Maternal and Child Health Services Title V Block Grant

Rhode Island

FY 2021 Application/ FY 2019 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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Providence, RI 02908-5097

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Michael Warren, MD, MPH, FAAP
Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18N33
Rockville, Maryland 20857

September 2, 2020

Doctor Warren,

Thank you for the opportunity to share Rhode Island's maternal and child health needs assessment, resulting priorities, and accomplishments over the past year. RI's needs assessment and the COVID-19 pandemic have highlighted long-standing systemic health and social inequities largely impacting racial and ethnic minority groups. As the lead MCH authority in the state, RIDOH's Health Equity Institute is responsible for ensuring that MCH initiatives, within RIDOH and throughout the state, are a coordinated, family-centered system of care for mothers, children, and families. We continue to do so while advancing RIDOH's Strategic Priorities: address the social and environmental determinants of health, eliminate the disparities of health in Rhode Island and promote health equity, and ensure access to quality health services for Rhode Islanders including our vulnerable populations.

We are committed to working with all key state agencies, family organizations, minority owned businesses, faith communities, Health Equity Zone partners, and community partners in moving forward with a clear equity agenda to improve maternal and child health outcomes in RI. The Health Equity Institute will continue to provide leadership, planning, and infrastructure for RIDOH's efforts in responding to these priorities while ensuring that the needs of families and children in Rhode Island are addressed.

As always, we are grateful for MCHB support.

Sincerely,

Deborah Garneau, MA
Title V MCH / Special Needs Director
Health Equity Institute Director

State of Rhode Island

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

1. Executive Summary

The Rhode Island Department of Health's (RIDOH) Maternal and Child Health (MCH) Program supports and promotes the health of all womxn, children, and families. Rhode Island performs better than the national average for most of the Title V National Performance Measures. This can be attributed to robust public health planning, integrated systems of care, and efforts focused on the state's most vulnerable populations. Despite these positive trends, health disparities persist by age, race/ethnicity, geography, socioeconomic status, educational attainment, and health insurance coverage. In 2019-20, RIDOH completed an extensive MCH needs assessment that incorporated feedback from a wide array of stakeholders, including community organizations, clinical providers, advocates, and families. Information was gathered from more than 1000 individuals via surveys, facilitated discussions, large community meetings, and listening sessions. The resulting data were used to develop the following MCH priorities for 2020--2025:

- Reduce Maternal Mortality/Morbidity
- Improve Prenatal Health
- Strengthen Caregiver's Behavioral Health and Relationship with Child
- Support School Readiness
- Support Mental and Behavioral Health
- Provide Effective Care Coordination for CSHCN
- Adopt Social Determinants of Health in MCH Planning and Practice to Improve Health Equity.

MCH Framework

RIDOH has three leading priorities and five strategies that guides all RIDOH work including MCH, with the goal of improving the health and well-being of all Rhode Islanders.

Nestled within the RIDOH Health Equity Institute, RI's MCH program seeks to address systemic inequities so that all Rhode Island families achieve their ideal life outcome regardless of their race, geography, disability status, education, gender identity, sexual orientation, religion, language, age, or economic status. Public health research and data show that generations-long social, economic, and environmental inequities, including structural racism and other forms of discrimination, have resulted in adverse health outcomes for several MCH populations.

MCH recognizes that achieving health equity requires action, leadership, inclusion, cross-sectoral collaboration and shared responsibility throughout RIDOH, and communities across the state. The MCH Program ensures that its work is

coordinated by collaborating with and supporting a broad range of partners, including other State agencies, Medicaid, public and private insurers, family organizations, healthcare systems, clinical providers, community-based organizations, and other RIDOH programs. This work spans a variety of direct, enabling, and systems-level interventions.

In response to RI's disparities and in an effort to achieve health equity, RIDOH has invested in **Health Equity Zones (HEZ).** Established in 2014, Rhode Island's Health Equity Zones initiative braids funds from several sources, including the state's Title V program. In the 6 years of the program, 10 HEZ across the state have been able to form strong collaboratives, define their unique needs, and address them with innovative solutions. In 2019, 3 additional communities were selected to become HEZ after a competitive selection process. In early 2020, 2 additional communities were added through COVID CARES funding as HEZ has demonstrated the ready-made infrastructure to support community-led investment to meet RI's hardest hit by COVID communities. With the assistance of MCH, HEZ embodies four key components to successful and sustainable implementation, including (1) health equity-centered approach to prevention work that leverages (2) place-based, (3) community-led solutions to address the (4) social determinants of health (SDoH).

1. Health equity-centered means that measuring and responding to population health disparities is the primary organizing principle to prevention.
2. Place-based indicates that an equitable prevention approach should focus on providing resources to specific geographic areas, rather than funding all places equally. Any successful prevention effort must confront environmental factors that contribute to health inequities.
3. Community-led signifies that the state or local department of health must share power with the community in a meaningful way and allow them to choose projects based on their own needs and priorities.
4. The social determinants of health are the primary root causes of health inequities, besides the surrounding physical environment. SDoH include factors like access to education, quality job opportunities, safe housing, political participation, and healthy food.

RI's Health Equity Zones are having a transformational impact on both the ability of the state's Title V program to align its goals with community-led initiatives and to improve the lives of the MCH population in RI's most disparate communities.

Family-Centered Services

A long-standing tenet of RIDOH's MCH Program is the representation and engagement of family, youth, children and youth with special healthcare needs (CYSHCN), and consumers at all levels of planning through implementation. RIDOH has partnered with the local chapter of Family Voices at the Rhode Island Parent Information Network to engage, train, and employ families of CYSHCN within the Rhode Island system of care. Family liaisons who are hired, trained, and certified as community health workers are supported in RIDOH's CYSHCN, WIC, Newborn Screening, Birth Defects, Family Planning, Immunization, and Family Home Visiting Programs. RIDOH also convenes an active Youth Advisory Council that meets monthly, engages in policy development, and assists in the implementation of RIDOH programs. MCH strategic planning regularly includes families who have received services.

Partnerships

RIDOH is the sole public health entity in Rhode Island—there are no local health departments. As such, RIDOH relies heavily on partnerships to advance its work throughout the community. These partnerships include advocacy groups, colleges and universities, community-based organizations, federally qualified health centers, health insurers, Medicaid, professional organizations (Rhode Island Chapter of the American Academy of Pediatrics, Rhode Island Chapter of the American College of Obstetricians and Gynecologists, etc.), committees and coalitions, and other State agencies. During 2019-2020, RIDOH MCH staff convened or participated in more than 70 committees or advisory boards.

Recent Accomplishments

Women's/Maternal Health

In this area, RIDOH focused on improving access to oral health services and improving preconception care and education. In 2018, the Family Home Visiting Program incorporated oral health screening and referral in its case management and data collection systems, the WIC Program added an oral health education model for WIC participants, and the RIDOH Childhood Lead Poisoning Prevention Program began distributing bilingual oral health materials in all of the certified lead centers across the state. Preconception health continues to be an area of focus because of its significance in affecting perinatal health outcomes. In the last several years, promotion of pregnancy intention screening, using the One Key Question model, has been used to encourage reproductive health counseling that empowers individuals to clarify their health needs in accordance with their personal goals. After reviewing and exploring existing data, RIDOH participated in an AMCHP communications technical assistance training and created an issue brief on maternal mortality and morbidity. Rhode Island recently formed the Pregnancy and Post-Partum Death Review Committee based on 2019 legislation.

Perinatal/Infant Health

Rhode Island is fortunate to have breastfeeding laws that support breastfeeding and lactating mothers. These laws allow womxn to breastfeed in all public spaces, require health insurance companies to cover breast pumps, and compel employers to provide a private, clean space for pumping. Currently, more than 95% of babies are born in certified baby-friendly facilities – four of five birthing centers. In 2018, breastfeeding materials were developed for dissemination at birthing hospitals, WIC offices, and through community partners that provide services to pregnant and parenting individuals. AMCHP selected these materials for inclusion in its Implementation Toolkit for National Performance Measure 4. RIDOH also oversees the implementation of four home visiting models throughout the state: First Connections, Nurse-Family Partnership, Healthy Families America, and Parents as Teachers. The Family Home Visiting Program at RIDOH continues to identify, enroll, and provide services for families most at-risk for poor health outcomes. From July 2019 to June 2020, the Program served 4,634 families and conducted 24,124 visits. Finally, upon recommendation by its advisory committee, RIDOH's Newborn Screening Program added three conditions to the blood spot screening panel, effective October 1, 2018. RIDOH's MCH Program has also been responsible for convening several groups focused on addressing perinatal health disparities: the Rhode Island Task Force on Premature Births, Disparities in Infant Mortality Work Group, Safe Sleep Interagency Work Group, and Task Force to Support Pregnant and Parenting Families with Substance-Exposed Newborns.

Child Health

Please note: It is premature to determine the full impact of the Covid 19 Pandemic on RI's Child Health and Adolescent Health programs, so these accomplishments are based on previously realized successes. Rhode Island is a leader in several child health indicators, including healthcare coverage and immunization rates. High immunization rates can, in part, be attributed to the State's universal vaccine policy that provides immunizations at no cost to medical providers for children, adolescents, and young adults. KIDSNET, an integrated birth to 18 child health and immunization registry, is used by public health professionals, medical providers, and several community-based providers (Early Intervention) to improve the health and well-being of children across the state. SEALRI!, a school-based dental sealant program, provides free dental exams and sealants to help prevent tooth decay among children who live in low-income communities throughout the state. In addition, beginning in late 2018, RIDOH's Childhood Lead Poisoning Prevention Program pilot tested finger-stick lead screening at WIC sites for children identified in KIDSNET as needing screening. RIDOH supported passage of a school recess law by the state's General Assembly. This law requires 20 consecutive minutes of unstructured free play each day in grades K – 6. RIDOH also participated in a statewide data project to collect overweight and obesity data and publish an issue brief.

Adolescent Health

Please note: It is premature to determine the full impact of the Covid 19 Pandemic on RI's Child Health and Adolescent Health programs, so these accomplishments are based on previously realized successes. RIDOH completed an Adolescent Health Strategic Plan that utilizes the Healthy People 2020 and MCH Title V performance measures as a guide in identifying health priorities. Youth transition to adult healthcare services is an important area of work for RIDOH. For more than 10 years, RIDOH has also planned and sponsored the Dare to Dream Student Leadership Conference for high school students. While the conference was originally intended for youth with special healthcare needs, because of its overwhelming successes, it has been expanded to all youth. RIDOH also supports two minority youth leadership programs: Princes 2 Kings (P2K) and Girls Empowerment Mentoring Support (RI-GEMS). These programs provide learning and internship opportunities; pair youth with adult mentors; and address the unique academic, emotional, and environmental needs of the participants. Finally, RIDOH provides safety-net

services for family planning and sexually transmitted infection (STI) screening and treatment through contracts with community clinical providers. The Teen Outreach Program, a pregnancy prevention program, has served more than 850 youth since 2013.

Children and Youth with Special HealthCare Needs (CYSHCN)

RIDOH has played a key role in the planning, development, and implementation of Patient-Centered Medical Homes for children (PCMH-Kids) throughout the state. Primary partners include Rhode Island's four health insurers, the Rhode Island Chapter of the American Academy of Pediatrics, the State's Executive Office of Health and Human Services, and the Care Transformation Collaborative. The primary goals of this project are to create pediatric medical homes and improve care coordination, especially for children with special healthcare needs. Currently there are 37 pediatric and family medicine practices participating in the PCMH-Kids initiative, including 260 primary care providers and trainees, covering more than 110,000 lives and representing more than 80% of the State's pediatric Medicaid population. RI is also one of a few states that has established a medical home portal that provides comprehensive diagnostic, education, specialty care, social service, and resource information to improve the system of care and health outcomes for CYSHCN. Additionally, RIDOH contracts with the RIPIN for the provision of the Family to Family Health Information Line, support groups, resource development, peer resource specialists (community health workers), and advocacy for CYSHCN. RIDOH also oversees an internship program, recently designated by AMCHP as a Promising Practice, that provides workplace experience to CYSHCN and assists them with the transition to adulthood.

Cross-cutting Initiatives

In order to improve MCH systems of care, RIDOH's MCH Program is working with a wide variety of internal and external partners. In the past few years, several collaborative projects have included the Governor's Overdose Prevention and Intervention Task Force, the Task Force for Substance-Exposed Newborns, the Governor's Initiative to improve Third Grade Reading, Plans of Safe Care, and a safe sleep campaign. Partners include: the Rhode Island Departments of Education; Children, Youth, and Families; Human Services; Corrections; and Behavioral Healthcare, Developmental Disabilities, and Hospitals; the Rhode Island Executive Office of Health and Human Services; Medicaid; and the Office of the Health Insurance Commissioner. RIDOH also has been an integral partner in the State Innovation Model (SIM) Grant planning and implementation. MCH Program staff have given valuable feedback to the SIM steering committee related to several SIM-funded MCH projects, including Patient-Centered Medical Homes for Children; the Pediatric Psychiatry Referral Network; Community Health Teams; Screening, Brief Intervention and Referral to Treatment; and a workforce development initiative.

III.A.2. How Federal Title V Funds Support State MCH Efforts

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How Title V Funds Support State MCH Efforts

The 2019 Title V investment of $1,646,441 was a small part of RIDOH's overall MCH budget of $107,056,440. Title V dollars are used to support and enhance MCH programs across RIDOH and the system by supporting key staff, contracts, and projects in MCH priority areas. While Title V funds rarely fund direct services in Rhode Island, they are used to improve systems by working with, and leveraging, other programs and assets that improve maternal and child health outcomes throughout the state. The Title V program ensures program coordination and collaboration internally and externally. The flexibility of Title V funds is critical as it allows RIDOH to fill gaps where reductions in other funding threaten MCH systems and services or to enhance work that is already being done.

III.A.3. MCH Success Story

MCH Success Story

Throughout 2019 and 2020, Rhode Island's Health Equity Zones continued working towards improving Maternal and Child Health outcomes by addressing disparities in physical, behavioral, social and environmental determinants of health within their communities. With the introduction of COVID-19 into RI's communities, we learned that COVID-19 has disproportionately impacted several municipalities in Rhode Island, where the case rates are much higher than the statewide average and that house the majority of RI's families in poverty. The Health Equity Zones offered (and continue to offer) a ready-made infrastructure to support immediate and longer-term response efforts in these communities most affected by the COVID-19 crisis through implementing the following strategies: identifying challenges and gaps in services, informing the selection of testing sites, sharing culturally and linguistically appropriate information, dispelling misinformation and fears related to the virus, providing vital feedback to inform response efforts. In addition, Health Equity Zones are playing an active role in rebuilding and recovery planning efforts, ensuring efforts are equity-focused and community-led, and focusing on the critical policy and systems changes needed to build more just, resilient communities across our state.

III.B. Overview of the State

Title: Overview of State:

Rhode Island Demographics, Geography, Economy, and Urbanization

In 2019[1], Rhode Island had a population of just over 1M (1,059,361) people with a median age of 40 and a median household income of $63,296 representing a 0.98% decrease from 2018. Children under 5 years of age represent 5.1% of RI's population and 19.3% of the population is under the age of 18. In addition, individuals aged 65 and older constitute 17.7% of the population and 9.8% of the population are disabled individuals under the age of 65.

The state of Rhode Island (RI) is a small, coastal area that measures just 48 miles from north to south, and 37 miles from east to west, with a total area of 1,214 square miles and over 400 miles of coastline. Rhode Island encompasses urban, suburban, and rural topography. Generally, it takes approximately an hour to travel from one side of the state to the other. The City of Providence, the state capital, holds the largest estimated residential community of 178,335 persons. The other core cities are Pawtucket, Central Falls, and Woonsocket. In addition, six smaller cities, fourteen suburban areas and fifteen rural towns surround the state's core cities.

Municipality Organizational Structure

RI is unique as it has organized its government and distribution of services differently than any other state or territory in the country. Since Rhode Island has no county level of government, its 39 cities and towns provide services commonly performed by county governments in other states such as primary and secondary education, subdivision of land and zoning, and housing code enforcement in their local community. The state's cities and towns may adopt one of four forms of government: council–manager, mayor–council, town council–town meeting, or administrator–council. All of the core cities have a mayor-council structure whereas in the suburban areas a council -manager structure is more common.

Racial and Ethnic Diversity

The 2019 U.S census data indicate that residents are 71.4% White, not Hispanic; and 16.3% Hispanic or Latinx. The racial distribution in Rhode Island is White 83.6%, 8.5% Black or African American, 3.7% Asian, 2.9% Multiracial, and 1.3% Native American, Alaskan Native, Native Hawaiian, or Pacific Islander. It is estimated that 13.6% of Rhode Island residents are immigrants. In 2015, the largest share of the foreign-born population in RI was from the Dominican Republic (17.8 % of immigrants), Portugal (9.8%), Guatemala (9.3 %), Cape Verde (7.2 %), and China (4.9 %).[2] Among RI residents over 5 years of age, 22.1% speak a language other than English at home, and Spanish is the most common of those languages (52%).

Communities of color are growing rapidly throughout many areas of Rhode Island, and most of Rhode Island's population growth over the last few decades is attributable to people of color. Between 2000 and 2010, the Latinx population experienced the most growth (44%), followed by Asian population (29%), and the Black, non-Latinx population (28%). This trend is expected to continue well into the future, as people of color are projected to represent 41% of the population by 2040[3]. Interestingly, this growth has occurred even as the state's overall birth rate has decreased, in 2018, to 50.5 per 1,000 womxn ages 15-44. The largest communities of color are found in Providence, Pawtucket, Central Falls, Cranston, Woonsocket, and East Providence. It is also estimated that about 32,000 undocumented individuals live in RI and approximately 8,000 of these individuals are parents of U.S. born children.

Gender Inclusivity

RIDOH seeks to recognize the breadth of gender identities among the Maternal Child Health Populations. This includes individuals who are trans, non-binary, and intersex. However, there are limitations on population-based data reported among these individuals. Throughout this annual report, data are presented as they were originally collected and reported for gender, age, race, and ethnicity. RIDOH recognizes that these categories may not reflect how people and communities define themselves. We acknowledge these limits and strive to use language that is welcoming and inclusive of every Rhode Islander whenever possible such as womxn, womxn of color, and Latinx.

Structural Racism & Inequity

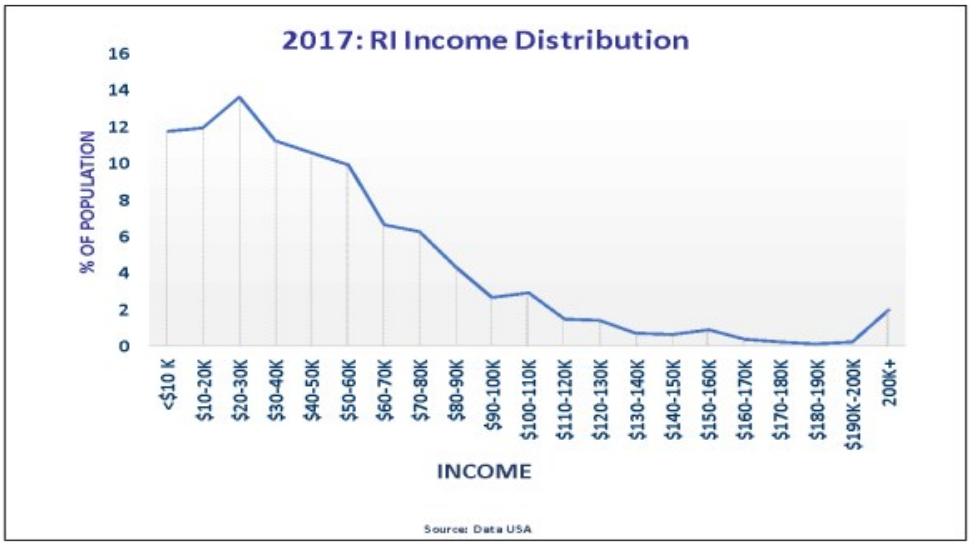
From the early days of Rhode Island's colonization and the subsequent reliance on Black slaves for both labor and trade, through widespread displacement and asset-stripping through eminent domain via the Federal Housing Act, and the use of redlining to perpetuate racial segregation in the 20th Century, Black Rhode Islanders have been dealt an unfair hand. The historical legacy of centuries of unequal treatment manifests today across many socio-economic indicators which will be discussed later in this document.[4] In addition, new immigrants to Rhode Island from Liberia, Nigeria, other African nations and the Caribbean may have different experiences than native-born African Americans, yet still be subject to the similar prejudices and barriers that have held back the native-born population.

