemiologists and evaluators across the Department; reviews of surveillance documents, including briefs, burden documents, and reports; a system review of Health Data Inventory; and reviews of meeting notes from workgroup meetings.

## Evaluation and Measurement

The State Plan will be evaluated as a part of the larger Coordinated Chronic Disease Prevention and Health Promotion Program to assess and monitor progress toward achievement of objectives and long-term outcomes. Information about the program will be collected systematically to assess areas of program improvement, program effectiveness, and future program direction.

Three types of evaluation will be used for assessing the State Plan development and implementation.

- Formative evaluation that is conducted during program development and implementation to help improve the initiative from an early stage when opportunities for influence are likely to be the greatest.
- Process evaluation that documents and analyzes the procedures and tasks used during program implementation, including assessing whether strategies were implemented as planned and whether anticipated outputs occurred.
- Outcome evaluation that measures the short-term, intermediate, and long-term outcomes of the program, policy, systems, or environmental change strategies to assess impact and effectiveness of the strategies.

Formative evaluation was used to 1) understand the evaluation of integration efforts, 2) understand knowledge and attitudes about integration, 3) determine appropriate activities and strategies to include in the State Plan, and 4) determine available datasets for measuring chronic disease risk factors. A case-study of the evaluation processes from the CDC Negotiated Agreement Pilot States was performed. This was conducted to understand how chronic disease prevention and health promotion integration evaluation efforts were carried out, what did and did not work well, and to understand effective evaluation tools for integration.

Division staff members have been surveyed (using the Integration Knowledge and Attitudes survey) to assess readiness for integration and to obtain information to improve internal integration efforts. External partners were surveyed to understand their knowledge of integration efforts and their readiness to participate in integration activities. Additionally, using the Stakeholder Assessment Inventory, external partners were surveyed to determine the kinds of activities and strategies they were using in each of the four domains of the Coordinated Chronic Disease Prevention and Health Promotion Program (Surveillance, Epidemiology, and Evaluation; Strategies to Support and Reinforce Healthy Behaviors; Healthcare Systems Quality Improvement; and Community-Clinical Linkages).

An assessment tool is being used to collect information about datasets currently being utilized throughout the Rhode Island Department of Health. This tool will help evaluators and epidemiologists better understand the data available to measure chronic disease risk factors and rates, and better understand differences in the ways in which risk factors and demographics are measured and tracked. Findings from these formative efforts help to inform ongoing evaluation efforts, provide baseline data, and provide information to improve the State Plan and future statewide integration efforts.



Stakeholder input is an important part of evaluation. A Strategic Evaluation Committee was convened that consists of representatives from all teams within the Division (see page 7). The group is responsible for prioritizing key activities to be evaluated within three programmatic areas: 1) State Health Department Capacity and Practices, 2) Partnerships, Collaboration, and Training, and 3) Data and Communication.

An Evaluation Advisory Group exists for each of these three programmatic areas. The Partnerships, Collaboration, and Training Evaluation Advisory Group will prioritize the stakeholder engagement and the State Plan. In both process and outcome evaluations, they will draw on many data sources, including:

- Meeting notes and minutes
- Key informant interviews
- Division coalition membership form
- Meeting attendance sheets and training rosters
- Training needs assessment
- Rhode Island Chronic Care Collaborative Electronic Health Records
- Surveillance datasets (e.g. Behavioral Risk Factor Surveillance System, Youth Risk Behavior Survey, hospital discharge data, vital records)
- American Community Survey

The Coordinated Chronic Disease Prevention and Health Promotion Program Evaluation Plan provides more details about evaluation activities of the program, including more details in the areas of partnerships, collaboration, and training. It includes evaluation questions, methods of gathering evidence, indicators, and data sources. Indicators and data sources for each State Plan objective are also located in the Goals, Objectives, and Strategies section of this document. This Evaluation Plan will be reviewed and updated, as needed, to account for any changes to priorities in the State Plan as it is implemented.

The periodic dissemination of evaluation results will provide information for continuous improvement. Results will be shared with all stakeholders, including Coordinated Chronic Disease Prevention and Health Promotion staff, Division staff, community partners and collaborative partners, policy and decision-makers, and funders. Interim findings from the evaluation will be shared in presentations, emails, handouts, and formal reports. In addition, evaluation documents will be posted on the Division Administrative Site to allow internal staff access to the documents. External partners will have similar access to the material. Evaluation results will also be shared with the CDC through interim and annual reports on the CDMIS, deliverables, in success stories, and through CDC conference calls. Final evaluation results will be conveyed to appropriate stakeholders in presentations and written documents.



## Communications

Media advocacy, the dissemination of individual communications, and long-term communication campaigns are all being utilized to advance the goals and objectives of the State Plan. Programs in the Division, partner organizations, and members of the Rhode Island Collaborative for Healthy Equity are collaborating, and will continue to collaborate, in the planning, development, implementation, and evaluation of these initiatives. Examples of these initiatives include:

- An Online Resource Network. This Online Resource Network will be an electronic network used by organizations (public, private, governmental, and others) to better connect and serve their constituents in Rhode Island. Participating organizations will be able to use the network to partner with other organizations to share resources and collaborate on projects.
- The promotion of the Community Health Network. The Community Health Network is a network of self-management programs that Rhode Islanders can use to address chronic conditions such as diabetes, obesity, and arthritis. The individual self-management programs are operated by community organizations such as the YMCA and the Arthritis Foundation.
- A coordinated communications campaign to promote vaccination against influenza to Rhode Islanders who are most at risk for serious complications from the illness, such as the elderly and people with chronic medical conditions. This communications campaign incorporates the efforts of many organizations, including the Ocean State Adult Immunization Coalition and the Rhode Island Department of Elementary and Secondary Education. Private sector partners include the major pharmacy chains and health insurance in the state.

