



RHODE ISLAND DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH AND EQUITY
2019-2020

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Dear Friends,

Every person deserves an equal opportunity to harness their talents, achieve their dreams, and reach their full health potential regardless of their race, ethnicity, sexuality, gender orientation, ZIP code, or level of education or income. Advancing health equity by addressing the socioeconomic and environmental factors that contribute to health disparities is crucial to creating the conditions for healthy, resilient communities in which every person can thrive.



The Rhode Island Department of Health (RIDOH) Strategic Framework serves as the blueprint for everything we do. Our three leading priorities are to: 1) address the socioeconomic and environmental determinants of health, 2) eliminate health disparities and promote health equity, and 3) ensure access to quality health services for all Rhode Islanders, including the state's vulnerable populations.

From these leading priorities, we developed five overarching strategies and implemented 23 population health goals, which set targets for RIDOH and the other State agencies and local partners with whom we collaborate. We can only achieve health equity if we are willing to sit at the same table, embrace a shared vision for a stronger, thriving Rhode Island, and work toward that vision together.

RIDOH is partnering with people from across the state to promote health equity through our Health Equity Zones (HEZ) – RIDOH's place-based initiative designed to build healthy communities. If we are truly going to make a difference in the health of Rhode Islanders, we need to start that change at the community level, where people live, learn, work, and play.

This vision is also strongly aligned with the focus of the 2019 Association of State and Territorial Health Officials (ASTHO) President's Challenge that I am directing during my term as ASTHO President. The focus of the President's Challenge is to provide tools to help health officials across the country mobilize community-led, place-based models that address the root causes of health inequities at the local level through collaboration with nontraditional partners, such as business leaders and policy makers.

I thank our many colleagues and partners who are working collectively to eliminate the injustice of health disparities and to make Rhode Island a healthier, safer, more enjoyable place to live for all of us. I look forward to our continued collaboration.

A handwritten signature in black ink, appearing to read 'Nicole Alexander-Scott'. The signature is fluid and cursive, with a large initial 'N'.

Nicole Alexander-Scott, MD, MPH

Director, Rhode Island Department of Health





Dear Colleagues,

It is with great enthusiasm that the Division of Community Health and Equity (CHE) shares the 2019-2020 division booklet with you. The purpose of the booklet is to share our mission, vision, and program work. Together we are building stronger and healthier communities for everyone.

Through collective impact efforts we are leading a movement for more inclusive, safe, and healthy environments for all Rhode Islanders. In partnership with you, we are creating conditions that help people thrive and achieve their optimal health.

With support from the Centers for Disease Control and Prevention, Health Resources Services Administration, United States Department of Agriculture, Substance Abuse and Mental Health Services Administration, Active Community Living, Administration for Children and Families, payers, foundations, and State funding, CHE is advancing the Rhode Island Department of Health's three leading priorities and the statewide population health goals included in this document.

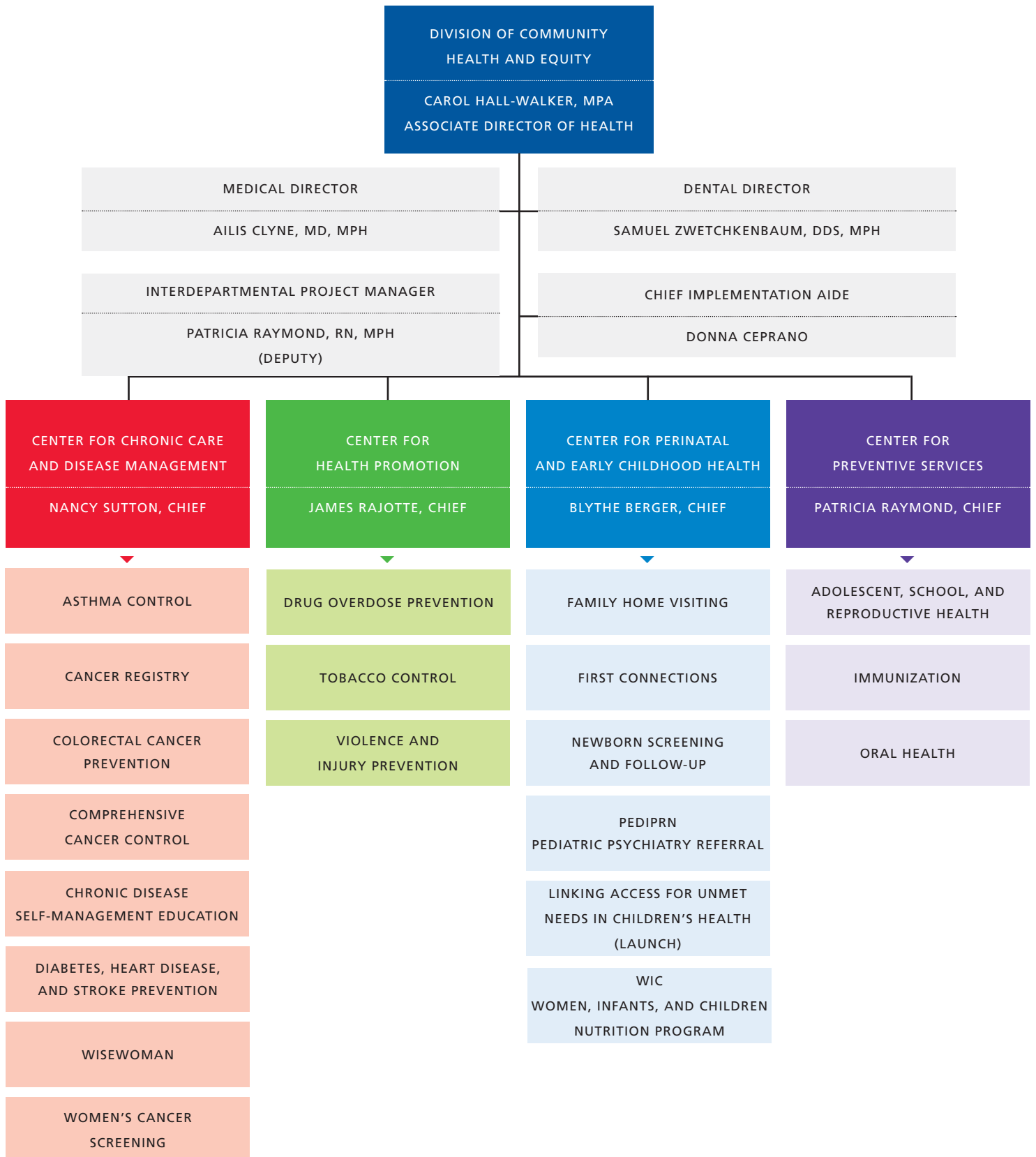
To learn more about how we are working with our community partners to build healthier neighborhoods, and about our local investment in Health Equity Zones (HEZs) visit www.health.ri.gov/equity. We know this investment, which supports leaders and residents to work together, is making a difference in the health and well-being of all Rhode Islanders. We look forward to continuing our collaboration with you to achieve this end.