Similarly, structural racism and inequity has impacted indigenous people present in RI. From 1635 to the present day, the Narragansett tribe has endured, persevered, and challenged a variety of social injustices and interferences from colonists and the state. This includes but is not limited to "pressure to abandon the traditional ways and adopt Waumpeshau (white man) ideas of civilization", slavery, slaughter, forced indebtedness, land seizures, a depletion of hunting and farming lands, discrimination and racism, and illegal state detribalization attempts.[5]

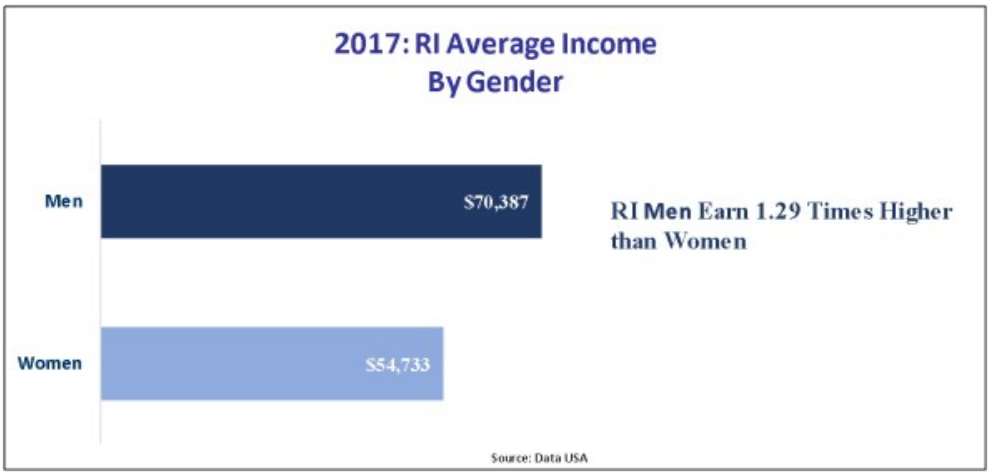
Sparked by the national social justice movement and accelerated by RI's disparate COVID infections, RI is challenging its racial past and working to achieve racial equity. RI's racial equity charge is the just and fair inclusion of all people, immaterial of their race or ethnicity, into a society where they can participate, prosper, and reach their full potential. This requires eliminating unjust policies, practices, attitudes and cultural messages that reinforce differential outcomes by race.[6] Racial Equity is best achieved through a social justice lens that understands both past and present social injustices and how these inequities have led to poor outcomes for communities of color. Today, RI is still grappling with its historical ties to colonialism and racial injustice, most notably the current political movement to drop Providence Plantations as a part of RI's official legal name.

Income Landscape

Rhode Island see income gaps among various genders, races, and ethnicities.



RI An income gap also exists between men and women. In 2017, men earned 1.29 times more than women. [7]



From 2014-2018, the median family income of white families ($88,569) was higher than that of Asian ($82,051), Black ($49,980), Hispanic ($40,624), Native American ($35,796), and Multiracial ($54,562) families. Generally, 11.6% of individuals in the state live in poverty. From 2014-2018, nearly one in six (18%) children in RI (a total of 37,402 children) lived in poverty with 63% of whom being Native American, 35% Hispanic, and 26% Black. There is also a large percentage of the population with incomes above the poverty level who have a difficult time meeting the high costs of housing, utilities, food, childcare, and health care in RI. [11]

Within the four "core" cities, the poverty rate is 34.5% and nearly twice the poverty rate of the entire state (18.2%). Between 2014 and 2018, nearly two thirds of Rhode Island's children (24,073) living in poverty lived in the four "core" cities of Providence, Central Falls, Pawtucket, and Woonsocket. 37% of children living in poverty live in single parent families. This is in comparison to 7% of children who are in poverty while living in married-couple families. In 2018, the four core cities also had substantial numbers of children living in extreme poverty, defined as families with incomes below 50% of the federal poverty threshold, or $10,116 for a family of three with two children and $12,733 for a family of four with two children. The overall state had a lower percentage of children living in extreme poverty (8%) compared to Central Falls (14.8%), Pawtucket (10.9%), Providence (14.5%), and Woonsocket (16%). During the 2018-2019 school year, RI public school personnel identified 1475 children as homeless. Of these children, 70% lived with other families ("doubled up"), 16% lived in shelters, 13% lived in hotels or motels, and 1% were unsheltered. Within each of RI's cities and towns, there are communities that are afflicted by poverty and attain extremely low wages. [8]

Roles, Priorities, and Interests of the RI Department of Health

Statewide Priorities & Equity Indicators

RIDOH's three leading priorities are to: (1) Address the socioeconomic and environmental determinants of health; (2) Eliminate disparities and promote health equity; and (3) Ensure access to quality healthcare for all, including the state's vulnerable populations. These priorities are the foundation that guides all RIDOH work, with the goal of improving the health and well-being of all Rhode Islanders. Health equity means everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences. Consequences of health obstacles include powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare. Through an extensive community engagement process, the Community Health Assessment Group developed a core set of 15 indicators in five domains that affect health equity: integrated healthcare, community resiliency, physical environment, socioeconomics, and community trauma. It is important to understand these indicators because these domains affect community residents. Inequitable health dynamics within a community may mean shortened life span lengths, higher rates of illness, and a decreased ability to carry out daily activities. Please reference the following website for up to date information and statistics on health equity indicators: https://health.ri.gov/data/healthequity/. Please reference the appendix for a fuller explanation of health equity indicators.

RIDOH Role and Structure

RIDOH is the lead RI agency responsible for addressing the maternal and child health needs throughout the state. Section 23-13 of the RI General Laws gives RIDOH broad authority for administering and overseeing Title V MCH services. RIDOH is located within the state's Executive Office of Health and Human Services (EOHHS), a cabinet agency that reports directly to the Governor. (See Appendix for organizational charts). Further, the RI MCH (Title V) Program is a part of the newly created Health Equity Institute (HEI). HEI was created by Director Nicole Alexander-Scott, MD, MPH in 2016 as a strategy to promote RIDOH's three leading priorities. The priorities include:

1. addressing the social and environmental determinants of health
2) eliminating the disparities of health and promote health equity
3) ensuring access to quality health services for Rhode Islanders, including our vulnerable populations.

The mission of the HEI is to address systemic inequities so that all Rhode Islanders achieve their ideal life outcome regardless of their race, geography, disability status, education, gender identity, sexual orientation, religion, language, age, or economic status. HEI recognizes that achieving health equity requires action, leadership, inclusion, cross-sectoral collaboration and shared responsibility throughout RIDOH, and communities across the state. HEI has substantial expertise in providing communities and policy-makers with data, technical assistance, and evidence-based programs to address health disparities in vulnerable populations. Several large programs are housed within the HEI, including: Disability & Health, Minority Health, Refugee Health, Maternal and Child Health and the Health Equity Zones (HEZ). HEI also provides collaborative support to all of RIDOH's equity initiatives including:

1. The Social Justice Roundtable
2. Sexual Orientation and Gender Identity Workgroup
3. Social Determinants of Health Workgroup,
4. Community Health Assessment Group,
5. Commission for Health Advocacy & Equity,
6. Kresge Initiative

HEI systematically addresses health disparities across the Department by providing guidance on data analysis, the development of joint work plans, and technical assistance. Health equity is an important priority if the Title V program, especially for womxn and children, people with disabilities, and racial and ethnic minorities. The HEI is strategically located in the Office of the Director, who provides leadership, vision, communication, and direction across all RIDOH divisions and programs.

2. Interagency Initiatives

It is the responsibility of the RI Title V Program to assure that that MCH initiatives, within RIDOH and throughout the state, work together to ensure a continuous system of care for mothers, children, CSHCN, and families that is coordinated, comprehensive, and community-based. Various RIDOH programs take the lead on different MCH strategies. All RIDOH's programs work together to ensure a statewide system of services. This complex work is pursued utilizing a variety of strategies that engages other state agencies, policy makers, community-based agencies, clinical and social service providers, and target populations.

Children's Cabinet

Governor's Children's Cabinet is authorized to engage in interagency agreements and appropriate data-sharing to improve services and outcomes for children and youth. The general goals of the organization are to improve the health, education, and well-being of all children and youth, increase the efficacy, efficiency, and coordination of service delivery, and improve data-driven, evidence-based decision-making through strengthened data sharing capacities among agencies and research partners, while adequately protecting the privacy rights of children.

Early Intervention Interagency Coordination Council (ICC)

ICC is composed of representatives from organizations that serve the Early Childhood population and parents of children

who are currently or formerly enrolled in Early Intervention. The ICC is an advisory council to assist EOHHS with program implementation. ICC is a venue for information sharing and we encourage programs to work together on initiatives that are being implemented across the state. The ICC also acts as a sounding board for families and providers to discuss challenges and successes in their Early Intervention experiences.

Task Force to Support Pregnant and Parenting Families with Substance-Exposed Newborns (SEN)

The SEN Task Force is composed of medical professionals, substance use treatment providers, peer recovery coaches, early intervention/family home visiting professionals, educators and representatives from the key Health Cabinet agencies. Their aim is to work through interagency collaboration to reduce the number of substance exposed newborns and provide adequate support for affected families and children. This complements the work of the broader Overdose Prevention and Intervention Taskforce.

Successful Start

This is an advisory board comprised of representatives from state and local agencies. The board works to advise on Healthy Families America, Project Launch, Project Autism, and DCYF related programming. A parent advisory board gives feedback on these programs and discusses any relevant issues affecting them and their communities.

Community Agencies

RIDOH also highly values and works with the community as a core partner in MCH and works with the state's 39 cities and towns to assure that equity in maternal and child health becomes a reality. The following types of roles community agencies take on in the state. The community agencies take on a variety of different roles within RI including advocacy and policy work, direct services, and clinical services.

Strengths and Challenges that Impact Maternal and Child Health

RI's small size is an advantage for the state to be at the forefront of developing and testing innovative statewide health care policies that work to improve the health and well-being of the state's maternal and child health (MCH) populations. In RI, all public health services are managed by the RIDOH, there are no local health departments. The centralization of RI's public health services to a single agency helps simplify the management and implementation of statewide strategic plans, programs, and initiatives, including those that address maternal and child health. The RIDOH upholds strong partnerships with many community organizations, hospitals, healthcare providers, and academic institutions. Through these partnerships, various initiatives, programs, and population health priorities can be integrated at all levels of public health service and health care delivery throughout the state. Community, healthcare, and academic partners also help assess the health needs of all Rhode Islanders. From place-based community health evaluations to hospitals, they provide data that may highlight emerging issues, diseases, or inequities.

Racial and ethnic populations, disparities still exist for several maternal and infant health outcomes in Rhode Island. Minority women are more likely than White women to receive delayed or no prenatal care and to have preterm births. From 2014-2018, Black (345 per 10,000), Hispanic (254 per 10,000), and Asian (262 per 10,000) women have higher rates of maternal morbidity than that of White women (189 per 10,000). Black children are more likely to die in infancy (10.6 infant mortality rate per 1,000 live births) than White, Hispanic, or Asian children. Hispanic, Native American, and Black youth have a higher teen pregnancy rate than White and Asian youth. Black and Hispanic children in RI are more likely to be hospitalized as a result of asthma than White children. Racial and ethnic differences in asthma are connected to issues such as poverty, exposure to indoor and outdoor air pollution, stress and access to healthcare. A more comprehensive review of the strengths and challenges of the state can be referenced in the Needs Assessment. [12]

Maternal Child Health Administrative Structure

Other State Agencies Role

Various state agencies are responsible for independently and collaboratively working together and with community partners to care for birthing parents and their children. It is important to note that these departments are centralized at the state level and serve every city and town in the state. Some of the agencies listed below are particularly created and proposed for

serving this subset of the population. Other generalist agencies have fashioned programs and units that serve the needs of birthing parents and children.

Executive Office of Health & Human Services & Hazard building (EEOHHS)
(EOHHS) serves as “the principal agency of the executive branch of state government” (R.I.G.L. §42-7.2-2) responsible for overseeing the organization, finance and delivery of publicly funded health and human services. In this capacity, the EOHHS administers the state’s Medicaid program and provides strategic direction to Rhode Island’s four health and human services agencies: Department of Health (DOH); Human Services (DHS); Children, Youth, and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

Child Welfare Agencies:
Department of Children, Youth, & Family Services (DCYF):
DCYF is the sole child welfare agency for the state of Rhode Island. They consist of numerous departments including but not limited to, Child Protective Services, Licensing, the Family Service Unit, Developmental Disability Unit, Child Support Unit, Juvenile Corrections, Juvenile Probation, Legal Department, Intake Unit, Monitoring Unit, Central Referral Unit, Children’s Behavioral Health Unit and the Contract Compliance Unit. In short, DCYF is the state child welfare, children's mental health and juvenile corrections services agency which promotes safety, permanence, and well-being of children through partnerships with family, community, and government.

Office of the Child Advocate (OCA):
The OCA serves as the oversight agency to DCYF and monitors each child open to DCYF. OCA is responsible for monitoring the operation of each unit within the Department and must ensure best practices for child welfare and general compliance with internal policies and protocols, state law and federal law.

Health Centered Agencies:
The Office of the Health Insurance Commissioner (OHIC)
The OHIC makes sure that insurance companies selling policies in the state follow Rhode Island and federal law. OHIC issues recommendations, orders, and/or penalties to protect Rhode Islanders in the case where state or federal law is not followed. OHIC also creates new regulations and updates current regulations as needed. Consumer protection is at the core of all of the work in the agency as it oversees and researches the appropriateness of any insurance premium increases.

Department of Behavioral Healthcare, Development Disabilities, and Hospitals (BHDDH)
BHDDH has three major operational divisions: Behavioral Healthcare, Developmental Disabilities, and Eleanor Slater Hospital. BHDDH serves over 50,000 Rhode Islanders who have intellectual and/or developmental disabilities or need Long-Term Acute Care in the state hospital system, known as the Eleanor Slater Hospital. The Department works to create safe, accessible, high quality and integrated services for all Rhode Islanders, while collaborating with community partners for those in need of assistance.

Housing Centered Agencies:
Office of Housing & Community Development (OHCD)
OHCD provides opportunities for healthy and affordable housing through production, lead hazard mitigation, and the coordination of the homeless system and implementation of the State’s plan to end homelessness. OHCD provides financial and operational support for all housing programs administered by the Housing Resources Commission (HRC), including a rental assistance program, which will provide housing to homeless individuals and families by non-profit homeless service providers. OHCD’s Community Development branch administers the federal Community Development Block (CDBG) program, and related programs.

Education Agencies:

Department of Education (RIDE)
RIDE oversees administratively all primary and secondary schooling within the state. The agency also oversees the educational services in which special needs children and youth receive in their schooling.

Disability Agencies:
Commission on Deaf & Hard of Hearing (RICDHH)
RICDHH is an advocacy, coordination, and service providing entity committed to promoting an environment in which deaf and hard of hearing individuals in Rhode Island are afforded equal opportunity in all aspects of their lives. The RICDHH develops policy; initiates and lobbies for favorable legislation; fosters cooperation and awareness among state agencies and community organizations; and educates and advises consumers, state agencies, and employers about the Americans with Disabilities Act (ADA) rights to equal access.

Governor's Commission on Disabilities
A governor organized commission that believes that all people with disabilities should have the opportunity to exercise all the rights and responsibilities given to citizens of this state. They believe each person with a disability should be able to reach his/her maximum potential in independence, human development, productivity and self-sufficiency.

Developmental Disabilities Council
There are 24 governor appointed Rhode Islanders serving on the Council who are proponents of legislative and systems changes that account for obstacles in education, employment, transportation, housing, recreation, and health care that confront people with disabilities throughout their lives.

Insurance in the System of Care

General Insurance Overview

Public health insurance is insurance that is either offered by or in part subsidized by the U.S federal, state, or local government. For instance, RIte Care is RI's Medicaid managed care program for families and children, pregnant individuals, children under the age of 19. It is important to explain the Medicaid Managed Care Organizations delivery system structured to manage cost, utilization, and quality of healthcare services. Medicaid managed care allows recipients to receive Medicaid health benefits and additional services via contracted arrangements between the state Medicaid agencies and managed care organizations (MCOs). These MCOs allow for a set per member per month (capitation) payment for these services. Eligible individuals can choose from three of the following insurance plans: 1) Tufts Health Plan, 2) Neighborhood Health Plan of RI, and 3) United Healthcare Community Plan.

Private health insurance is insurance that is marketed to individual consumers or employers who buy private companies not in affiliation or subsidization with the government. Some private health insurance companies in the state include Blue Cross Blue Shields, Aetna, etc. A person may choose to buy their own insurance, but many do receive it as a benefit from their employers. It can be noted that there are quasi-public insurance companies that are generally private sector companies that are supported in some way by the government and charged with providing insurance.

HealthSource RI is the state's health insurance marketplace. HealthSource RI enrolls customers for both commercial health insurance and the state's Medicaid program. HealthSource RI held its fifth open enrollment period between November 1, 2017, and December 31, 2017. During that time, the Healthsource RI Open Enrollment 2018 Report, 30,637 total customers were enrolled in private plans through the state marketplace (and paid their first month's premium). Of those, 22,603 were renewing customers and 8,034 were new customers. Recently released data from the 2019 open enrollment period show that 32,486 customers enrolled, which is an increase of 1,849 customers from the previous year. During state fiscal year 2017, Rhode Island's Medicaid Program served an average of 305,000 enrollees with full Medicaid benefits and another 17,6000 average enrollees received partial benefits. Children and families represent 51% of the enrollment (165,894) and children with special health care need represented 4% of all enrolled (12,060). [9]

Insurance Oversight

Office of the Health Insurance Commissioner (OHIC) provides the state oversight on healthcare insurance providers within

the state. OHIC is responsible for: Guarding the solvency of health insurers; Protecting the interests of consumers; Encouraging policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and Viewing the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access. Consumer protection is at the core of the work of the Office of the Health Insurance Commissioner. OHIC helps consumers understand the healthcare system and protects Rhode Island consumers by making sure federal and state laws are followed.

RIDOH participates in the standards development and implementation of *Accountable Entities (AE)* which is Medicaid's version of an Accountable Care Organization (ACO) where a provider organization is accountable for quality health care, outcomes and the total cost of care of its population. Rhode Island launched its first pilot AE in the spring of 2016. Six (6) organizations participated in the AE pilot and five (5) became certified AEs when standards were released in 2018. Guiding Principles of Rhode Island's AEs reflect several MCH priorities and include:

- Promoting and supporting multi-disciplinary capacity, a strong foundation in primary care, effective behavioral health integration
- Having the ability to manage the full continuum of care, including "social determinants"
- Having analytic capacity to support data driven decision-making and real time interventions.
- Focusing on high utilizers- Medicaid beneficiaries with complex needs or high costs

Birthing Parent System of Care

It is important to lay out the system of care birthing parent receive as they enter antepartum and intrapartum. For reference, antepartum is referred to as the pregnancy and intrapartum spans from the onset of labor to the delivery of placenta. There is network of support for birthing parent as they journey through the conception and gestation process. Primary care providers and obstetrician-gynecologists (OB-GYNs) are generally the first providers that interact with a person's sexual health before and during pregnancy. During visits with practitioners, many individuals are educated on and gain access to family planning options. Family planning promotes reproductive health by helping people prevent unplanned pregnancy or achieve intended pregnancy. This is an important option for individuals as, in 2018, one in three womxn had an unintended pregnancy.

Title X Family Planning Clinics are funded by the federal Title X grant and provide individuals with comprehensive family planning and related preventive health services. It is important to note some past Title X Grant recipients such as Planned Parenthood have foregone this funding stream with the release of recent mandates concerning family planning methods. In 2018, approximately 6 out of 10 individuals served at Title X clinics use a family planning method defined as most to moderately effective, such as an IUD or hormonal injections.[10]

During antepartum, Title X clinics, OB-GYNs, midwifes, doulas, and primary care providers become important to ensuring the health of a pregnant individual and developing fetus. Recent estimates show that there is a total of 30 prenatal care practices in the state. In 2017, 83.6% of RI pregnant women had a prenatal visit during their first trimester. This state percentage is higher than the national average of 77.3% of women receiving prenatal visits.[11]Additionally, Family Home Visiting programming, such as Nurse Family Partnership, supports and helps prepare pregnant individuals for parenthood.

During intrapartum, a pregnant people can choose to access hospital, midwifery, and doula services. Women and Infants Hospital, part of the Care New England system, specializes in care of womxn and newborns, and is the 9th largest stand-alone obstetrical service in the US. In 2019, over 80% of newborns in RI are delivered at Women and Infants Hospital. There are four additional birthing hospitals located throughout the state that split the remaining birth. Within many of these hospitals, their respective Obstetric and Labor and Delivery Units not only birth babies but preform fetal surgery, examine placenta and products of conception, and preform neonatal postpartum exams.

Perinatal/Infant System of Care

RI Birthing Hospitals contain postpartum and Neonatal Intensive Care (NICU) units that assess and care for delivered babies. During Postpartum, RI birthing hospitals are legally required to coordinate with the Office of Newborn Screening and Follow up to screen all newborns in Rhode Island for metabolic, endocrine, hemoglobin, hearing, and developmental risk factors. All babies are tested, because babies with these disorders often appear healthy at birth. Serious problems, including death, can be prevented if the disorders are discovered early.

Generally, the Office Newborn Screening and Follow-Up work to support systems and services that screen newborns. In total, the program provides universal newborn screening for 33 core blood disorders, Critical Congenital Heart Disease, and a Hearing and Developmental Risk Assessment. Their goal is to screen 100% of newborns annually and thoroughly monitor the number of follow-up forms completed by diagnostic clinics in KIDSNET. The Office encompasses the Newborn Hearing Screening Program that works to screen, evaluate, refer, and provide resources and educational supports to newborns with hearing loss.