(These campaigns, among many others within the four domains of chronic disease prevention and health promotion work in Rhode Island, are presented in detail in a separate Coordinated Chronic Disease Prevention and Health Promotion Communications Plan.)

Messages are being crafted using formative research from the market and audience testing conducted by national organizations, such as CDC, and Rhode Island-based groups, such as the state's many community-based organizations and the categorical chronic disease prevention and health promotion programs. Audiences are being segmented using geography, socio-economic status, and primary language spoken, among other factors.

Strategies for the dissemination of the State Plan include:

- A link to the State Plan for members of the Rhode Island Collaborative for Health Equity to post on the home pages of their organizations' websites.
- Announcements with information for accessing the State Plan through the newsletter of the Director of the Rhode Island Department of Health, HEALTH Connections. HEALTH Connections is distributed monthly to the state's physicians and other healthcare providers.
- Media advisories, press releases, and community events that include success stories and personal testimonies.



# Goals, Objectives, and Strategies

## Overarching Goals

A priority of the State Plan is to integrate across a multitude of diseases and risk factors beyond those traditionally related to chronic disease. As such, Rhode Island adopted the *Healthy People 2020* overarching goals to:

- Attain high-quality, longer lives free of preventable disease, disability, injury and premature death.
- Achieve health equity, eliminate disparities and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.

## Long-Term Objectives

The long-term objectives for the State Plan relate to 8 of the 26 leading health indicators identified for *Healthy People 2020*. They are adopted for Rhode Island. For each objective, a baseline proxy measure for Rhode Island is provided. Rhode Island will strive to reach the national targets set forth for these objectives and where targets are met, Rhode Island will endeavor to continue improving.

### Access to Health Services

*Healthy People 2020*: By 2020, increase the proportion of persons with health insurance to 100% (national).

Indicator: Percent of population with health insurance

Rhode Island Baseline Proxy Measures:

Children aged 0-17 who have any kind of healthcare coverage, including prepaid plans such as HMOs, or government plans such as Medicaid: 94.1%

Adults aged 18-64 who have any kind of healthcare coverage: 85.4%

Baseline data sources for Rhode Island: 2007 National Survey of Children's Health; 2010 Behavioral Risk Factor Surveillance System

*Healthy People 2020:* By 2020, increase the proportion of persons with a usual primary care provider to 83.9% (national).

Indicator: Percent of population with a usual primary care provider

Rhode Island Baseline Proxy Measure: Adults aged 18+ who have at least one personal doctor or healthcare provider: 88.6%

Baseline data source for Rhode Island: 2010 Behavioral Risk Factor Surveillance System

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### **Clinical Preventive Services**

*Healthy People 2020:* By 2020, increase the proportion of adults with hypertension whose blood pressure is under control to 61.2% (national).

Indicator: Percent of adults with hypertension whose blood pressure is under control

Rhode Island Baseline Proxy Measure: Patients aged 18-85 with cardiovascular disease enrolled in a federally qualified health center that participates in the Rhode Island Chronic Care Collaborative and who have their blood pressure under control: 50.6%

Baseline data source for Rhode Island: 2011 Rhode Island Chronic Care Collaborative

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### **Environmental Quality**

*Healthy People 2020:* By 2020, reduce the proportion of children aged 3 to 11 years exposed to secondhand smoke to 47.0% (national)

Indicator: Percent of children aged 3 to 11 years exposed to secondhand smoke

Rhode Island Baseline Proxy Measure: Children aged 3-11 who live with a smoker who smokes inside the home: 14.5%

Baseline data source for Rhode Island: 2007 National Survey of Children's Health

## **Nutrition, Physical Activity, and Obesity**

*Healthy People 2020:* By 2020, increase the proportion of adults who meet the objectives for aerobic physical activity and for muscle strengthening activity to 20.1% (national)

Indicator: Percent of adults who meet the objectives for aerobic physical activity and for muscle strengthening activities

Rhode Island Baseline Proxy Measures: Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week: 48.4%

Adults with 20+ minutes of vigorous physical activity three or more days per week  
29.0%

Baseline data source for RI: 2009 Behavioral Risk Factor Surveillance System

*Healthy People 2020:* By 2020, increase the contribution of total vegetables to the diets of the population aged 2 and older to 1.1 cup equivalents per 1000 calories (national)

Indicator: Proportion of population aged 2 and older who have 1.1 cup equivalents per 1000 calories of total vegetables in their diets.

Rhode Island Baseline Proxy Measure: Public high school students grades 9 – 12 who consume fruits and vegetables five or more times per day: 19%

Adults aged 18+ who consume fruits and vegetables five or more times per day: 26.1%

Baseline data sources for Rhode Island: 2007 Youth Risk Behavior High School Survey;  
2009 Behavioral Risk Factor Surveillance System

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## **Tobacco**

*Healthy People 2020:* By 2020, reduce the proportion of adults aged 18 years and older who smoke cigarettes to 12.0% (national)

Indicator: Percent of adults aged 18 years and older who smoke cigarettes

Rhode Island Baseline Proxy Measure: Adults aged 18+ who are current smokers: 15.7%

Base line data source for Rhode Island: 2010 Behavioral Risk Factor Surveillance System

*Healthy People 2020:* By 2020, reduce the proportion of adolescents who smoke cigarettes (past 30 days) to 16.0% (national).

Indicator: Percent of adolescents who smoke cigarettes (past 30 days)

Rhode Island Baseline Proxy Measure (*HP2020 – Met*): Public high school students grades 9-12 who are current smokers: 11.4%

Baseline data source for Rhode Island: 2011 Youth Risk Behavior Survey

## Coordinated Infrastructure

### Goal

Enhance capacity in leadership, management, advocacy, communication, surveillance, evaluation, and community mobilization to promote a culture of collaboration and advance disease prevention and health promotion.

