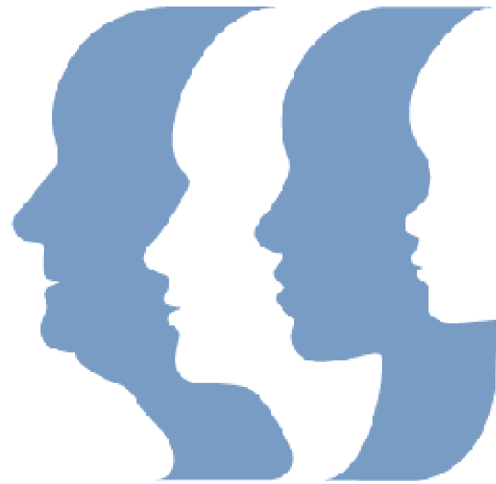

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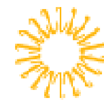

WELCOME AND INTRODUCTION

- Karen Rosene-Montella, MD

  Co-Chair Women's Health Council

  SVP Women's Services & Clinical Integration, Lifespan

  Vice Chair of Medicine for Quality and Outcomes

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  Alpert Medical School of Brown University

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ACKNOWLEDGEMENTS

- Co-Chair
- Conference Committee
- Website and Design
- Speakers
- Lifespan
- Dignitaries

Women's Health Council of RI

HISTORY OF THE WOMENS HEALTH COUNCIL

- The Women's Health Council of RI was formed as a collaboration of women's health providers, payers and patients
- As part of its mission, the definition of both Women's Health and Provider were expanded and enhanced.
- Women's Health: Comprehensive coordinated research, education, clinical care and policy/advocacy that improve the social, physical and mental health of women across their lifespan.
- Provider: anyone who can contribute to the health of women

MISSION

- Our mission to bring more cost effective, evidence based improvements for women's health care into integrated practice through research, education, clinical care, policy and advocacy

- The common themes in our work are
  - the bridging of physical and behavioral health
  - collaboration and integration across disciplines to prevent gaps in and improve access to care

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RESEARCH EDUCATION CLINICAL CARE

We pose new questions for investigation and work to translate research and new therapies into effective practice and policy

We link providers across disciplines in discussions to inform integration of clinical care and identify women at risk to improve outcomes

QUALITY and POLICY INITIATIVES

- The WHC continuously tracks metrics and health outcomes of the women of RI and compares them to national data
- These are presented as the RI Women's Health Report Card
- Data are reviewed with quality representatives from the payers and with policy makers
- Continuous improvement in these indicators and tracking to prioritize initiatives are integral parts of the council's work.

Data Vignettes from the RI Women's Health Report Card

GOAL The Women's Health Council of RI continues to track metrics and report card data as well as advocate for research, analysis and policy improvements for Women's Health. Check back often for more information at www.womenshealthcouncil.org.

SCREENING has been effective in the traditional areas of Women's Health

Mandated coverage for cancer screening in women

Nationally we rank high for screening:

	Screening NATIONAL RANK
BREAST	5/50 for women 50 or older
CERVICAL	6/50
COLORECTAL	14/50

Mortality for these cancers in women is low compared to incidence

Cancer	Incidence NATIONAL RANK	Mortality NATIONAL RANK
BREAST	47/50	20/50
CERVICAL	18/50	N/A (very low numbers)
COLORECTAL	46/50	17/50

Opportunity

Indicates that statewide efforts on advocacy, education and resource dissemination can lead to positive health outcomes

NOTE: All data reflect the state of women's health in Rhode Island

LEGEND

Green indicates improved health outcomes
Red indicates poor health outcomes, and an opportunity for improved education and care

SOURCE

The RI Women's Health Report Card has been compiled by Council members from the following sources:

RIDOH, 2009, Top Ten Leading Causes of Burden of Disease
www.Statehealthfacts.org
www.CAHI.org
www.Statecancerprofiles.cancer.gov
http://hrc.nwlc.org/

LUNG CANCER AND COPD have not been a traditional focus for Women's Health; RI women are doing poorly