It is important to note the support a birthing parent receives in the initial phases of parenthood. For instance, consultation on breastfeeding is available to birthing parents both inside the hospital and in the community. There are Certified Lactation Counselors (CLCs) and International Board-Certified Lactations Consultants (IBCLCs) that can help birthing parents through the breastfeeding process. Both IBCLCs and CLCs are tasked with assessing, advocating, educating, and consulting birthing parents. RIDOH plays a role in monitoring IBCLCs and CLCs, digitally listing all certified practitioners in the state, and examining any consumer complaints. Additionally, Family Home Visiting Programs are influential in supporting the lives of parents with newborns and young children and connecting them to pertinent resources.

Childhood & Adolescent System of Care

There is a variety of care options for children and youth in the state. For instance, there are 60 pediatric practices in the state that serve children and youth. Additionally, Hasbro Children's Hospital, the pediatric division of Rhode Island Hospital, is RI's primary dedicated children's hospital. Hasbro has RI's only pediatric emergency department, Level 1 Trauma Center, and pediatric critical care teams. Hasbro is part of the Lifespan health system and is affiliated with the Warren Alpert Medical School of Brown University. Children and youth also have access to programming either structured through the state or through community agencies.

Children and Youth with Special Healthcare Needs Services

There is a variety of developmental resources that are tailored in supporting children with special healthcare needs (CSHCNs). In the state, 21% of children have at least one healthcare need. [12] 61% of CSHCNs have multiple diagnoses and chronic conditions. [11] Medical Assistance benefits is a financial resource, for children and adults with a disability, through the federal Supplemental Security Income Program. Additionally, the Katie Beckett Program is a Medicaid coverage category that is given to eligible CSHCNs. Additionally, home visiting programs and community agencies in the state play a supportive and active role in the lives of many special healthcare needs children.

There are various educational resources provided to special needs children. As of June 30, 2019, 2,358 children were provided appropriate Early Intervention services through nine certified EI provider agencies, as required by the *Individuals with Disabilities Education Act (IDEA) Part C*. Also, as of June 30, 2018, there were 3,156 children between ages three and five who received preschool special education services. Many schools provide an Individualized Education Program (IEP) to special needs children. In terms of demographics of special needs students, majority of identified students are White, boys and, not low-income. This demographic information is presented with the understanding that individuals may not have access to a diagnosis or support due to their economic, racial, or other characteristics. [11]

As of June 2019, there were 21,868 students ages six to 21 receiving special education services through RI public schools. Thirty-six percent of these students had a learning disability. Disabilities and developmental delays are usually diagnosed in children who have not reached developmental milestones that generally reached by children in that age group. Developmental screenings, evaluations, and diagnoses have been helpful in identifying resources that children need learn and thrive. All school districts coordinate with the Child Outreach program to screen all enrolled children ages three to five years old. [11]

Federally Funded Assistance Programs

Supplemental Nutrition Assistance Program (SNAP)

RI offers various federally funded assistance programs and services to underserved and vulnerable populations. SNAP is available to households with a gross monthly income below 185% of the federal poverty level ($38,443 for a family of three in 2018). SNAP, usually through electronic benefit transfers (ebt), distributes monthly monetary funds to help families buy non-hot food items. Hot foods are referred to as food that is sold for on-premises consumption. In 2019, 50,827 children and

99,403 adults were enrolled in SNAP. [11]

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC serves pregnant, postpartum, and breastfeeding womxn, infants, and children under five years of age living in households with incomes below 185% of the federal poverty level. Any individual who participates in SNAP, RIte Care, Medicaid, or RI Works is automatically income-eligible for WIC. Participants must also have a specified nutritional risk, such as anemia, abnormal growth, or high-risk pregnancy. In September 2019, 20,549 women, infants, and children were enrolled in WIC in Rhode Island. In 2019, only 47% of those eligible for the program were enrolled. [11]

Rhode Island Works (RIW)

RIW program assists qualifying families through various methods including temporary cash assistance, job training and job search assistance, and transportation costs in preparation for employment. As of December 2019, 4,298 children were enrolled in RI Works.

Child Care Assistance Program (CCAP)

CCAP is meant to subsidize the cost of childcare for eligible RI families with children under the age 13 and are families that are either US citizens or legal residents. The program and parent usually share in the costs of the child care expenses. The share in expenses is calculated based upon a family's income and size, and amount of children already receiving child care subsidizes.

Conclusion

Rhode Island is a small but diverse state that offers a variety of services for birthing parents, children, and youth. The state is always pushing the needle on how to more adequately serve its constituents and help them towards a healthy and prosperous life. The MCH program builds upon the comprehensive health care and social service system to prioritize the state's most disparate populations with a racial / health equity lens. MCH works to expose that social, economic, and environmental inequities have resulted in adverse health outcomes and have a greater impact than individual choices for mothers, children, and families in RI. The sections to follow will outline the priorities that Title V MCH will focus on to further increase maternal and child health outcomes.

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III.C. Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Needs Assessment
III.C. 2. a Process Description:

Title V Grant Guiding Framework

The Title V Needs Assessment was guided by the following conceptual frameworks: the RIDOH Strategic Framework and the Lifecourse Approach. RIDOH's strategic framework serves as the Department's Framework for reducing health disparities and achieving health equity in RI. This framework encompasses three leading priorities and five strategies:

Additionally, RIDOH will adopt a racial equity framework that will be applied to MCH implementation and priorities. Your race, ethnicity, ZIP code, language, sexual orientation, gender identity, disability status, religion, occupation, income, age, or level of education shouldn't determine your health. Yet many population groups face obstacles to health that are systemic, avoidable, unfair, and unjust. Racial inequities persist in every system across our country, from healthcare to education, criminal justice, housing, and the economy. These inequities can't be explained by differences in socioeconomic status. Rather, they result from powerful forces in our system and institutions. To improve health outcomes for everyone we serve, public health must make advancing racial equity a core part of its

mission.

Finally, the Lifecourse Approach is a way of looking back across an individual's (or a group's) life experiences to better understand current patterns of health and disease. It aims to identify the underlying biological and behavioral processes that operate across the lifespan. Currently, the RIDOH takes a life course approach when collecting, analyzing, and reporting health indicators. Some important principles of the Lifecourse Approach include:

1. Today's experiences influence tomorrow's health.
2. The broader community environment strongly affects health.
3. There are critical periods of growth and development (not just in early infancy, but also during childhood and adolescence) when environmental exposures can do more damage to long-term health than they would at other times in a person's life.

These conceptual frameworks were utilized in order to guide every action taken to complete the Title V Needs Assessment. Our methodologies of analyzing and interpreting data, collecting community input, and selecting priorities and strategies were influenced by these core concepts of health equity, social determinants of health, and upstream and downstream effects.

Methodology

The needs assessment process was undertaken in an efficient and collaborative manner that involved stakeholders from across the state. These collaborators will be discussed more in-depth throughout this section. The needs assessment was a systematic process that aimed to acquire an accurate picture of the strengths and weaknesses of Rhode Island's public health system and identify the most appropriate programs and policies to promote the health of pregnant or child-bearing aged individuals, infants, children (including children with special healthcare needs), adolescents, and their families. As will be discussed below, the needs assessment team took the time to thoroughly understand the varying concerns and burdens of culturally and socio-economically diverse communities across the state.

Planning Phase

The needs assessment required a cooperative planning process before tasks were undertaken. A key partner of the RI Title V MCH Needs assessment was the statewide Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Needs Assessment. RI MIECHV supports voluntary, evidence-based home visiting services for pregnant individuals and families with children under the age of four. Due to both assessments being due in 2020, it was a unique opportunity for both programs to leverage and align efforts, activities, and fiscal resources. Other key and innovative Department of Health partners included the Adolescent, School & Reproductive Health Programs, Center for Health Data Analysis (CHDA), Health Equity Zones, and KIDSNET. The process also included contracting with a consulting agency, ABT Associates, and community partners, SISTA FIRE and Rhode Island Parent Information Network (RIPIN). SISTA FIRE is a member-led network of womxn of color working to build our collective power for social, economic, and political transformation. RIPIN is a 501(c)(3), charitable, non-profit organization that helps to support and advocate for parents with children with special healthcare needs (CSHCN). All contracted relationships supported this needs assessment in outlining digital and personal strategies for community and health professional workforce outreach. The planning process took place over the course of a year and involved bi-weekly to monthly meetings with contracted and partnering programs. During the planning phase, the Title V team compiled and reviewed other statewide and community based reports that were available. Some of these reports included, the Preschool Development Grant Birth to Five Family and Workforce Needs Assessments, 2019 Health Equity Zones Substance Use Disorder Needs Assessment, 2018 DCYF Statewide Assessment Instrument, 2020 Health Equity Zone Needs Assessments, 2019 Rhode Island Parent Information Network policy brief, 2017 RI HIV, Sexually Transmitted Diseases, and Viral Hepatitis Surveillance Report, 2019 Community Health Needs Assessment Service Area Demographics reports, etc.

Secondary Data Analysis

The Title V Program's commitment to data is essential for informing the 5-year needs assessment process. To help identify future state priority needs in Rhode Island, the Title V Program intends to review and describe ongoing MCH population-based data. In the preliminary phase of the secondary data analysis, we examined Title V measures by comparing them to national data and Healthy People 2020 targets, as well as identify existing disparities within racial/ethnic groups and populations with disabilities. The results of this analysis currently exist in our Title V MCH dashboard, which was shared with MCH program staff. This analysis provided a broad examination of locating areas of concerns using Title V measures. To better understand health problems that lead to sound data-driven decision making, there is a need to explore and analyze all MCH data available.

The Title V program entered a second phase of secondary data analysis which examined MCH data collected at RIDOH using the problems-based needs assessment approach. The purpose of this approach is to help quantify MCH problems. An MCH problem can be a health status measure, a risk factor, or a health service deficiency. MCH-related programs were contacted to collaborate and identify a list of MCH problems from MCH population-based data. Data sources used for this analysis were birth and death certificates, hospital discharge data, Pregnancy Risk Assessment Monitoring System (PRAMS), Youth Risk Behavior Surveillance System (YRBS), National Survey of Children's Health (NSCH), and registries from birth defects and sexually transmitted infections. After a final review of the data, there were a total of 67 MCH problems identified for analysis.

The next step in this phase was to develop criteria that would prioritize the MCH problems using selected criteria: magnitude, trend, and racial ethnic disparities. The magnitude indicator measured the impact among demographic populations. The trend indicator looked at the overall improvement or regression of the measure over time. The racial/ethnic indicator measured whether the gap has widened or narrowed between racial/ethnic groups over time. A four-item scale (4 = worst outcome, 1 = best outcome) was used to calculate a score for each of the three indicators. A final composite score, called the Matrix score, was calculated to make standardized comparison among domain-specific measures. This Matrix score would later be selected as one of the criteria for prioritization in selecting state priority needs.

The third phase of the secondary analysis was to compile data to report to internal and external stakeholders as issue briefs. Title V program and epidemiologist staff met routinely to discuss the content of these issue briefs, as well as provide input. Issue briefs were created for each Title V domain. The Title V issue briefs introduced demographic information regarding the Title V domain's MCH population, followed by a comparison of Rhode Island and national Title V measures related to the domain. The issue briefs also included key data points, as well as major health disparities.

Community & Workforce Outreach

Survey Collection & Outreach

MIECHV and MCH program leaders organized an efficient and strategic plan for community and workforce engagement. The initial step was to get a sampling of what population needs were present within each domain. In collaboration with Adolescent, School & Reproductive Health Programs, the MCH needs assessment team released a survey targeted towards RI youth. RIDOH utilized community partners across the state to garner, in total, 188 responses. In 2019, RIPIN dispersed a survey and obtained 117 survey responses from parents who were supporting children or youth with special healthcare needs. The goal of this survey was to understand the challenges these parents encounter when trying to access care and services for their children.

October-February 2020, SISTA FIRE distributed surveys for womxn of color within the childbearing age. This survey was aimed at comprehending the unique challenges womxn of color face within their respective Rhode Island communities. It is important to note that data collection for this population was centered within the urban core since most RI communities of color resided within these areas. In total, this survey garnered 200 responses from womxn of color. Additionally, SISTA FIRE shared their past findings that were drawn from both their birthing story collection and a 2017 community wide survey (approx. 300 responses). In terms of birthing story collection, SISTA FIRE spent 8

months gathering information on that state of maternal health for black womxn and womxn of color in RI. SISTA FIRE specifically focused on the experiences this community has had at the Women & Infants Hospital during pregnancy, delivery and postpartum. The information that follows in the MCH Population Health Status section is a result of the organization conducting Community Based Participatory Action Research. The goal of this research method is meant to engage those most affected by community issues to conduct research on and analyze the issues, with the goal of developing strategies to resolve issues and envision new solutions.

During the same time period, ABT Associates supported the production and distribution of a general community survey and health professional workforce survey. This was done to get an overview of what Rhode Islanders and professionals felt were pressing health concerns for the needs assessment's priority communities. In total, the state received 476 community surveys and 449 professional surveys. ABT Associates analyzed the data and submitted their written findings to the MCH needs assessment team.

Stakeholder Meetings & Focus Groups

Once survey collection was completed, informal and formal avenues of contact were utilized in order to outreach to communities and health workforce professionals. In February 2020, the MIECHV and Title V Need Assessment teams and Abt Associates collaborated to host a series of focus groups at the Health Equity Zone Collaborative. The Collaborative is a conference, meeting every other month, that brings together statewide Health Equity Zone leads, local organizations, community activists, and constituents. Conference members were split into smaller focus groups and assigned MCH populations to cover that aligned with their organizational focus. Groups were given MCH issue briefs that gave them a snapshot of their assigned population's leading and lagging indicators. The review of the briefs was followed by a comprehensive discussion on what the state and local community can do to support the health needs of MCH population groups.

In parallel to this effort, RIPIN collected input from parents of CSHCNs through holding a focus group, soliciting written stories, and holding a conference on September 9, 2019, to discuss findings and relevant next steps. The conference allowed parents to share their written stories, express hardships, and give policy recommendations to state policymakers and local implementation agencies. The cumulative results of this outreach and data collection were summarized within a published RIPIN data brief.

Prioritization

The process for identifying priority issues was guided by the National Association for County & City Health Officials' *Guide to Prioritization Techniques.* The overall process included the following steps: (Step 1) reach consensus on criteria to guide prioritization decisions, (Step 2) convene large group discussions to identify issues in each domain that have potential to be selected as top priorities and review relevant data, and (Step 3) use a rubric to score each potential issue on the criteria identified in Step 1 in order to identify which issues are the highest priority ones for each domain.

As a first step, Abt facilitated a discussion to determine which criteria should be used to prioritize issues. Together, the team reached consensus on five final criteria to be used in guiding the decision-making process: (1) racial/ethnic disparities; (2) community support/political will; (3) availability of resources/agency capacity; (4) potential for public health influence; and (5) the matrix score (composite score from information about magnitude, trend, and racial/ethnic disparities). RIDOH staff recognized the need to support Title V's racial equity framework, which drove the need to include racial/ethnic disparities as one of the criteria. The importance of data was a motivating factor in selecting the matrix score, which has been previously calculated in the secondary analysis.

In the second step, Abt developed a list of all possible priority issues for each domain. Abt facilitated discussions with RIDOH staff to identify any topics that were potentially missing from the list. The final list identified forty potential state priorities. For each potential priority, relevant findings (e.g., four statewide surveys with community members, professionals, parents of CSHCNs, and youth, community feedback sessions with Health

Equity Zones, state administrative data, focus groups, SISTA FIRE's data collection with womxn of color) were also shared with RIDOH staff, who were also given an opportunity to explain to the group which issues they felt were highest priority and why.

Finally, staff used a rubric to score the issues agreed upon during Step 2. One scoring rubric was used for each domain. In the first column of the rubric, the group listed domain-specific issues identified in Step 2 as potential top priorities. The next columns in the rubric are the five criteria, where participating RIDOH staff select from a three-item scale to quantify the importance for each criterion (1 = least important, 3 = most important). Once the rubrics were completed by RIDOH staff, Abt collected and tallied the results.

Strategy Selection

After identifying the priority issues that RIDOH would aim to address for the next 5 years, we worked to identify *strategies* for tackling each issue. Because of the pandemic, we were unable to meet in person for this step, so we opted to use an online tool called "Waggl". Waggl polls were administered to staff from RIDOH and local Health Equity Zones. For each Title V priority issue, 15 respondents used Waggl to (1) add strategies for consideration and (2) vote on these proposed strategies to identify the most promising ones.

Prior to proposing strategies, RIDOH staff were asked to consider the following questions:

- Is the strategy appropriate for serving diverse populations? Is it culturally and linguistically responsive?
- Is it evidence-based?
- If it is not evidence-based, is there other reason to believe that this strategy is particularly promising?
- Are there resources currently in place to support this strategy? If the resources are not currently in place, how ambitious would it be to identify new resources?
- How feasible is it for HEZ communities to roll out the strategy?

In Exhibit 5 below we present the Waggl findings, organized by the Title V domains and the 1-2 priority issues for each. Specifically, for each priority issue we present: the top five strategies that emerged after participants voted, the total number of strategies proposed, the number of respondents who engaged with the process (i.e., someone who added a strategy, viewed the questions, voted on responses, or viewed the results), and the win likelihood. RIDOH staff reviewed the Waggl results and selected the top two suggested strategies for each MCH state priority need.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

SECTION HEADING: III.C.2.b Findings

III.C.2.bi MCH Population Health Status

Women's/Maternal Health (Preconception, Pregnancy, and Postpartum Health)

The Preconception, Pregnancy, and Postpartum Health domain section has taken into consideration that the care and outcomes of womxn, children, and families are impacted by the systemic racism, discrimination, unaddressed language barriers, and a lack of culturally responsive providers. The following quantitative, qualitative, and anecdotal information tries to tease out health disparities and the overarching healthcare needs of communities.

Preconception Health

The proportion of women who had a preconception discussion with a health care provider decreased from 27.7% in 2012 to 24.8% in 2015. In 2019, 64.5 % of Title X clients were using moderate to most effective family planning methods. There was a worsening trend among women reporting that didn't exercise or exercised little before pregnancy, from 24.8% in 2016 to 29.4% in 2018. Women less than 20 years old are more likely to experience depression before pregnancy (15.8%) than women 34 years and older (10.4%).

Health Equity Zone SUD reports there was an emphasis of family planning being coupled with substance use treatment. For instance, in the Olneyville HEZ SUD report, several interviewees noted that substance exposed

newborns almost always resulted from unplanned pregnancy. Many suggested that broader family planning initiatives are needed to be available for women currently in and out of treatment. Examples of increased initiatives include supporting family home visiting agencies, community health workers, and peer recovery coaches to more broadly teach family planning while meeting with their clients..

Health During Pregnancy

While trends have been improving for all racial/ethnic populations, disparities remain in reported unintended pregnancies, with 33.1% of Non-Hispanic Whites compared to 45.6% of Hispanics 45.6%, and 61.9% Non-Hispanic Blacks. The percentage of short interpregnancy interval (< 18 months) among RI resident women in 2018 was 26.1%, which is a slight decrease from 26.8% in 2017. In 2018, Hispanic women were 40% more likely to have a short interpregnancy interval than Non-Hispanic White women. Moreover, the disparity between both groups has increased from 2014 to 2018. Vital Records data show that 2.3% of women who gave birth in 2018 reported having a previous preterm birth. Among RI-resident women who have birth in 2018, 7.6% had gestational diabetes and 8.1% had gestational hypertension/preeclampsia. Although the overall trend of cigarette smoking during the last 3 months of pregnancy has decreased from 40.0% in 2018 to 36.0% in 2018, pregnant women with disabilities has a higher percentage (13.8%) smoking during pregnancy than pregnant women with no disabilities (5.8%). The decreasing trend in cigarette smoking during pregnancy may not account the likely increasing trend in electronic cigarette use. In 2019, 84.7% of pregnant women who gave birth received prenatal care beginning in the first trimester, a slight increase from 82.7% in 2018.

The RIDOH community survey reports that participants chose mental health (e.g., postnatal depression or anxiety (29%) and culturally responsive pregnancy/postpartum education and care (12%) as the top issue related to pregnancy and birth that the DOH should focus on to support families. Similarly, the SISTA FIRE Womxn of Color survey found that participants ranked the following as the three most important things to be addressed to improve the health and wellbeing of parents/caregivers: 1)Mental health (68%), 2) Pregnancy/Postpartum Education & Care (41%), and 3) Violence & Abuse in Relationships (40%). For reference, there are a variety of social determinants of health, such as housing and food insecurity, structural racism, etc., that contribute to mental, emotional and toxic stress. These survey results show a need for the RIDOH to invest in supporting the mental, emotional, and physical health of caregivers, especially through prenatal care and education.