Sincerely,

A handwritten signature in blue ink that reads "Carol Hall-Walker". The signature is fluid and cursive.

Carol Hall-Walker, MPA
Associate Director of Health
Division of Community Health and Equity
Rhode Island Department of Health

DIVISION OF COMMUNITY HEALTH AND EQUITY ORGANIZATIONAL STRUCTURE



MISSION

In conjunction with the mission of the Rhode Island Department of Health (RIDOH), the Division of Community Health and Equity (CHE) strives to prevent disease and protect and promote the health and safety of the people of Rhode Island.

VISION

CHE envisions that all Rhode Islanders will have the opportunity to achieve optimal health. To this end, CHE strives to:

- Eliminate health disparities and achieve health equity by addressing the socioeconomic and environmental determinants of health.
- Plan and implement public health activities using evidence-based and promising practices across the life course.
- Engage communities as key partners in public health.



OUR CORE VALUES

- We are accountable to each other and to our Rhode Island communities.
- We promote health equity and social justice.
- We are committed to eliminating all health disparities.
- We seek community-driven involvement and participation.
- We believe in open and respectful communication.
- We respect and embrace the diversity of our staff and the communities we serve.
- We foster collaboration throughout the department and among our national, state, and local partners.
- We value teamwork and the unique skills, contributions, and voice of each member.
- We support ongoing high-quality professional development for all staff.
- We encourage a culture of Quality Improvement and data-driven decision making.

WHAT WE DO

CHE's four Centers collaborate and integrate to promote and advance public health priorities:

1. **CENTER FOR CHRONIC CARE AND DISEASE MANAGEMENT:** Uses a systems approach to reduce the incidence, burden, and associated risk factors related to Alzheimer's disease, asthma, arthritis, cancer, diabetes, heart disease, and stroke to improve health outcomes.
2. **CENTER FOR HEALTH PROMOTION:** Uses evidence-based and promising public health practices to create social, policy, and physical environments that support healthy living through all stages of life and for all Rhode Islanders. Areas of focus include tobacco control and violence and injury prevention, including youth suicide prevention and drug overdose prevention.
3. **CENTER FOR PERINATAL AND EARLY CHILDHOOD HEALTH:** Supports healthy birth outcomes, positive early childhood development and school readiness, and preparation for healthy, productive adulthood by providing and assuring mothers, children, and adolescents access to quality maternal and child health services.
4. **CENTER FOR PREVENTIVE SERVICES:** Uses evidence-based practices to improve the quality of preventive care by increasing access for at-risk populations, diminishing ethnic and racial health disparities, and enhancing community partnerships. Areas of focus include adolescent and school health, reproductive health, immunization, and oral health.

HEALTH EQUITY FRAMEWORK

The social and environmental determinants of health, life course approach, integration of programs, and social and emotional competencies are the four pillars of the Division of Community Health and Equity (CHE)'s approach to public health. When allocating resources and making data-driven decisions on what interventions should be implemented, CHE uses the Health Equity Framework as a guide. To learn more about health equity and the Health Equity Framework visit: www.health.ri.gov/equity





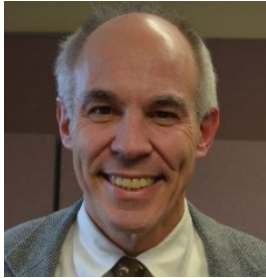
CAROL HALL-WALKER, MPA
ASSOCIATE DIRECTOR OF HEALTH
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"Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane."
Dr. Martin Luther King, Jr.



AILIS CLYNE, MD, MPH
MEDICAL DIRECTOR
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"The true measure of any society can be found in how it treats its most vulnerable members"
Mahatma Gandhi



SAMUEL ZWETCHKENBAUM, DDS, MPH
STATE DENTAL DIRECTOR
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"Without oral health, you're not healthy, and oral health is about more than just the health of the teeth."
David Satcher, US Surgeon General 1998-2002



PATRICIA RAYMOND, RN, MPH
DEPUTY INTERDEPARTMENTAL PROJECT MANAGER
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"If you have health, you probably will be happy, and if you have health and happiness, you have all the wealth you need, even if it is not all you want."
Elbert Hubbard



JULIE DEMELO
ASSISTANT ADMINISTRATOR (FINANCIAL MANAGEMENT)
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"He who has health, has hope; and he who has hope, has everything."
Thomas Carlyle



DONNA CEPRANO
CHIEF IMPLEMENTATION AIDE (ADMINISTRATIVE SUPPORT)
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"Cheerfulness is the best promoter of health and is as friendly to the mind as to the body."
Joseph Addison



The Center for Chronic Care and Disease Management uses a systems approach to reduce the incidence, burden, and associated risk factors related to Alzheimer's disease, arthritis, asthma, cancer, diabetes, heart disease, and stroke to improve health outcomes.

NANCY SUTTON, MS, RD, CENTER CHIEF

Note: New Alzheimer's Disease Program

In June 2019, the State of Rhode Island passed bills H-5178 S/S-0223 to establish a program within the Rhode Island Department of Health to address Alzheimer's disease. Starting in July 2019, the program will begin by embarking on the creation of an Alzheimer's Advisory Council, which will advise the Governor, Speaker of the House, and President of the Senate on the development of, and advances toward, the diagnosis, treatment, and prevention of Alzheimer's disease. This will include defining the burden of Alzheimer's disease in the state; identifying research, resources, and services for treatment and care; and recommending updates to the Alzheimer's State Plan. In addition, the program will be responsible for the establishment of an Alzheimer's disease assessment protocol, and medical professional training and healthcare facility requirements as it pertains to this disease.

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Chronic Disease Self-Management Education Program:: Jasmine Franco, MS, 401.222.4520

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Women's Cancer Screening Program :: Eric Lamy, BA, 401.222.1161

ASTHMA CONTROL PROGRAM

The Asthma Control Program works to reduce overall asthma burden and asthma health disparities in Rhode Island. It aims to lower asthma-related hospitalizations, emergency room (ER) visits, health inequalities, and missed days of work and school. The program addresses the social and environmental determinants of health by advocating for healthy environments where people with asthma live, work, learn, and play, focusing on the four high-poverty core cities of Providence, Pawtucket, Central Falls, and Woonsocket.