	Incidence NATIONAL RANK	Mortality NATIONAL RANK
LUNG CANCER	40/50	33/50

Risk Factors

Smoking is related to 5 of the top 10 Diseases for Women in RI: Heart Disease, COPD (Chronic Obstructive Pulmonary Disease), Cerebral Vascular Disease, Trachea/Bronchus/Lung Cancer, Breast Cancer

Women are attempting to stop smoking but **smoking** rates are still high

	PERCENT	NATIONAL RANK
ATTEMPT TO QUIT	66.4%	5/50
SMOKE	16.8%	28/50

No coverage for nicotine replacement therapy in RI may hurt efforts to decrease disease

Opportunity

Give women the resources to be successful in their efforts to stop smoking

Pay for nicotine replacement therapy

Publicly educate women about the available resources

Have providers disseminate information on resources to stop smoking (see complete list at www.womenshealthcouncil.org)

Implement a statewide approach to research into the effectiveness of different programs and new ways to change behavior

Implement policy changes among payors for stronger incentives for women to change behaviors

HEART DISEASE, the leading cause of death among women, has poor outcomes suggesting a need for greater attention

HEART/CV DISEASE: 24.4% of all causes of disease/injury

	Incidence NATIONAL RANK	Deaths PER 100,000
HEART DISEASE	31/50	165.4

Risk Factors

	PERCENT	NATIONAL RANK
HIGH BLOOD PRESSURE	27.5%*	30/50
SMOKING high in RI	16.8%	28/50
OVERWEIGHT/OBESITY high in RI	54%	

* EVER DIAGNOSED

Implement statewide intervention to address these contributory factors

Enhance research to identify ways to further modify behavior patterns

Tie postpartum visit to primary care to catch issues early and increase patient awareness

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Bridging the Gap, Data Vignettes from the 2011 RI Women's Report Card

Behavioral Health

GOAL: The Women's Health Council of RI continues to track metrics and report card data as well as advocate for research, analysis, and policy improvements for women's health. Check back often for more information at www.womenshealthcouncil.org

SUBSTANCE DEPENDENCE/ABUSE

Adolescent abuse of prescription drugs has risen over the past 5 years. Prescription drugs may now be more accessible to young people, and they may perceive that prescription drugs are safer than street drugs.

2010, age 12+, Percentages	RI	US
Alcohol		
Use	8.24	7.37
Needing But Not Receiving Treatment For Alcohol Use In Past Year	7.77	6.98
Illicit Drugs		
Use	**4.15**	2.81
Needing But Not Receiving Treatment For Alcohol Use In Past Year	**3.49**	2.53

Opportunity

Research and implement strategies to prevent alcohol and substance abuse before they start or become serious.

Screen and provide behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women.

Monitor the frequency of requested prescription refills, assess medical need, and refer to mental health services when indicated.

MENTAL ILLNESS

Mental health disorders are the leading cause of disability in the US. Comorbidity with medical conditions is the rule rather than the exception. Women are twice as vulnerable as men to stress related disorders. Only 25% of adults with mental health symptoms believe that people are caring and sympathetic to persons with mental illness. RI's incidences of mental illness are 25% - 33% higher than the national average

In Past Year, age 12+, Percentages	RI	US
Any Mental Illness	24.19	19.67
At Least One Major Depressive Episode	**9.46**	6.49
Serious Mental Illness	**7.20**	4.60

Opportunity

Educate the public about how to support persons with mental illness.

Reduce barriers for those seeking or receiving treatment for mental illness.

Promote physical health, which considerably influences mental health and well-being.

SELF-HARM AND SUICIDE

Intentional self-harm (suicide) was the 10th leading cause of death in the U.S. Self-harm is the second leading cause of injury-related hospitalization in RI. Rhode Island suicide rates peak among individuals between the ages of 35 and 54, compared to national rates, which peak among the elderly. Statewide, there are more than twice as many suicides as homicides. Serious thoughts of suicide in RI are nearly double the national average.

Percentages	RI	US
Age 12+: Serious thoughts of suicide	**5.09**	3.71
Age 18+: Serious thoughts of suicide	**6.2**	3.7

Opportunity

Research factors that could contribute to RI's high rates of behavioral health risks.