RI Health Equity Zones (HEZ) completed community and stakeholder outreach to inquire about and report on Substance Use Disorder, especially as it pertained to substance exposed newborns (SENs). HEZ SUD reports revealed a couple of barriers to pregnant women accessing support included social stigmatization and a fear of having their children taken away by DCYF. Some pregnant individuals did continue to face stigma even as they enrolled in medication assisted treatment (MAT). For example, a pregnant women in recovery from opioid use disorder and receiving methadone treatment must not only continue to receive methadone but must also receive a higher dosage of it because her growing baby will metabolize part of the drug. Family members who do not understand how methadone treatment affects unborn babies will sometimes pressure women to stop treatment and accuse them of harming their unborn child.

Delivery and Postpartum Health

In 2019, 27.2% of women had cesarean delivery with a low risk first birth. The 2019 maternal morbidity rate (including blood transfusions) was 271.4 per 10,000 delivery hospitalizations, which is an increase from 242.0 per 10,000 In 2018, Black women (382.7 per 10,000 delivery hospitalizations) had a higher maternal morbidity rate than White women (224.8 per 10,000). Racial/ethnic disparities can also be seen among delivery hospitalizations regarding blood transfusions (Black women: 293.9 per 10,000; White women: 141.2 per 10,000) and hypertensive disorders (Black women: 520.4 per 10,000; White women: 288.7 per 10,000). According to Pregnancy Mortality Surveillance System data, there were 13 pregnancy-associated deaths in 2012-2016. PRAMS data show that the percentage of women reporting symptoms of postpartum depression was 12.3% in 2018, a slight increase from

10.9% in 2014. In 2018, women who identified as Other reported 17.5% reporting postpartum depressive symptoms compared to NH White women with 11.0%. An even larger disparity in postpartum depression existed between women with disabilities (32.9%) and women with no disabilities (10.5%).

We will view SISTA FIRE's key learnings through the overarching lens that discrimination and racial injustice permeate all corners of our society. Although SISTA FIRE draws on findings from WIH, these issues are present within various healthcare settings, hospitals, and practices across the state. SISTA FIRE, found three overarching issues that WOC wanted WIH to address in order to develop high quality delivery and postpartum care: 1) Translation & Interpretation, 2) Trauma Informed Care, and 3) Informed Consent. During triage, inpatient services, and discharge, WOC, especially non-English speaking WOC, felt that they were not properly communicated to, especially in their preferred language or dialect, about their condition, treatment, or about postpartum community resources and services. Even without a language barrier many WOC felt that their needs, pain, and suffering was not properly acknowledged, empathized with, and treated during their hospital stay. For instance, one respondent felt ignored when she questioned her repeated examinations. She viewed the experience as violating and invasive. She wasn't asked permission if doctors could use her as a practice patient and bring in multiple medical students at the teaching hospital. This story underlines the need for birthing hospitals to adequately communicate with their womxn of color patients in a culturally and linguistically responsive manner about their condition.

WOC often felt judged and nervous by staff asking personal questions, under the assumption that patients weren't responsible parents. Due to this, patients often did not want home visiting services. Patients also expressed a real fear that DCYF would be contacted and that mothers would be separated from their children based on stereotypes they felt hospital staff held about womxn of color mothers. "This was my first pregnancy, so I didn't really know.... I'm asking the nurses, and they are like 'Yeah, she's fine, it is kind of weird that her eyes are open, but she's good.'.... Then the doctors start asking me questions, 'Oh do you have any kind of infection or disease that we don't know about?' ...They kind of made it seem like I was hiding something, and this is why my daughter is not showing the typical behavior for a newborn. So I felt like they were blaming me." This quote underlines the need for birthing hospitals to create supportive and non-judgmental atmospheres that center trauma informed care of patients.

Perinatal/Infant

Poor Birth Outcomes

In 2019, there were 786 infants who were born with low birth weight (< 2,500 grams), this represents 7.7% of all infant born. In the same year, 95.4% of all very low birth weight (< 1,500 grams) infants were born in a Rhode Island Level III NICU hospital. Racial disparities are also observed in low birth weight babies. The preterm birth (< 37 weeks gestation) rate in Rhode Island is 9.4% in 2019. This represents an increase from the preterm birth rate of 8.2% in 2017. The difference in between Non-Hispanic White (8.0%) and Non-Hispanic Black (11.1%) births is 3.1 per 100 births. Provisional data for 2019 indicate that the infant mortality rate in RI is 5.5 deaths per 1,000 live births. The Black/White infant mortality ratio for 2017-2019 is 4.2, with Non-Hispanic Blacks having infants having a mortality rate of 13.0 per 1,000 live births compared to that of Non-Hispanic White infants with 3.1 per 1,000 live births.

Caregiver Relationship with Infant

In 2019, home visitors observed 72.3% of caregivers interacting with their children using a validated tool. In 2017-18, 67.6% of caregivers are able to handle the day-to-day demands of raising children very well, which increases to 73.0% when raising children ages 0-5. However, the number of caregivers able to handle the demands of raising children ages 0-17 with special healthcare needs very well is statistically lower (49.7%) than caregivers raising children without special healthcare needs ages 0-17 very well. The mental/behavioral health of a women may impact the ability to care for their child(ren). In 2018, after giving birth, 25.4% of women responded that they often or sometimes felt down, depressed, or hopeless.

Substance Exposed Newborns

Hospital discharge data in 2019 show that 86 newborns were discharged with neonatal abstinence syndrome. This represents a rate of 89.4 per 10,000 newborn hospitalizations, a decrease from the NAS rate of 110.6 per 10,000 in 2018. Hospital discharge data in 2019 show that 86 newborns were discharged with neonatal abstinence syndrome. This represents a rate of 89.4 per 10,000 newborn hospitalizations, a decrease from the NAS rate of 110.6 per 10,000 in 2018. Both in HEZ SUD reports and SISTA FIRE Key Learnings parents of SENs report being stigmatized and judged by medical care providers and hospital staff.

The RIDOH community survey showed that participants chose mental health (e.g., postnatal depression or anxiety (29%) and culturally responsive pregnancy/postpartum education and care (12%) as the top issue related to pregnancy and birth that the DOH should focus on to support families. Similarly, the RIDOH & SISTA FIRE Womxn of Color survey found that participants ranked the following as the three most important things to be addressed to improve the wellbeing of newborns/infants: 1) Support new moms in caring for their infant (social, emotional, & financial), 2) Screening newborns for health conditions and diseases, and 3) Bonding and attachment.

Young mothers of SENs interviewed by the Pawtucket & Central Falls HEZ also reported poor treatment when going to prenatal checkups, when arriving in the hospital to give birth, at the hospital after birth, and when visiting their baby if s/he is going through withdrawal. One woman shared her experiences of giving birth twice at Women and Infants Hospital. The first time she successfully hid her addiction to opioids and alcohol from hospital staff. She remarked that she was treated “like a princess” and given a special birthing suite. The second time she gave birth, she was “deep in the throes of her addictions” and it showed on her face, her body, and in her comportment. She arrived at the ED and was left alone on a gurney in the waiting room for hours. When she was finally attended to she was fully dilated and ready to give birth. She was supposed to have had a C section but by then it was too late. Overall, these experiences show a need for a reduction of stigma and more comprehensive and compassionate care for substance using mothers giving birth.

Child Health

Children’s Health Data

NSCH 2017/18 data also show that 74.1% of children were continuously and adequately insured in the past year. Furthermore, 53.1% of children without special healthcare needs meet the criteria of having a medical home. According to the 2018 National Immunization Survey, 75.1% of children in RI ages 19 to 35 months were fully immunized. RI is ranked high among other states in the nation for immunizations of toddlers. However, disparities exist among certain health conditions. In 2017/18, 19.3% of Hispanic children are reported to currently have asthma compared to only 5.6% of Non-Hispanic White children. Also, 25.1% of Hispanic children ages 10-17 were obese compared to 8.8% of Non-Hispanic White children ages 10-17.

Child Literacy

Early literacy is an important precursor for developing a foundation to school readiness. In 2018, 17.9% of postpartum women reported not reading or looking at book with their baby in the past week. Disparities exist among race/ethnicity, where 25.4% of Hispanic postpartum women were not currently reading to their infant compare to 15.0% of Non-Hispanic White postpartum women. In 2017/18, 49.6% of family members were reading to their child ages 0-5 everyday. However, the disparity remains between Hispanic family members reading to their child ages 0-5 (29.6%) compared to Non-Hispanic White family members reading to their child (59.1%). Family Visiting Program in 2019 supported 2017/18 NSCH data, reporting that 49.3% of children were read, told stories, or sung songs by family members every day.

Community Surveys

The RIDOH gathered information from community, professional, and womxn of color specific surveys. In the dispersed RIDOH community and Professional surveys, both sets of survey participants ranked the following as their

top issue related to education that the RIDOH can focus on to better support families: 1) Schools that are safe, healthy, and high quality, & 2) Child care that is affordable and high quality. Similarly a SISTA FIRE survey found that 50% of the womxn of color surveyed thought screening for milestones and healthy development were important to improving health and wellbeing of young children (1-4 years old). Surveyed womxn of color also ranked the following as their top three important things to improving the health and wellbeing of children (5-12 years old): 1) Social & Emotional Health (62%) , 2) Bullying (43%), and 3) Nutrition & Physical Activity (37%).

These current survey findings are further supported by prior RIDOH community engagement completed for the Preschool Development Grant. A majority of the surveyed caregivers reported access to affordable childcare as their priority (44%). Among families identified as experiencing significant stressors by the state, over 1/3 stressed a need for more "information about available programs for my family." Families with young children and special needs and/or foster care indicated a particular need for "information about available programs for my family" and "childcare close to home". Cumulatively, these surveys show that there is still a need for the state to support the overall development and social and emotional health of children, especially those at a particularly young.

Adolescent Health

Healthcare and Immunization

According to the NSCH 2017/18, 75.0% of adolescents ages 12 to 17 received a past year preventive medical visit. In 2018, NIS reports that 89.3% of teens ages 13 through 17 have received at least one dose of the HPV vaccine, a slight increase from 88.6 in 2017. RI has the highest rates of HPV vaccination in the US. Additionally, 78.0% of adolescents were vaccinated against seasonal influenza in 2017/18. Other adolescent immunizations were also high in 2018 with 98.7% receiving at least one dose of the meningococcal conjugate vaccine and 96.3% receiving at least one dose of the Tdap vaccine, both increases from 2017. Seasonal influenza, meningococcal, and Tdap vaccination in RI exceeds U.S. rates among adolescents. Rates of chlamydia and gonorrhea have increased by 25% and 133% respectively from 2014 to 2018 among youth ages 15-24.

Behavioral/Mental Health

There was a slight decrease in bullying in school property among high school students from 17.3% in 2017 to 16.4% in 2019. LGB high school students continue to be more likely to be bullied on school property (37.2%) than heterosexual high school students (13.0%), as well as more likely to be electronically bullied (LGB HS students: 26.5%; heterosexual HS students: 10.9%). Suicide ideation is an important issue which the MCH Program monitors. YRBS 2019 data report a slight decrease among high school teens who seriously considered committing suicide from 13.6% in 2017 to 12.1% in 2019, but a statistically significant increase from 9.9% in 2013. Disparities exist between 16.6% of Non-Hispanic Black teens who seriously considered committing suicide compared to 10.6% of Non-Hispanic White teens in 2017. In 2019, the prevalence of having attempted suicide was higher among gay, lesbian, and bisexual students (36.5%) than heterosexual (9.7%) students. The percentage of binge drinking (11.2%) among high school teens in 2017 has dropped slight in 2019 (10.7%).

In 2019, RIDOH Title V and Adolescent Reproductive Health staff collaboratively outlined and administered a youth survey. In the survey, youth ranked the following as their top four priorities that should be addressed to improve the health and well-being of teens: 1) Mental Health (54%), 2) Safe & Healthy Schools (53%), 3) Suicide Prevention (37%), & 4) Healthy Relationships (with adults, friends, and partners) (36%). Similarly, 32% of teens ranked Mental health(Anxiety, depression, etc.) as one of their top four things that concerned them on a day to day basis. Rhode Island and SISTA FIRE collaboratively distributed a survey that asked womxn of color the top three important things that need to be addressed to improve the health and well-being of adolescents (12-17 years old). The top priorities that rose to the top are as follows: 1) Sexual Health (58.9%), 2) Mental Health (45.4%),& 3) Social & Emotional Health (40.2%).

Similarly, womxn of color ranked the top three important things needed to be addressed for the health and well-being of young adults (18-24 years old). The following three priorities were overwhelmingly chosen: 1) Mental

Health (64.2%), 2) Social & Emotional (44.9%), and 3) Sexual Health (42.6%).

All three surveys overwhelming align to show that there is a need to support the mental and behavioral health and development of youth. This theme was further fleshed out during a youth focus group the Title V needs assessment team held with the Youth Advisory Council (YAC). The youth agreed that mental health was an immense issue among their peers that encompassed substance and drug use and mental illness. Youth participants did see substance use, vaping, and drug use occurring within social scenes and gatherings. However, all agreed that much of the persistent drug use, substance use, and vaping they saw was tied to youth masking or self-treating underlying social and emotional issues. In all, Youth focus group participants emphasized that mental illness should be destigmatized and schools and providers should find more educational and supportive avenues to help bolster youth mental health.

Children with Special Health Care Needs

In RI, according to 2017/18 NSCH, 20.3% of RI children ages 0-17 years have at least one special health care need, compared to 18.5% in the nation. Among children 3-17 years old, the prevalence of ADD/ADHD is 10.0%. It is also estimated that the current prevalence of autism, Asperger's Disorder, or other ASD in RI is 2.2%.

Medical Home/Care Coordination

Several essential criteria are required to be considered a medical home. It includes being accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. In RI, NSCH 2017/18 data report that 38.4% of children with special healthcare needs (CSHCN) had a medical home, compared to 53.1% of children without special health care needs. This RI CSHCN measure does not meet the Healthy People 2020 target objective of 54.8%. In 2017/18, only 40.5% of CSHCN received effective care coordination. A larger combined sample size is needed to better understand families and CSHCN in receiving effective care coordination. In 2017/18, 68.2% of CSHCN are continuously and adequately insured in RI.

Impact on Families

RI continues to study and monitor the financial impact that many families with CSCHN experience. The NSCH 2017/18 reports that 8.7% of families with CSHCN have had problems paying for any of the child's medical or health care bills in RI, compared to 18.1% of families with CSHCN nationwide. NSCH also reports that 14.9% of RI families of CSHCN had a family member stop working or cut down hours of work because of the child's health or health conditions, compared to 1.5% families of children without special health care needs in 2017/18.

Overall, parents/guardians highlighted that increased coordination of care across agencies and programs is essential to better address the needs of children with special healthcare needs and their families. In general, they agreed there are some high-quality providers in the state, but limited connection and communication between programs. For instance, a desire for better coordination between the RIDOH and RI Department of Education came up as a way to help make services more seamless for CSHCNs. Overall, there was consensus that better coordination between agencies and programs would reduce overall confusion and travel burden on families.

The RIDOH in collaboration with the Rhode Island Parent Information Network (RIPIN) surveyed, interviewed, collected stories, published a issue brief, and held a conference that centered the voices of parents of CSHCNs. Surveyed parents and caregivers reported the following three overarching areas where they felt were challenges to accessing care: 1) Mental & Behavioral Healthcare, 2) Neurology & Neuropsychology, and 3) In-home Nursing and Respite Care. Overall, parents/guardians reported that they struggled to obtain timely services for their children, especially as it pertained to these three key areas. Families, especially those on Medicaid, were frustrated by the limited rate of insurance acceptance by providers and programs in RI. Some families do report trying to explore and access more timely services out of state but face significant resistance from insurance providers. Additionally, many noted that it was hard to hire and retain qualified home-based caregivers and therapists due to the general applicant

pool lacking expertise related to complex pediatric conditions due to low and noncompetitive salaries and insurance reimbursement rates. This issue is further underlined by the RIDOH and SISTA FIRE survey showing the following answers, assistance with the activities of daily life (46%) and parent support and respite care (39%), as their top two for improving the health and wellbeing of children with special health care needs.

Cross/Cutting Systems Building

Social Determinants of Health

Throughout the Title V Needs Assessment the state has collected quantitative, qualitative, and anecdotal information on how social determinants of health and structural inequities impact the outcomes of all Rhode Islanders. The SISTA FIRE Maternal Child Health Survey found that WOC ranked the following as what they were most concerned on a daily basis: not enough jobs that pay a living wage or have a career path (52%), paying monthly bills (41%), and wealth creation (34%). These daily stressors and needs of WOC do contribute to emotional, mental, and toxic stress. SISTA FIRE Survey found that 8% of Womxn of Color (WOC) responded always experiencing racism in the healthcare setting and 49% WOC experienced racism sometimes. Additionally, there were a higher unawareness of certain types of state programming and services such as: free breastfeeding support (41% unaware), free insurance during pregnancy (43% unaware), and home visiting (45% unaware).

Health Equity Indicators

BRFSS 2018 data show that 78.3% of Hispanics report visiting their doctor in the past year compared to 86.0% of Non-Hispanic Whites. The community resilience indicator measures Health in All Policy by calculating the percentage of low- and moderate-income housing. This indicator shows that cities such as Woonsocket (15.9%), Providence (14.9%), and Central Falls (11.2%) in 2016 had a higher percentage of low- and moderate-income housing than the statewide estimate (8.2%). Housing burden, a socioeconomic indicator, is calculated by identifying the percentage of cost-burdened renters and owners for RI cities and towns. This composite metric from 2019 HousingWorks RI Factbook's data showed that the communities with the highest total burden are Central Falls (55%), Providence (45%), and Pawtucket (42%). In 2018, nearly 4,000 women, men, and children experiencing homelessness sought shelter in RI. This number does not include those using RI's recently implemented coordinated entry system, which aims to triage households experiencing housing insecurity and "divert them from ending up in limited shelter beds; and the more than 1,500 RI students, who are measured by a different standard, but do not have a place to call home—a nearly 24 percent increase from the prior school year."[1] In 2019, the graduation rate among high school students who completed 4 years (2015/16 freshman class) was 83.9%, which is an increase from 2016 (2012/13 freshmen class) with 82.8%.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

Section Heading: III.C.2.bii Title V program capacity

III.C.2.bii.a Organizational Structure

Organizational Structure

RIDOH is the lead RI agency responsible for addressing maternal and child health needs throughout the state. Section 23-13 of the RI General Laws gives RIDOH broad authority for administering and overseeing Title V MCH

services. RIDOH is located within the state's Executive Office of Health and Human Services (EOHHS), a cabinet agency that reports directly to the Governor. Because RIDOH is the only health agency in the state (there are no local or county health departments), it has the unique ability to build capacity and coordinate direct partnerships with other state agencies, institutions, organizations, and communities. The Title V Program is part of the Health Equity Institute (HEI). The HEI is strategically located in the Office of the Director.

It is the responsibility of the RI MCH Program to ensure that that MCH initiatives, within RIDOH and throughout the state, are coordinated and family-centered for mothers, children, CSHCN, and families. The Title V program is managed by the State MCH/CSHCN Director, the MCH Program Manager, a MCH leadership team, and a MCH policy team. The MCH policy team meets monthly to discuss progress on Title V strategies, share relevant information and resources, and improve alignment and collaboration across RIDOH programs. Various RIDOH programs take the lead on different MCH strategies as indicated in the organizational chart.

Emerging Public Health Issues

Covid-19 Pandemic

On March 2, 2020, Rhode Island reported its first case for SARS-CoV-2 (Covid-19), a highly infectious coronavirus disease that primarily causes respiratory illness. On March 11th, the World Health Organization has declared Covid-19 a pandemic. Since then, Rhode Island has reported 21,683 confirmed cases of Covid-19 as of August 31st, of which 1,046 have resulted in death. RIDOH has activated the Incident Command System to respond to the Covid-19 crisis, working with Governor's Office and other state agencies. The Covid-19 pandemic has implications on the MCH populations served and has brought attention to inequities among vulnerable populations and communities. Although most MCH Program staff are concurrently activated to respond to the pandemic, MCH areas and populations affected by the pandemic are being addressed.

As of June 17, there were 107 pregnant women in Rhode Island who were positive for Covid-19, of which there were no reported deaths. An MMWR report found that pregnant women were more likely to have severe illness than non-pregnant women. To date, there are no newborns infected with Covid-19. To increase knowledge in the potential relationship between Covid-19 and pregnancy outcomes, RIDOH is collaborating with the CDC to submit Covid-19 data linked to Vital Records. To protect their clients and workers, RIDOH programs such as Family Visiting and WIC are offering telehealth services to pregnant women, postpartum women, and their families. Of the known age demographics of confirmed Covid-19 cases, 2% represent children ages 0-4, and 9% represent ages 0-18. Of the known age demographics, only 2% of confirmed cases represent children ages 0-18. Rhode Island reported a pediatric case with multi-systemic inflammatory syndrome, although the prognosis was good and its proven to be extremely rare. Although transmission of Covid-19 among daycare centers seemed worrisome, an MMWR report showed that there is limited transmission of child day care sites in RI due to high compliance with

With the statewide shutdown earlier in the pandemic, there has been delayed or missed healthcare for many MCH populations. Most notable are the children population, where immunizations have dropped beginning in April 2020. Overall, 24% fewer vaccine doses were given in March to July 2020 compare the same time period in 2019. The decline was greater (43%) for older children ages 7 or older and Black children (26% decline). Vaccines for Covid-19 will be monitored through the Rhode Island Child and Adult Immunization Registry (RI-CAIRT). Childhood lead screening resulted in a steeper decline, where overall 43% fewer children were screened for lead poisoning in March to July 2020 compared to the same time period in 2019. Covid-19 has disproportionately impacted several municipalities in RI, where the case rates are much higher than the statewide average. The Health Equity Zones (HEZs) offer a ready-made infrastructure to support immediate and longer-term efforts in High Density Communities (HDCs) most affected by the Covid-19 crisis.