Key Initiatives

- The Asthma Control Program has combined key initiatives into the *Comprehensive Integrated Asthma Care System*, which serves as a unified access point for a set of community-based services and interventions.
- The Home Asthma Response Program (HARP) provides children who have had asthma emergency room visits or an asthma hospitalization with up to three home visits by a Certified Asthma Educator and Community Health Worker. HARP teaches families how to manage asthma and provides supplies to get rid of asthma triggers in the home.
- Breathe Easy at Home (BEAH) allows healthcare providers to make a referral to housing code enforcement if they suspect that substandard housing conditions are creating asthma triggers and impacting a child's health. Referrals and communication are done through KIDSNET, Rhode Island's integrated child health information system. BEAH can also help tenants get legal support.
- Controlling Asthma in Schools Effectively (Project CASE) works with elementary schools to offer Hasbro Children's Hospital Draw a Breath classes for students with asthma, train school staff about asthma needs, promote asthma-friendly policies and healthy indoor air quality at schools, and promote the use of asthma action plans.

Key External Partners

Asthma Regional Council of New England, Brown University, Community Based Agencies, Environmental Justice League of Rhode Island, Federally Qualified Health Centers, Hasbro Children's Hospital, PCMH-Kids, Rhode Island Alliance for Healthy Homes, Rhode Island Asthma Control Coalition, Rhode Island Association of Certified Asthma Educators, Rhode Island Care Transformation Collaboration, Rhode Island Department of Education (RIDE), Rhode Island Medicaid, St. Joseph Health Services, and Thundermist Health Center.

CANCER REGISTRY PROGRAM

The Cancer Registry Program (CR) collects newly diagnosed cancer cases among Rhode Island residents and reports the statewide cancer burden. The CR operates and manages the state-based central cancer database, in collaboration with the Hospital Association of Rhode Island and local reporting hospitals and facilities throughout the state. The CR annually submits data to the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries and to the North American Association of Central Cancer Registries, which create and update national and international cancer datasets and statistical reports.

Key Initiatives

- Prepare and publish extensive technical and statistical reports and publications, using the Rhode Island Cancer Registry data and other public health data sources (e.g. Vital Records).
- Improve and maintain quality, completeness, and timeliness of cancer data collection and reporting, and comply with a nationally standardized reporting guideline.
- Support hospital tumor registries and promote cancer programs accredited by the American College of Surgeons in acute-care hospitals throughout Rhode Island.
- Support evaluation plans for the RIDOH Comprehensive Cancer Control, Women's Cancer Screening, and Colorectal Cancer Prevention Programs.
- Develop queries and analyze the cancer data to provide surveillance reports for the Rhode Island Comprehensive Cancer Control, Women's Cancer Screening, and Colorectal Cancer Prevention Programs, and other interdepartmental programs, as well as the media, healthcare systems, and consumers.

COLORECTAL CANCER PREVENTION PROGRAM

The goal of the Colorectal Cancer Prevention (CRC) Program is to increase CRC screening rates among persons age 50 to 75 within partner health systems. This goal is accomplished through the implementation of four key evidence-based interventions: provider assessment and feedback, provider reminders, client reminders, and reducing structural barriers using small media and patient navigation.





Skin Cancer Screening Event, East Matunuck State Beach

Key Initiatives

- Upon request, work with a Data Consultant Contractor to provide all Federally Qualified Health Centers (FQHCs) technical assistance with their Electronic Health Records and/or methods on how to improve clinical workflow.
- Provide resources, training, and guidance to identified colorectal patient navigators within each FQHC with the goal of helping patients overcome barriers to colorectal cancer screening. Also, closely track patient navigation activities in order to identify best practices and to measure effect on screening rates.
- Offer assistance to FQHCs, in conjunction with the American Cancer Society, in establishing and building on current colonoscopy referral infrastructures with gastroenterology practices and hospitals. Our collective goal is for all age-appropriate patients to have the ability to get screened for colorectal cancer, regardless of insurance status.

Key External Partners

Blackstone Valley Community Health Care, Inc., Comprehensive Community Action, Inc., East Bay Community Action Program, Narragansett Indian Tribe, Northwest Community Health Care, Providence Community Health Centers, Thundermist Health Center, Tri Town Community Action Agency, Wood River Health Services, Inc.

COMPREHENSIVE CANCER CONTROL PROGRAM

The Comprehensive Cancer Control (CCC) Program assesses and works to reduce the burdens of cancer in Rhode Island. The CCC Program employs evidence-based policy, systems, and environmental-change strategies to guide sustainable cancer control. The CCC Program develops, implements, and evaluates efforts to improve the quality of cancer care and address the needs of cancer survivors. The CCC Program promotes primary prevention and recommended cancer screenings, monitors and releases information on Rhode Island's cancer epidemiology, organizes and supports community-based efforts to reduce

cancer, and strives to enhance cancer survivors' quality of life. The CCC Program works closely with a statewide coalition, The Partnership to Reduce Cancer in Rhode Island, and with other community-based cancer control stakeholders.

Key Initiatives

- Employ policy, systems, and environmental change (PSE) strategies to reduce the burdens of cancer in Rhode Island.
- Work collaboratively with partners to improve primary cancer prevention strategies and to eliminate cancer disparities.
- Promote evidence-based cancer screening initiatives that help to find cancers earlier.
- Identify opportunities to decrease cancer-associated incidence and mortality rates.
- Promote palliative care and survivorship care as two means of improving the quality of life for cancer survivors.
- Issue surveillance briefs and educational materials describing the burdens of cancer in Rhode Island, using reliable data sources.
- Promote community utilization of comprehensive cancer control strategies (including those employed in prevention, screening and detection, survivorship, and palliative care) by publishing periodic five-year strategic cancer prevention and control plans.
- Support the work of the Partnership to Reduce Cancer in Rhode Island, and the Rhode Island Latino Cancer Control Task Force, and other local cancer control organizations.





CHRONIC DISEASE SELF-MANAGEMENT EDUCATION (CDSME) PROGRAM: LEARN MORE. FEEL BETTER.

The goal of the Chronic Disease Self-Management Education (CDSME) Program is to empower adults and older adults to live productive, healthy lives through the delivery of evidence-based self-management interventions in a statewide, accessible system that is integrated through community-clinical linkages. The CDSME Program will expand access to evidence-based programs including Tools for Healthy Living, the Chronic Pain Self-Management Program (CPSMP), and Walk with Ease (WWE).