### Short-Term Objectives

**Objective 1.1:** By 2014, increase the number of Division of Community, Family Health and Equity program action plans that are aligned with the State Plan from 7 to 15.

The seven are Tobacco Control, Heart Disease and Stroke, Initiative for a Healthy Weight (Obesity), Diabetes Prevention and Control, Asthma, Comprehensive Cancer Control, and Healthy Homes Collaborative

Indicator: Name and number of action plans that are aligned; description and number of goals, objectives, and strategies that are aligned

Data Source: Annual Action Plans

Strategies:

- Review, prioritize, and select objectives and strategies from Division's annual action plans that align with CCDPHP grant goals.
- Work with diverse community partners, including individuals and organizations that represent people with disabilities, racial/ethnic minorities, and rural populations to refine the State Plan.
- Conduct review of grant opportunities that reflect selected priority areas and address health equity and the social determinants of health.
- Review all Division funding and staffing resources and planning processes to identify integration opportunities.
- Develop a centralized electronic system to support priority activities and evaluation.
- Develop standard language for community contracts that includes healthy housing/healthy communities training requirements, CLAS standards language, health systems, linkages to resources, etc.

**Objective 1.2:** By 2014, increase the number of skill areas addressed by staff, contractors, and consultants in the four domain areas to support a Rhode Island Collaborative for Health Equity from 0 to 10.

The ten include epidemiology/surveillance; evaluation; policy development/program planning; communications; cultural competence; community dimensions of practice (e.g. community mobilization, stakeholder engagement, etc.); public health sciences; financial; planning/management; leadership/systems thinking; and workforce development.

Indicator: Description and number of skill areas addressed by those working on the grant

Data Source: Staff organizational charts, job descriptions, contracts, and training records

Strategies:

- Conduct needs assessment with Coalition members to identify skill areas needed for implementation of the State Plan and for sustaining the Coalition.
- Develop and implement CCDPHP enrichment trainings for internal staff, Coalition partners and consultants.
- Identify leadership and staff support for the Coalition.

**Objective 1.3:** By 2014, increase the number of training sessions provided to internal staff and external partners in health equity principles and evidence-based chronic disease prevention and health promotion practices from 8 to 15.

Indicator: Number of and name of programs represented by internal staff and external partners who participate in trainings; description and number of training sessions; percent of participants ratings of effectiveness and satisfaction

Data Source: Training records, meeting notes, retrospective pre-test

Strategies:

- Incorporate core competencies of health equity and enrichment trainings on evidence-based CCDPHP practices into orientation for Collaborative members.
- Provide participants with the knowledge, skills, and tools to integrate equity principals into policies and programs.
- Provide participants with the knowledge, skills, and tools related to evidence-based disease prevention and health promotion.
- Hold train-the-trainer sessions.

## Intermediate Objective

**Objective 1.4:** By 2016, increase the number of 3-year workforce development plans that addresses gaps identified through a formal study from 0 to 1.

Indicator: Description of workforce development plan; Number of Rhode Island Department of Health employees using an annual training plan to maintain certification and develop professional skills

Data Source: Workforce Development Study Report, Workforce Development Plan, Rhode Island TRAIN System

Strategies:

- Analyze job specifications, inventory staff skills and assess academic interest
- Assess professional development needs
- Develop a structure for training, tracking and development supported by Human Resources
- Identify professional training needs
- Maintain each Rhode Island Department of Health staff's TRAIN account
- Train Rhode Island Department of Health's workforce to meet the needs of the Department
- Rhode Island Department of Health maintains the TRAIN system to promote career and professional development for all staff
- Review workforce development plan intermittently to adjust for changes to staff training needs

# Surveillance, Epidemiology, and Evaluation

## Goal

Create an integrated surveillance system that provides information on health-related risk and protective factors across the life span.

## Short-Term Objectives

**Objective 2.1:** By 2014, increase the number of Rhode Island Department of Health internal work groups that are building the capacity of the health department to improve measurement and reporting of population-based health outcomes across the life span, including health disparities, social determinants of health, and clustering of risk and protective factors, from 0 to 4.

Indicator: Name and number of Rhode Island Department of Health internal work groups

Work groups newly formed or in place by 2014 include: 1) Epidemiology and Evaluator Work Group; 2) Health Data Inventory Group; 3) Life Course Performance Metrics Work Group; and 4) Statistical Precision and Confidentiality in Public Health Reporting Work Group.

Data Source: Work Group products

Strategies:

- Form internal work groups with representation from evaluation and epidemiology staff across divisions and programs to build the capacity of the Rhode Island Department of Health to improve measurement and reporting of population-based health outcomes across the life span.
- Ensure that Rhode Island Department of Health data sources are aligned with widely accepted chronic disease surveillance indicators and use standardized data collection methodology to measure chronic disease behavioral risks, preventive practices, illness, and death.
- Identify sustainable resources to support data collection, analysis and communications that support surveillance activities using an integrated chronic disease and health promotion framework.

**Objective 2.2:** By 2014, increase the number of internal electronic systems in place for collecting and sharing evaluation tools, templates, and products from 0 to 1.

Indicator: Description of system; name and number of categories by which products are organized; name and number of tools, templates, and products included in electronic system

Data Source: Meeting notes; Evaluation Tools Electronic System

Strategies:

- Create workgroup with internal evaluators and epidemiologists to identify appropriate platform and products to be included in electronic system.
- Develop plan for organization of electronic system.
- Create electronic system with categories and populate with initial tools and products.
- Disseminate information about system widely, including how to access and add products to system.

**Objective 2.3:** By 2014, increase the number of coordinated communications plans used to make data sources and evaluation results known and accessible to users and potential users from 0 to 1.