Drug Overdose

The goal is to reduce opioid overdose deaths by one-third within three years by addressing four key strategies:

treatment, overdose rescue, prevention, and recovery. Although there is still a lot of work to do, between 2016 and 2018, RI overdose deaths decreased by 6.5 percent. In 2019, the Taskforce updated its strategic action plan. The new plan keeps the strategic pillars--prevention, rescue, treatment, and recovery, and puts a new focus on using data to inform response, engaging diverse communities, changing negative public attitudes on addiction and recovery, incorporating harm-reduction principals, and confronting the social determinants of health. RIDOH has emphasized the importance of community-driven response to the opioid epidemic. In 2019, 34 of RI 's 39 municipalities developed their own local overdose response plan, aligned with the statewide plan, and twenty of those communities have begun implementation and evaluation of evidence-based or innovative initiatives. For more updated data on the opioid epidemic and local resources see PreventOverdoseRI.org.

III.C.2.b.ii.b. Agency Capacity

III.C.2.bii.b Agency Capacity

The RI Title V Program works closely with RIDOH programs, other state agencies and community partners to promote and protect MCH populations, including ensuring a statewide system of comprehensive, community-based and family- centered care. RIDOH is the sole public health entity in RI. There are no local health departments. As such, RIDOH relies heavily on partnerships to advance its work throughout the community. These partnerships include advocacy groups, colleges and universities, community-based organizations, federally qualified health centers, health plans, Medicaid, professional organizations (RIAAP, RIACOG, etc.), committee and coalitions, and other state agencies. RIDOH MCH staff convene and participate in over 70 committees or advisory boards. Recent efforts have been focused on building infrastructure at the community level through the Health Equity Zone initiative. This effort promotes collaboration to support public health at the community level.

As part of its needs assessment, RI Title V surveyed community members and MCH professionals. 476 community members and 449 professionals filled out all or some of the survey. Reponses related to issues identified by respondents provide some insight into the extent of collaboration within the Rhode Island MCH community and capacity to provide and assure services within each population health domain.

(i) Capacity to provide and assure services within each of the five population health domains.
The needs assessment survey of community professionals showed good collaboration among the organizations that serve the MCH populations in each domain. However, about a third of professionals indicated that additional collaboration was needed with various types of organizations in order to better support families. Limited staffing and time were cited as barriers to collaboration, and 40% indicted that limited availability of services in the area was a barrier. Transportation, system navigation, childcare, and waitlists were identified as leading barriers to services. The priorities identified by the professionals mirrored those of community members. Mental health was the leading priority, followed by culturally responsive pregnancy/postpartum education and care. Money/employment and housing, affordable high quality child care and safe, healthy, quality schools also were identified as priorities.

(ii) RI Title V does not provide direct services to CYSHCN. RI's Title V CSHCN program enjoys a collaborative working relationship with RI Medicaid and RI Office of Rehabilitation Services. Title V CSHCN participates on advisory committees with consumers and state leaders to ensure Medicaid services and supports are organized and comprehensive. Title V CSHCN leadership sits on the Medicaid Managed Care Advisory Committee for CSHCN.

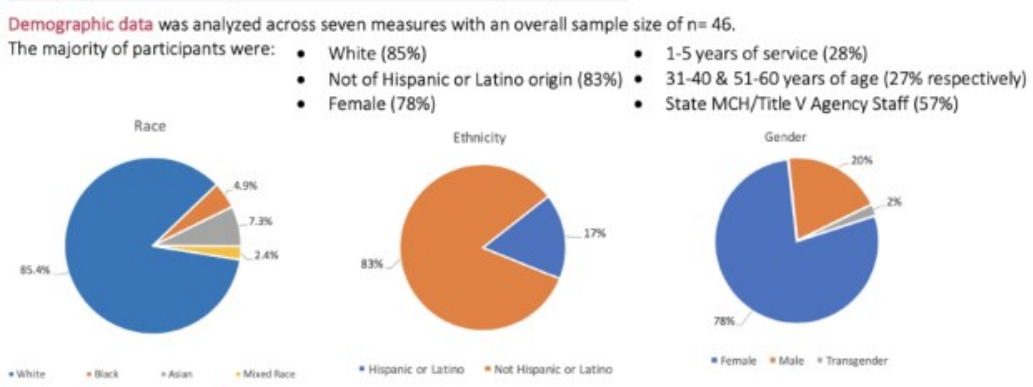
III.C.2.b.ii.c. MCH Workforce Capacity

III.C.2.bii.c MCH Workforce Capacity

There are over 100 FTEs employed by RIDOH who are working on MCH related programs and services. This includes staff that provide planning, implementation, evaluation, and data analysis.
MCH leadership:
Dr. Nicole Alexander-Scott - Director of Health
Deborah Garneau– Director, Health Equity Institute and Title V/CSHCN Director
Jaime Comella – Program Manager, Title V MCH Program (temporarily assigned to COVID)
Aidea Downie-- Coordinator, Title V Needs Assessment and MCH Disparities Specialist
Colleen Polselli – Program Manager, CYSHCN Program
Carol Hall-Walker-- Division Director, Division of Community Health and Equity
Dr. Ailis Clyne– RIDOH Physician Consultant and Pediatrician (temporarily assigned to COVID)
Blythe Berger – Chief, Center for Perinatal and Early Childhood
Kristine Campagna – Deputy Chief, Center for Perinatal and Early Childhood (temporarily assigned to COVID)
Sam Viner-Brown – Chief, Center for Health Data and Analysis
Ellen Amore – KIDSNET Program Manager, Center for Health Data and Analysis

Ana Novais, previous Title V Director, has accepted a new position in state government as the Assistant Secretary of the Executive Office of Health and Human Services (EOHHS). Although no longer at RIDOH, her new role and long-standing relationship with MCH leadership will no doubt continue to be an asset to MCH. RIDOH also directly supports the MCH workforce through many community contracts including Family visitors, peer resource mental health specialists, parent consultants (12 work at RIDOH and 27 work in community settings), community health workers, safety-net clinical providers, youth advisory groups, sexual health counselors, breastfeeding lactation consultants, and prevention educators.

As Title V worked through the 5-year needs assessment process, an understanding of their workforce composition and learning needs was essential to gauge strengths and areas of growth. The MCH Navigator prepared this report of professionals in Rhode Island who have taken the online self-assessment in 2019 to serve as a snapshot of workforce demographics and knowledge/skills across the MCH Leadership Competencies.



The MCH Navigator provided a self-assessment to MCH as an opportunity for professionals to reflect on competency-based strengths and areas to grow in order or identify learning needs and reinforce new skills in order to improve performance. The self-assessment analyzed mean knowledge and skill scores for each of the 12 MCH Leadership Competencies for Rhode Island. In line with national data trends, cultural competency had the largest gap in knowledge and skills (where knowledge is higher than skills), and policy has the lowest knowledge and skills scores across competencies. Overall, a majority of RIDOH Title V staff have multiple years of experience and a range of competencies and skills that complement Title V's mission and goals.

Family Centered Services

A long-standing tenant of RI's MCH Program is family, youth, CSHCN, and consumer representation and engagement at all levels of planning through implementation. RIDOH has partnered with the local chapter of Family Voices of the RI Parent Information Network to engage, train and employ families of CYSHCN within the RI system of care. Family liaisons that are hired, trained, and certified as community health workers are supported in RIDOH's CYCHCN program, WIC, newborn screening programs, birth defects program, centralized communications, family planning, immunization, and family home visiting. RIDOH also convenes an active Youth Advisory Council that meets monthly, engages in policy development, and assists in the implementation of RIDOH programs. MCH strategic planning regularly includes families who have received services.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

III.C.2.biii Title V program partnerships, collaboration, coordination

Partnerships, Collaboration, and Coordination

The RI MCH program is a consistent leader in maternal and child health policy and programs. RIDOH staff champion the interests of mothers and children statewide in over 70 committees and boards in which they participate in or convene. A full list of these committees can be found in the supporting documentation section of the report and is called "2019 RIDOH MCH Partnerships and Collaborations".

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Identifying priority needs and linking to performance measures

Below is the summary table with the top two MCH priorities by MCH domains conducted by the internal prioritization sessions:

Priorities	Preconception Pregnancy, Postpartum	Perinatal/ Infant	Child	Adolescent	CSHCN	Cross-cutting
Highest Priority	*Maternal Morbidity/ Mortality	*Caregiver's Behavioral/ Mental Health and Relationship with Child	*School Readiness	*Mental/ Behavioral Health	*Care Coordination	*Social Determinants of Health
Second Highest Priority	*Prenatal Health	Infant Mortality	Toxic Stress/ Exposure to ACEs (Adverse Childhood Experiences)	Nutrition and Physical Activity	Behavioral Health	

*Chosen MCH state priorities for 2021-2025

The highest MCH state priorities were selected based on scoring from five criteria: (1) racial/ethnic disparities; (2) community support/political will; (3) availability of resources/agency capacity; (4) potential for public health influence; and (5) the matrix score (composite score from information about magnitude, trend, and racial/ethnic disparities). These priorities were selected based on the input from various professional and community voices that stressed the importance of addressing racial/ethnic disparities. The ability to drive change based on current workforce capacity resources guided the selection process. MCH leadership also decided to potentially include the second highest priority for each domain based on consensus. In this case, the Title V Program included improving

prenatal health as an additional state MCH priority because of the importance of the inter-related work among RIDOH programs that focus on prenatal health issues such as oral health, substance use, and behavioral/mental health.

Below is a table of the seven MCH state priorities linked to Title V performance measures.

MCH State Priority	Performance Measure
Reduced maternal morbidity/mortality	**NPM 2** Low-risk Cesarean deliveries
Address prenatal health disparities	**NPM 14.1** Percent of women who smoke during pregnancy
Strengthen caregiver's behavioral health and relationship with child	**NPM 5** A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Improve school readiness	**NPM 6** Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Support adolescent mental and behavioral health	**NPM 9** Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Ensure effective care coordination for children and youth with special health care needs	**NPM 11** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Adopt social determinants of health in MCH planning and practice to improve health equity	**(SPM Graduation rate)**

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,700,000	$1,624,486	$1,700,000	$1,647,805
State Funds	$2,079,960	$1,815,653	$2,071,934	$1,921,703
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$1,494,427
Program Funds	$28,726,379	$29,444,033	$30,958,381	$30,515,416
SubTotal	$32,506,339	$32,884,172	$34,730,315	$35,579,351
Other Federal Funds	$75,202,279	$67,953,126	$76,482,469	$65,403,192
Total	$107,708,618	$100,837,298	$111,212,784	$100,982,543

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,900,000	$1,646,441	$1,950,000	
State Funds	$2,167,896	$1,936,929	$2,281,459	
Local Funds	$0	$0	$0	
Other Funds	$0	$2,643,619	$2,450,041	
Program Funds	$34,000,771	$30,645,189	$38,024,089	
SubTotal	$38,068,667	$36,872,178	$44,705,589	
Other Federal Funds	$72,533,251	$73,964,022	$66,841,053	
Total	$110,601,918	$110,836,200	$111,546,642	

	2021	
	Budgeted	Expended
Federal Allocation	$1,900,000	
State Funds	$2,192,023	
Local Funds	$0	
Other Funds	$2,517,587	
Program Funds	$36,320,104	
SubTotal	$42,929,714	
Other Federal Funds	$55,910,645	
Total	$98,840,359	

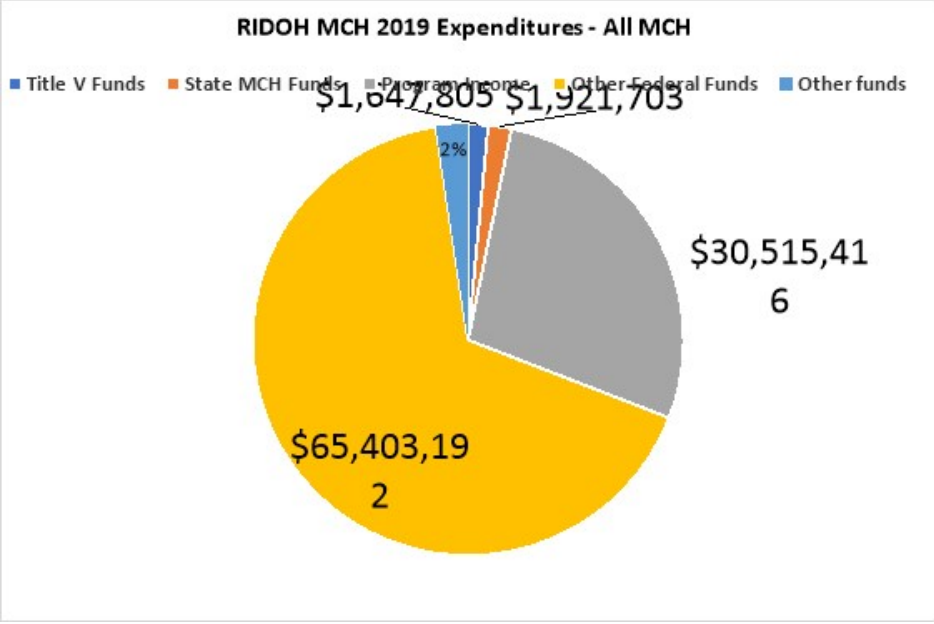
III.D.1. Expenditures

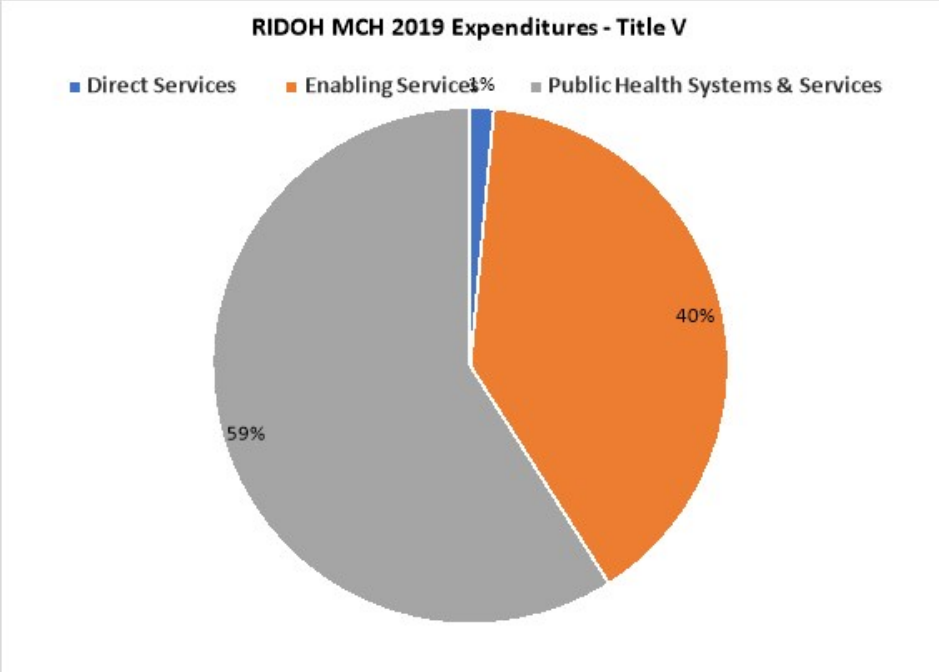
1. Financial Narrative
A. Expenditures

2019 Expenditures (forms 2, 3a, 3b)

For SFY19, the federal allocation funding of $1,646,441 was fully expended. The amount of State Funds expended is $230,967 less than budgeted due to a reduction of newborn screening expenditures by $228,211 compared to the SFY19 Governor's recommended budget request. There is an increase of $3,779,760 for total expenditures compared to the budget mainly due to increased award received for Prescription Drug Overdose Prevention grant.

2019		
	Budgeted	**Expended**
Federal Allocation	$1,900,000	$1,646,441
Unobligated Balance	$0	$0
State Funds	$2,167,896	$1,936,929
Local Funds	$0	$0
Other Funds	$2,552,913	$2,643,619
Program Funds	$34,000,771	$30,645,189
Subtotal	$40,621,580	$36,872,178
Other Federal Funds	$66,434,860	$73,964,022
Total	$107,056,440	$110,836,200





The FY19 budget partially supported 15 full time RIDOH employees for a total personnel cost of $369,193. General office and program supplies accounted for 4.34% of the total budget ($71,517) and consisted of costs for printing, copying, information technology, postage, telephone and computer supplies. Consultant costs made up 23.46% of the total expended and was primarily allocated towards our Rhode Island Parent Information Network (RIPIN) Resource Specialist program ($104,055), John Snow Inc. (JSI) Child Death Review analysis ($33,311), and the First Connections contracts ($47,356). Our contractual budget totaled $801,089 with supporting the Health Equity Zones (HEZ) at a total cost of $424,000. Other major contracts include the RIPIN Family Voices program ($228,373), Can we talk Healing program ($23,900), Trauma-informed schools program ($25,000).

RIDOH has invested resources in the HEZ initiative to develop place-based and community-owned infrastructure to address the social and environmental factors that affect health outcomes. These factors, often described as social and environmental determinants of health (SDOH), are systemic barriers to achieving optimal health that exist outside the clinical setting in the places people live, work, and play. HEZs address SDOH through establishing diverse collaboratives of local stakeholders, conducting comprehensive needs assessments, and implementing data-driven plans of action. The model focuses on improving the health of communities at highest risk of adverse health outcomes, such as obesity, illness, injury, chronic disease, or poor maternal and child health outcomes, due to poverty or other social, economic, and environmental determinants of health. RIDOH currently has contracts with 10 Health Equity Zones that are located in communities throughout the state. Three are defined by inner-city neighborhood boundaries, several are city-wide, and one encompasses an entire county, largely rural in nature. The populations of the HEZs range from about 5,500 (the Olneyville neighborhood) to 178,000 (the City of Providence). Two of the neighborhood HEZs are located within the geographic bounds of another city-wide HEZ (the City of Providence—Rhode Island's largest and arguably most diverse city). Rhode Island's model is organized around a four-year funding cycle consisting of flexible funding, which helps communities develop their capacity to address the socioeconomic and environmental factors that prevent people in the community from being as healthy as possible. Traditionally, public health departments have provided communities with separate sources of funding to implement specific programs or address specific health concerns, such as diabetes or cancer. The HEZ model braids together state and federal funds from several sources, so that communities can work together to achieve shared goals for

sustained community health and economic well-being. In Rhode Island, this grant funding is viewed as an initial seed investment to build capacity and spark community development. RIDOH is working with communities to identify sustainable investments with flexible funding to maintain and expand their efforts over the long term.

Budget and Expenditure Details by Type of Individuals Served (Form 3a)

Rhode Island has continued to be successful in meeting the budget requirements of at least 30% of our federal MCH funds being utilized for Preventive and Primary Care for Children ($497,031 at 30.19%) and at least 30% for Children with Special Health Care Needs ($677,606 at 41.16%). The proportion of federal MCH funds expended for FY19 for Administrative Costs is 8.20% ($134,949), which is under the allowable 10%.

Budget and Expenditure Details by Type of Services (Form 3b)

For FY19, there was $23,900 expended for direct services for Can we talk Healing program for Post-Traumatic Healing. $650,683 (39.52%) of the FY19 budget was spent on enabling services. The largest portion, 59.03% of the FY18 budget, ($971,858) was spent on public health systems and services.

2019- 2020 Venture Capital Funds

Each year the Title V Program allows RIDOH MCH Programs to apply for "Venture Capital" funds to support special projects. This funding is intended to augment, not replace other federal funds. Projects must align with Title V priorities and strategies. The MCH management team reviews the applications and decides which projects to fund based on the merit of the application and the amount of money that is available. This past year, $401,671.25 was approved through this process. The projects are outlined below.