Key Initiatives

- Increase the number of provider referrals to the CDSME, CPSMP, and WWE programs.
- Increase the number of Rhode Island adults enrolled in statewide programs as a means of supporting prevention and ongoing self-management education.
- Provide training to expand a diverse team of quality trained workshop peer leaders to deliver such programs, proven to work, in all Rhode Island communities.
- Strengthen partnerships and coalitions (including with other State agencies) to share resources and benefit from networking opportunities found in a small state with an aging population.

Key External Partners

Federal Hill House, Healthcentric Advisors, Rhode Island Geriatric Education Center, Rhode Island Parent Information Network

DIABETES, HEART DISEASE, AND STROKE PROGRAM

The Diabetes, Heart Disease, and Stroke (DHDS) Program envisions a healthcare system where providers are connected to the communities in which they serve, and communities are connected to the providers within their neighborhoods. The mission of DHDS is to prevent and reduce death and disability due to diabetes, heart disease, and stroke. DHDS is committed to healthcare transformation to improve chronic disease management and prevention for those with, or at risk for, prediabetes, diabetes, and hypertension. Key initiatives work together synergistically and on multiple levels (i.e., individual, health system, environmental, community, state) to constitute a comprehensive systems approach to prevention and control.

Key Initiatives

- Implement and promote evidence-based diabetes and diabetes prevention self-management programs.
- Build community-clinical linkages and health system interventions with a focus on Health Equity Zone communities to eliminate health disparities.
- Provide quality improvement training, data, tools, and individualized technical assistance; and funding.
- Manage specific initiatives to facilitate quality improvement changes in healthcare systems, scale evidence-based wellness programs in the community, support Community Health Workers to connect clinical and community resources, and streamline efforts by connecting partners to share best practices and lessons learned.



Key External Partners

Community Health Network Advisory Council, Diabetes Education Partners (DEP), Diabetes Prevention Program Stakeholder Network (DPPSN), Heartsafe Advisory Committee, Mary Ann Hodorowicz Consulting, LLC., Own Your Health Collaborative, Rhode Island Business Group on Health, Rhode Island Public Education Advisory Council on Organ and Tissue Donation, Rhode Island Stroke Task Force, Care Transformation Collaborative of Rhode Island, Advocates for Human Potential, Community Health Worker Association of Rhode Island (CHWARI), Rhode Island Health Center Association (RIHCA), Comprehensive Community Action Program, WellOne Primary Medical and Dental Care, Clinica Esperanza/Hope Clinic, The Rhode Island Free Clinic, Providence Community Health Centers, Thundermist Health Centers, TriCounty Health Centers, Wood River Health Services, Healthcentric Advisors, The Rhode Island Stroke Coordinators Network (RISCN), East Providence Senior Center, Bristol Parks and Recreation, Lifespan Community Health Institute, National Association of Chronic Disease Directors (NACDD), Progreso Latino, Rhode Island Parent Information Network (RIPIN), Rhode Island Medical Society, Rhode Island Primary Care Physicians Corporation, South County Health Diabetes Center, West Bay Community Action Program, YMCA of Greater Providence

WISEWOMAN PROGRAM

The Well-Integrated Screening and Evaluation for Women across the Nation (WISEWOMAN) Program is funded by the CDC to prevent cardiovascular disease (CVD) among eligible women enrolled in the Rhode Island Women's Cancer Screening Program, as well as women enrolled in Medicaid. The program assesses cardiovascular risk factors and provision of services provided to reduce those risks through improved diet, physical activity, tobacco cessation, and medication adherence support. Health systems and community-clinical linkages that are supportive of these preventive health services are major components of the program.

Key Initiatives

- Offer the WISEWOMAN Program to practices that target at-risk populations, including the Rhode Island Department of Corrections, Clinica Esperanza, the Rhode Island Free Clinic, and Providence Community Health Centers.
- Continue to ensure all eligible women are identified and offered WISEWOMAN screening and health behavior support opportunities.
- Provide lifestyle programs to WISEWOMAN participants, at no cost, to address diet, physical activity, tobacco use, and other disease prevention and management behaviors.

Key External Partners

Rhode Island Chronic Care Collaborative sites, Community Health Network Collaborative, Weight Watchers, YMCAs, Diabetes Education Partners, Rhode Island Woman's Cancer Screening practices, Health Equity Zones

WOMEN'S CANCER SCREENING PROGRAM

The goal of the Women's Cancer Screening Program (WCSP) is to reduce the burden of breast and cervical cancer among low-income women, with special emphasis on reaching un/underinsured, older, medically under-served populations; racial, ethnic, and/or cultural minorities (including American Indians, Alaska Natives, African-Americans, Hispanics/Latinos, Asian Americans); lesbians; women with disabilities; and other emergent populations in Rhode Island. The program accomplishes this by providing free breast/cervical cancer screening, follow-up, and referral for treatment. All women must live in Rhode Island and have incomes within 250% of the Federal Poverty Level.

Key Initiatives

- Promote greater awareness among all populations to increase breast and cervical cancer screening rates throughout the state by conducting public education and targeted outreach.
- Support practices and health system changes to promote and support high-quality screening for all age-appropriate clients.
- Promote the use of evidenced-based interventions including patient and provider reminders, provider assessment and feedback, and Patient Navigation activities.

Key External Partners

American Cancer Society, Gloria Gemma Breast Cancer Resource Foundation, Rhode Island Breast Cancer Coalition, Community Based Agencies, Primary Care Physicians, OB/GYN offices/Primary Care Providers, Radiology Facilities, Laboratories, Surgeons, Hospitals, Federally Qualified Health Centers, Secondary Providers, YWCAs, Women & Infants Hospital Community Outreach, Lifespan Breast Health Navigators, For Profit/Non-Profit Organizations, Social Clubs, Community Action Agencies





The Center for Health Promotion uses evidence-based and promising public health practices to create social, policy, and physical environments that support healthy living through all stages of life and for all Rhode Islanders. Areas of focus include tobacco control, violence and injury prevention, including youth suicide prevention, and drug overdose prevention.

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Tobacco Control Program :: Valentina Adamova, MBA, 401.222.3207

Violence and Injury Prevention Program :: Jeffrey Hill, MS, 401.222.7627

DRUG OVERDOSE PREVENTION PROGRAM

The mission of the Drug Overdose Prevention Program (DOPP) is to advance and evaluate comprehensive state-level interventions to prevent drug misuse, abuse, and overdose. The program engages a multi-sector collaboration of partners with shared authority to prevent drug overdoses. RIDOH and Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) Directors co-chair the Governor's Overdose Prevention and Intervention Task Force, which convenes eight workgroups: 1) Prevention, 2) Rescue/Naloxone, 3) Substance Exposed Newborns (SEN), 4) First Responders), 5) Family Task Force, 6) Harm Reduction, 7) Treatment, and 8) Recovery. DOPP staff lead the first three groups. Long-term evaluation goals are to decrease rates of opioid abuse, increase opioid use disorder treatment, decrease the rate of opioid-related Emergency Department visits, decrease drug overdose death rates, and improve health outcomes in state "hot spots".