Indicator: Description of plan; name and description of coordinated data and evaluation products and results disseminated

Data Source: Communications, data, and evaluation products; communications staff interviews

Strategies:

- Create a time-limited work group with Center for Health Data and Analysis, Center for Public Health Communications, and Program Managers to identify key audiences, data users and potential users.
- Create an integrated data communications plan with a rolling timeline and responsibilities assigned.
- Implement plan.

# Strategies to Support and Reinforce Healthy Behaviors

## Goal

Create social, political and physical environments that support healthy living through the life course for all Rhode Islanders.

## Short-Term Objectives

**Objective 3.1:** By 2016, increase the number of Rhode Island Healthy Places Learning Collaborative workshops held for partners, which address social, and/or environmental solutions to population-based disease prevention and health promotion from 2 to 10.

Indicator: Number and description of workshops held for partners, which address social, and/or environmental solutions to population-based disease prevention and health promotion.

Data Source: Workshop meeting notes, attendance records, and evaluation reports

### Strategies:

- Assign a staff person to coordinate the Rhode Island Healthy Places Learning Collaborative.
- Conduct a survey of Centers for Health Equity and Wellness grantees, members of the Rhode Island Collaborative for Health Equity, and other interested stakeholders to determine interest and need.
- Select priority topics, and develop a plan and timetable for implementation of workshops over a 12-month period.
- Identify and secure qualified workshop teachers/facilitators for scheduled workshops.
- Secure venues for workshops.
- Communicate workshop opportunities and calendar to stakeholders.
- Conduct workshops.
- Evaluate workshops.
- Document and share lessons learned with stakeholders.
- Begin cycle of activities for the next 12-month period.

**Objective 3.2:** By 2014, increase the number of plans to expand or create two entities to address the comprehensive health and safety needs of children in school settings and in early childhood education settings, including nutrition standards and physical activity, and environmental health concerns, from 0 to 1.

Indicator: Number and description content of plans to expand or create two entities to address the comprehensive health and safety needs of children in school settings and in early childhood education settings, including nutrition standards and physical activity, and environmental health concerns.

Data Source: Plan with timeline and identified responsible parties and needed resources

Strategies:

- Identify a staff person to lead plan development.
- Recruit qualified community membership with skills, experience and interest working in the area of nutrition, physical activity and environmental health school and early childhood education settings.
- Develop a plan to support current work plans for nutrition standards and physical activity, and environmental health concerns in school and early childhood education settings.
- Submit plan to Rhode Island Collaborative for Health Equity and Division leadership for consideration.
- Implement between July 2014 and August 2016.

**Objective 3.3:** By 2016, increase the number of Rhode Island Health Equity Zones that use the Guide to Designing Healthy Communities to create Healthy Places from 0 to 8.

Indicator: Number and description of Health Equity Zones work plans.

Data Source: Health Equity Zones work plans and reports

Strategies:

- Identify Health Equity Zones.
- Provide training and technical assistance to Health Equity Zones in how to use the Guide.
- Document inclusion of Guide strategies in Health Equity Zones work plans.
- Document implementation successes, barriers, lessons learned.
- Share accomplishments and lessons learned with other communities.

**Objective 3.5:** By 2014, increase the number of Rhode Island Collaborative for Health Equity protocols for rapid membership mobilization to inform, educate, and where appropriate, advocate around state policy and legislation that impacts health from 0 to 1.

Indicator: Number and description of protocols for rapid membership mobilization to inform, educate, and where appropriate advocate, around state policy and legislation that impacts health.

Data Source: Rhode Island Collaborative for Health Equity protocol document; Rhode Island Collaborative for Health Equity documentation of approval of protocols; Rhode Island Collaborative for Health Equity meeting notes

Strategies:

- Assign members of the Rhode Island Department of Health's Coordinated Chronic Disease Prevention and Health Promotion Project Management Team and co-chairs of the Rhode Island Collaborative for Health Equity to draft a strategy for membership mobilization.
- Include youth mobilization in the strategy.
- Outline potential roles and mechanisms for membership mobilization.
- Conduct a survey of Rhode Island Collaborative for Health Equity membership to identify preferred communications methods and willingness to take on informing, educating and advocacy roles.
- Present a protocol to the Rhode Island Collaborative for Health Equity full membership for approval.
- Revise if necessary, and document approval.
- Implement protocols when appropriate.
- Document and share successes and lessons learned with stakeholders.
- Implement protocols between July 2014 and August 2016.

# Healthcare Systems Quality Improvement

## Goal

Enhance services and systems in place that expand access to and utilization of coordinated healthcare services and reduce morbidity and mortality of preventable chronic diseases and risk factors.

## Short-Term Objectives

**Objective 4.1:** By 2014, increase the number of trained people that provide evidence-based programs in the Chronic Conditions Work Force Collaborative, including chronic disease prevention, health promotion, and disease management/self-management both internal and external to the Rhode Island Department of Health from 500 to 700.

Indicator: Number and description of evidence-based programs provided by the Chronic Conditions Workforce Collaborative; number of people trained in one program; number of people trained in more than one program

Data Source: Training records; Evidence-based programs' documents

Strategies:

- Expanded the integrated chronic conditions work force system to provide evidence-based disease prevention and self-management programs to support primary care practices (patient centered medical homes), patients, and the health system.
- Provide trainings to expand the workforce to meet the needs of the target populations and health system.
- Create centralized referral system to improve access to programs.

**Objective 4.2:** By 2014, increase the number of programs that are reimbursed as part of covered benefits by at least one health insurance provider that includes prescribed evidence-based disease prevention, health promotion, and disease management/self-management services from 2 to 4.