Program	Amount Requested	Project Name	Project Description
Adolescent & School Health	$5,050	Building Infrastructure to Advance School Health	1.) Support the development of a Rhode Island School Nurse Orientation Program to provide training on the school health regulations and practice standards for conducting vision, hearing, and postural screening of school-aged children. 2.) Cover School Nurse Consultant time to consult on statewide orientation project
Minority Health	$25,000	Can We Talk Healing Program	The program will be in one of the city's high stress neighborhoods, take place one evening a month for approximately two- and one-half hours, and be staffed by a project coordinator, artistic director, licensed clinician, program navigators (2), administrative support (1), faith leadership, and volunteers.
PRAMS	$14,995	Marijuana & Prescription Drug PRAMS Supplement	Use of these standardized PRAMS supplement questions in RI can provide comparable state-based surveillance estimates to monitor and evaluate policies and programs.
Tobacco Control Program	$25,000	Media Campaign to Promote Tobacco Cessation Services to	Paid and earned media campaign activities will address and seek to reduce smoking and other tobacco use (e.g. e-cigarettes) in the home environment among Rhode Island's most vulnerable populations (e.g. smokers who are pregnant/nursing, womxn of low SES, womxn of color,

		Pregnant Women and Reduce Asthma Triggers	individuals who identify as LGBTQIA+, families and individuals in multi-unit housing, womxn with disabilities, womxn with chronic health conditions).
Tobacco Control Program	$25,000	Rhode Island End Game	support and reinforce tobacco-free living in home and community environments, deterring initiation and continued use of harmful tobacco and nicotine products, and easier to quit. Specifically, expand youth prevention activities in the state through the existing programs such as the RI Tobacco Free Teen Alliance and the Live Smoke Free,
Family Visiting	$16,700	Family Involvements in RIDOH's Early Childhood Program	funding to increase family involvement in the Rhode Island Department of Health's Early Childhood program. We will do this by continuing to develop and sustain a Parent Advisory Committee (PAC).
Oral Health Program	$25,000	Seal RI!	provide additional support to the teachers and staff involved with obtaining consent forms for sealant dental screenings. With these items the goal is to help increase return of sealant consent forms and incentivize those that provide support of obtaining the consent forms in a timely manner. (Pizza Party, Amazon Gift Cards, Silicone Wristbands, direct mailings)
Violence & Injury Prevention	$25,000	Youth Sports Concussion Program	offer neuropsychological baseline testing (NBT) to middle and high school age youth (ages 11-18), who participate in school sports and youth athletic leagues. This project proposes the use of the Impact neuropsychological baseline test to capture a baseline for youth athletes
Home Visiting	$5,000	Home Visitor Safety Trainings	offer multiple Home Visitor Safety Trainings through the Institute and the Study of the Practice of Non-Violence. This will support both seasoned and new family visitors to learn and refine their skills in safety in neighborhoods and client's homes.
Family Visiting	$25,000	Newport Hospital CHW	RIDOH and the community would like to integrate a Community Health Worker (CHW) at Newport Hospital to engage families and connect them to community-based services.
Family Visiting	$24,926	RIH Outreach to Educated & Empower Families	partner with and support all birthing hospitals in Rhode Island to integrate the CDC's "Learn the Signs. Act Early" to educate and empower families being discharged from the regular care nursery.
Special Needs	$20,000	Youth Advisory Council	The Youth Advisory had 18 members during the project year 2018-2019 which included 5 new members (1 male, 3 female and 1 identifying as binary) and 13 returning members. The Advisory has three focus areas which include: • Professional Development and Training • Group Social Skills Building • Project/Event Planning and Facilitation
Family Visiting	$50,000	First Connections	Home visiting Program
Special Needs	$10,000	Dare to Dream	Dare to Dream is an annual youth leadership conference to address social emotional health, exploration of personal strengths, and tools for resiliency for nearly 1000 adolescents with special needs.
Violence & Injury	$25,000	RISAS cost	Outreach and coordination with schools to promote

Prevention		for minimum Youth Suicide Prevention	knowledge and utilization of neuropsychological online testing for student athletes.
Adolescent & School Health	$5,000	Linda Mendonca	Contract with Linda Mendonca to provide Adolescent and school health support
MCH/Special Needs	$50,000	Adolescent Transition - CTC learning collaborative and quality improvement	RIDOH is contracting with the Care Transformation Collaborative of RI (CTC) on a Pediatric / Adult Transition Quality Improvement Initiative to focus attention on transitions of care between pediatric and adult practice, and provide training, support, and technical assistance to selected PCMH-Kids practices.
SEN Taskforce	$25,000	SEN Strategic Planning	Strategic planning/visioning process that will incorporate short- and long-term plans

Budget

Reorganization

As part of the Rhode Island Department of Health's reorganization in 2016, the MCH Title V block grant was transferred to the Health Equity Institute (HEI). HEI is comprised of the Minority Health Program, Refugee Health Program, Maternal and Child Health Program, Special Needs Systems Integration Program, Disability and Health Program, Prevention Block Grant, and Health Equity Zones.

In addition to RIDOH's programs transferring to better align with the department's priorities, Central Management has also been spending some time on restructuring the operations and finance core functions to better support the department as well as our partners. Core function teams are being developed in the following areas: state budgeting, purchasing, grants management, revenue, Medicaid and cooperative agreements, and human resources. Each core function team will have a lead, a dedicated staff person and expert/support staff. The core function team serves as a resource to bring expertise to all the divisions. It supports the standardization of processes and communication of those processes. In addition, the structure provides opportunities to support workforce development and ensures capacity for operations and finance responsibilities.

RIDOH Budget

The SFY 2021 Governor's Recommended budget for RIDOH is a total of $186,724,931 which is $32,999,978 (17.67%) in general revenue, $104,298,145 (55.86%) in federal funds, $49,026,808 (26.26%) in restricted receipts, and $400,000 (0.21%) in operating transfers from other funding sources.

Below is the list of the Department's Departmental Divisions including their SFY 2021 budgets:

1. **Division of Central Management ($15,696,096)** provides leadership, administrative, and programmatic oversight to the various programs and operations of the Department. The HEI is strategically positioned within the Director of Health's Office and applies the health equity lens to all RIDOH programs and policies to a priority population of people with disabilities and racial/ethnic minorities.
2. **Division of Policy, Information and Communications ($5,347,758)** responsible for the acquisition and use of clear, accurate and appropriate data to inform public health policy as well as the provision of high-quality, timely, and accurate health information to the public so they can understand health risks and make healthy and safe choices.
3. **Division of State Laboratories and Medical Examiner ($13,370,906)** supports the Department's mission of "safe and healthy lives in safe and healthy communities" through scientific identification of pathogenic microorganisms, toxic substances, and criminals that threaten the health and safety of Rhode Islanders, and through the investigation of suspicious or unexpected deaths.
4. **Division of Preparedness, Response, Infectious Disease & Emergency Medical Services ($15,702,040)** creates and promotes a state of readiness and prompt response to protect the health of Rhode Islanders during catastrophic events, large-scale disasters, and other types of emergencies; controlling person-to-person spread of infectious diseases; and licensing, regulating, and oversight of emergency medical services.
5. **Division of Community Health and Equity ($106,737,511)** aims to achieve health equity for all populations by eliminating health disparities, assuring healthy child development, preventing and controlling disease and disability, and working to make communities healthy.
6. **Division of Environmental Health ($14,559,634)** regulates and provides oversight of population-based

activities related to safe food; potable water; healthy homes in the areas of lead, asbestos, radon; and health and safety in the workplace.

7. **Division of Customer Services ($15,310,986)** assures that minimum standards for the provision of health care services are met. To that end, the program licenses, investigates and disciplines health care professionals, healthcare facilities, and health-related facilities. The Customer Services division also includes the public-facing Center for Vital Records which ensures the integrity and appropriate access to permanent records related to births, deaths, marriages, and civil unions for Rhode Island.

Title V Budget

In FY2021, RIDOH proposes to spend $1,900,000. Title V funds rarely fund direct services. Instead, they are used to improve systems by working with and leveraging other programs and assets that improve maternal and child health outcomes throughout the state. The Title V program ensures program coordination and collaboration both internally (e.g., Family Visiting, Family Planning, Oral Health, Immunization) and externally (e.g., Medicaid, Accountable Entities, Hospitals, Insurers).

Personnel costs are allocated across population domain categories that are reflective of staff time and effort and account for $562,632 (29.61%) of the total budget.

Name	Base salary	Base Fringe	Percentage	Months
Garneau, Deborah	$114,067	$71,290	38%	12
Boucher, Carmen	$54,353	$42,846	53%	12
Golding, Deborah	$70,483	$50,531	53%	12
Polselli, Colleen	$77,870	$41,594	53%	12
Hu, Krissy	$77,127	$41,589	15%	12
Tinajera, Alvaro	$93,600	$69,548	10%	12
Vacant(Kim's backfill)	$70,000	$56,000	10%	12
Comella, Jaime	$86,147	$51,272	43%	12
Diane Hernandez	$65,329	$47,582	40%	12
Arias, William	$82,215	$47,024	28%	12
O'Connell, Sophie	$93,963	$49,180	10%	12
Katz, Margo	$76,462	$52,772	25%	12
Patriarca, Mia	$91,048	$61,510	53%	12

Similarly, travel costs are spread across all Title V population domains for a total $23,958. General office and program supplies are classified as Administrative costs and are budgeted at $51,311. The contractual budget is $750,000 and consists of Rhode Island Parent Information Network (RIPIN) Family Voices program, multiple First Connection contracts, and support for Health Equity Zones (HEZ). The RIPIN Family Voices contract is $200,000 is 100% in support of Children with Special Health Care Needs. A total of $50,000 is budgeted for our First Connection contracts, a postnatal home visiting program for high risk mothers and babies.

Our $311,000 consultant budget consists of support for our Behavioral Risk Factor Surveillance System ($10,500), John Snow Inc. ($50,000) for the Child Death Review Committee, University of Utah ($27,500) for the Medical Home Portal, ADIL Business Systems for needs assessment and evaluations ($108,000) and RIPIN ($115,000) for community health workers, family/consumer input, and systems development for CSHCNs.

Annually, the Title V Program offers other internal RIDOH programs an opportunity to apply for up to $25,000 for one-time funds to support an MCH projects related to the ten priority areas. Approximately, $130,000 is reserved to

support the approved Venture Capital Requests (VCR) during the FY21 budget period and $25,000 is budgeted for obligated VCR from FY20 budget period. Once applications are received the MCH Management team meets to review and make final decisions. These projects area monitored closely for spending at the regular meetings with finance staff.

Details by Type of Services

Of the $1,900,000 proposed, 48.23% ($916,383) will support Enabling Services and 51.77% ($983,617) will support Public Health Systems and Services.

Budget Details by Type of Individuals Served

The FY2021 MCH Title V budget allocates 15.81% ($300,306) for pregnant womxn, 32.72% ($621,672) for preventive and primary care services, 36.25% ($688,750) for children with special care needs and 4.43% ($84,142) for administrative costs.

Federal Grant Monitoring Procedures

RIDOH Operations and Finance team monitors all federal grants on a monthly basis. Every grant is assigned to an Operations Liaison, who works with the Program Manager throughout the duration of the federal grant. When a Notice of Award is received by the Division, the grant budget is reviewed and purchasing mechanisms are discussed. The Operations Liaison continues to meet at least quarterly with the Program Manager to review expenditures, budget re-directions (if necessary), and projections for the federal grant. Monthly expenditures are tracked by the Operations Liaison in a Uniform Grant Spreadsheet (UGS) by line item in comparison to the grant budget that was submitted and approved by the federal funding agency. Scheduled meetings assist the Operations Liaison in completing timely and accurate Federal Financial Reports.

Staff time is tracked through a quarterly time and effort workbook in which the staff enter their hours worked in a certain program on a daily basis and submit weekly. The workbook includes the time worked and the time the employee is allocated to each account and has a variance report which captures all 13 weeks within the quarter. Any variances from the budgeted allocation are adjusted on a quarterly basis by the finance division liaison. RIDOH has developed a policy and procedure for the time and effort tracking while our Department of Administration is working on the possibility of an electronic system.

The Operations and Finance Team maintains budget documentation for block grant funding/expenditures for reporting consistent with Section 505(a) and section 506(a)(1) for auditing. For the Title V MCH Block Grant, the Operations Administrator meets with RIDOH's Executive Director and MCH Program Manager to review spending, performance, and quality assurance issues for the Title V MCH federal grant. The MCH Program Manager is responsible for monitoring the MCH funded projects performance and assuring the projects align with the National Performance Measures and selected State Priorities.

Audits from both the state Office of the Auditor General and the state Bureau of Audits are conducted at RIDOH annually. Within the past 2 years, the WIC and 1422 programs were audited by the Auditor's General's Office and last year the state Bureau of Audits conducted an audit review of 16 federal grants, in which the Title V MCH block grant was one of the grants selected.

RIDOH participates in an Executive Office of Health and Human Services audit workgroup. The workgroup is responsible for determining the subrecipients who meet the threshold of receiving a minimum of $750,000 of federal funding per the Uniform Grant Guidance. Audits are being reviewed for finds and if needed, follow-up on the status of

the corrective actions of the findings and/or subrecipient financial site visits.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Rhode Island

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

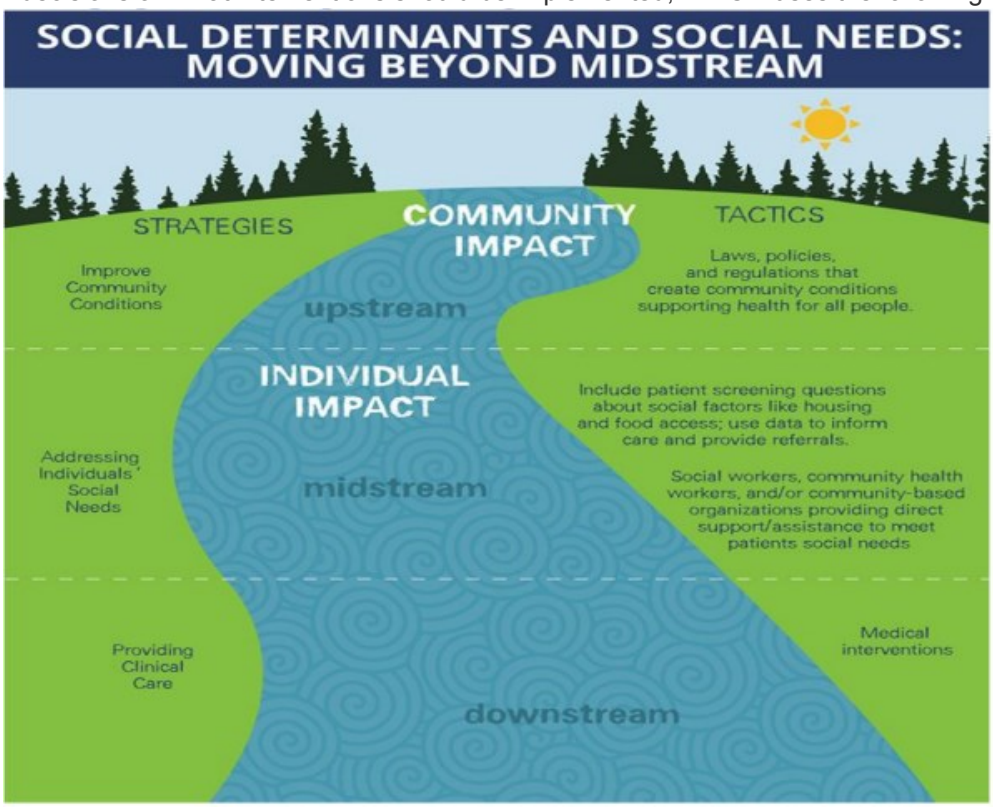
III.E.2.a. State Title V Program Purpose and Design

State Title V Purpose and Design

RI's Title V Program is uniquely situated in the Health Equity Institute (HEI) within the office of the Director. In this organizational structure, Title V acts as a convener, collaborator, and partner in addressing MCH issues within RIDOH and statewide. Heavy emphasis and investment are placed in health equity and place-based approaches to improving MCH outcomes, including addressing the social determinants of health. While the responsibility of Title V coordination and reporting falls on HEI staff, the larger Title V team includes staff from all RIDOH programs that touch MCH populations. This team approach allows Title V to be represented at virtually every MCH policy discussion, committee, or advisory group in the state.

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 RIDOHs approach to public health. When allocating resources and making data-driven decisions on what interventions should be implemented, RIDOH uses the following tool to help prioritize its work.



Measuring Health Disparities

The identification of health disparities is necessary to better identify and describe vulnerable populations in RI so that these groups can be prioritized in public health interventions. In RI, health disparities are most commonly found among disability, race, ethnicity, geography, education, and income. HEI currently uses both absolute and relative measures for rates and proportions to measure health disparities. Current disparity data can be found in each domain update. Notably, over the past two years the Health Equity Institute (HEI) went through an extensive community engagement process where the Community Health Assessment Group developed a core set of 15 indicators in five domains that affect health equity: integrated healthcare, community resiliency, physical environment,

socioeconomics, and community trauma. Data comes from various sources. When possible, data are reported by geographic location, race/ethnicity, disability status, income level, or other demographic characteristics. *A complete list of Rhode Island's Statewide Health Equity Indicators can be found in the Appendix.* As part of the Five-Year Title V Needs Assessment, RIDOH contracted with SISTA FIRE, an organization that works to create a network of womxn of color to build collective power for social, economic and political transformation. They focus on racial, economic, and gender justice work. Birthing stories, an internal SISTA FIRE survey, and a RIDOH/SISTA FIRE survey were included as part of the needs assessment.

Addressing Health Disparities

In recognition that health happens in our homes, schools, jobs, and communities and to respond to the systemic inequities, RIDOH supports 2 main strategies to address health disparities for MCH populations – Health Equity Zones and Community Health Workers.

In 2015, RIDOH launched the "Health Equity Zone" (HEZ) initiative — structured as community-led collaboratives to assess and flexibly address community priority projects. As the HEZ initiative has grown and matured over the past five years, RIDOH has identified four key components to successful and sustainable implementation of the model. We believe that these components are indispensable for doing prevention work in the 21st century. In a sentence, the HEZs exemplify a health equity-centered approach to prevention work that leverages place-based, community-led solutions to address the social determinants of health (SDoH). It is no coincidence that the majority of activities carried out through the HEZ are by community health workers. Community Health Workers play an essential role in addressing factors like these that contribute to the health of individuals, families, and communities. They serve as a link between individuals or communities and needed health or social services. They also bridge cultural differences between communities and health and social services by providing culturally appropriate health education.

MCH Program Leadership

RI General Law Section 23-13-1 provides RIDOH with broad authority for administering Title V MCH services. Specifically, the statute "designates RIDOH as the state agency for administering in RI, the provisions of Title V of the Social Security Act relative to maternal and child health services". As the lead Maternal and Child Health (MCH) authority in the state, the RIDOH has primary responsibility for assessing the health and developmental needs of young families and children in the state; for planning effective measures to address those needs; for evaluating programs and policies affecting the health and development of womxn, children, and families in the state; and for implementing effective measures to address those needs. Every year, RIDOH reviews its successes and challenges and sets its focus and direction for the coming year. Last year included a 5-Year Needs Assessment for a more in-depth analysis and planning process. RIDOH evaluates its response to the state priorities and to any emerging issues impacting maternal and child health in Rhode Island. RIDOH takes into consideration the broad political, social, and environmental factors impacting Rhode Island's population health, particularly those impacting families. The state of RI's economy, jobs, healthcare-reform implementation, economic development and recovery, early childhood education, and affordable housing continue to be in the forefront of public debate and state leadership.

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

Supportive Administrative Systems and Processes

MCH Workforce Development

There are over 100 FTEs employed by RIDOH who are working on MCH related programs and services. This includes staff that provide planning, implementation, evaluation, and data analysis.

MCH leadership:

Dr. Nicole Alexander-Scott - Director of Health
Deborah Garneau – Director, Health Equity Institute and Title V/CSHCN Director
Jaime Comella – Program Manager, Title V MCH Program (temporarily assigned to COVID)
Aidea Downie -- Coordinator, Title V Needs Assessment and MCH Disparities Specialist
Colleen Polselli – Program Manager, CYSHCN Program
Carol Hall-Walker -- Division Director, Division of Community Health and Equity
Dr. Ailis Clyne – RIDOH Physician Consultant and Pediatrician (temporarily assigned to COVID)
Blythe Berger – Chief, Center for Perinatal and Early Childhood
Kristine Campagna – Deputy Chief, Center for Perinatal and Early Childhood (temporarily assigned to COVID)
Sam Viner-Brown – Chief, Center for Health Data and Analysis
Ellen Amore – KIDSNET Program Manager, Center for Health Data and Analysis

Ana Novais, previous Title V Director, has accepted a new position in state government as the Assistant Secretary of the Executive Office of Health and Human Services (EOHHS). Although no longer at RIDOH, her new role and long-standing relationship with MCH leadership will no doubt continue to be an asset to MCH.

RIDOH also directly supports the MCH workforce through many community contracts including Family visitors, peer resource mental health specialists, parent consultants (12 work at RIDOH and 27 work in community settings), community health workers, safety-net clinical providers, youth advisory groups, sexual health counselors, breastfeeding lactation consultants, and prevention educators.

RIDOH Internal Coordination & Communications

RIDOH makes an effort to convene regular meetings to facilitate the cross pollination of ideas related to RIDOH's strategic priorities. Meetings are held at all levels of the organizational structure to ensure bi-directional communication both vertically and horizontally. These meetings include:

MCH Management Meetings – On a bi-weekly basis, the State MCH Director and MCH Program Manager (Title V Coordinator) meet with senior MCH leadership. These meetings are used for program planning, systems and policy development, strategic planning, and budget discussions.

