



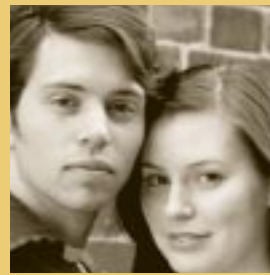
RHODE ISLAND DEPARTMENT OF HEALTH

DAVID R. GIFFORD, MD, MPH, DIRECTOR OF HEALTH

DONALD CARCIERI, GOVERNOR

MAY 2006

A HEALTHIER RHODE ISLAND BY 2010 MID-COURSE REVIEW



SAFE AND HEALTHY LIVES IN SAFE AND HEALTHY COMMUNITIES
RHODE ISLAND DEPARTMENT OF HEALTH

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LETTER FROM THE DIRECTOR

In 2000, the U.S. Department of Health and Human Services launched the third generation of national health objectives with the creation of Healthy People 2010. Healthy People 2010 was designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

Rhode Island, like most other states, has adopted the Healthy People 2010 agenda using the two Overarching Goals and ten Leading Health Indicators, as well as the twenty-seven corresponding Objectives included in this Mid-Course Review. Healthy Rhode Island 2010 is intended to serve as a roadmap for prevention in the state, as well as to provide a framework for “doing public health better.” Specifically, The Rhode Island Department of Health (HEALTH) has identified the elimination of health disparities and childhood obesity as two main priorities for the coming years and uses Governor Carcieri’s 5 Wellness goals to guide its work and advance HEALTH’s agenda and priorities.

As evidenced by the data reported here, Rhode Island leads the nation in a number of public health areas, and has made striking improvements in others. Although we have not seen improvements in all of the objectives or for all population groups and there is still more to do, we would like to acknowledge those who are responsible for our many successes—those who “lead by example.” We have

OVERARCHING GOALS

1. Increase quality and years of healthy life
2. Eliminate health disparities

LEADING HEALTH INDICATORS (LHIS):

1. Physical Activity
2. Overweight and Obesity
3. Tobacco Use
4. Substance Abuse
5. Responsible Sexual Behavior
6. Mental Health
7. Injury and Violence
8. Environmental Quality
9. Immunization
10. Access to Health Care

therefore chosen a number of inspiring policies, initiatives, and programs to highlight in this document. They are role models for all of us working to improve the public’s health and valuable resources for our state.



David R. Gifford, M.D., MPH
Director of Health

HEALTHY RI 2010: LEVELS OF IMPROVEMENT FROM BASELINE TO MID-COURSE

OBJECTIVE	NOTABLE IMPROVEMENT	MARGINAL IMPROVEMENT	NO IMPROVEMENT	NEGATIVE DIRECTION	INSUF. DATA
1-1: Adult Physical Activity					X
1-2: Adolescent Physical Activity			X		
2-1: Adult Obesity				X*	
2-2: Adolescent Overweight				X	
2-3a: Adult Fruits and Vegetables		X			
2-3b: Adolescent Fruits and Vegetables		X			
3-1: Adult Tobacco Use		X			
3-2: Adolescent Tobacco Use	X*				
4-1: Adolescent Substance Use	X*				
4-1a: Adolescent Alcohol Use	X*				
4-1b: Adolescent Cocaine Use			X		
4-1c: Adolescent Marijuana Use		X			
4-2: Adult Drug Use					X
4-3: Adult Binge Drinking				X*	
5-1: Adolescent Responsible Sexual Behavior	X*				
5-2a: Adult Female Responsible Sexual Behavior		X			
5-2b: Adult Male Responsible Sexual Behavior		X			
6-1: Depression Treatment					X
6-2: Suicide		X			
7-1: Motor Vehicle Crash Deaths		X			
7-2: Homicides				X	
8-1: Ozone			X		
8-2: Environmental Tobacco Smoke	X*				
8-3: Childhood Lead Poisoning	X				
8-4: Drinking Water				X	
8-5: Home Radon Testing	X				
8-6a: Foodborne Pathogens: Campylobacter	X				
8-6b: Foodborne Pathogens: Salmonella	X				
9-1: Childhood Vaccinations	X				
9-2a: Adult Influenza Immunizations			X		
9-2b: Adult Pneumococcal Immunizations	X*				
10-1: Health Insurance Coverage				X*	
10-2: Specific Source of Ongoing Care					X
10-3: Prenatal Care			X		
TOTALS	11	8	5	6	4

Statistically significant changes (from baseline to mid-course) are denoted by a *

INTRODUCTION

“Doing Public Health Better,” means improving on what we do well now and evaluating where we need to make a greater effort. In an era of increasing needs and limited resources, evaluation is very important in order to assure that we are on the right track to reach our goals. The Healthy Rhode Island 2010 Mid-Course Review is the preliminary evaluation that will guide the rest of our journey towards a healthier Rhode Island in 2010.

The mid-course review is intended as a supplement to the Healthy Rhode Island 2010 Plan for Action (2004). In this document, you will find the most recent data available from the Department of Health (HEALTH) for all but two of the 27 Objectives included in the Rhode Island Plan.¹ Additionally, this Mid-Course Review highlights a number of programs, policies, and initiatives that have been doing effective work towards achieving the Healthy RI 2010 targets.

Also included in this review, is a snapshot of current racial/ethnic health disparities and methodological/statistical issues that have arisen since the beginning of Healthy Rhode Island 2010. A partner document has also been developed this year titled, “Health Disparities and People with Disabilities: Mid-Course Review”. This document highlights the health status of people with disabilities on the ten leading health indicators and related disparities of people with disabilities.

GOVERNOR CARCIERI'S WELLNESS INITIATIVE GOALS

By 2010, to cut the rates in half for the number of Rhode Islanders with the following unhealthy and unsafe habits:

- » Are Overweight or Obese
- » Adult Smoking
- » Not meeting the recommended daily intake of fruits and vegetables
- » Not exercising regularly
- » Do not wear a seatbelt.

Looking back at both Healthy Rhode Island 2000 and 2010, a challenging pattern can be observed: the targets for environmental change objectives are more consistently attained than the targets for objectives that require behavior change. The data make it clear that we need to rethink our strategies in order to reach our 2010 targets for the key behavior change objectives. We also need to acknowledge the importance of the steps we are currently making, along with the big-picture, long-term goals towards which we are striving.

Finally, we welcome you to make use of the publications, resources, and web links listed at the end of this review.

¹ New data for Objective 6-1 (Treatment for Depression) and Objective 10-2 (Specific Source of Ongoing Care) were not available at the time of publication.

MINORITY HEALTH DISPARITIES²

Even though there are constant advances in public health and medicine, progress has not been spread equally between all groups in the state. One of the two Healthy Rhode Island 2010 Overarching Goals is to eliminate health disparities. Health disparities define the existing health differences between Rhode Island's racial and ethnic minority populations and the overall population on key measures of health, mortality, behavioral risks, and access to health care in the state.

The population of Rhode Island is becoming increasingly diverse. From 1990 to 2000, Rhode Island's minority population increased by 77% while the White (non-Hispanic) population decreased by 3%. In 2004, 18% of the state population is a racial or ethnic minority. Health-related services in Rhode Island must change to keep up with the shifting demographics. By resolving systemic biases we can incorporate interventions and services that are culturally and linguistically appropriate in order to best serve the entirety of our state.

The data available on racial and ethnic health disparities is, unfortunately, incomplete. There is almost no mid-course data on Asians, Pacific Islanders and Native Americans/American Indians due to the difficulty in obtaining adequate samples of the small populations of both of those groups in Rhode Island. The table on the next page contains some of the main disparity issues that we do know about for each of the racial and ethnic minority

groups that live in Rhode Island, as evidenced by the mid-course Healthy Rhode Island 2010 data.

HEALTH is working hard to improve the health status of Rhode Island's ethnic and racial minorities, focusing on the goal of eliminating health disparities. Since FY 1994, The HEALTH Office of Minority Health (OMH) has awarded nearly \$2.4 million in grants to community-based agencies serving minority populations. These grants are designed to assist community-based organizations in developing Minority Health Promotion Centers (MHPC) to:

- (1) provide health education and information addressing those health conditions for which minorities experience a disproportionate health burden;
- (2) conduct community outreach in order to inform community members of HEALTH services and programs and MHPC services;
- (3) provide education regarding consumers' rights and responsibilities within the health care system; and
- (4) work with health care providers and community clinics to assure minority access to health screenings and follow-up care, if needed.