Indicator: Number and names of health plans engaged that review evidence-based programs as part of covered benefit; number and name of evidence-based programs included in benefit

Data Source: Health Insurance Benefit Packages

Strategies:

- Promote the use of evidence based preventive services, for example, integrating preconception health and family planning measures within the health sector.
- Train providers (e.g., doctors, nurses and other health professionals) on evidence based health promotion and chronic disease management strategies.
- Develop a chronic disease Business Plan that documents and communicates the cost effectiveness and improved quality of care and health that results from prevention and disease management efforts.
- Sustain a strategic communications effort to educate and inform health and health insurance providers about the cost effectiveness and improved quality of care and health that results from prevention and disease management efforts.

## **Intermediate Objective**

**Objective 4.3:** By 2016, increase the number of practices collecting population based data on clinical preventive services (e.g. blood pressure control, tobacco/nicotine use/cessation, Hemoglobin A1c control, arthritis management, and Body Mass Index) from 18 to 50.

Indicator: Name and number of provider practices providing population based information and clinical preventive data results

Data Source: Rhode Island Chronic Care Collaborative and the Chronic Sustainability Initiative and Beacon funded primary care practices

Strategies:

- Work with above data sources to obtain population based data.
- Work with Health Information Exchange, Health Plans, and Medicaid to obtain similar population based data.

# Community-Clinical Linkages

## Goal

Expand access to community-based preventive services and strengthen their linkages with clinical care.

## Short-Term Objectives

**Objective 5.1:** By 2014, increase the number of coordinated evidence-based interventions in targeted settings that link individuals to community resources addressing healthy living and social/environmental hazards from 20 to 30.

Indicator: Name and number of interventions that link individuals to community resources; name and number of community resources for referral

Data Source: Intervention program records; program materials; referral form/log

Strategies:

- Develop interventions for health provider settings, community-based organizations, schools, childcare settings, worksites and faith-based organizations.
- Coordinate with the Rhode Island Business Group on Health to make the business case for wellness among Rhode Island businesses.
- Develop a standardized system of assessing, addressing, and tracking home and neighborhood hazards.
- Identify resources and mechanisms to pay for prevention and remediation services.
- Develop Healthy Homes Center model, to which families can be referred to address environmental health issues within the home.

**Objective 5.2:** By 2014, increase the number of people with a chronic disease that have attended community-based self-management programs from 10,000 to 25,000.

Indicator: Number of people who participated in programs and name(s) of program participated in by each individual; description of location and schedule for programs offered

Data Source: Living Well Rhode Island, Arthritis Self Management and Exercise Programs and Matter of Balance Exercise Programs, Draw a Breath Asthma Program, Smoker's Quitline, YMCA Diabetes Prevention, YMCA Livestrong Program, Diabetes Self Management Program, and Diabetes Education, Cardiovascular Education, and Asthma Education Programs, Arthritis Foundation Exercise Program, Walk with Ease, Chronic Pain Self Management Program

Strategies:

- Expand the use of community health workers, patient navigators, and home visiting programs.
- Create an integrated recruitment and referral system to connect people, including people with disabilities and other identified priority groups, to community resources to meet multiple health needs.
- Work with System Partners, e.g. the YMCA to establish wellness centers statewide.
- Link community based programs for health promotion and chronic disease self-management with other sectors such as, healthy housing, transportation, and worksites.

## **Intermediate Objective**

**Objective 5.3:** By 2014, increase the number of families screened in Maternal Infant and Early Childhood Home Visiting Programs that are referred to appropriate programs to address multiple risk factors and chronic disease conditions from 101 to 350.

Indicator: Number and description of risk factors and conditions screened for; number of visits where referral is necessary and is made; percent of visits that assess for multiple risk factors

Data Source: Maternal Infant Early Childhood Home Visiting Data System Efforts to Outcomes; KIDSNET; Home Visiting Program materials

Strategies:

- Train a multi-discipline workforce to address home, school, childcare and neighborhood risks.
- Create a unified system for all home visitors for screening and referral to community and clinical prevention services and for data collections, including:
  - Radon materials and referrals
  - Diabetes, Heart Disease, Asthma, Arthritis, Tobacco Use, Obesity, Falls Risks, and other chronic conditions and risk factors
  - Healthy housing checklist and remediation protocols
- Use Continuous Quality Improvement to determine if programs are meeting families' needs, barriers to enrollment for those families referred but not enrolled, and gaps in service availability and capacity.

The Rhode Island Department of Health used information gathered from program staff, community meetings, analysis of data from various sources available to the Department, and its experience in the implementation of disease prevention and health promotion strategies included in the State Plan.

Evidence-based and promising practices are drawn from a variety of sources. They include:

1. Centers for Disease Control and Prevention, *The Guide to Community Preventive Services*, Ongoing.
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3. U.S. Department of Health and Human Services, *Multiple Chronic Conditions: A Strategic Framework*, 2010.
4. U.S. Department of Health and Human Services, *Rethinking Maternal and Child Health: The Life Course Model as an Organizing Framework*, 2010.
5. U.S. Department of Health and Human Services, *Healthy People 2020 – Improving the Health of Americans*, 2010.
6. U.S. Preventive Services Task Force, *Prevention and Chronic Care Program*, 2009-2010.
7. Robert Wood Johnson Foundation, *Shortchanging America's Health*, 2009.
8. Stanford School of Medicine. Chronic Disease Self-Management Program, Ongoing.

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- <sup>2</sup> Centers for Disease Control and Prevention. Chronic Diseases and Health Promotion. Available online at: <http://www.cdc.gov/chronicdisease/overview/index.htm>
- <sup>3</sup> Centers for Disease Control and Prevention. Healthy Communities Program. Preventing Chronic Diseases and Reducing Health Risk Factors. The links on this webpage (<http://www.cdc.gov/healthycommunitiesprogram/overview/diseasesandrisks.htm>) provide information and resources about chronic diseases and health risk factors addressed by CDC's Healthy Communities Program.
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## 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.