MCH Policy Meetings - The MCH Program works closely with many other programs at RIDOH to address the MCH Title V priorities. Programs serving MCH populations convene monthly to share information and updates to facilitate alignment and ensure the coordination of activities. Program representation includes: Children with Special Health Care Needs, Family Home Visiting, Oral Health, Violence and Injury Prevention, KIDSNET, WIC, Newborn Screening, Adolescent Health, Preconception Health, Vital Records, Immunization, Physical Activity and Nutrition, Lead Prevention, and RI State Systems Development Initiative (SSDI), EMS for Children, and the Center for Health Data and Analysis.

Executive Leadership Team Meetings (ELT) – Weekly ELT meetings are structured to ensure that the Department's senior-level leaders are engaged in formulating, executing, and achieving strategic results in pursuit of RIDOH priorities.

Health Policy & Leadership Meetings (HP&L) - Weekly HP&L meetings are structured to ensure that the Department's

leadership and senior managers have a forum for tapping into the breadth and depth of staff expertise needed for RIDOH to achieve its mission. Discussions on specific topic areas are chosen to engage the team and promote collaboration with internal and external partners and promote the health and safety of the people of RI while positively demonstrating the purpose and importance of public health. Meetings occur weekly.

Program Managers Meetings - The goal of the program managers meetings are to provide a forum for the Director, her Executive Director, and RIDOH program managers and supervisors to gather and discuss the latest successes, challenges, trends, and best practices related to the work of those individuals tasked with supervisory and program management work within the agency. This setting provides an opportunity for open discussions on top-of-mind topics among many of the RIDOH program managers, supervisors, and the Director. Meetings occur monthly.

Front Line Staff Meetings – The goal of font line staff meetings is to provide a forum for the Director, her Executive Director, and RIDOH frontline employees to gather and exchange discussions on the latest successes, challenges, trends, and best practices. Discussions are related to the work of these individuals who are at the core of delivering frontline service and creating a positive experience for RIDOH customers. This setting provides an opportunity for open discussions on top-of-mind topics among many of the RIDOH frontline staff while convened together with the Director. This meeting occurs every other month.

MCH Workforce Development – External to RIDOH

In addition to its internal workforce, RIDOH has made the following recent investments in workforce development within the larger MCH system.

Community Health Workers - RIDOH supports the community health worker initiative across RI through the Community Health Worker Association of RI (CHWARI) and supporting the Community Health Worker Certification through the RI Certification Board. CHWARI sponsors and catalogs trainings and professional development opportunities, provides job-finding and networking opportunities, advocates for CHW livable wages and professional identity, provides a space for CHW peer support, and assists CHWs seeking certification.

Peer Resources Specialists / Parent Consultants - The Rhode Island Parent Information Network, a RIDOH contracted agency, as developed and registered an apprenticeship program with RI Department of Labor and Training, to further support the development of certified community health workers (CCHWs). RIPIN has also aligned its professional development programming to the domains of the CHW certification standards.

Childcare providers/teachers - LAUNCH supported workforce development in three communities where the model is implemented. Thirty-seven childcare providers and leaders of teachers of children between the ages of 1-5 years old completed the Incredible Beginnings training, a training focused on creating an environment that supports children's optimal early development. In addition, 20 professionals completed the Incredible Years Parent Group Leader training to prepare them to lead evidence-based parenting programs focused on strengthening parenting competencies. Fifty-seven members of the Washington County and Woonsocket workforce took part in a trauma training designed to teach knowledge, skills, and values related to working with children who have experienced trauma.

School Leaders – The RI Healthy Schools Coalition Breakfast for School Leaders was held on October 9, 2018. A total of 463 individuals registered for the 2018 event with 57% being school personnel (including superintendents, asst superintendents, principals, school committee members, school nurse teachers, PE/Health teachers, parents, food service, school counselors/psychologists) and 43% being community wellness leaders. 34 of RI's 36 public school districts had representation at the 2018 event and 24 districts reserved an entire table of 10 for a committed team to attend. The event included valuable learning sessions and highlighted various nutrition and physical activity initiatives going in in RI schools. RIDOH was a lead sponsor and exhibitor at the event. Unfortunately the 2020 breakfast was cancelled due to COVID.

Pediatricians and family practitioners – The RI Early Hearing detection and Intervention Program (EHDI) outreached to pediatricians and family practitioners through multi-disciplinary grand rounds and a new newsletter. Additionally, a series of presentations were made by a multi-disciplinary group of providers including parents and educators of the deaf to the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) grant that is held by Dr. Pam High. Annual state supplied vaccine workshop is offered to all healthcare practices enrolled in the program, or those interested in enrolling, to provide education and technical assistance in on-line enrolling and vaccine ordering, vaccine storage and handling, vaccine administration. Immunization trainings, resources, and tools are regularly provided to all state supplied vaccine providers and their staff through site visits, webinars, and electronic newsletters.

Asthma Educators – The RI Asthma Control Program has continued to provide support to the development of certified asthma educators. The Asthma Educator Institute (AEI) Preparatory Course, a 2-day AEI Prep Course, took place on May 15-16, 2019. This course is useful for those who are interested in becoming AE-Cs to take before completing the NAECB exam for certification. There are currently **32** AE-Cs in Rhode Island.

Nursing students - The RI Dental Director presented to four groups of nursing students during 2019. Roughly 50 students attended each session for a total of 200 nursing students from RI College receiving training on oral health.

OBGYNs **–** a consultant physician was contracted visit OB/GYN providers to provide education and resources about the importance and safety of providing dental care to pregnant womxn. Aside from being provided with various *TeethFirst!* resources, including the newly updated flipbook that includes information about pregnant womxn, dental providers were able to strategize and discuss how best to identify and communicate with womxn of child baring about seeing a dentist when pregnant.

Pediatric Residents - The RI Oral Health Program Manager met with 20 Hasbro Children's Hospital pediatric residents to discuss the importance of the age one dental visit. She provided them with *TeethFirst!* flipbooks, brochures on the importance of oral health during pregnancy, toothbrushes, and other relevant materials.

Lactation Consultants & Advocates – WIC Breastfeeding Peer Counselor training March 2019; RI Breastfeeding Coalition Annual Conference March 25,2019; Certified Lactation Counselor training April 8-12, 2019

Adolescent Sexual Health Workforce - Family Planning Program worked in collaboration with the RI HIV & STI Prevention Coalition to host the sixth annual Conference on Youth Sexual Health Education (CYSHE), which was attended by nearly 100 youth-serving professionals. CYSHE workshop topics included intersectionality, inclusive sexual health education, peer education, trans health, and HIV/STI updates screening protocols.

Reproductive Health Workforce - Family Planning Program hosted a Reproductive Health Summit for 100 RI professionals with topics including preconception health, pregnancy intention screening, HIV/STI updated screening protocols, reproductive justice, and patient-centered contraceptive counseling. A one-day Reproductive Justice training complemented the Reproductive Health Summit and offered 20 professionals an in-depth training to provide knowledge and skills to apply the reproductive justice framework to practical settings.

Public Health Scholars - RIDOH welcomes students looking for experiential learning opportunities with practicing public health professionals in Rhode Island. RIDOH Public Health Scholars (previously referred to as interns) are challenged to apply what they have learned at school to help create innovative solutions to public health problems. Students gain insight about the multiple disciplines contributing to public health, and work within teams to develop policies, programs, and interventions that impact many Rhode Islanders. RIDOH Public Health Scholars are an important part of the RIDOH workforce - each year, up to 100 scholars gain valuable public health experience that influences their future careers.

Health Equity Zones Collaboratives - RIDOH support training and on-site technical assistance for Health Equity Zone (HEZ) Collaboratives. Topic areas include capacity-building strategies (community engagement, outreach, coalition building, policy

development and advocacy, collective impact, etc.) as well as program-specific subject matter, including maternal and child health. Training and TA is delivered in group settings bimonthly in the HEZ Learning Networks and to individual HEZs.

III.E.2.b.ii. Family Partnership

Family Partnerships

RIDOH partners with the RI Parent Information Network's (RIPIN) to support family engagement and family leadership development.

Advisory Committees

RIPIN Family Voices staff attends many advisory committees to provide the family perspective within RI systems. Staff maintain attendance at the following advisory committees:

- Executive Office of Health and Human Services (EOHHS) Consumer Advisory Council
- The Medicaid Managed Care Plan, Neighborhood Health Member Advisory Board
- The DOH Pediatric Emergency Medical Services Advisory Board
- The Title V Policy Team
- The Governor's Commission on Disabilities
- The Children's Coalition Advisory Board - Department of Children, Youth, and Families
- Governor's Children's Cabinet

Within these committees, the Family Voices staff provides their perspective as a family supporting a child/young adult with special health care needs. Because they are consumers of the many services that are utilized by this population, they can articulate and work towards ways to better communicate with providers.

Materials Development

Through our partnership with RIDOH, Family Voices has created many valuable resources that are shared with families that are navigating the special needs systems in RI. Those materials created are:

- *The Family Voices Connecting the Dots Resource Guide* - A booklet of commonly used community – based resources and services compiled into a printable format and placed on the RI Parent Information Network website.
- *The Family Voices Making the Connection Support Group Guide* - A booklet of local support and peer groups that families can use to connect to other families in like situations.

Program Outreach and Awareness

RIPIN maintains a calendar of regular outreach and workshops. The RIPIN Workshops are 2-hour sessions that are FREE to parents and provides a helpful overview of many RI systems. These workshops are presented throughout the year (minimum of 1 per month) in various communities upon request, and in the RIPIN Office. Because families do not always have access to transportation or time away from work, RIPIN also offers some of the workshops as online webinars for families to access at a time that is convenient to their needs. The topics covered include:

- Basic Rights in Special Education in English & Spanish (also a Webinar)
- Bullying and Harassment of Students with Disabilities – What Parents and Educators Need to Know in English & Spanish (also a Webinar)
- Caregiver Self Care (webinar)
- Coping During COVID (webinar)
- Developmental Disability Application Process (webinar)
- Effective Facilitation Skills
- Homework Help
- IEP: A Blueprint for Student Success ages 3-13
- IEP: A Blueprint for Student Success ages 14-21
- Pathways to Adulthood for Youth with Developmental Disabilities

- Policy 101
- RI Medicaid Options for Families with CYSHCN
- Section 504: A Parent's Guide in English & Spanish (also a Webinar)
- Skills to Effective Parent Advocacy in English & Spanish, also Online as a Webinar
- Transition to Early Intervention to the Successful Pre-School IEP (also a Webinar)
- Family Guide to Rhode Island's Multi-Tiered System of Support (also a Webinar)

Block Grant Development and Review

RI Department of Health invites a family member to the Title V grant review each year to assist families with understanding Title V and to provide the family perspective on navigating the complex systems of care for those with disabilities. RIPIN staff are also invited to take part in the health needs assessment.

RIDOH MCH Programs & Family Involvement

The Perinatal and Early Childhood Health Team at RIDOH applied for Title V MCH Venture Capital funds to increase family involvement in the RIDOH's early childhood programs. The early childhood programs depend on parents and caregivers to provide feedback on the system of services available to families in RI communities. It has been a challenge to identify, engage, and retain parents. The funding was requested to: 1) To create and sustain an effective Parent Advisory Committee (PAC) and 2) To be trained on how to run Parent Cafés. As a result of the Title V funding, staff attended the National Family Support Network's Together for Families National Conference including the pre-session training on Developing and Sustaining Effective Parent Advisory Committees. The orientation/kick-off session was held July 2019 for interested parents. Participants were selected, oriented and regular meetings took place through early 2020. This work was rolled into the Family Visiting strategic plan, which includes a focus on actively involving parents/caregivers in input, guidance, and feedback about RIDOH's early childhood programs.

Disparities in Infant Mortality (DIM) Advisory Board

When undertaking the IM CollN project, RIDOH sought to convene a diversity of stakeholders in order to thoroughly assess the nuances of why certain gains made in supporting pregnancy and the perinatal period were not being felt by all segments of the population in the state. For the Disparities in Infant Mortality Advisory Board, RIDOH prioritized identifying womxn of color active in the perinatal health community at the community-level, as well as diverse stakeholders in perinatal health. Community-level stakeholders represented doula work and a parenting support and education agency. Other stakeholders included health care providers and public health. RIDOH invited public health representatives from the Center for Health Data and Analysis (CHDA), the Family Home Visiting Program (FHV), the Maternal and Child Health (MCH) program leadership, as well as the Health Equity Institute (HEI). In its first year the DIM group brought together 12 individuals representing 4 diverse stakeholder groups. Heading into the second year of the group, stakeholders representing policy and advocacy, as well as community organizing were added, and membership increased to 16 individuals. The DIM advisory board met throughout 2018-2019 to discuss data, consider the perspectives of womxn of color in the community as shared by the advisory board members, and develop recommendations for the MCH leadership team. Seeking to follow in the footsteps of Oregon, Minnesota and most recently New York City, the DIM group considered how to put a strategy forward for doula reimbursement for Medicaid beneficiaries. Several members supported RI's Doula Bill and the certification of the doula workforce. The DIM advisory board and the MCH program will work with community advocates over the next year and continue to advise on different aspects of the bill.

Birth Centers Regulatory Advisory Committee - The Birth Centers Regulatory Advisory Committee (BCRAC) was established in 2018 as a collaborative effort between the RIDOH MCH program and Health Facilities Regulations program. In response to requests for further discussion on revisions to the regulations, RIDOH established and convened the BCRAC, including representatives from the obstetrics/gynecology, midwifery, community health worker,

and doula professions among its membership. The goal of the BCRAC was to draw together these various interested party groups, review/discuss the Regulations, receive detailed input on possible revisions to the regulations, and produce a report on the BCRAC's findings for presentation to the Director of RIDOH. The BCRAC met 6 times during period of 5 months. The recommendations will then be implemented at the discretion of the RIDOH Director and the department's facilities regulations team. This is the first advisory committee of its kind at the department of health focused on regulations. The regulations were worked on by the RIDOH team and presented back to the BCRAC in the Fall of 2019. The regulations received extensive public input and should be finalized in late 2020. The MCH program was instrumental in recruiting a diverse cross-section of participants from the community to serve on the committee, which is a testament to its partnerships and collaborations in the community.

Priority: Improve System Coordination

- ***Support certification process & core competencies for MCH workforce statewide through Community Health Worker workforce development initiatives.***

RI has benefited from a Certification Program for Community Health Workers since 2016. To date, there have been 425 Certified Community Health Workers in RI, each with demonstrated competency in the following domains:

Domains

- Engagement Methods and Strategies
- Individual and Community Assessment
- Culturally and Linguistically Appropriate Responsiveness
- Promote Health and Well-Being
- Care Coordination and System Navigation
- Public Health Concepts and Approaches
- Advocacy and Community Capacity Building
- Safety and Self-Care
- Ethical Responsibilities and Professional Skills

Standards

1. Experience: Six months or 1000 hours of paid or volunteer work experience within five years
2. Supervision: 50 hours specific to the domains
3. Education: 70 hours relevant to the domains
4. Portfolio: Demonstrated competency through approved portfolio. The portfolio is a collection of personal and professional activities and achievements. This part of the requirement for the Community Health Worker is highly personalized and no two applicants will submit the same documentation. Components of the portfolio include documentation and requirements of at least three of these categories: Community Experience & Involvement; Research Activities; College Level Courses / Advanced or Specialized Training; Community Publications; Presentations & Projects; Statement of Professional Experience; Achievements / Awards; Resume / Curriculum Vitae (CV); Performance Evaluation

Training and Development - RI MCH Program partners with the following training entities for CHW education and preparation:

- Community Health Innovations of RI provides ongoing training and apprenticeship opportunities especially for CHWs based in the community through health Equity Zones;
- Rhode Island College Healthy Jobs offers ongoing CHW courses at Central Falls Parent College, Rhode Island College campus in Providence throughout the academic term, and in a centralized Warwick location;
- RIDOH Chronic Disease Programs offers core community health worker training and modules specific to patient navigators working in chronic disease.

- Dorcas International Institute offers a training for CHW working with refugees through funding by RI Foundation;
- Rhode Island Parent Information Network provides ongoing training opportunities for Resource Specialist including parents of children with special healthcare needs;
- Clinica Esperanza sponsors ongoing Navagante trainings for Bilingual / Bicultural CHWs.

All of these training programs have aligned their curriculum with Rhode Island's Certified Community Health Worker standards meeting the certification requirements.

RI MCH Program also partners with the Department of Labor & Training in supporting the Community Health Worker Association of Rhode Island (CHWARI) at the Rhode Island College. CHWARI is an organization to provide CHWs resources around trainings and other professional development opportunities. The Community Health Worker Association of Rhode Island (CHWARI) actively supports frontline healthcare workers who work in underserved communities to improve high quality healthcare access for people in need. CHWARI envisions a state in which all Rhode Island communities receive high quality, equitable health and social services in order for all individuals to realize their optimal state of health and well-being. The mission of CHWARI is to Increase the power of Rhode Island's Community Health Workers to promote health equity through increasing access to quality healthcare and social services and conducting advocacy.

- ***Engage community members, CHWs, and consumers in all areas of program, policy, and systems change.***

- Health Equity Institute – Special Needs - A main tenant of the MCH Program is supporting, empowering, training, hiring, and promoting parents and family partners at all levels of decision making, policy development, service provision, and community development. RIDOH partners with the RI Parent Information Network, Parent Support Network, Sherlock Center on Disabilities (RI's UCEDD), the Autism Project of RI, and other disease specific family organizations. Parent leaders are cultivated and supported to lead policy initiatives, make systems improvements and champion principles of parent-professional partnerships. Parent support groups are organized throughout the state. RIDOH has contracted with RIPIN (Family Voices) to maintain a calendar of support groups based on topic, age, and language. Through the Family Voices Leadership Team, RIDOH has addressed systems barriers and developed a parent policy team to provide peer-to-peer support in addressing statewide policy, especially health reform. Throughout RI over 1850 parents have been trained in navigating the special needs service delivery system such as basic rights, college success for students with disabilities, options for medical assistance, and transition planning.

- Peer Resource Specialists – Peer Resource Specialists are culturally diverse family members with experience accessing MCH services and are assigned to various RIDOH programs based on the program's need for parent and consumer participation. Peer resource specialists are full partners in policymaking, outreach, and program quality assurance and evaluation. Currently, resource specialists are assigned to WIC, Immunization, Birth Defects, Diabetes Prevention, Wise Woman, Integrated Chronic Disease, Health Communications, Family Visiting, EDHI, Emergency Preparedness, and the Health Equity Institute.

- Youth Resource Specialists - Since 2014, the Health Equity Institute has invested in hiring and supporting Youth Resource Specialists. Their input into the transition process and generation of self-determination resources has been invaluable. Youth Resource Specialists are engaged in planning and leading the Dare to Dream Student Leadership event, represent RI at national youth forums, and promote inclusion in RI's youth

serving organizations. In 2019, youth resource specialists led a monthly Youth Advisory Council where an average of 35 students with disabilities served as advisors to RIDOH programs and policies; presented at the national AMCHP Conference; organized the Dare to Dream conference attended by 450 students; and presented at the Turn Up Rhode Island Conference featuring career exploration for 300 students of color. Unfortunately, youth conferences expected to take place in the Spring of 2020 were cancelled due to Covid.

- Health Equity Zones (HEZ) – Each of the 10 funded Health Equity Zones has a lead organization (local government or local non-profit entity), that acts as a backbone on behalf of the coalition of key community stakeholders and residents in the proposed geographic area. One of the key requirements of HEZ funding is heavy stakeholder and resident engagement. This ensures that individuals who are experiencing poor health outcomes and health disparities are represented and are included in the decision-making process.

- RI Asthma Control Program - The RI Asthma Control Program (RIACP) is working closely with families and seeking to develop family leadership in multiple areas including but limited to: improving indoor air quality at home and in schools; asthma and chronic disease self-management skills; healthy housing policies; and training and support for development of advocacy skills. The RI Asthma Control Coalition, in partnership with RI Parent Information Network, helped RIACP initiate "Asthma Advocates in Action," to help people with asthma and their caregivers build advocacy and leadership skills.

- ***Continue to support a comprehensive system of engagement & leadership development for vulnerable populations.***

Health Equity Institute –Health Equity Institute (HEI) was created by Director Nicole Alexander-Scott, MD, MPH in 2016 as a strategy to promote RIDOH's three leading priorities. The priorities include: 1) addressing the social and environmental determinants of health; 2) eliminating the disparities of health and promote health equity; and 3) ensuring access to quality health services for Rhode Islanders, including our vulnerable populations. The mission of the HEI is to address systemic inequities so that all Rhode Islanders achieve their ideal life outcome regardless of their race, geography, disability status, education, gender identity, sexual orientation, religion, language, age, or economic status. HEI recognizes that achieving health equity requires action, leadership, inclusion, cross-sectoral collaboration and shared responsibility throughout RIDOH, and communities across the state.

HEI has substantial expertise in providing communities and policymakers with data, technical assistance, and evidence-based programs to address health disparities in vulnerable populations. Several large programs are housed within the HEI, including: Disability & Health, Minority Health, Refugee Health, Maternal and Child Health, and the Health Equity Zones (HEZ). HEI also provides collaborative support to all of RIDOH's equity initiatives including: the Social Justice Roundtable, Sexual Orientation and Gender Identity Workgroup, Vulnerable Populations Data Collection Workgroup, Disparities in Population Health Goals, Social Determinants of Health Workgroup, Community Health Assessment Group, Commission for Health Advocacy & Equity, Community Health Resiliency Project, and the Kresge Initiative.