Ten community-based agencies are currently funded as MHPC, bringing the grand total of funded organizations to thirty-three since the program began. In addition, the OMH awards mini-grants targeting first-time applicants to provide culturally and linguistically appropriate community-based outreach and education services to racial and ethnic minority populations.

2 Adapted in part from *Minority Health Facts in Rhode Island* published by DOH, 2004.

RACIAL ETHNIC GROUP	DISPARITIES
Hispanic/Latino	Physical activity Overweight and Obesity Fruit & Vegetable Consumption Homicides Access to Health Insurance and Prenatal Care
African American/Black (Non-Hispanic)	Physical activity Overweight and Obesity Fruit & Vegetable Consumption Tobacco Use Homicides Access to Health Insurance and Prenatal Care
Asian & Pacific Islander Prenatal Care	Access to Health Insurance and Prenatal Care
Native American/ American Indian	Tobacco Use Access to Prenatal Care



1. PHYSICAL ACTIVITY

Objectives

Objective 1-1: The measurement for adult physical activity in the national Behavioral Risk Factor Surveillance System (BRFSS) was changed in 2000, making it impossible to follow up on the original baseline for this Objective. Because of this, a new baseline and target have been created for the physical activity Objective using more recent data (Please see the Statistical Notes section for more information). Mid-course data is not yet available.

Disparities data show that Whites do significantly more physical activity than their Black and Hispanic counterparts, and men do more physical activity than women.

National trends show little improvement in physical activity levels over the past decade.*

Objective 1-2: There has been no change in the proportion of adolescents meeting the physical activity guideline since the baseline data was collected. This is consistent with national trends for this age group.

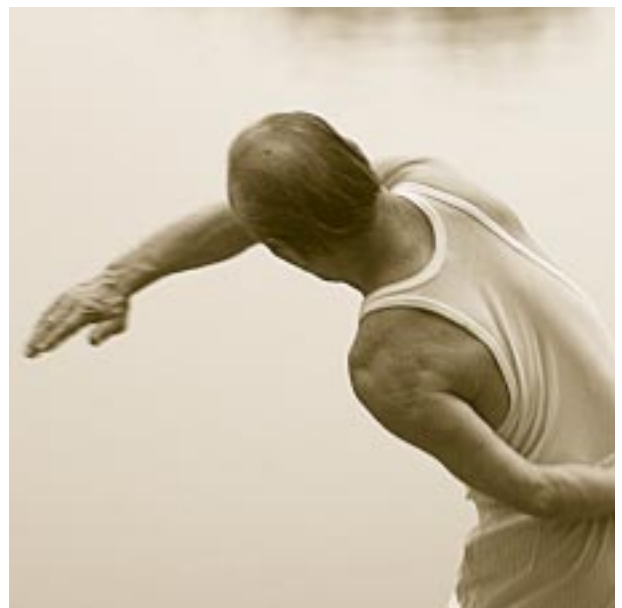
Hispanic students do significantly less physical activity than White students. Male high school students do significantly more physical activity than female high school students.

Meeting the Physical Activity Challenge

The Initiative for a Healthy Weight

In 2000, the Rhode Island Department of Health (HEALTH) was one of the first six states to receive funding from the U.S. Centers for Disease Control and Prevention to respond to the epidemic of overweight and obesity. HEALTH established the *Initiative for a Healthy Weight (IHW)* to build the state's capacity to reverse this epidemic.

The vision of the IHW is a Rhode Island where safe and healthy communities support healthy eating and active living, and the program's mission is to prevent obesity among Rhode Islanders.



IHW coordinates, supports, and implements activities to promote lifelong healthy eating and active living through partnerships, community capacity building, policy and environmental changes, and targeted interventions. IHW works with community partners to implement interventions in schools, worksites, communities, and healthcare settings. IHW addresses the obesity epidemic by focusing on four targeted behaviors contributing to overweight and obesity: nutrition, physical activity, screen time and breastfeeding.

South Providence Neighborhood Ministries

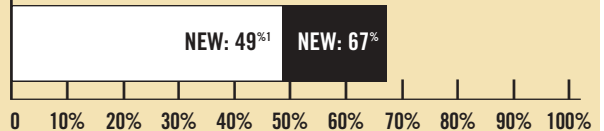
South Providence Neighborhood Ministries (SPNM), a non-profit multi-service neighborhood center expanded to include health promotion when it received its first RI Department of Health Minority Health grant in 1998. Since then, SPNM has assisted neighbors to access health resources and provided hundreds of diagnostic screenings and health education workshops. Topics have included: nutrition, genetics information, obesity prevention, physical activity, asthma, pedestrian safety, tobacco prevention, second hand smoke, creative problem solving, and violence prevention.

In May 2001, the *SPNM Broad Street Path to Health* opened with the goals of increasing the health and well-being of residents by encouraging increased physical activity, improving the safety and feeling

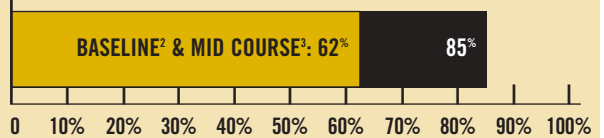
PHYSICAL ACTIVITY IN RHODE ISLAND

□ BASELINE
 ■ MID-COURSE
 ■ TARGET 2010

OBJECTIVE 1-1: Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day.



OBJECTIVE 1-2: Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 minutes or more per occasion.



Data Sources: 1) BRFSS 2001-2003; 2) YRBS 1997; 3) YRBS 2003

of security of people walking on Broad Street, and promoting community pride in this neighborhood of diverse ethnic, racial and cultural backgrounds. In 2004, *Broad Street Path to Health* had 12 exercise programs, leading to 158 neighborhood residents getting exercise regularly. Currently, SPNM offers free, year-round, bilingual physical activities such as Latin dancercise, youth and adult walking clubs, Pilates classes, and a new Healthy Lifestyle support group (that includes nutrition and health education).

The SPNM has also recently published the *Southside Physical Activity Directory*, which lists free and low cost exercise and nutrition resources on the south side of Providence. It has been printed in English and Spanish, and is posted on the SPNM website at www.spmn.org. The directory is sponsored by South Providence Neighborhood Ministries through a grant from the US Centers for Disease Control and the Initiative for Healthy Weight, Rhode Island Department of Health, in cooperation with the Broad Street Path to Health Coalition.

* National trends are taken from the Healthy People 2010 website, unless otherwise noted: <http://www.healthypeople.gov/data/PROGRVW/>

2. OVERWEIGHT AND OBESITY

Objectives

Objective 2-1: Reduce the proportion of adults who are obese.

The proportion of adults in Rhode Island who are obese has risen significantly since the baseline. Adult overweight has also shown a similar increase. As overweight and obesity have recently been acknowledged as a major health problem in the United States, Rhode Island is taking steps to curb the growing obesity epidemic.

Adult women show slightly lower rates of obesity than men. Asian/Pacific Islanders continue to have the lowest obesity rates and the group that has shown



the greatest improvement in decreasing the amount of obesity is the Black/Non-Hispanic population.

Objective 2-2: Reduce the proportion of children and adolescents who are overweight and obese.

There has not been a significant change in levels of adolescent obesity since the baseline.

Objective 2-3: Increase the proportion of persons aged 2 years and older who consume at least five daily servings of fruits and vegetables.

(New) Objective 2-3a: Increase the proportion of adults aged 18 and older who consume at least five daily servings of fruits and vegetables.

(New) Objective 2-3b: Increase the proportion of adolescents aged 14 through 18 who consume at least five daily servings of fruits and vegetables.

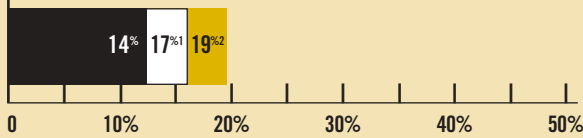
There has been no significant change in fruit and vegetable consumption within any of the age groups for which there is data. This is consistent with the national trends for this Objective.