Key Initiatives

- Increase use of the Prescription Drug Monitoring Program (PDMP) by making it easier to use and through providing academic detailing, continuing medical education events, and other outreach on responsible prescribing.
- Convene weekly Surveillance Response Intervention (SRI) meetings to identify and notify regions that have experienced spikes in overdoses.
- Improve access to drug overdose and resources data through development and maintenance of the web site www.PreventOverdose.ri.gov.
- Implement community interventions aimed at preventing drug overdose and abuse such as providing peer recovery coaches to high-risk populations, supporting municipalities in the development and implementation of strategic action plans, and providing mini-grants to community-based agencies for rapid response projects, such as through the Health Equity Zones.
- Conduct ethnographic surveillance of active drug users.
- Convene a Drug Overdose Death Review Team to analyze drug overdose deaths.



- Increase access to naloxone for high-risk populations and provide training and education to communities.
- Implement and evaluate a pilot program that embeds a clinical social worker in a law enforcement agency to connect people to treatment and recovery services in lieu of arrest.
- Provide nurse care managers in primary care settings and discharge planners in the Department of Corrections (DOC) to increase access to medication-assisted treatment.

Key External Partners

BHDDH, DOC, Medical Reserve Corps, Preventing Overdose and Naloxone Intervention, ANCHOR Recovery, Law Enforcement, Fusion Center, Recovery and treatment community, URI School of Pharmacy

TOBACCO CONTROL PROGRAM

The mission of the Tobacco Control Program (TCP) is to protect and promote health and prevent chronic disease and death among all Rhode Islanders. It uses a comprehensive approach to reduce tobacco initiation and use and exposure to cancer-causing secondhand smoke and aerosols, and provides access to safe and effective tobacco cessation services. TCP informs policy decisions that support and reinforce 100% tobacco-free living in homes, workplaces, and community environments, making it harder for youth to get addicted to nicotine. Preventing use of tobacco products including emerging products such as e-cigarettes and candy-flavored cigars, and making it easier for smokers and other tobacco users to quit safely and effectively. TCP works with federal, state, and local partners to make tobacco-free living the norm, with a focus on those communities that experience disparities in health outcomes. TCP also works in concert with media as well as community-based, school-based, clinical, and other stakeholders to provide public health science, information, and resources to individuals, families, prevention specialists, housing authorities, businesses, educators, and city, town, and state leaders throughout the state.

Key Initiatives

- Monitor disparities in health outcomes due to tobacco use in adults and youth.
- Innovate, implement, and evaluate emerging and best practices to reduce tobacco initiation and use among youth and adults within neighborhoods and populations most negatively impacted by the tobacco epidemic, while addressing emerging tobacco products (e.g. e-cigarettes and candy-flavored tobacco products) that are mainly marketed to and target teens and young adults.
- Provide and support cessation services for smokers, e-cigarette users, and other tobacco users who are underinsured; refer clients to evidence-based, safe, and effective tobacco cessation services; promote a certified tobacco treatment specialist workforce; enforce no-smoking/no vaping laws; implement best practices; and collect, analyze, and share data.
- Create and launch media campaigns to encourage tobacco cessation and effective nicotine addiction treatment services.
- Educate and inform stakeholders (communities, worksites, schools, clinicians, health systems, advocates, cancer survivors, policy-makers, etc.) about evidence-based policy strategies that restrict youth access to tobacco, facilitate accessibility/availability of Medicaid coverage for tobacco cessation, restrict exposure to secondhand tobacco smoke and e-cigarette aerosols, and protect bystanders from harmful secondhand exposure to cancer-causing agents from tobacco products in parks and recreation areas, housing, schools, workplaces, college campuses, and other public places.
- Ensure that Rhode Island investments are informed by reliable data and CDC best and promising practices and support health equity.
- Facilitate health system changes to include tobacco treatment at the clinical level.

Key External Partners

American Cancer Society, American Heart Association, American Lung Association, Tobacco Free Rhode Island, National Jewish Health, concerned citizens

VIOLENCE AND INJURY PREVENTION PROGRAM

The mission of the Violence and Injury Prevention Program (VIPP) is to give communities and policy-makers the information, including data and research, and resources they need to develop lifesaving policies and implement evidence-based programs. Injury, including unintentional injury, violence, and suicide, is the leading cause of death for Rhode Islanders age 1-44. Many injuries are predictable and preventable, lending themselves to a public health approach. Mitigating risk factors in individuals (host), the mechanisms (agent) of injury, and the physical and social environments in which injury occurs, can prevent injury and violence.

Key Initiatives

- Integrate emotional regulation Project TRAC model into Rhode Island Student Assistance Services (RISAS) Program Project SUCCESS in selected middle schools.
- Partner with the Brain Injury Association of Rhode Island to expand the use of neuropsychological baseline testing for middle/high school aged youth who participate in sports.
- Support data collection and analysis to inform policy and practice for traumatic brain injury prevention.
- Partner with and execute a memorandum of understanding with the Rhode Island Department of Transportation and other stakeholders to enhance Rhode Island laws to prevent motor vehicle crash injury and death.
- Contract with multiple partners to reduce sexual violence by reducing risk factors for violence

Key External Partners

Departments of Transportation, Corrections, Education, Children Youth and Families, Human Services, Public Safety, and Veterans Affairs; Office of Attorney General, Rhode Island Hospital Injury Prevention Center, AAA, Traffic Safety Coalition, Providence College, Health Equity Zones, Community Mental Health Centers, Coalition Against Domestic Violence, SAFEKIDS Rhode Island Coalition, Day One





The Center for Perinatal and Early Childhood Health supports healthy birth outcomes, positive early childhood development and school readiness, and preparation for healthy productive adulthood by providing and assuring mothers, children, and adolescents access to quality maternal and child health services.

BLYTHE BERGER, ScD, CENTER CHIEF

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Newborn Screening and Follow-Up Program :: Emily Eisenstein, MPH, 401.222.5924

Pediatric Mental Health Access :: Monika Drogosz, MPH, 401.222.7720

WIC - Supplemental Nutrition Program for Women, Infants, and Children ::

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FAMILY HOME VISITING PROGRAM

The Family Home Visiting Program provides evidence-based home visiting to mitigate or prevent poor health and developmental outcomes, and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program implements evidence-based home visiting programs for pregnant women and families with a child younger than four years of age, focusing on communities at risk for poor maternal and child health outcomes through three evidence-based models: Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. Communities served include Providence, Pawtucket, Central Falls, Woonsocket, Newport, East Providence, Cranston, Coventry, West Warwick, Westerly, and surrounding communities.