Understand the many contextual factors that may coexist with substance abuse and mental illness.

Continue to research the connection between behavior and illness.

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NOTE: Red indicates that RI's rate is significantly higher than the US average (when comparing the 95% confidence intervals) and an opportunity for the WHC to intervene.

SOURCES: Healthy People 2020, WHO estimates, 2002, RWJ Policy Brief No. 21, February 2011, CDC preliminary data, 2009, SAMSHA estimates, 2008/2009, RI DOH, 2006, www.adaa.org

Bridging the Gap, Data Vignettes from the 2011 RI Women's Report Card

Physical Health

GOAL: The Women's Health Council of RI continues to track metrics and report card data as well as advocate for research, analysis, and policy improvements for women's health. Check back often for more information at www.womenshealthcouncil.org

COMMUNITY INDICATORS

Conditions may support or hinder health for women

	RI (%)	Goal (%)	RI State Rank
No health insurance (2008-2009)	**13.4**	0	15
Poverty (2008-2009)	**12.6**	0*	26
High school completion (2008-2009)	**84.8**	90	44
Wage gap (2009)	**79.4**	100*	10

Opportunity

Advocate for increased access to timely, comprehensive, quality health services.

Provide uninsured women with health insurance. Regular access to the health system improves their health status and likelihood of receiving medical services.

Understand that health disparities are often linked to social and economic factors, so long-term solutions to health inequities must consider demographics.

*Goal refers to ideal situation

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CARDIOVASCULAR HEALTH AND DIABETES

More women die of heart disease each year than men

Data: 2009	RI (%)	Goal (%)	State Rank
Smoking	**14.9**	12.0	16
Overweight or obese	**54.4**	NA	14
No leisure-time physical activity	**28.3**	20.0	33
Less than 5 fruits/veggies a day	**70.4**	50.0	16
Binge Drinking	**11.4**	6.0	36

Chronic Condition	RI (%)	Goal (%)	State Rank
High blood pressure	**28.6**	26.9	30
Diabetes	**7.0**	2.5	11

Age-Adjusted Death Rate per 100,000 (2005-2007)	RI	Goal	US
Heart disease	172.9	100.8	154.0
Stroke	33.1	33.8	41.3

Opportunity

Create a social and physical environment that supports healthy eating and active living.

Increase the awareness of risk for chronic illness, including the "numbers" (blood pressure, cholesterol, triglycerides, blood sugar, hemoglobin A1c).

Increase disease management and education for people with diabetes.

Encourage all women to be physically active at least 2.5 hours per week; limit alcohol; refrain from smoking; and maintain a healthy diet and a normal weight.

CANCER

Screening can identify certain cancers early but prevention is key

RI requires private insurers to cover these cancer screenings

	RI %	Goal %
Mammogram within past 2 years Aged 40+ (2010)	81.4	70.0
Pap test within past 3 years Aged 18+ (2010)	**83.1**	90.0
Colorectal cancer screening in lifetime Aged 50+ (2008)	67.3	50.0

Age-Adjusted Incidence Rate per 100,000 (2008)

Cancer	RI	US
Breast	136.3	121.7
Cervical	7.1	8.0
Colorectal	38.9	38.8
Lung/Bronchus	**66.8**	54.9

Opportunity

Ensure that all women have access to mammography and other cancer screening services.

Increase investment in tobacco control programs to reduce high frequency of smoking in RI.

Advocate for quitting or never starting smoking as the best prevention for lung cancer, since there is no easy screening for it.

NOTE: **Red** indicates a poor health condition compared to the Healthy People benchmark and and opportunity for the WHC to intervene. All data reflect the state of women's health in Rhode Island.

SOURCES: Current Population Survey, American Community Survey, Behavioral Risk Factor Surveillance System, National Vital Statistics System, National Program of Cancer Registries

Smoking in Rhode Island

GOAL The Women's Health Council of RI continues to track metrics and report card data as well as advocate for research, analysis and policy improvements for Women's Health. Check back often for more information at www.womenshealthcouncil.org.