Women eat significantly more fruits and vegetables than men as adults, though male high school students have greater consumption levels than females. White adults have higher fruit and vegetable consumption rates than Black and Hispanic adults, though current trends indicate that there has been improvement rates for Blacks and Hispanics.

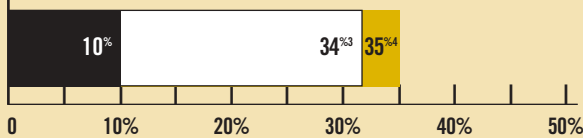
OVERWEIGHT AND OBESITY IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

OBJECTIVE 2-1: Reduce the proportion of adults who are obese.



OBJECTIVE 2-2: Reduce the proportion of children and adolescents who are overweight and obese.



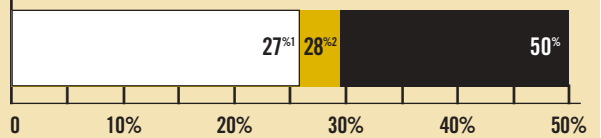
Data Sources: 1) BRFSS 1998-2000; 2) BRFSS 2002-2004; 3) RI HIS 2001; 4) RIHIS 2004

OVERWEIGHT AND OBESITY IN RHODE ISLAND

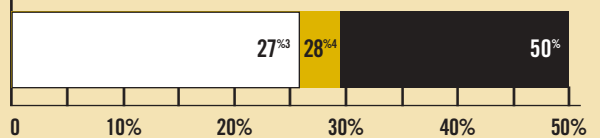
- BASELINE
- MID-COURSE
- TARGET 2010

OBJECTIVE 2-3: Increase the proportion of persons aged 2 years and older who consume at least five daily servings of fruits and vegetables.

(NEW) OBJECTIVE 2-3A: Increase the proportion of adults aged 18 and older who consume at least five daily servings of fruits and vegetables.



(NEW) OBJECTIVE 2-3B: Increase the proportion of adolescents aged 14 through 18 who consume at least five daily servings of fruits and vegetables.



Data Sources: 1) BRFSS 1998-2000 ; 2) BRFSS 2002-2003; 3) YRBS 2001; 4) YRBS 2003

Meeting the Overweight and Obesity Challenge

The Rhode to Health Coalition

In an effort to coordinate and synergize community benefits among Rhode Island hospitals and to expand health promotion/ disease prevention initiatives for Healthy Rhode Island 2010, the Rhode Island Department of Health in collaboration with the 15 non-federal hospitals in Rhode Island, organized the Rhode To Health Coalition. To promote the goals of Healthy Rhode Island 2010, RTHC selected physical activity and overweight & obesity as its priorities, which are the first two Leading Health Indicators listed in *“A Healthier Rhode Island by 2010: A Plan for Action”*.

RTHC allows the public to receive clear and consistent promotional messages about physical activity and nutrition. RTHC has created the following materials in English and Spanish: Stairway Prompts, Fast Food Prompts, and a Healthy Shopping Lists.

The Rhode to Health Coalition’s website is available at <http://www.health.ri.gov/topics/rthc/>

Breastfeeding Promotion

Breastfeeding promotion is one of the four key strategies to reduce childhood overweight problems. HEALTH received funding from the Centers for Disease Control and Prevention and the U.S. Department of Agriculture to create and implement a comprehensive state plan to promote breastfeeding. HEALTH is collaborating with health care

professionals and local media statewide to increase breastfeeding rates and enhance breastfeeding support. Rhode Island is also one of 18 sites nationwide involved with the *National Breastfeeding Awareness Campaign* (“Babies were Born to be Breastfed”).

Women, Infants, and Children Supplemental Nutrition Program (WIC) supports and promotes breastfeeding among participants. Many local WIC agencies offer mother-to-mother breastfeeding support through the *WIC Breastfeeding Peer Counselor Program*. This program was expanded in 2005, doubling the number of peer counselors—now almost every WIC site has a breastfeeding peer counselor.

Rhode Island has recently made advances in breastfeeding policy on a statewide level. In 2003, *The Physician’s Committee for Breastfeeding in Rhode Island* was instrumental in getting the *Nursing Working Mothers Law* passed, which states that employers should provide a breastfeeding mother with flexible breaks and a safe, clean, private place to pump or breastfeed her child (R.I. Gen. Laws § 23-13.2-1). Rhode Island also has a law (passed in 1998) that protects women who breastfeed in public (R.I. Gen. Law § 11-45-1).



3. TOBACCO USE

Objectives

Objective 3-1: Reduce cigarette smoking by adults.

Adult cigarette smoking rates have shown marginal improvement in the past few years. This is consistent with the national trend of a slow decline in tobacco use rates among adults.

Men smoke at a significantly higher rate than women. Whites and Hispanics have lower smoking rates than other racial and ethnic groups in the state, and Native Americans have the highest smoking rates of all groups in Rhode Island.

Objective 3-2: Reduce cigarette smoking by adolescents.

Rhode Island has seen a strong decline in youth smoking rates since 1997. While the national trend also shows a decrease in youth smoking rates, the Rhode Island numbers are particularly strong.

White adolescents smoke more than their Hispanic peers, and female adolescents smoke more cigarettes than male adolescents.

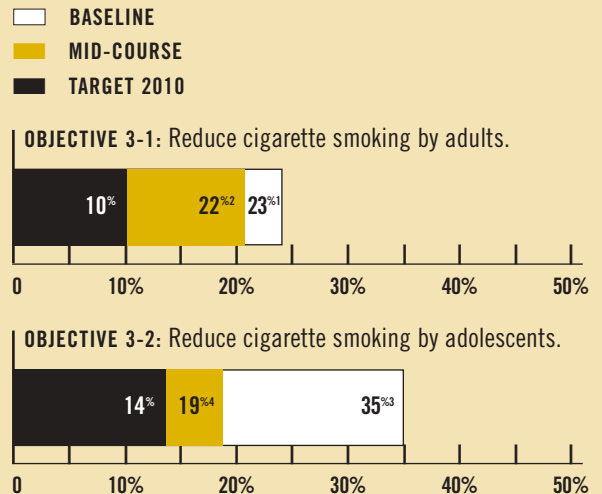
Meeting the Tobacco Use Challenge

Tobacco Control

Rhode Island is a national leader in tobacco control. To meet adolescent smoking-reduction goal, the HEALTH Tobacco Control Program combined the two strategies recommended to reduce youth smoking: increased cigarette excise taxes and multi-media campaigns.

- Rhode Island has the highest statewide cigarette tax in the country.

TOBACCO USE IN RHODE ISLAND



Data Sources: 1) BRFSS 1998-2000; 2) BRFSS 2002-2004; 3) YRBS 1997; 4) YRBS 2003



- Rhode Island also had a very successful youth media campaign funded for a three-year period by the American Legacy Foundation. The campaign used ads created by youth themselves to counter the targeting of youth by the tobacco industry.

To meet the adult tobacco use reduction goal, the HEALTH Tobacco Control Program carried out evidence-based strategies to reduce tobacco use in the environment and to provide tobacco dependence treatment to smokers and smokeless tobacco users who wish to quit.

- On March 1, 2005, Rhode Island became the seventh state to implement a smoke-free workplace and public places law to protect workers and the public from exposure to secondhand smoke. States that have passed this legislation have seen a decrease in adult cigarette smoking rates.
- The Tobacco Control Program offers a free tobacco dependence treatment program, 1-800-TryToStop for anyone in the state who wants to quit smoking or using smokeless tobacco. The program provides a choice of quit smoking materials, telephone counseling, face-to-face counseling with free patch and/or gum, and an interactive quit website (www.trytostop.org).

- Two media campaigns were carried out simultaneously to inform Rhode Islanders about the new smoke-free law, and to offer free quit smoking services. In response to these campaigns, public demand for quit smoking services skyrocketed.

Department of Mental Health, Retardation and Hospitals

To facilitate meeting the adolescent smoking-reduction goal, the Department of Mental Health, Retardation and Hospitals seeks to reduce youth access to tobacco products. Using retailer education and sales compliance testing, retailer non-compliance with state tobacco sales laws has decreased from 26.8 percent in Federal Fiscal Year 2000 to 9.5% in FFY 2005.