Key Initiatives

- Increase the number of WIC sites, healthcare centers, and obstetric practices that refer to Family Home Visiting.
- Train professionals to use a trauma-informed approach to identify and address adverse experiences.
- Use continuous quality improvement to support Family Home Visiting agencies to increase family engagement and retention.



Key External Partners

Rhode Island Chapter of the American Academy of Pediatrics (AAP), Children's Friend, Community Care Alliance, Federal Hill House, Blackstone Valley Community Action, Connecting for Children and Families, Family Service of Rhode Island, Meeting Street, East Bay Community Action Program, The Providence Center, Comprehensive Community Action, Department of Human Services, Department of Children, Youth, and Families, Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, Department of Education, South County Home Health Services, VNS of Newport and Bristol Counties, Westerly School Department

FIRST CONNECTIONS PROGRAM

First Connections Program supports families and their children prenatally through age three by supporting child development, providing information, and connecting them with appropriate services to mitigate risk factors so children can develop in a healthy way and be ready for school.

Key Initiatives

- Increase the capture rate for visits to families who are identified as at risk at the time of birth.
- Conduct risk assessment and support families to engage in appropriate services.

Key External Partners

Children's Friend, Community Care Alliance, South County Home Health, Visiting Nurse Home and Hospice (DBA VNS of Newport and Bristol Counties), Family Service of Rhode Island, Department of Children, Youth, and Families, Executive Office of Health and Human Services, Primary Care Providers, Health Centers, WIC Providers, Early Intervention Providers, Rhode Island Birthing Hospitals, Department of Human Services, Early Head Start Providers, Long-Term Family Home Visiting Providers, Women & Infants Hospital, South County Health, Kent Hospital, Landmark Medical Center, Newport

PROJECT LAUNCH

Linking Access for Unmet Needs in Children's Health (LAUNCH) works to ensure that children (birth to age eight) in Woonsocket, Newport, and Washington County succeed in school by building social-behavioral capacities into community-based early childhood programs and systems of care in order to integrate physical and behavioral health wellness. The core components include developmental screening in primary care settings for children from birth to age eight, mental health consultation to primary care providers and/or in early child care and education settings, and building the capacity of parent support and education for children ages three to eight who are at risk of poor outcomes without support.

Key Initiatives

- Increase the number of practices in participating communities conducting standardized developmental screening.
- Increase the number of Incredible Years groups that are implemented in communities.
- Increase the number of children reached by mental health consultation in primary care.

Key External Partners

Bradley Early Childhood Research Center, South County Health (Washington County Health Equity Zone backbone organization), Connecting for Children and Families (Woonsocket-based community organization), Looking Upwards, Inc. (Newport County-based community organization), Successful Start Steering Committee Members, Department of Human Services, Care Transformation Collaborative of Rhode Island

NEWBORN SCREENING AND FOLLOW-UP PROGRAM

This program screens all newborns in Rhode Island for metabolic, endocrine, hemoglobin, hearing, developmental, and other conditions to identify and treat these conditions as early as possible, prevent death and disability, and enable children to reach their full potential.

Key Initiatives

- Continue to screen 100% of newborns annually.
- Continue to monitor the number of follow-up forms completed by the diagnostic clinics in KIDSNET.
- Support systems and services for children with hearing loss.

Key External Partners

Birthing Hospitals, Rhode Island Hearing Assessment Program, Woman & Infants Hospital, New England Newborn Screening Laboratory, Pediatric Cardiology Center, Specialty Clinics (hemoglobin, metabolic, endocrine, cystic fibrosis, immunology), VNA of Care New England, Early Intervention, Rhode Island Hospital, Audiologists, Rhode Island Home Birth & Hope Family Health, Birthcare Midwifery, Partnership to Reduce Cancer Coalition, Brown University, Hospital Association of Rhode Island, the American Congress of Obstetricians and Gynecologists

PEDIATRIC PSYCHIATRY RESOURCE NETWORK

The Rhode Island Pediatric Psychiatry Resource Network (PediPRN) is a state-wide clinical psychiatric consultation service that connects primary care providers with mental health consultation services to support their patients. It is available statewide to primary care providers who see children. Services are provided by clinicians at Emma Pendleton Bradley Hospital.

Key Initiatives

- Expand primary care involvement in the PediPRN.
- Expand training and technical support to primary care providers.
- Increase telephone consultation and referral coordination services.

WIC - SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN

The goal of the WIC program is ensuring healthy pregnancies, healthy birth outcomes and healthy growth and development for women, infants, and children up to age five who are at nutritional risk. WIC is a part of the healthcare system, and the program screens for growth, iron levels, immunizations, and lead results. Clients or their parents are given an opportunity to ask a nutrition professional questions they may have during pregnancy, such as food safety, what to do about nausea, monitoring for excessive swelling, or questions about feeding a new baby and when to introduce solids, bottle use, breastfeeding, and feeding toddlers. WIC provides the resources a client or parent may need to assist with behavior issues, preschool, tobacco use, referrals to doctors, and many other services. Studies have shown that participation in the WIC Program has improved birth outcomes and the health and development of young children and led to increases in breastfeeding rates. These outcomes are the result of WIC education and services that offer opportunities for children to reach their potential during the most critical stages of growth and development creating positive outcomes throughout their lifetime.



Key Initiatives

- Increase breastfeeding initiation and duration.
- Reduce rate of low birth weight and premature infants.
- Reduce overweight and obesity rates of children enrolled in WIC.

Key External Partners

Rhode Island Breastfeeding Coalition, Women & Infants Hospital, Wood River Health Center, Children's Friend, Thundermist Health Center, Meeting Street, Comprehensive Community Action Program, East Bay Community Action Program, West Elmwood Housing Development Corporation, Scalabrini Dukceovich Center, West Bay Community Action Program, Mount Hope Neighborhood Association, Tri-Town Community Action Program





The Center for Preventive Services uses evidence-based practices to improve the quality of preventive care by increasing access for vulnerable populations, diminishing ethnic and racial health disparities, and enhancing community partnerships. Areas of focus include adolescent and school health, family planning and preconception health, immunization, and oral health.