TOBACCO PREVENTION AND CONTROL SPENDING

CURRENT STATUS

$121 million: RI cigarette tax revenue, 2009

$15 million: CDC recommended spending

$4 million: total funding for state tobacco control programs

GRADE: F

Opportunity

Increase spending on tobacco control programs to reduce high economic costs of smoking in RI

SMOKE-FREE AIR concerns toxic secondhand smoke and encouraging smokers quit

CURRENT STATUS

2009: Smokefree Workplace & Public Place Law passed

GRADE: A

Opportunity

Promote smoke-free environment at home and in enclosed vehicles, especially when children are present.

CIGARETTE TAX

CURRENT STATUS

$3.46: state cigarette tax- the highest in the country

GRADE: A

Opportunity

Minors who smoke paid $6.92 million in cigarette tax (2010). Earmark funds to enforce minor access laws and exposure to advertising.

CESSATION concerns making medications and counseling covered and accessible

CURRENT STATUS

Medicaid programs cover over-the-counter treatments, prescription treatments, and smoking cessation counseling

Private insurance mandate for cessation provisions spending

GRADE: D

Opportunity

Integrate more smoking cessation and prevention services in the primary care setting

SOURCE

Behavioral Risk Factor Surveillance Survey, 2010, http://www.cdc.gov/brfss/index.htm

RI Department of Health

American Lung Association

Women's Health Council of RI

ADULTS WHO CURRENTLY SMOKE (2010)

15.7% of RI adults **17.3%** of US adults

HEALTH CONSEQUENCES OF SMOKING

The average reduction in life expectancy attributed to smoking: **14 years**

1 out of every 5 deaths in the US each year is caused by smoking

Lung cancer is the leading cause of cancer death in the US and there are **no widely recommended screening tests** for this cancer

SMOKING IN RI

Economic cost associated with smoking in RI: **$869,948,000**

Estimated **number of people who die each year** in RI from illnesses directly linked to tobacco use and secondhand smoke exposure: **1,750**

Each year, **1,400 children** in RI under the age of 18 **become new daily smokers**

The estimated **children exposed to secondhand smoke at home**: **50,000**

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INITIATIVES FOR PREVENTION VIA IDENTIFICATON OF WOMEN AT RISK

- PREGNANCY AS A WINDOW INTO FUTURE HEALTH
- EARLY IDENTIFICATION OF IPV
- SMOKING CESSATION
- DEPRESSION AND SUICIDE RISK SCREENING

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PREGNANCY AS A WINDOW INTO FUTURE HEALTH

- PREGNANCY MAY UNMASK CHRONIC DISEASE
- PREGNANCY OUTCOMES MAY PREDICT FUTURE DISEASE
- PREGNANCY OFFERS AN OPPORTUNITY TO IDENTIFY HEALTH RISKS AND PREVENT ADVERSE HEALTH OUTCOME

The Scope of the Opportunity

- There are 62 million women of childbearing age in the US, 85% of whom will give birth by age 44.
- One third of women enter pregnancy with chronic medical illness and 50% are overweight or obese
- Only 55% will have obtained preventive health services in any given year and 17 million women do not have health insurance
- 50-69% of women with publically funded insurance at delivery were uninsured before pregnancy and likely will be post partum

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Pregnancy as a Stress Test

- The physiologic adaptations and stress of pregnancy may unmask a woman's predisposition to certain diseases, eg GDM
- There is an increasing body of evidence for preeclampsia as a marker for maternal disease in later life including hypertension, ischemic heart disease, stroke and chronic renal disease.