4. SUBSTANCE ABUSE

Objectives

Objective 4-1: Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.

The proportions of adolescents reporting no cocaine and marijuana use did not change between the baseline and mid-course surveys. However, Rhode Island has seen a dramatic increase in the number of adolescents who report no alcohol use, which has been the driving force behind the significant improvement in the overall adolescent substance use rate. Long-term national trends show increases in illicit youth drug use since the early 1990s.

Male adolescents report slightly higher rates of alcohol use, and female adolescents report slightly higher rates of illicit drug use. White adolescents report slightly higher rates of all types of substance use than their Hispanic peers.

Objective 4-1a: Increase the proportion of adolescents who report no alcohol use in the past 30 days.

Objective 4-1b: Increase the proportion of adolescents who report no cocaine use in the past 30 days.

Objective 4-1c: Increase the proportion of adolescents who report no marijuana use in the past 30 days.

Objective 4-2: Reduce the proportion of adults using any illicit drugs during the past 30 days.

In 2002, the National Household Survey on Drug Abuse (NHSDA) underwent a name change, becoming the National Survey on Drug Use and Health (NSDUH). Certain methodological changes that impact prevalence estimates were also implemented at that time. One advantage to this change is that the new survey data may be closer to true population prevalence numbers. However, these changes make it unreliable to compare the original baseline data with the most recent numbers in order to assess changes over time. Because of this, it was necessary to set a new baseline and target for this Objective using more recent data (please see the Statistical Notes section for more information). Mid-course data is not yet available.

Rhode Island illicit drug use rates are higher than most other Northeastern states, though not the highest in the nation. Nationally, there has been an increase in illicit drug use since the low-point that occurred in 1992.

Objective 4-3: Reduce binge drinking by adults in the past 30 days.

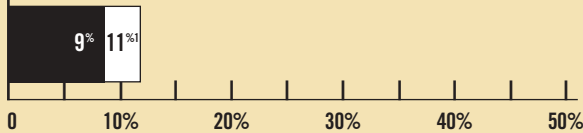
There was a statistically significant increase in adult binge drinking.

The racial and ethnic disparities data available do not indicate significant differences between the White, Black, and Hispanic populations. Males are at almost three times higher risk for binge drinking than females. When broken down by age, it is clear

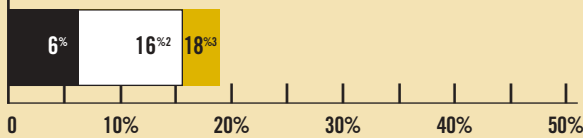
SUBSTANCE ABUSE IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

OBJECTIVE 4-2: Reduce the proportion of adults using any illicit drugs during the past 30 days.



OBJECTIVE 4-3: Reduce binge drinking by adults in the past 30 days.



Data Sources: 1) NSDUH 2002-2003; 2) BRFSS 1999; 3) BRFSS 2004

that the highest risk population is young adults ages 18-24, followed by adults ages 25-44. National data from the NSDUH show that the peak rate of binge drinking occurs at age 21.

Beginning in 2005, Healthy Rhode Island 2010 will be using the National Survey on Drug Use and Health (NSDUH) for estimates of binge drinking for better comparison against the national data for this objective.

Meeting the Substance Abuse Challenge

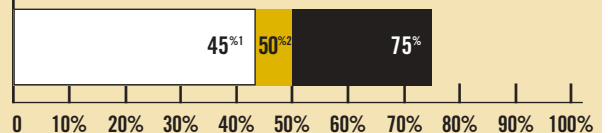
Needle Exchange Program

Rhode Island has seen a steady decline in HIV cases resulting from intravenous drug use since the early 1990's. This can be attributed to a number of factors, including education about safe needle use and the increased availability of clean needles and needle cleaning kits. Rhode Island has a needle exchange program known as ENCORE that was launched in 1995. Additionally, the Syringe Repeal Act passed in Rhode Island in 2002, which allows people to buy syringes at pharmacies without a prescription, has increased access to safe injection supplies.

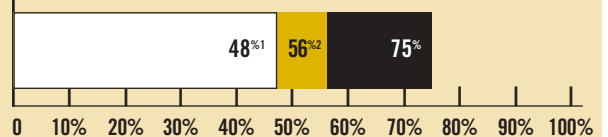
SUBSTANCE ABUSE IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

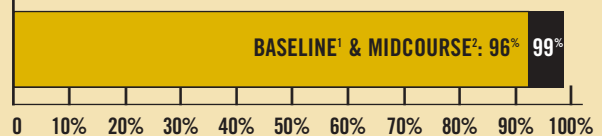
OBJECTIVE 4-1: Increase the proportion of adolescents not using alcohol or any illicit drugs during then past 30 days.



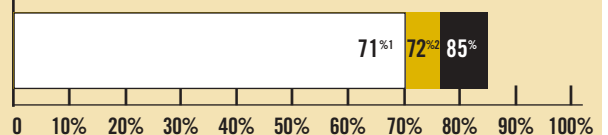
OBJECTIVE 4-1A: Increase the proportion of adolescents who report no alcohol use in the past 30 days.



OBJECTIVE 4-1B: Increase the proportion of adolescents who report no cocaine use in the past 30 days.



OBJECTIVE 4-1C: Increase the proportion of adolescents who report no marijuana use in the past 30 days.



Data Sources: 1) YRBS 1997; 2) YRBS 2003



5. RESPONSIBLE SEXUAL BEHAVIOR

Objectives

Objective 5-1: Increase the proportion of adolescents who have never had sexual intercourse, have abstained from sexual intercourse in the past 3 months, or used condoms at last sexual intercourse.

There was a statistically significant increase in the percentage of adolescents practicing responsible sexual behavior. The greatest share of the increase resulted from more adolescent condom use. National rates of condom use have increased as well, surpassing the national 2010 targets. Rates of abstinence among Rhode Island adolescents did not change significantly.

Hispanic adolescents in Rhode Island were much less likely to report never having had sexual intercourse than their White peers. Hispanic adolescents were also somewhat less likely to report practicing responsible sexual behavior than their White counterparts. Overall, male adolescents were more likely than females to report practicing responsible sexual behavior.

Objective 5-2: Increase the proportion of unmarried sexually active persons who use condoms.

Objective 5-2a: Increase the proportion of unmarried sexually active adult females who use condoms.

Objective 5-2b: Increase the proportion of unmarried sexually active adult males who use condoms.

There was a small increase in the proportion of unmarried sexually active adult females and males between the ages of 18 and 44 reporting condom use at last sexual intercourse. National trends from the past decade also show increased condom use among at-risk populations.

Hispanic males were more likely to report condom use than White males. There were no significant differences between the rates of condom use for Hispanic and White women.

Meeting the Responsible Sexual Behavior Challenge

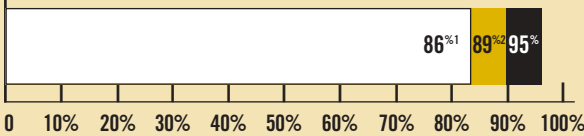
YIA Program Highlight:

Youth in Action (YIA) is a community-based organization located in Providence that is known for its innovative youth-led programming and leadership development focus. Participants in YIA are mainly African-American and Hispanic adolescents from Providence, and are mostly from low- to moderate-income families. YIA runs a behavior-based individual-level intervention program called Supporting Teens, Avoiding Risks (STAR) that has been effective in promoting responsible sexual behavior among its participants. Participants in STAR report increased intentions to use condoms and an increased ability to refuse unwanted sex.

RESPONSIBLE SEXUAL BEHAVIOR IN RI

- BASELINE
- MID-COURSE
- TARGET 2010

OBJECTIVE 5-1: Increase the proportion of adolescents who have never had sexual intercourse, have abstained from sexual intercourse in the past 3 months, or used condoms at last sexual intercourse.