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



*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.*

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.

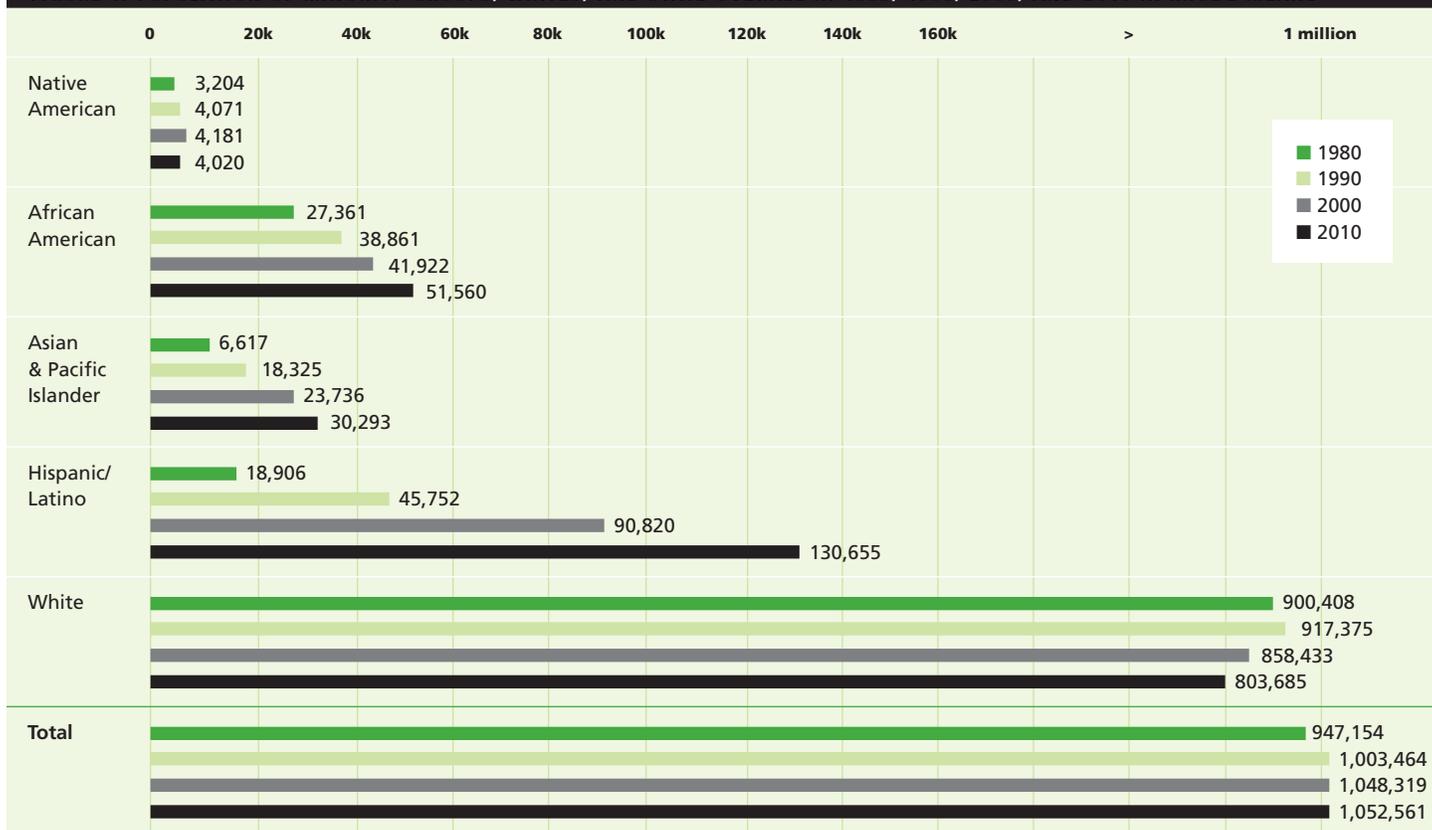
- » About 4,020 Native Americans live in Rhode Island. Tribal affiliation is diverse, with more than ten tribes with more than 100 members and numerous others with fewer than 100 members. The Narragansett tribe holds the largest membership with over 2,000 people. Over 60% of the urban Native American 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 <sup>1</sup>	AFRICAN AMERICAN <sup>1</sup>	NATIVE AMERICAN <sup>2</sup>	ASIAN & PACIFIC ISLANDER <sup>1</sup>	WHITE <sup>1</sup>	STATE <sup>1</sup>
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 <sup>1</sup>	AFRICAN AMERICAN <sup>1</sup>	NATIVE AMERICAN <sup>2</sup>	ASIAN & PACIFIC ISLANDER <sup>1</sup>	WHITE <sup>1</sup>	STATE <sup>1</sup>
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 <sup>3</sup>	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 <sup>1</sup> (2005–2008)	65.3	69.2	66.9	36.4	61.2	61.4
Percentage of adult population (20 yrs+) who is obese <sup>2</sup> (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)  $\geq 25$

2. Obesity defined by CDC as BMI  $\geq 30$

**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 <sup>1</sup>	63.9	290.8	+	24.8	19.7	38.0
Chlamydia <sup>1</sup>	865	1525	+	368	146	300
Tuberculosis <sup>2</sup>	12.6	14.6	0	22.4	1.3	3.7
HIV/AIDS <sup>3</sup>	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](http://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 <sup>1-</sup>	21.6	24.1	23.9	25.4	13.5	15.5
Rate of births to teens ages 15-19 (per 1000 teens) <sup>1*</sup>	77.9	63.5	129.1	22.9	27.1	28.3
Percentage of births to mothers with less than 12 years of education <sup>1</sup>	36.5	23.2	35.7	14.3	14.2	16.6
Percentage of infants with low birth weight (<5.5 lbs) <sup>1</sup>	8.1	10.6	13.6	9.0	7.4	8.0
Infant mortality rate (per 1000 live births) <sup>2</sup>	7.7	12.8	+	10.4	5.5	6.3
Percentage of children in poverty (<18 years old) <sup>3</sup>	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:**