PATRICIA RAYMOND, RN, MPH, CENTER CHIEF

Center for Preventive Services Team ::

Patricia Raymond, RN, MPH, Center Chief, 401.222.5921

Adolescent, School, and Reproductive Health Program :: Souni Phanthavong, MPH, 401.222.5984

Office of Immunization :: Tricia Washburn, BS, 401.222.5922

Oral Health Program :: Sadie DeCourcy, JD, 401.222.7743

ADOLESCENT, SCHOOL, AND REPRODUCTIVE HEALTH PROGRAM

This program aims to create a comprehensive and coordinated adolescent health system that supports families and communities in promoting positive adolescent development so that all children have access to appropriate, high-quality healthcare, education, and social and community services as needed to support optimal healthy development and successful transition to adulthood.

Family Planning

Family Planning promotes reproductive/sexual health in Rhode Island through policy development, systems coordination, community outreach and engagement, collaborative partnerships, and program activities. Program activities serve Rhode Islanders seeking to achieve intended pregnancy or to prevent unintended pregnancy by providing the information and means to exercise personal choice in determining the number and spacing of their children. It provides high-quality, comprehensive, affordable, and confidential family planning clinical and educational services to Rhode Island women, men, and adolescents, as supported by federal Title X funds. Title X family planning services include a broad range of effective contraceptive methods; contraceptive and reproductive health counseling and education; pregnancy testing; preconception care; HIV/STI counseling, testing, and referral services; and related preventive services, including breast and cervical cancer screening.

Key Initiatives

- Increase the number of adolescents, age 12-17, who receive teen pregnancy prevention and positive youth development programming through the Teen Outreach Program (TOP).
- Provide services and supports to ensure that pregnant and parenting adult and teen students can achieve academic success through higher education.
- Utilize the Adolescent Health Strategic Plan's recommendations for the development and implementation of policies and programs that will help all Rhode Island adolescents lead healthy lives and be prepared for adulthood.



- Increase the number of middle and high school students connected to positive youth development (PYD) programs.
- Support Health Equity Zones with best practice, training, technical assistance, and funding to implement substance use prevention strategies.
- Support implementation of clinical recommendations in the CDC/Office of Population Affairs Morbidity and Mortality Weekly Report (MMWR) *Providing Quality Family Planning Services*.
- Implement routine pregnancy intention screening with One Key Question® model.

Key External Partners

Rhode Island Department of Education, Rhode Island Office of the Attorney General, Rhode Island Department of Human Services, Rhode Island Office of the Postsecondary Commissioner, Rhode Island Alliance for Teen Pregnancy Prevention, Rhode Island Chapter of the American Academy of Pediatrics, Rhode Island Association of School Principals, Rhode Island Certified School Nurse Teacher Association, Parent Support Network, Rhode Island Parent Information Network, Thundermist Health Center, Rhode Island Coalition Against Domestic Violence, Successful Start, Adolescent Transition, Rhode Island HIV and STI Prevention Coalition, Family Planning Advisory Council, Healthy Youth Rhode Island, School Health Advisory Committee, Rhode Island School Safety Committee, Rhode Island Healthy Schools Coalition, Coalition to Support Rhode Island Youth, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and Intersex (LGBTQQI) Committee for Youth in State Care, School Behavioral Health Network, Ocean State Immunization Collaborative, Skip Nowell Academy, Dunamis Synergy, West Elmwood Housing, Blackstone Valley Advocacy Center, Rhode Island Partnership for Community Schools Advisory Council, Rhode Island Family Engagement Advisory Council, Youth in Action, Sojourner House, TriCounty Community Action Agency, Progreso Latino, Pawtucket School Department, Connecting for Children and Families, Rhode Island Public Health Institute, Blackstone Valley Community Health Center, Comprehensive Community Action Program (Family Health Services), East Bay Community Action Program, Planned Parenthood of Southern New England, Providence Community Health Centers, Thundermist Health Center, Tri-County Health Center, Northwest Health Center (dba WellOne), Partnership to Reduce Cancer Coalition, Brown University, Hospital Association of Rhode Island, the American Congress of Obstetricians and Gynecologists



OFFICE OF IMMUNIZATION

The goal of the Office of Immunization is to prevent and control vaccine preventable disease in Rhode Island by maximizing the number of residents who are fully immunized, maintaining effective systems for vaccine quality assurance, purchase, and distribution; community and school-located vaccination programs; public and provider education and information dissemination; and vaccine preventable disease surveillance and community collaboration. The Office of Immunization includes a universal pediatric program that provides all recommended childhood vaccines to providers for children birth through age 18, as well as an adult immunization program that provides all recommended adult vaccines, except shingles vaccine, to providers for individuals age 19 and older. The Office also implements a seasonal influenza vaccination program and a school-based vaccination program called Vaccinate before You Graduate.

Key Initiatives

- Improve and sustain vaccination coverage levels.
- Track vaccine returns/waste in order to stay below the CDC allowance of 5% annually.
- Ensure that vaccine providers comply with Vaccines for Children (VFC) program requirements through performance site visits.

Key External Partners

Rhode Island Pharmacist Association, Rhode Island Vaccine Advisory Committee, Rhode Island Vaccine Advisory Vaccine Assessment Subcommittee, American Lung Association, the New England Chapter of the American Cancer Society, the Rhode Island Chapter of the American Academy of Pediatrics and American Academy of Family Physicians, Rhode Island Lung Association, Rhode Island Partnership to Reduce Cancer Coalition, Brown University, Hospital Association of Rhode Island, the American Congress of Obstetricians and Gynecologists

ORAL HEALTH

The overarching mission of the Oral Health Program (OHP) is to achieve optimal oral health for all in Rhode Island by: (a) eliminating disparities in oral health including access to and quality of care; and (b) integrating oral health with overall health. To achieve this mission, the OHP focuses on documenting the burden of oral disease in Rhode Island, collaborating with statewide partners through the Rhode Island Oral Health Commission, and preventing oral disease through evidence-based strategies of dental sealants and community water fluoridation. In association with these partnerships, the OHP implements goals and objectives identified in the Rhode Island Oral Health Plan, including improved access to oral healthcare services, medical-dental integration, increased oral health literacy of Rhode Islanders, a strong oral health workforce, and effective oral health policy decisions.

Key Initiatives

- Develop and maintain an up-to-date and responsive oral health surveillance system which can inform oral health policy.
- Continue promotion of SEAL RI! (school-based dental sealants) program.
- Support effective community water fluoridation in Rhode Island public water systems.
- Develop and test pilot programs using teledentistry to improve access to preventive dental services.
- Train dental hygienists to improve nutrition practices of patients and develop strategies around reimbursement.
- Expose students in diverse and under-served communities to health professions through shadowing and other career training opportunities.