A: Never had sexual intercourse:



B: Had sexual intercourse but not during the last 3 months:



C: Had sexual intercourse in the past three months and used a condom:



D: Had sexual intercourse in the past three months but did not use a condom:

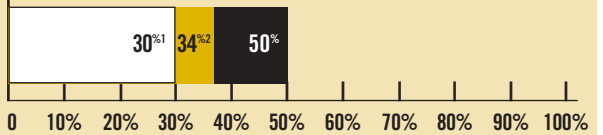


Data Sources: 1) YRBS 1997; 2) YRBS 2003

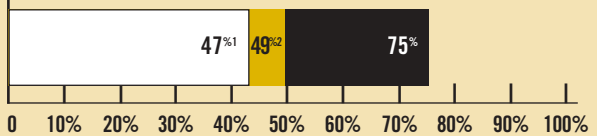
RESPONSIBLE SEXUAL BEHAVIOR IN RI

- BASELINE
- MID-COURSE
- TARGET 2010

OBJECTIVE 5-2A: Increase the proportion of unmarried sexually active adult females who use condoms.



OBJECTIVE 5-2B: Increase the proportion of unmarried sexually active adult males who use condoms.



Data Sources: 1) BRFSS 2002; 2) BRFSS 2003

*Office of Minority Health and the Office of HIV & AIDS
Minority Community Partnership*

The Rhode Island Department of Health Office of Minority Health, working in partnership with the Office of HIV & AIDS is coordinating a statewide response to the HIV/AIDS education and prevention needs of Native Americans, Asians, and incarcerated and newly-released women of color.

The overall goal(s) of the project is first developing an integrated community-based response to the HIV/AIDS crisis through community dialogue and interaction that reaches un-reached populations. Accomplishment of this goal through collaborations between the Office of Minority Health, Office of HIV/AIDS and community partners continues to improve access and refine programs to best serve our communities and assist in keeping effective HIV and AIDS education and information in Rhode Island communities that need it most.

Women of Color in Prison and Newly Released

(Project P.E.A.C.E.) provides peer education sessions to inmates on advanced skills building in the areas of HIV/AIDS transmission, domestic violence, Sexually Transmitted Infections, self-esteem, healthy relationships, negotiating, cultural competency, decision making and presentation skills for the women in prison. They also provide extensive services to women upon their release from incarceration

These same sessions and aftercare services are conducted with adolescent women in the Rhode Island Training School

*Narragansett Indian Tribe
and the Rhode Island Indian Council*

Group sessions are held with tribal and urban native youth, addressing such issues as HIV/AIDS, domestic violence, sexually transmitted infections, traditional morals and values, cultural preservation, and healthy lifestyles among Native youth. Additional workshops addressing problems such as infectious diseases focusing on HIV virus, substance abuse and domestic violence within the native community are ongoing.

6. MENTAL HEALTH

Objectives

Objective 6-1: Increase the proportion of adults with recognized depression who receive treatment.

Mid-course data for this Objective was not available at the time of publication. Updated depression data will be available in 2007.

Objective 6-2: Reduce the suicide rate.

The suicide rate in Rhode Island has decreased somewhat since the baseline. The national suicide rate has seen little change since the beginning of Healthy People 2010. In Rhode Island and the nation, males are about 4 times more likely to commit suicide than females. While racial and ethnic disparities data for Rhode Island is not reliable for this Objective, on a national level the suicide rate among Whites is higher than among any other racial group, followed by that of Native Americans.

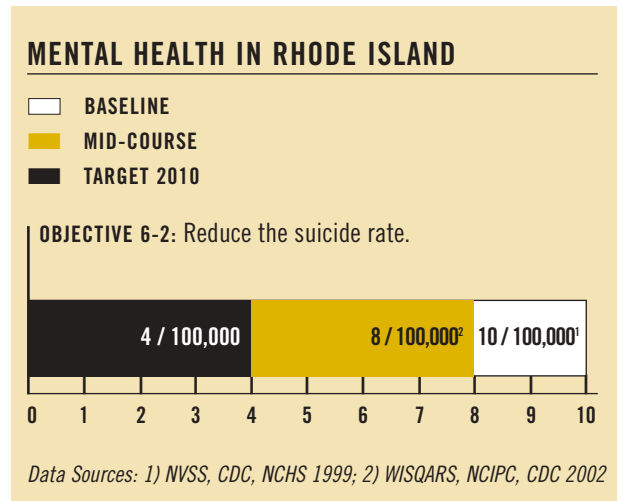
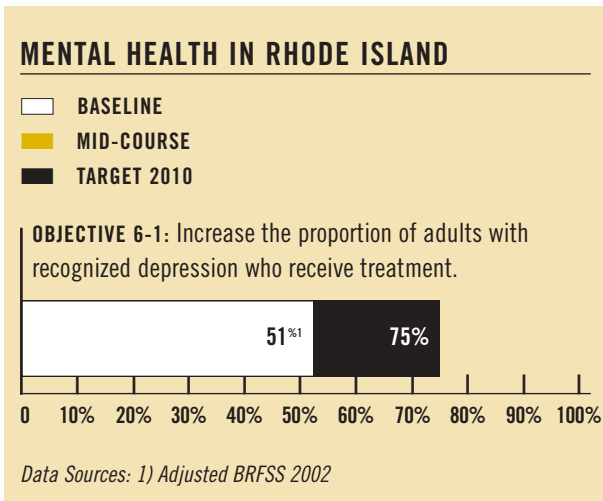
Meeting the Mental Health Challenge

“Mental Health Check-up” for Suicide Prevention

The Providence Center has been selected by Columbia University as the state’s first site to implement the Columbia University TeenScreen Program (TeenScreen). TeenScreen is a voluntary “mental health check up” designed to identify potential emotional problems in high-school students. The goal of the program is to help teens and their parents’ spot problems that can lead to academic trouble, drug use, violence and suicide.

The screening does not diagnose students with any particular problem; it simply identifies signs





that a teen may be at risk for depression or another mental health problem. Identification of a mental health problem at an early stage provides a better opportunity for intervention and remediation.

A Partnership that Honors the Body/Mind Connection

Three years ago, The Providence Center and the Providence Community Health Centers, which provide medical care to low-income and medically underserved adults and children, teamed up to implement a grant that funded Providence Center services at one of the health center’s locations. Each week psychiatrists and social workers from The Providence Center visited the health center to see patients – regardless of their insurance status – and to consult with physicians.

After the grant ran out, Neighborhood Health Plan of Rhode Island (NHPRI), which provides managed health care services to Rhode Islanders covered by the state’s RItE Care health plan, stepped in early in 2004 to continue funding The Providence Center’s care of NHPRI members onsite at the health center. While The Providence Center must serve uninsured patients at its own location, a significant number of RItE Care members still can access mental health services in the familiar surroundings of their health center.

The beauty of making a connection between primary and mental healthcare providers is most evident in patient care. Today, at PCHC’s Central Street and Onleyville sites- health center physicians can be seen conferring with Providence Center psychiatrists on the proper dosing of psychotropic medications, and patients can receive guidance and support for their mental health conditions from specialized mental health professionals.

Planning is currently underway to expand the project, making it possible for more health center patients to receive head-to-toe coordinated care under one roof.

7. INJURY AND VIOLENCE

Objectives

Objective 7-1: Reduce deaths caused by motor vehicle crashes.

Rhode Island is making headway in reducing motor vehicle deaths. This improvement is particularly noteworthy in light of the fact that motor vehicle crash deaths have been increasing on a national level.

While the racial and ethnic disparities data is unreliable, there is some evidence that Black (non-Hispanic) Rhode Islanders are more likely to die in motor vehicle crashes. Rhode Island males are over two times more likely to die in motor vehicle crashes than females.

Objective 7-2: Reduce homicides.

The number of homicides in Rhode Island has increased since the baseline, which is consistent with the national trend for homicide rates.

Homicide disparities data tell an upsetting story. Blacks (non-Hispanic) are about eight times more likely to die due to a homicide than non-Hispanic

Whites are. No progress has been made in decreasing this disparity since the baseline. New data shows that Hispanics are over four times more likely to die from a homicide than non-Hispanic Whites. Males are three times as likely to die from a homicide as females.