**THE OFFICE OF MINORITY HEALTH**

**DIVISION OF COMMUNITY, FAMILY HEALTH, AND EQUITY**

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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](http://www.health.ri.gov/programs/minorityhealth)

SEPTEMBER 2011



### Rhode Island Collaborative for Health Equity

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C Kelly Smith	Partnership to Reduce Cancer in Rhode Island
Candace Sharkey	VNs of Newport and Bristol Counties
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Carol Hall-Walker	Rhode Island Department of Health
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Denise Kaplin	YMCA of Greater Providence
Diane Dufresne	Pawtucket Prevention Coalition
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Joseph Wendelken	Rhode Island Department of Health
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Kathi York, RN	Neighborhood Health Plan of Rhode Island
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Katy Heneghan	Rhode Island Department of Health
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Kristen Brown	Breastfeeding Coalition
Kristi Paiva	Rhode Island Department of Health
Laurie Leonard	RI Department of Health/RI Oral Health Commission
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Lisa Piscatelli	YWCA Rhode Island
Lisa Schaffran	Rhode Island Parent Information Network
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Martha Machnik	YMCA of Greater Providence
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Sarah Aneyci	YWCA Rhode Island
Sarah Marotto	Wood River
Shirley Moore	FSRI FCCP
Sonya Taly	Children's Friend
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Steve Seaward	Family Service of RI
Suelem Rosalino	Family Service of Rhode Island
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Susan Roberts	The Partnership for Cancer and The American Cancer Society
Tania Quezada	Ready to Learn Providence
Tara Townsend	RI Parent Information Network
Tara Treffry	FHHA
Teresa Fortes	Pawtucket Citizens Development Corporation Project RENEW
Thomas Bertrand	APRI
Tiesha Nieves	Providence YMCA Youth Services
Toby Simon	Bryant University
Valerie Joseph, RN	CEHC
Virginia Burke	<u>Health Care Association</u>
Yongwen Jiang	CHDA at RI Department of Health
Youa Yang	Center for Southeast Asians



## Rhode Island Coalition for Health Planning Process September 2012-January 2013

What	Who	When
<p>Online survey goes out to those who attended the first core group meeting with these goals:</p> <ul style="list-style-type: none"> <li>• evaluate the meeting,</li> <li>• seek commitment to participate in the core group through 4 more meetings,</li> <li>• gain additional input on the criteria for selecting integration priorities for the State Plan, and</li> <li>• ask a few questions to gauge initial thoughts on the structure and role of the RI Coalition for Health.</li> </ul>	M+R to re- survey; Rhode Island Department of Health (RIDOH) Senior Management Team to review and provide input Survey to be launched by M+R	Survey launched early in the week of 8/20
Doodle poll launched to those who attended the first meeting as well as those who were interested but could not/did not attend to identify dates for the next 4 meetings	M+R	8/20
State Plan is submitted to CDC	RIDOH	8/24
Circulate via email the State Plan to Core Group members with clear instructions on its purpose, flexibility, and related action items for Meeting #2	RIDOH	8/25
Place personal calls to Core Group members alerting them to look at the State Plan that has been emailed to them and urging their attendance at upcoming meeting	Cindy McDermott, co-chair Coalition, RIDOH staff, M+R	Between 8/24 and Meeting #2
<p>Meeting #2 of Core Group – held sometime in early September. The goals of that meeting will be:</p> <ul style="list-style-type: none"> <li>• Brief review/recap of the first meeting</li> <li>• Review of the role/responsibility of the core team: <ul style="list-style-type: none"> <li>○ Develop an integrated State Plan for health</li> <li>○ Based on the State Plan provide guidance to RIDOH in creating a broader statewide coalition</li> <li>○ Depending upon the relevance of the State Plan to their organization, hopefully commit to participating in the broader coalition</li> </ul> </li> <li>• Present the integration selection criteria as refined through survey</li> <li>• Present the State Plan (that was submitted to CDC on 8/24) as a foundation for exploring integration opportunities within RIDOH and externally. This inventory of RIDOH strategies will serve as a starting point to invite feedback from Core Group.</li> <li>• Seek reactions to the RIDOH inventory, begin to apply the criteria in order to prioritize potential strategies, and identify any gaps/missing opportunities</li> <li>• Add potential strategies</li> </ul>	RIDOH with assistance from M+R	Early September