Key External Partners

Centers for Disease Control and Prevention, Health Resources and Services Administration, Maternal and Child Health Bureau, Bureau of Primary Health Care, Bureau of Health Professions, Office of Rural Health Policy, Office of Women's Health, Association of State and Territorial Health Officials, Association of State and Territorial Dental Directors, Children's Dental Health Project, Center for Oral Health Systems Integration and Improvement, Pew Charitable Trust's Children's Dental Campaign, National Maternal & Child Health Resource Center, Tri-State Fluoride Varnish Workgroup, New England Rural Health Roundtable, Rhode Island Dental Association, Rhode Island Dental Hygienists' Association, Rhode Island Dental Assistants Association, Other State Agencies (Departments of Human Services; Elementary and Secondary Education; Children, Youth and Families; Elderly Affairs; Behavioral Healthcare, Developmental Disabilities and Hospitals), Academic Training Program Partners: Community College of Rhode Island, Pediatric Dentistry Residency Program, General Dentistry Residency Program, Dental Public Health Residency Program/St. Joseph Health Services, Dental Schools in Massachusetts and Connecticut, Brown University, Warren Alpert Medical School, University of Rhode Island, Rhode Island College, Providence College, Rhode Island Oral Health Commission, Community Health Centers/other Safety-Net Sites, The Rhode Island Foundation, Rhode Island KIDS COUNT, Head Start/Early Head Start programs, Schools, Hospitals, the public



38 STAFF DIRECTORY

NAME	EXT	ROOM	CENTER
Adamova, Valentina	3207	409	CHP
Ahamiojie, Jolayemi	1173	409	CHP
Andoscia, George	3047	408	CCDM
Angell, Jillian	2589	408	CCDM
Ariza, Cindy	7636	404	CCDM
Ayers, Victoria	2507	205	CHP
BarboneNiemczyk, Gail	2973	404	CCDM
Barone, Ann	4604	302	PECH
Barron-Magee, Michelle	5827	409	CCDM
Belhumeur, Randi	3667	408	CCDM
Berger, Blythe	5949	302	PECH
Bertoldi, Erin	5919	302	PECH
Bessette, Evan	1380	302	PECH
Bisono, Maria	5948	302	CPS
Blinn, Kelsey	4620	302	PECH
Boehm, Lisette	7632	304	CCDM
Boucher, Carmen	5926	302	CHP
Boudreau, Matthew	2227	408	CCDM
Bowman, Sarah	4610	302	PECH
Campagna, Kristine	5927	302	PECH
Cappelli, Denise	6737	302	CPS
Ceprano, Donna	1624	408	ADO
Clyne, Ailis	5928	408	ADO
Conkey, Lauren	7622	408	CHP
DeCourcy, Sadie	7743	302	CPS
DeLuca, Gina	7468	408	CHP
DeMelo, Julie	2107	302	ADO
DePina, Luisa	4621	302	PECH
Dixon, Kelsea	7635	404	CCDM
Drix, Julian	7742	409	CCDM
Drogosz, Monika	7720	302	PECH/HEI
Ducharme, Blake	5939	302	PECH
Duggan-Ball, Sue	1580	309	CPS
Dumont, Dora	4804	206	CCDM
Eisenstein, Emily	5924	302	PECH
Fallon, Megan	7462	409	CCDM
Flanders, Sharon	1151	303	CCDM
Fogarty, Ashley	6272	409	CCDM
Franco, Jasmine	4520	409	CCDM

NAME	EXT	ROOM	CENTER
George, Elise	2030	209	CCDM
Guardino, Geri	3044	409	CHP
Guilmette-Cipriano, Kathy	4630	302	PECH
Hall-Walker, Carol	5935	408	ADO
Hill, Jeffrey	7627	409	CHP
House, Jahzmyn	5926	302	PECH
Joyce, Meaghan	7545	408	CCDM
Katz, Margo	5354	302	PECH
Kaur, Preet	4633	302	PECH
Koziol, Jennifer	4964	205	CHP
LaCasse, Melissa	7641	408	CCDM
Lafazia, Kristen	3293	409	CHP
Lafferty-Ritt, Adelaide	4040	409	CCDM
Lamy, Eric	1161	408	CCDM
Lauder, Michael	5930	408	PECH
Learman, Jordyn	2839	302	CPS
Lopez, Dahianna	2082	201	CHP
Maloney, Jenna	4606	302	PECH
Manzi, Anthony	5885	304	PECH
Marceau, Kathy	4624	309	CPS
McAtee, Cali	4723	201	CCDM
McCants Derisier, Dana	7625	409	CHP
McCormick, Meghan	5977	201	CHP
McPhail, Leah	4354	309	CPS
Mendonca, Linda	5921	309	CPS
Muccino, Rick	3059	401	CCDM
Oh, Junhie	4577	409	CCDM
Orr, Morgan	1250	201	CHP
Petrarca, Antonio	4932	304	ADO
Phanthavong, Sounivone	5984	302	CPS
Phillippi, Alaina	4626	302	CPS
Piluso, Lauren	4639	302	CPS
Pontes, Stephanie	4637	302	PECH
Rajotte, James	4872	409	CHP
Raymond, Patricia	5921	309	CPS
Remington, Sara	5946	302	PECH
Reynoso, Emma	4623	302	PECH
Rosa DaFonseca, Veronica	2744	302	CPS
Roy, Kathryn	4605	408	PECH

NAME	EXT	ROOM	CENTER
Santiago, Stephanie	7876	302	ADO
Santos, Benvinda	7637	409	CHP
Santos, Ramona	5932	302	CPS
Scharff, Sidra	5934	302	PECH
Sena, Pricilla	2589	409	CHP
Shen, HsiuChin	1254	302	CPS
Smith, CKelly	7899	409	CCDM
Stone, Carol	3366	204	CHP
Sutton, Nancy	6957	409	CCDM
Tamburro, Denise	4642	302	PECH
Taveres, Mely	3646	302	CPS

NAME	EXT	ROOM	CENTER
Tavares, Monica	1673	205	CHP
Then, Liza	6146	302	PECH
Veazey, John	6843	403	CCDM
Volquez, Venus	3283	404	CCDM
Votta, Carol	3497	409	CCDM
Wallace, Heidi	4631	302	CPS
Washburn, Tricia	5922	302	CPS
Weil, Madeline	4602	302	CPS
Whitcomb, Kristy	5950	302	PECH
Zwetchkenbaum, Samuel	6079	302	CPS

CENTER KEY

CENTER	NAME
ADO	Associate Director's Office
CCDM	Center for Chronic Care and Disease Management
CHP	Center for Health Promotion
CPS	Center for Preventive Services
PECH	Center for Perinatal and Early Childhood Health



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