Meeting the Injury and Violence Challenge

Homicide Prevention

In June of 2005, Rhode Island became the 41st state to pass legislation to protect domestic violence victims from abusers with guns. The Homicide Prevention Legislation gives judges the power to remove firearms from domestic violence abusers who have permanent restraining orders against them. Data show that domestic assault victims living with abusers who own guns are more likely to be a victim of domestic violence homicide. Other states that have passed similar legislations have seen a significant reduction in the number of intimate partner homicides. This legislation was passed in large part due to the efforts of the Rhode Island Coalition Against Domestic Violence. The Coalition's lobbying efforts were part of an overarching seven-point state plan to improve victim safety and batterer accountability.



Highway Safety Legislation

The Motor Vehicles/Transportation/Injury Prevention sub-committee of the Rhode Island Injury Community Planning group, working with the Rhode Island General Assembly during the 2005 legislative session, succeeded in passing two important pieces of legislation related to highway safety.

The first is an enhancement to the state’s graduated driver licensing program. The legislation limits the number of passengers allowed in cars driven by novice drivers with provisional licenses. During the 12 months of a provisional license, no more than one passenger younger than age 21 is allowed in the vehicle, except for immediate family and household members.

Second, statutory protection is now provided to tow trucks, transportation vehicles (flatbeds), and roadside assistance vehicles displaying flashing amber lights while assisting a disabled motor vehicle. It extends the present law on conditions requiring reduced speed and provides a fine for violators.

INJURY AND VIOLENCE IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

OBJECTIVE 7-1: Reduce deaths caused by motor vehicle crashes.

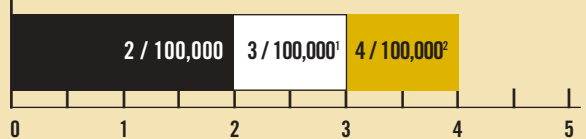


Data Sources: 1) NVSS, CDC, NCHS 1996-1998;
2) WISQARS, NCIPC, CDC 2002

INJURY AND VIOLENCE IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

OBJECTIVE 7-2: Reduce homicides.



Data Sources: 1) NVSS, CDC, NCHS 1996-1998;
2) WISQARS, NCIPC, CDC 2000-2002

8. ENVIRONMENTAL QUALITY

Objectives

Objective 8-1: Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency’s health-based standards for ozone.

Rhode Island’s ozone levels are heavily affected by pollution in other states, and it is in part because of this that little progress has been made in reducing the number of ozone exceedence days and therefore ozone exposure within Rhode Island. National trends show a slow decrease in the number of people living in ozone exposure areas. Unfortunately, all of Rhode Island is still affected. Because of how difficult it is to control ozone levels, the Rhode Island Department of Environmental Management has created a system to mitigate the impact of ozone—providing Rhode Islanders with warnings and services (such as free RIPTA bus service on days when there is a high ozone alert).

New Objective 8-2: Reduce the proportion of non-smokers exposed to environmental tobacco smoke.

[Proxy Objective: To reduce the proportion of households where smoking is permitted inside the house or inside the car all or most of the time. Data include households reporting regular smoking in the house or apartment, regular smoking in the vehicle (for households with children under the age of 18), and those that have no rules prohibiting smoking in the house or car.]

This data shows a significant change. There was a decrease in the proportion of households where smoking occurs and is permitted. *See statistical notes section.

Objective 8-3: Eliminate elevated blood lead levels in children.

The data system tracking childhood lead poisoning has been significantly improved since the baseline, leading to different lead poisoning prevalence estimates in the current document than the original Plan for Action. These changes made it difficult to compare the original baseline data with the available mid-course data, necessitating the use of a new baseline for this Objective.

Following national trends, Rhode Island has made great strides in reducing childhood lead poisoning. Minority disparities data are not available for childhood lead poisoning, as approximately 65% of ethnicity data and 40% of race data are missing from laboratory collection forms each year. There is a small gender difference in lead poisoning that is consistent in the baseline and the mid-course data—boys under the age of 6 have slightly higher rates of elevated blood lead levels than girls.

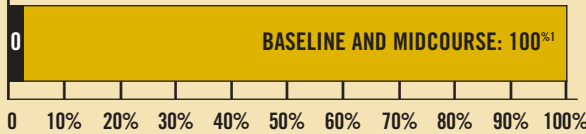
Objective 8-4: Increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act.



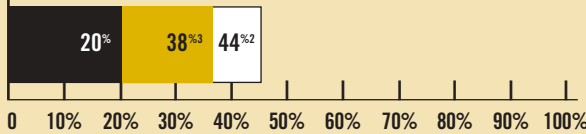
ENVIRONMENTAL QUALITY IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

8-1 OZONE: Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.



NEW 8-2 TOBACCO SMOKE: Reduce the proportion of non-smokers exposed to environmental tobacco smoke.



Data Sources: 1) RI DEM/OAR; 2) RI HIS 2001; 3) RI HIS 2004

While the mid-course data show backsliding for the water quality objective, it is not a permanent problem. There were a larger number of water quality problems in 2004 than is usual, leading to an anomaly in the state trend.

Objective 8-5: Increase the proportion of persons who live in homes tested for Radon concentrations.

Rhode Island is making steady progress towards the target for the radon Objective, increasing the number of homes in the state that have ever been tested by certified radon measurement businesses.

Objective 8-6: Reduce infections caused by key foodborne pathogens.

Objective 8-6a: Reduce infections caused by key foodborne pathogens: Campylobacter species.

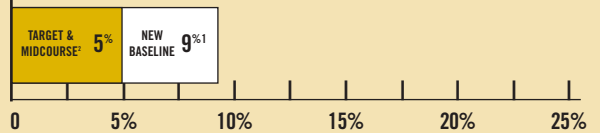
Objective 8-6b: Reduce infections caused by key foodborne pathogens: Salmonella species.

Rhode Island has seen improvements in food borne illness rates resulting from the salmonella and campylobacter pathogens. Improvements in the field of food safety can be seen on a national level as well.

ENVIRONMENTAL QUALITY IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

8-3 LEAD POISONING: Eliminate elevated blood lead levels in children.



Data Sources: 1) RI CLPPP 2000; 2) RI CLPPP 2004

Meeting the Environmental Quality Challenge

Childhood Lead Poisoning Prevention Program

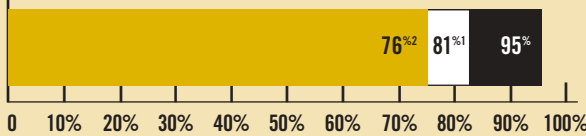
Created in 1976, the Rhode Island Childhood Lead Poisoning Prevention Program (CLPPP) coordinates the efforts within the Health Department to implement and enforce the state's lead poisoning prevention statute and regulations. This program has seen a tremendous decrease in blood lead levels in Rhode Island children over the past ten years, in large part due to the comprehensive and multi-level nature of the initiative. The RI CLPPP's responsibilities include: screening and surveillance, environmental inspection and enforcement, case management, and public education and outreach.

In Rhode Island, all public and private kindergartens, preschools, early childhood education programs, and other child care facilities require proof of a blood lead screening at the time of initial enrollment for any child under 6 years of age. All health insurers in the state, including Medicaid and RIte Care, are required to pay for blood lead screenings. Both of these state regulations have contributed to the increase in testing rates and to the success Rhode Island has seen in combating childhood lead poisoning.

ENVIRONMENTAL QUALITY IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

8-4 WATER: Increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act.

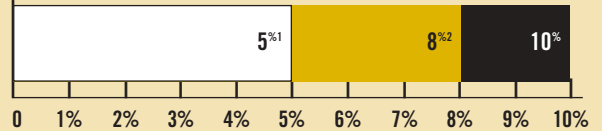


Data Sources: 1) RI ODWQ 2002; 2) RI ODWQ 2004

ENVIRONMENTAL QUALITY IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

8-5 RADON: Increase the proportion of persons who live in homes tested for Radon concentrations.