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Changing the Model

- Recast concept of care centered around conception to comprehensive care for women regardless of childbearing status
- Link Obstetric Care to Ongoing Primary Care for Women

New Models

Poor Birth Outcome → Chronic Disease

Risk Factor →

- Smoking
- Diabetes
- Obesity
- Hypertension
- Race
- Poverty
- Domestic violence

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PREVALENCE OF IPV
Lifetime

- 25% of American women will be physically or sexually assaulted by an intimate partner
- By clinical practice setting:
  - Primary Care: 26% of women patients
  - Ob-Gyn: 35% of patients
  - ED: 41% of women patients

(CDC. MMWR. 2008; McCloskey LA, et al. Acad Emer Med. 2005)

Intimate Partner Violence & Health Outcomes

Women's lifetime IPV victimization was significantly associated with the following individual outcomes/behaviors (N=42,566 women):

- high cholesterol (adjusted odds ratio 1.26),
- heart attack (adjusted OR 1.41),
- heart disease (adjusted OR 1.75),
- stroke (adjusted OR 1.79),
- use of disability equipment (adjusted OR 1.53),
- joint disease (adjusted OR 1.75),
- high blood pressure (adjusted OR 1.11),
- current asthma (adjusted OR 1.58),
- activity limitations (adjusted OR 2.12),
- HIV risk factors (adjusted OR 3.09),
- current smoking (adjusted OR 2.30),
- heavy/binge drinking (adjusted OR 1.71).

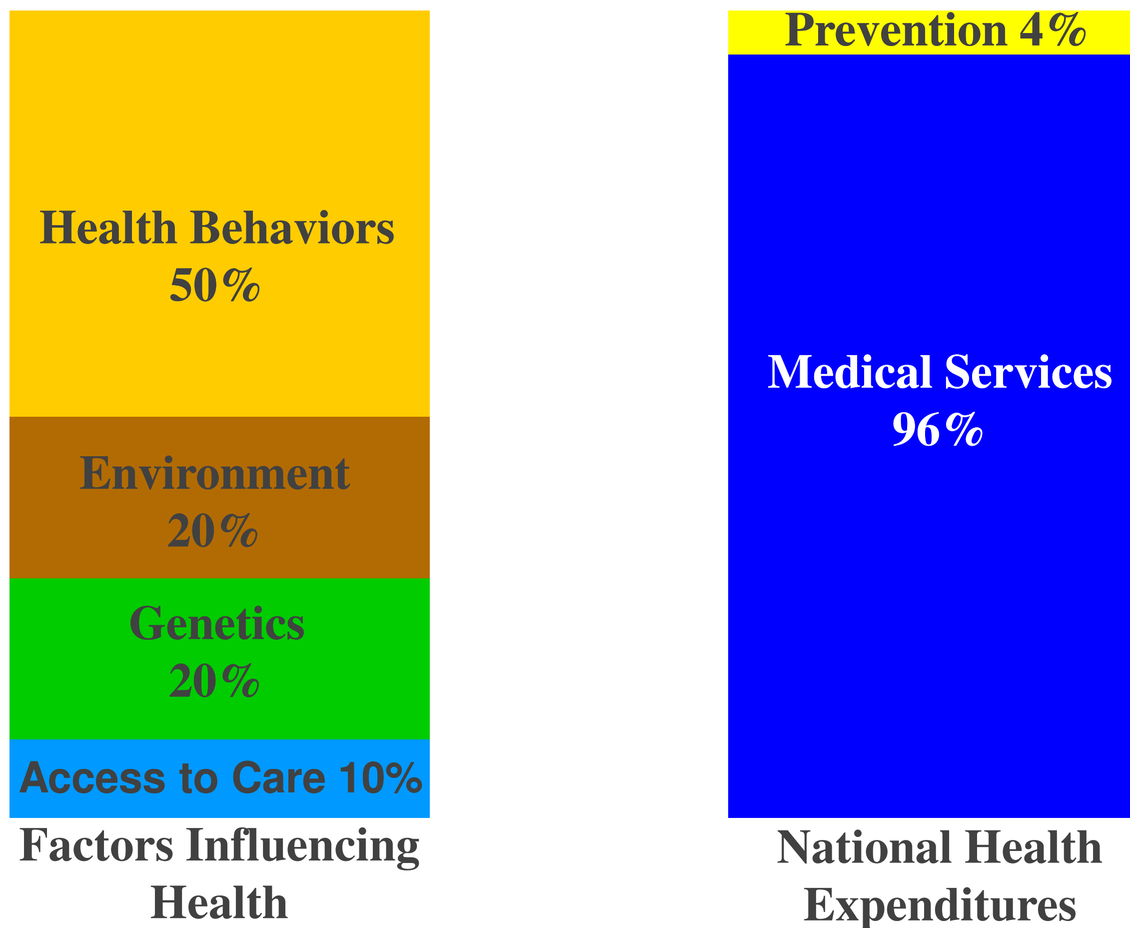
Breiding, M et al, Ann Epidemiol 2008;18:538–544.