Online survey of Core Group members to inventory their organization's involvement in the potential strategies identified in the State Plan. This will assess what organizations are spending time working on each of the potential strategies, the extent of that work, and what specific activities they are planning for the upcoming year.	M+R to survey; RIDOH to review and edit	Mid September
Place personal calls to Core Group members urging them to complete the inventory for their organization by deadline (4 days before Meeting #3)	Cindy McDermott, RIDOH staff, M+R	Shortly after Meeting #2
Based on most promising avenues for integration, investigate related statewide advocacy campaigns that may be in the pipeline through other coalitions for 2013 to inform Meetings #3 and #4	M+R	
Meeting #3 of Core Group – held sometime in early October. The goals of that meeting will be: <ul style="list-style-type: none"> <li>• Present inventory results which will be an inventory of Core Team members' organizations and their involvement in the strategies</li> <li>• Based upon the inventory and the agreed upon criteria, revisit the strategies and begin to prioritize strategies to be included in the State Plan</li> </ul>	RIDOH with assistance from M+R	Early October
Review State Plan and refine priorities identified during the Core Group Meeting	RIDOH with assistance from M+R	October
Reviewed State Plan is shared with Core Group members in advance of the next meeting	RIDOH	End of October
Meeting #4 of Core Group – held sometime in November. The goals of that meeting will be: <ul style="list-style-type: none"> <li>• Provide input/feedback on the State Plan and make any desired changes</li> <li>• Based on the strategies in the State Plan, begin to brainstorm a list of organizations and individuals that should be invited to participate in the broader coalition</li> <li>• Begin discussion about structure of the broader coalition</li> </ul>	RIDOH with assistance from M+R	Early November
The State Plan is updated with the changes/edits made during meeting #4.	RIDOH	November
Create email distribution lists for each of the workgroups that are dealing with specific integrated campaigns and establish an online hub for sharing documents, etc.	M+R	November
Have a one-on-one conversation with each Core Group member to assess their willingness to make a longer-term commitment to participate in the Core Group through the implementation phase	Cindy McDermott and Coalition members	November
Based on the input from meeting #4, develop a structure, roles, and responsibilities document for the broader RI Coalition for Health	M+R	End of November
Meeting #5 of Core Group – held in early December. The goals of that meeting will be: <ul style="list-style-type: none"> <li>• Review and approve the updated of the State Plan</li> <li>• Plan for a coalition kick-off meeting</li> <li>• Review structure, roles, and responsibilities document for the broader coalition</li> <li>• Seek nominations for a second co-chair for the coalition</li> <li>• Seek nominations for work group co-chairs for each agreed upon integration campaign</li> </ul>	RIDOH with assistance from M+R	Early December
Kick off meeting of coalition – held in early to mid January. The goals of that meeting will be: <ul style="list-style-type: none"> <li>• Discuss structure, roles, and responsibilities of the coalition</li> <li>• Review the State Plan and provide input and ideas</li> <li>• Seek commitment to be involved as a member of the coalition</li> <li>• Identify next steps</li> </ul>	Cindy McDermott and RIDOH with assistance from M+R	Early to mid January

# Rhode Island Collaborative for Health Equity

## GOAL: Healthy Communities

### Online Resource Action Team

An electronic network of organizations (public, private, and state/local government, and others) to better connect us and the work we do to serve Rhode Islanders.

**Leads:**

Tom Bertrand (AIDS Project RI) 519-2278  
Joseph Wendelken (RI Department of Health)

**Members:**

Michelle Barron (community member)  
Jim Coyne (RI Department of Health)  
Laurie Leonard (RI Department of Health)  
Katy Miller (Rhode Island Kids Count)  
C. Kelly Smith (RI Department of Health)

### Networking Action Team

Networking opportunities that will bring people together to enhance communication and strengthen relationships to promote health and well being for all people.

**Leads:**

Dona Goldman (RI Department of Health) 222-6957

**Members:**

Marcela Betancur (Providence Housing Authority)  
Denise Fenick (Rhode Island Breastfeeding Coalition)  
Joyce Dolbec (YWCA of Northern Rhode Island)

### Healthy Places Learning Collaborative

The Healthy Places Learning Collaborative brings people together to learn and work together to improve the health of communities. Members of the Collaborative celebrate the connections between the character of a neighborhood and the health of its residents.

**Lead:**

Mia Patriarca (RI Department of Health) 222-1225

**Members:**

Community Health Equity Wellness organizations  
RI Collaborative for Health Equity organizations  
Community at Large



## Surveillance Workgroups

### *Epidemiology and Evaluator Work Group*

This group meets monthly to discuss current evaluation and epidemiology activities and how this work can be enhanced across all programs and centers in the Rhode Island Department of Health.

### *Health Data Inventory Group*

This group is charged with developing an interactive Health Data Inventory website for internal users and the public. The inventory will provide information on health department population-based datasets in a user-friendly format. An index will organize data sources by several criteria: 1) by topic area, such as health outcomes; 2) by relevant age groups (e.g. children, adolescence); 3) by socioeconomic characteristics, such as education, income, and employment; 4) by whether the data provide information on risk and protective factors that cluster together and are associated with potentially avoidable hospitalizations for certain chronic conditions, such as hypertension, diabetes, and asthma, because these conditions can often be managed successfully in an ambulatory care setting with appropriate and timely primary care, thereby limiting the need for hospitalization; 5) by whether the data source can be used to track health disparities and/or the social determinants of health; and 6) by whether the database can be used to look at health outcomes across different periods in the lifespan.

### *Life Course Performance Metrics Work Group*

This group is charged with advancing the development of standardized metrics using a life course approach. Currently, there are no standardized metrics for the life course approach. In response to this emerging issue, the Association of Maternal and Child Health Programs launched a new project designed to identify and promote a set of indicators that can be used to measure progress using the life course approach to improve maternal and child health. Rhode Island's *Life Course Performance Metrics Work Group* is extending this effort to develop life course indicators from birth to old age. Indicators are assessed on five criteria: 1) implications for equity; 2) public health impact; 3) potential to leverage resources, such as funding; 4) ability to predict an individual's health and wellness or the health of her/his offspring; and 5) consistency with current science.

### *Statistical Precision and Confidentiality in Public Health Reporting Work Group*

This group is charged with conducting an in depth assessment of how health department data are used to inform program and policy interventions. Assessment criteria are being developed. Initial issues for inquiry include: 1) definitions and coding of health outcomes and related variables; 2) calculating nonresponse analysis and response rate calculations; 3) statistical approaches for developing estimates and projections; 4) data protection and confidentiality; and 5) dissemination of data-based products.