Data Sources: 1) RI Radon Test Database 1994-2000; 2) RI Radon Test Database 1994-2003

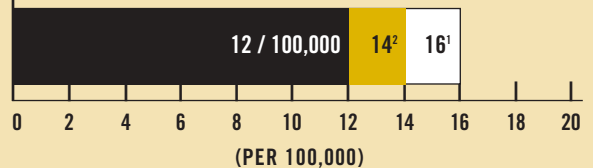
One of the most important and recent steps forward was the passage of the Lead Hazard Mitigation Law, which took effect on November 1, 2005. The Law sets minimum standards for the care and maintenance of rental housing built before 1978 that will help to keep properties safe and healthy for all residents and will improve the overall housing stock in Rhode Island. The RI CLPPP has been working closely with the Housing Resources Commission to design the classes rental property owners are required to take under the new Law. These classes are offered throughout the state in English and Spanish. Through a partnership with the Socio-Economic Development Center for Southeast Asians (SEDC), classes will be offered in Khmer and Laotian as well.

In order to comply with the requirements of the Lead Hazard Mitigation Law and to provide all Rhode Islanders with improved access to information about the quality of housing units across the state, the Department of Health publishes lists of rental properties that pose lead poisoning risks. The public lists can be found on the HEALTH website at www.health.ri.gov/lead.

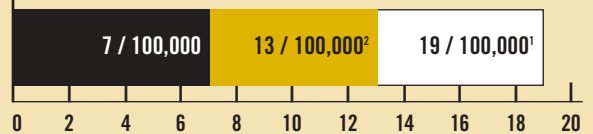
ENVIRONMENTAL QUALITY IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

8-6A CAMPYLOBACTER: Reduce infections caused by key foodborne pathogens: Campylobacter species.



8-6B SALMONELLA: Reduce infections caused by key foodborne pathogens: Salmonella species.



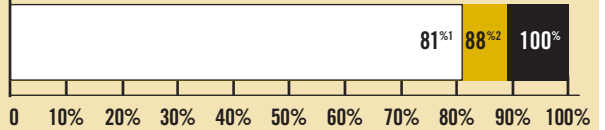
Data Sources: 1) RI DOH DDPC 2002; 2) RI DOH DDPC 2004

9. IMMUNIZATION

IMMUNIZATION IN RHODE ISLAND

- BASELINE
- MID-COURSE
- TARGET 2010

OBJECTIVE 9-1: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years.



Data Sources: 1) NIS, NCHS, NIP, CDC 2000; 2) NIS 3rd Q 2003, 2nd Q 2004

Objectives

Objective 9-1: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years.

Every year, Rhode Island children get closer to the 2010 target of 100% immunization levels. National childhood immunizations rates have also been rapidly increasing in the past few years.

White children have slightly higher immunization rates than their Hispanic peers.

Objective 9-2: Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.

Objective 9-2a: Increase the proportion of adults aged 65 years and older who are vaccinated annually against influenza.

Annual rates of flu vaccination for Rhode Islanders who are 65 years old or older have not changed since baseline. Vaccination rates for Whites in Rhode Island have been slightly higher than those of Hispanics in the past few years.

Objective 9-2b: Increase the proportion of adults aged 65 years and older who have ever been vaccinated against pneumococcal disease.

Rhode Island has seen great progress in the last half-decade in improving pneumonia vaccination levels among adults aged 65 years and older. This is consistent with improvements seen on a national level. Females in Rhode Island are more likely to have received a pneumonia vaccination than males.

Meeting the Immunization Challenge

Vaccinate Before You Graduate:

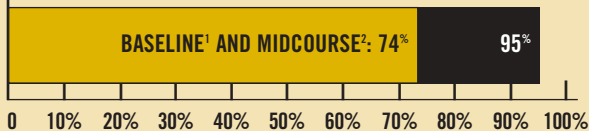
Vaccinate Before You Graduate (VBYG) is a program that offers free vaccinations through RI’s Vaccine for Children Program to all high school seniors in Rhode Island. The program offers adolescents a chance to “catch up” if they are missing any recommended vaccinations. The program targets mainly seniors in high school up to the age of 18 who are still eligible for free vaccinations. Many of these students need proof of vaccination for college or work the year after graduation (particularly meningococcal and Hepatitis B vaccinations).

VBYG has been in action for 4 years and has been very successful. In the 2003-2004 school year, VBYG worked in 53 schools and close to 1,500 students received vaccinations. 61 schools have participated since the beginning and the program has recently been renewed for another 4 years.

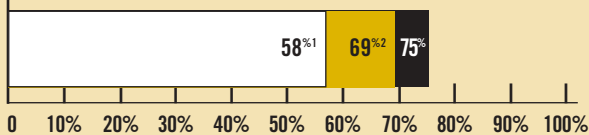
IMMUNIZATION IN RHODE ISLAND



OBJECTIVE 9-2A: Increase the proportion of adults aged 65 years and older who are vaccinated annually against influenza.



OBJECTIVE 9-2B: Increase the proportion of adults aged 65 years and older who have ever been vaccinated against pneumococcal disease.



Data Sources: 1) BRFSS 1998-2000; 2) BRFSS 2002-2004

In 2003, VBYG was highlighted at the National Immunization Conference and has been adopted as a model for programs around the country.

The Ocean State Immunization Coalition

The Ocean State Immunization Coalition works to improve vaccination rates in Rhode Island through many innovative initiatives.

The Coalition manages a Purchasing Cooperative, through which health care providers throughout the state can order the vaccines they need, giving the providers more price-negotiating power. The Cooperative has grown from 4 participating providers in 2002/2003 to over 50 in 2004/2005. The Cooperative has saved providers about \$1,000,000 in 2004/2005 alone.

The Coalition also organizes Reimbursement Workshops that bring the 5 main insurers in Rhode Island together with health care providers from all over the state. The goal of the workshops is to streamline the reimbursement process, encouraging higher rates of vaccination provision.

Additionally, the Coalition creates and distributes Provider Tool Kits. These kits contain 4 sections: influenza vaccines, pneumococcal vaccines, general vaccine storage and handling, and a sample of all of the Coalition's educational materials. Most of these materials are available in Spanish and Portuguese (plus a few in Laotian/Cambodian) and can be ordered in bulk free of charge.



10. ACCESS TO HEALTH CARE

Objectives

Objective 10-1: Increase the proportion of persons with health insurance.

Rates of health insurance in Rhode Island have decreased marginally since baseline. Nationally, there has been minimal progress in improving health insurance rates.

Hispanics, Blacks and Asian/Pacific Islanders in Rhode Island have lower rates of insurance coverage than Whites. Women have higher rates of coverage than men. Changes from baseline to mid-course for minority populations could not be reliably evaluated due to small sample sizes in each of the population groups.

Objective 10-2: Increase the proportion of persons who have a specific source of ongoing care.

Mid-course data for this Objective was not available at the time of publication. Updated ongoing care data will be available in 2007.

New disparities data for this Objective have recently become available from the 2000 and 2001 BRFSS. The data shows that Whites are more likely than Blacks and much more likely than Hispanics to have a specific source of ongoing care. Also, the proportion of females who have a specific source of ongoing care in Rhode Island is 10% higher than the proportion of males who do.

Objective 10-3: Increase the proportion of pregnant women who receive early and adequate prenatal care.

There has been no change in levels of first trimester prenatal care in Rhode Island since the baseline. Nationally, the levels of first trimester prenatal care have also shown little change in recent years.

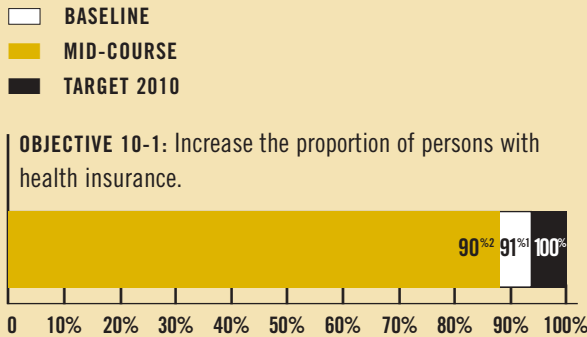
All ethnic and racial minority groups have lower levels of prenatal care than Whites, though Blacks and Native Americans have the lowest levels.

Meeting the Access to Health Care Challenge

The Family Outreach Program

The Family Outreach Program run by the Division of Family Health at HEALTH, and partially funded by the Rhode Island Department of Human Services, is a home-visiting program for expecting and new parents. Families that are identified as risk-positive or risk-suspect are offered home visits from the Outreach clinical team, which is made up of nurses, social workers and paraprofessionals from the local community. During these visits, the outreach team does basic parenting education and assessments of family resources and needs, leading to referrals to any needed services or agencies. Families in need of health insurance or with any other access to care barriers are aided in receiving the necessary services. The program is currently in the process of increasing the prenatal component, as research has shown early interventions to be very effective.