Violence Against Women: a risk factor for chronic disease

- Women who experience violence are significantly more likely to have serious health problems above and beyond any injuries they incur.
- Abuse survivors are at increased risk for many chronic conditions including cardiovascular disease, diabetes, and metabolic syndrome.
- Three common sequelae of violence against women – depression, hostility and sleep disturbance – may play a role in increasing the risk of chronic disease.
- The mechanism may involve an increase in pro-inflammatory cytokines such as IL-1β and TNF-α.

Kendall-Tackett, KA, Trauma, Violence & Abuse vol.8 no. 2, 2007:117-126

Health Expenditures NOT Aligned with Factors Influencing Health



SOURCE: CDC, Blue Sky Initiative, University of California at San Francisco, Institute of the Future, 2000

Conclusions & Policy Implications

- 80% of factors influencing health are modifiable
- Inequities are created; disparities are preventable
- Behaviors and choices are influenced by the social and physical environment
- Access is influenced determined by policies and systems
- Prevention is more than just health education and counseling, it's also policies and systems
- We must invest more toward the base of the pyramid
  - Changing the context
  - Addressing the social and environmental determinants of health

Conclusions & Policy Implications

- Clinical setting can be a venue to reinforce the broader definition of women's health
- Patient/consumer engagement is necessary to inform policies & interventions
- Apply best and promising practices
- Data should be used to tell a story and measure outcomes
- Establish performance and quality measures
- Communication, collaboration, and accountability across disciplines is mandatory
- **Health in all policies**- Policies made in governmental, corporate and nongovernmental sectors impact health and health behaviors both positively and negatively

SMOKING CESSATION. SMOKING PREVENTION

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THE SCOPE OF THE PROBLEM

- SMOKING IS THE MOST PREVENTABLE CAUSE OF EARLY DEATH IN THE US.
- ONE OUT OF EVERY FIVE DEATHS IN THE US EACH YEAR ARE CAUSED BY SMOKING
- THE AVERAGE REDUCTION IN LIFE EXPECTANCY RELATED TO SMOKING IS IN WOMEN IS 14.5 YEARS

SMOKING CESSATION. SMOKING PREVENTION

THE SCOPE OF THE PROBLEM

- THERE HAS BEEN A 600% INCREASE IN WOMEN'S DEATH RATES FROM LUNG CANCER SINCE 1950
- LUNG CANCER IS THE LEADING CAUSE OF DEATH FROM CANCER IN WOMEN
- THE INCIDENCE AND MORTALITY RATES FOR LUNG CANCER IN WOMEN IN RHODE ISLAND ARE GREATER THAN IN 40 AND 33 STATES RESPECTIVELY

SMOKING CESSATION. SMOKING PREVENTION

DISEASES ASSOCIATED WITH SMOKING

- CANCERS: Lung, Head and Neck, Esophagus, Kidney, Bladder, Cervix, Pancreas and Stomach
- HEART DISEASE, STROKE AND PERIPHERAL VASCULAR DISEASE
- COPD
- OSTEOPOROSIS
- PRETERM BIRTH
- EXPOSURE OF CHILDREN TO SECOND HAND SMOKE

DEPRESSION AND CHRONIC DISEASE

- After heart disease, depression is the next leading cause of medical disability in women in the United States
- There is increased mortality risk in women in whom depression and chronic illness such as diabetes or heart disease coexist
- Identification of women at increased risk for these conditions will decrease the overall burden of disease, mortality rate and expenditures as well as improve quality of life
- The opportunities identified need to inform programs, policy and payment models.