ACCESS TO HEALTH CARE IN RHODE ISLAND



Data Sources: 1) BRFSS 1998-2000; 2) BRFSS 2002-2004

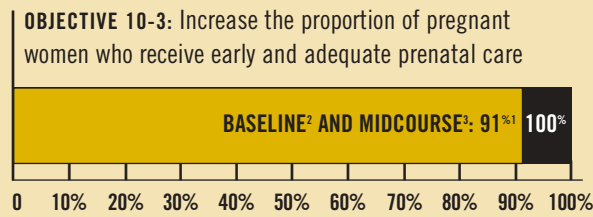
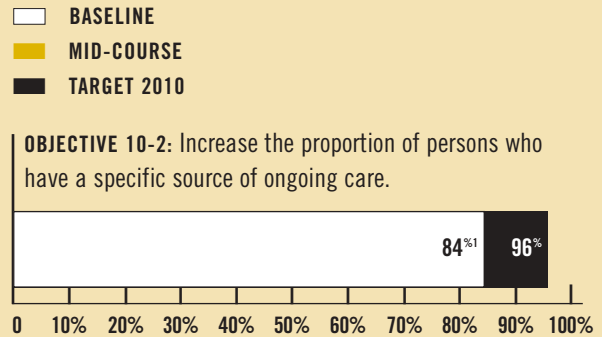
Rlte Care:

Fundamental to Rhode Island achieving the 2010 targets for access to care is Rlte Care, the statewide Medicaid program run by the Department of Human Services. While Rhode Island is not federally required to provide this type of program, the state has found it to be an important aspect of wellbeing in the state. Rlte Care provides eligible uninsured low-income families and pregnant women in Rhode Island with comprehensive health coverage. Families enroll in a health plan of their choice and receive most of their health care through one of three participating Health Plans: Neighborhood Health Plan of Rhode Island, United Healthcare of New England and Blue Cross and Blue Shield of RI. Covered benefits include doctor’s visits, prescriptions, immunizations, lab tests, hospital care, and more.

Refugee Health:

The Rhode Island Department of Health (HEALTH) initiated a Refugee Health Program in September 2003. The goal of the program is to ensure that refugees and asylees enter into a comprehensive system of care that adequately responds to their unique health care needs. Refugees in Rhode Island are a diverse group, including Liberians, Hmong, Rwandans and Somali Bantu. All refugees fled from experiences or threats of war or persecution and have experienced some combination of torture, violence, trauma, and loss of family, security and home.

ACCESS TO HEALTH CARE IN RHODE ISLAND



Data Sources: 1) BRFSS 2000; 2) Maternal and Child Health Database in Family Health and Vital Record 1997-1999; 3) Maternal and Child Health Database in Family Health and Vital Record 2001-2003

Refugees often require comprehensive medical services upon arrival, including: immunizations, treatment for infectious diseases, oral care, and mental health services. All refugees should receive a health screening within 30 days of their arrival, a process that has been streamlined through the efforts of HEALTH’s Refugee Health Program. Following the initial screening, refugees are referred for ongoing primary care and other necessary services.

The Refugee Health Program works with refugee resettlement agencies, state programs, and medical and social service providers to develop coordinated and comprehensive health services for refugees. The Refugee Health Program also provides training specifically for medical providers who work with refugees and maintains a database to track refugee health information for planning and reporting functions.

MID-COURSE REVIEW—STATISTICAL NOTES

Since the baseline Healthy Rhode Island data was collected, some statistical and methodological issues have arisen that need to be addressed. The following notes explain the issues in depth and the steps that have been taken to resolve them.

PHYSICAL ACTIVITY

(Objective 1-1):

In the BRFSS, the questions pertaining to physical activity have been changed substantially from when the original baseline data were collected. This has resulted in the new data not being comparable to the baseline. Because of this, we have set a new baseline using the first years that the new format questions were asked (2001 and 2003 were combined to provide disparities data). A new target was calculated to equal the same percentage increase over the new baseline as the original target was over the original baseline. Because the most recent data was used for this process, there is no mid-course update data to report in this publication.

OVERWEIGHT AND OBESITY

(Objective 2-2):

Since the Plan for Action was written, a norm has been established not to refer to children and adolescents as obese. While the objective mentions both overweight and obese, the changing definitions make it necessary to clarify the measurement of the

objective. The data used for this objective measures what used to be called obese and is now called overweight: the number of children and adolescents (ages 6 to 19) who are at or above the 95th percentile for their age and gender according to CDC growth charts. For more information on measures of childhood and adolescent overweight, please visit the CDC's website at <http://www.cdc.gov/growthcharts/>. Also, we were unable to recreate the statistical program that generated the analysis for the 2001 Objective 2-2 results, therefore a new baseline has been set to use from now on.

(Objective 2-3):

New data on adolescent fruit and vegetable consumption has become available since the baseline, and we have therefore added a new measurement under this objective in order to provide the most accurate and complete information possible. The original measurement for Objective 2-3 included only adult data and has been renamed Objective 2-3a (adult fruit and vegetable consumption). The new adolescent measurement has been named Objective 2-3b (adolescent fruit and vegetable consumption). The baseline data for Objective 2-3b are from the 2001 YRBS and the mid-course data are from the 2003 YRBS. Because the baseline data are identical for adolescents and adults, the adolescent target has been set at the same level as the adult target (50%).

SUBSTANCE ABUSE

(Objective 4-2):

SAMHSA provided the following explanation of the changes in the national drug use survey: “Although the design of the 2002 and 2003 NSDUHs is similar to the design of the 1999 through 2001 surveys, there are important methodological differences that impact comparability of 2002 and 2003 estimates with estimates from prior surveys. In addition to the name change, each NSDUH respondent is now given an incentive payment of \$30. These changes, both implemented in 2002 and continued in 2003, resulted in a substantial improvement in the survey response rate. The changes also affected respondents’ reporting of many critical items that are the basis of prevalence measures reported by the survey each year. Comparability also could be affected by improved data collection quality control procedures that were introduced in the survey beginning in 2001, and by incorporating new population data from the 2000 decennial census into NSDUH sample weighting procedures. Analyses of the effects of each of these factors on NSDUH estimates have shown that 2002 and 2003 data should not be compared with 2001 and earlier NHSDA data to assess changes over time.”

[<http://oas.samhsa.gov/nhsda/2k3nsduh/2k3Results.htm#1.4>]

A new baseline and target have been created to reflect these changes. The new target was calculated to equal the same percentage decrease from the new baseline as the original target was below the original baseline. Because the most recent data was used for this process, there is no mid-course update data to report in this publication.

MENTAL HEALTH and INJURY AND VIOLENCE

(Objectives 6-2, 7-1 and 7-2):

The International Classification of Diseases codes used to define the data for this objective changed in 2000 from ICD-9 to ICD-10. The equivalent codes have been matched to ensure accurate comparisons from baseline to mid-course.

ENVIRONMENTAL QUALITY

(Objective 8-2):

We were unable to recreate statistical program that generated the analysis for the 2001 Objective 8-2 results, therefore a new baseline has been set to use from here on.

(Objective 8-3):

The Childhood Lead Poisoning Prevention Program (CLPPP) at the Rhode Island Department of Health has improved their data system in the past five years (including data cleanup, address matching and verification, and removal of duplicates), leading to different estimates for RI lead poisoning prevalence than those in the baseline 2010 Plan for Action. To address this issue, a new baseline was created. Due to these data improvements and the strong progress made over the last five years, the RI CLPPP is currently reviewing and revising their Healthy People 2010 target. Although the new target is not completed in time for this publication, it will reflect the RI CLPPP’s continued commitment to eliminating childhood lead poisoning.



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Healthy Rhode Island 2010 is everyone's initiative and will only succeed with the support and dedication of all our partners.

A handwritten signature in black ink that reads "Anne P. Novak". The signature is written in a cursive, flowing style.