In addition to engaging diverse stakeholders in MCH work, RIDOH contracted with SISTA FIRE, an organization that works to create a network of womxn of color to build collective power for social, economic and political transformation. They focus on racial, economic, and gender justice work. Birthing stories, two SISTA FIRE surveys were included as part of the needs assessment. MCH intends to continue this contractual relationship to inform strategies in addressing health disparities throughout the MCH program.

State Systems Development Initiative and MCH Data Capacity Efforts

The State Systems Development Initiative (SSDI) supports MCH data collection and reporting in several ways including: responding to data MCH data requests; regular update of a shared document available to MCH leadership and Program Managers that includes all available minimum and core MCH dataset elements, as well as all State and National Outcome, Performance and Evidence-Based Strategy Measures; review of all RI measures to recommend modifications, eliminations, or additions to national and state performance, outcome and process measures to align with Title V guidance and five year needs assessment priority setting; working with Vital Records staff to improve quality and timeliness of access to birth and death data; participation in AMCHPs Infant Mortality Social Determinants of Health CollN; linkage of MCH (KIDSNET) data to Medicaid data in the RI "Data Ecosystem"; facilitation of the development and collection of neonatal abstinence syndrome and substance exposed newborn data; and, provision and data entry into TVIS of all national and state performance, outcome and evidence based strategy measures including the detail sheets, as well as TVIS forms 4, 5a, 5b, and 6. To expand data availability, SSDI is working with the Communications Team to develop use of PowerBI to present MCH data on the RIDOH website.

With the linkage of KIDSNET and birth data in the RI "Data Ecosystem", SSDI has achieved consistent annual access to all 8 of the desired MCH data sources for data linkage. Direct access has increased from 4 of the 8 to 5 of 8 (Birth, Death, Newborn Hearing, Hospital Discharge and PRAMS). These data are used to provide national and state performance, outcome and evidence-based strategy measures and to inform and support Title V programming, assessment and monitoring. For example, hospital discharge data and vital records births and deaths have been analyzed to inform discussion of maternal morbidity and mortality policy. In addition, SSDI has provided birth data to the prematurity task force and the Birth Center Regulations Advisory Committee to support their work. SSDI also provides data support to the MIECHV and 5-year MCH needs assessments.

Health Care Delivery System

RI health care services are consistently recognized as being high-quality, accessible, and affordable. According to the latest US News & World Report, RI ranks 5th best in the nation for health care, 6th best for health care access, 9th best for health care quality, and 19th best for public health.[1] Thanks in part to robust and successful implementation of the federal *Affordable Care Act*, the percentage of Rhode Islanders without health insurance also continues to decline. In 2017, 2.1% of RI children (3rd lowest in the nation) and 4.6% of RI adults (4th lowest in the nation) were uninsured.[2,3]

In RI, the maternal and child health population receives appropriate and timely health care in a variety of settings. There are eight major hospital health care systems with a presence in RI. Lifespan is the oldest and largest not-for-profit health system that includes RI Hospital (the state's only Level 1 Trauma Center), Hasbro Children's Hospital (premier pediatric specialty hospital) and Bradley Hospital (pediatric psychiatric hospital) among other entities. Care New England is the second largest not-for-profit health care system, which includes Women & Infants Hospital (state's largest birthing hospital) and Butler Hospital (adult psychiatric facility) among other entities. Additional hospital-based systems or hospitals include CharterCARE, Landmark Medical Center, South County Health, the federal Providence VA Medical Center, and the publicly funded Eleanor Slater Hospital. RI has 8 federally qualified health centers that provide medical, dental and behavioral health care services to 171,208 patients at locations throughout the state.[4] In addition, there are about 28 "urgent care" centers in the state, which are licensed as freestanding ambulatory care centers. CVS Minute Clinics also operate in 7 CVS pharmacy stores in RI.

RI like many other states faces challenges with healthcare workforce recruitment and retention. Current estimates of the primary care workforce in RI differ substantially, from a low of 701 primary care physicians to 1,002 primary care physicians. RIDOH estimates that there is a 1,718.1: 1 population to primary care physician ratio in RI, which is above HRSA ratio of 1,500: 1. In RI, Providence County, Washington County, and Newport County are designated primary care health professional shortage areas (HPSAs). RIDOH implements various loan repayment and scholarships programs to address health workforce gaps.[5]

While RIDOH Title V Program does not directly fund direct health care services, the RIDOH Title V Program does closely coordinate with RI's Medicaid state agency to ensure that low-income and vulnerable women, mothers, and children have access to high-quality, appropriate health care services and supports. To achieve this, the RIDOH Title V program provides input to the RI Medicaid waiver taskforce, helps coordinate the promotion and enrollment of various RIDOH funded MCH services among individuals enrolled in Medicaid, and shares expertise and data on reform initiatives impacting MCH and CSHCN populations. Because of this collaboration, the latest approved RI Medicaid waiver includes authority to seek federal reimbursement for various MCH and CSHCN services, including the family home visiting program, peer support services, home-based primary care services, behavioral health link crisis services, dental case management services, and psychiatric residential treatment services for children with serious emotional disturbances.[6] This authority will greatly help sustain and improve access to vitally needed MCH and CSHCN health care services. RIDOH Title V staff also continue to seek ways to further sustain MCH and CSHCN public health initiatives through active coordination and joint planning with the RI Medicaid agency as well as through legislative, regulatory and/or administrative enactments.

RIDOH Title V staff also serve on various coordinating statewide bodies that seek to optimize and incentive health care financial and service delivery models that improve care coordination, health care quality, and health outcomes among MCH and CSHCN populations. Examples of various bodies include Medicaid accountable care entities, various payment reform policy tables convened by the Office of the Health Insurance Commissioner, Patient Centered Medical Home Initiative for KIDS, State Innovation Test Model Steering Committee, and various other

public health policy tables (Prematurity Task Force, Substance Exposed Newborn Task Force, and Governor's Council on Disabilities, etc.). It is through this collective and ongoing engagement as well as the raising up community input from RIDOH Health Equity Zones that the RIDOH Title V program is able positively impact the RI health care system and RI Medicaid program.

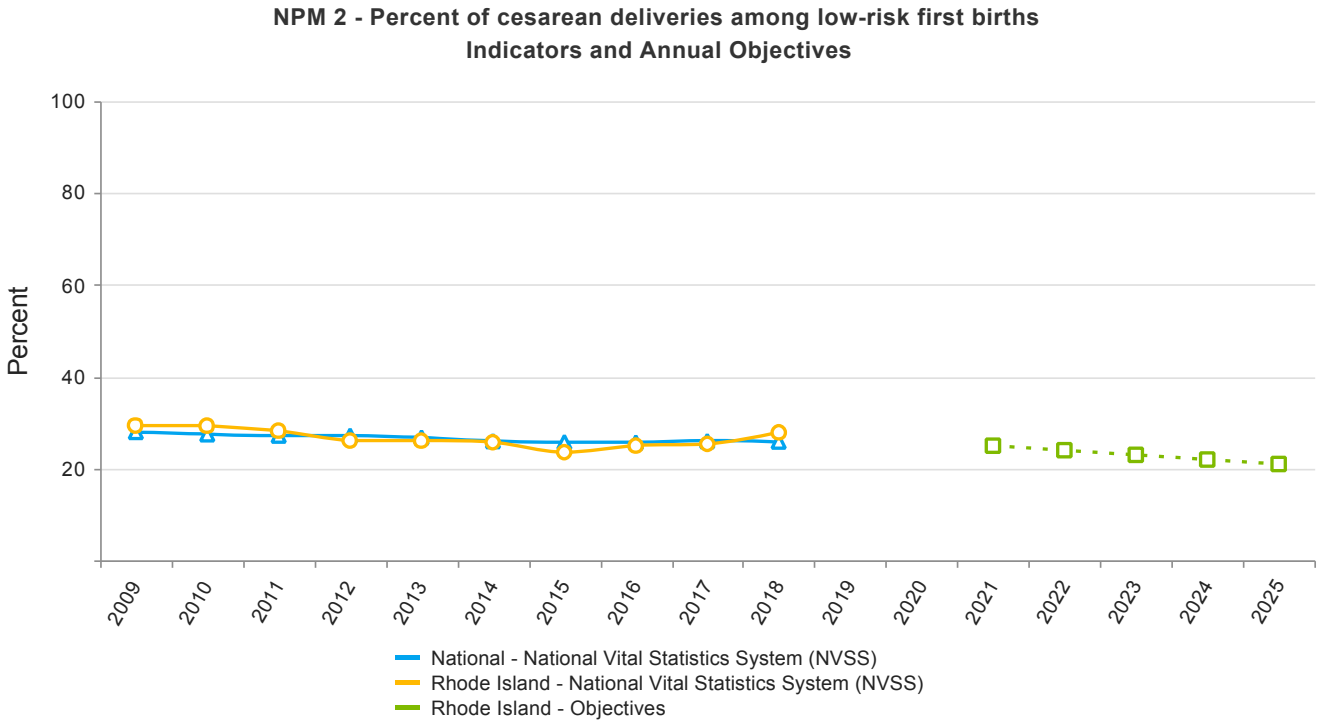
III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2017	104.7	NPM 2 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	Data Not Available or Not Reportable	NPM 2 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	7.6 %	NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	9.0 %	NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	24.7 %	NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	6.7	NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	6.2	NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.3	NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.9	NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	291.4	NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	94.0	NPM 14.1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	9.3 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	93.2 %	NPM 13.1 NPM 14.1

National Performance Measures



Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2019
Annual Objective	
Annual Indicator	27.8
Numerator	988
Denominator	3,556
Data Source	NVSS
Data Source Year	2018

State Provided Data	
	2019
Annual Objective	
Annual Indicator	27.2
Numerator	826
Denominator	3,041
Data Source	Vital Records
Data Source Year	2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	24.0	23.0	22.0	21.0

Evidence-Based or –Informed Strategy Measures

ESM 2.1 - AIM Provider Education

Measure Status:	Active

Baseline data was not available/provided.

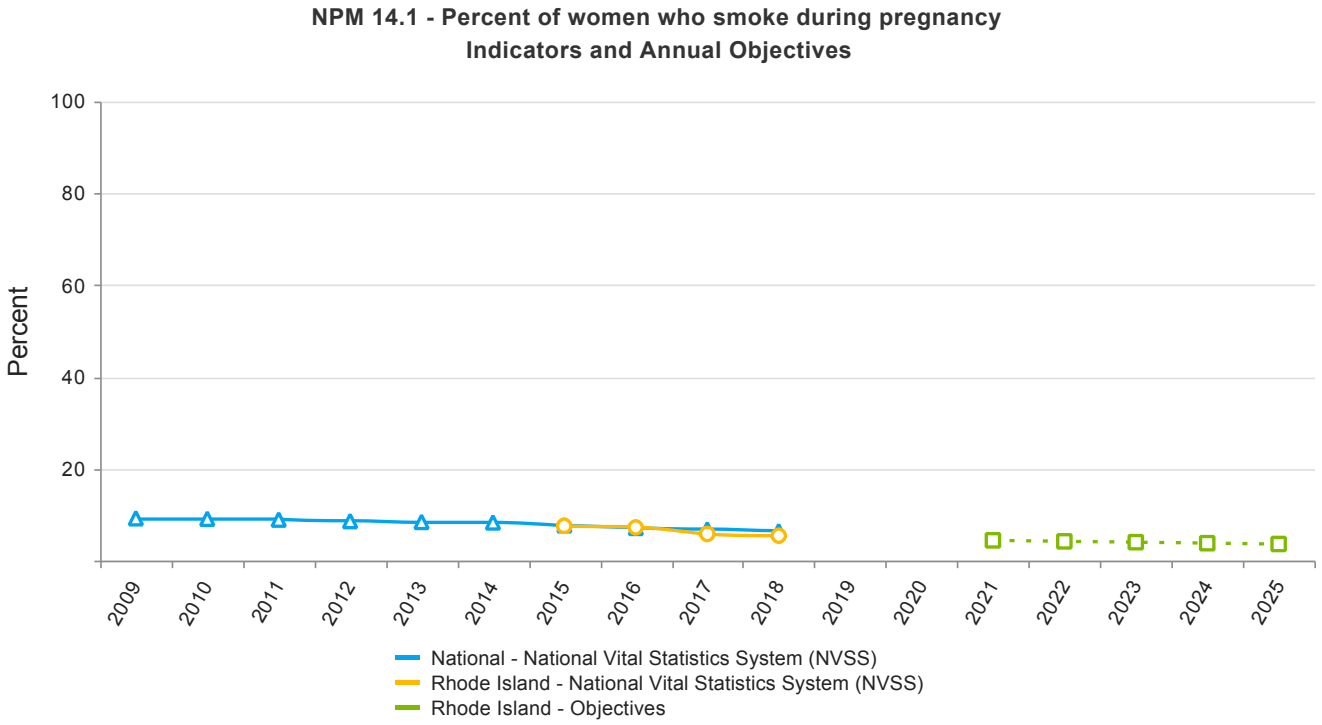
Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	40.0	60.0	80.0	100.0

ESM 2.2 - AIM Nurse Education

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	40.0	60.0	80.0	100.0



Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2019
Annual Objective	
Annual Indicator	5.5
Numerator	567
Denominator	10,346
Data Source	NVSS
Data Source Year	2018

State Provided Data	
	2019
Annual Objective	
Annual Indicator	4.7
Numerator	479
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	4.5	4.3	4.1	3.9	3.7

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Tobacco Cessation Community Resources

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	68.3
Numerator	43
Denominator	63
Data Source	Efforts to Outcomes MIECHV
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	70.0	72.0	74.0	76.0	78.0

State Performance Measures

SPM 5 - Effective Family Planning Methods among Title X Clients

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			64.5
Annual Indicator			64.5
Numerator			12,870
Denominator			19,939
Data Source			Title X Data System
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	66.0	67.0	68.0	69.0	70.0	71.0

State Outcome Measures

SOM 2 - Postpartum Hemorrhage Rate

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	984.1
Numerator	955
Denominator	9,704
Data Source	Hospital Discharge Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	970.0	955.0	940.0	925.0	910.0

State Action Plan Table

State Action Plan Table (Rhode Island) - Women/Maternal Health - Entry 1

Priority Need
Address prenatal health disparities

NPM
NPM 14.1 - Percent of women who smoke during pregnancy

Objectives
Reduce the percent of women who smoke during pregnancy from 5.5% in 2019 to 3.7% in 2025

Strategies
Address prenatal health disparities within prenatal health programs

ESMs	Status
ESM 14.1.1 - Tobacco Cessation Community Resources	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Rhode Island) - Women/Maternal Health - Entry 2

Priority Need

Reduce maternal morbidity/mortality

NPM

NPM 2 - Percent of cesarean deliveries among low-risk first births

Objectives

Reduce the percent of cesarean deliveries among low-risk first births from 27.2% in 2019 to 21% in 2025

Strategies

Rhode Island Pregnancy and Postpartum Death Review (MMRC)

Develop a perinatal quality collaborative with diverse representation from community

ESMs	Status
ESM 2.1 - AIM Provider Education	Active
ESM 2.2 - AIM Nurse Education	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

State Action Plan Table (Rhode Island) - Women/Maternal Health - Entry 3

Priority Need

Address prenatal health disparities

SPM

SPM 5 - Effective Family Planning Methods among Title X Clients

Objectives

Increase the percentage of Title X clients using effective family planning methods from 64.5% in 2019 to 71% in 2025

Strategies

Address prenatal health disparities within prenatal health programs

State Action Plan Table (Rhode Island) - Women/Maternal Health - Entry 4

Priority Need

Reduce maternal morbidity/mortality

SOM

SOM 2 - Postpartum Hemorrhage Rate

Objectives

Reduce Postpartum Hemorrhage Rate from 984 per 10,000 delivery hospitalizations in 2019 to 910 per 10,000 in 2025.

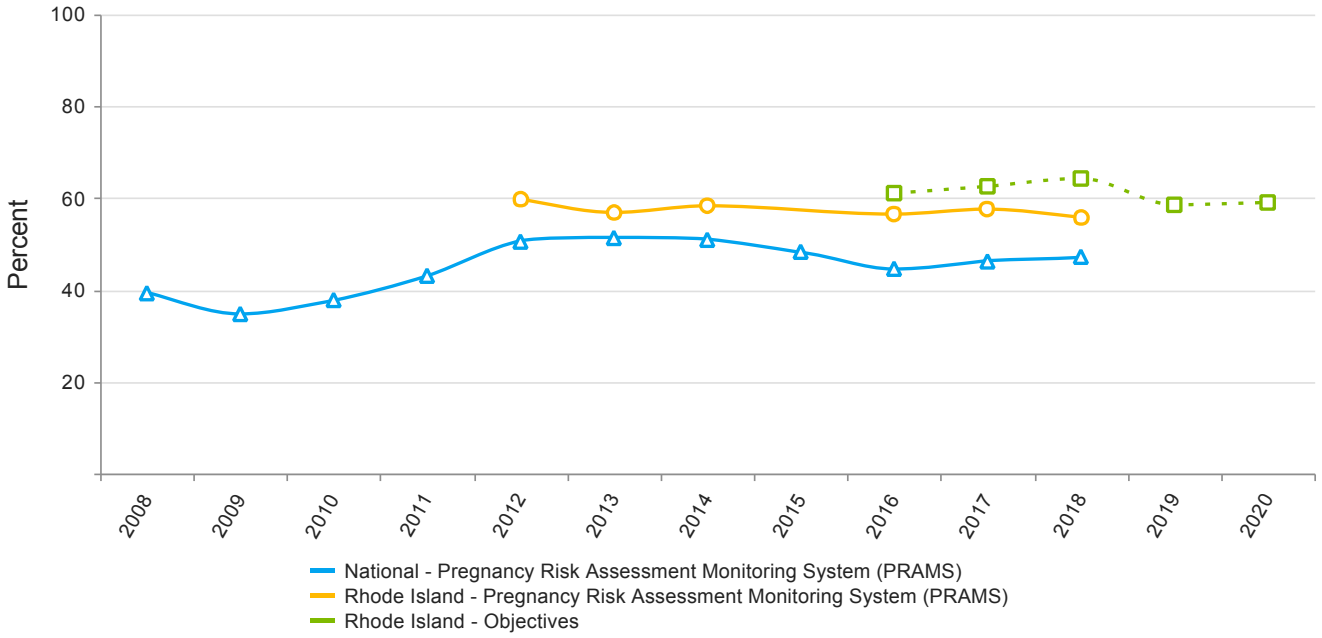
Strategies

Pregnancy and Postpartum Death Review Committee (MMRC)

Develop a perinatal quality collaborative with diverse representation from the community

2016-2020: National Performance Measures

2016-2020: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives



Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	61	62.5	64.2	58.5
Annual Indicator	58.4	58.4	57.7	55.6
Numerator	5,897	5,897	5,697	5,390
Denominator	10,093	10,093	9,869	9,692
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2014	2017	2018

State Provided Data				
	2016	2017	2018	2019
Annual Objective	61	62.5	64.2	58.5
Annual Indicator	56.6	57.7	55.6	
Numerator	5,628	5,697	5,390	
Denominator	9,947	9,869	9,692	
Data Source	PRAMS	PRAMS	PRAMS	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Provisional	

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 13.1.1 - Number of healthcare providers trained on Oral Health

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			250
Annual Indicator			230
Numerator			
Denominator			
Data Source			Oral Health Program
Data Source Year			2019
Provisional or Final ?			Final

2016-2020: State Outcome Measures

2016-2020: SOM 1 - Five year average birth rate among Hispanic teens (ages 15-19)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		35	33.4	31.2
Annual Indicator	38.9	35.3	32	29.6
Numerator	1,323	1,223	1,163	1,074
Denominator	34,015	34,692	36,318	36,318
Data Source	Vital Records/ACS (B01001I)	Vital Records/ACS (B01001I)	Vital Records/ACS (B01001I)	Vital Records/ACS (B01001I)
Data Source Year	2012-2016	2013-2017	2014-2018	2015-2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: SOM 2 - Five year average birth rate to Black teens (ages 15-19)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		24	14	13.5
Annual Indicator	25	14.9	12	10.5
Numerator	388	236	210	184
Denominator	15,551	15,864	17,560	17,560
Data Source	Vital Records/ACS (B01001B)	Vital Records/ACS (B01001B)	Vital Records/ACS (B01001B)	Vital Records/ACS (B01001B)
Data Source Year	2012-2016	2013-2017	2014-2018	2015-2019
Provisional or Final ?	Provisional	Final	Final	Final

2016-2020: SOM 8 - Teen Pregnancy Rate (ages 15-19) in RI core cities

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			18.4
Annual Indicator			27.2
Numerator			349
Denominator			12,847
Data Source			MCH Database/ACS 2018 5-year estimates
Data Source Year			2019
Provisional or Final ?			Final

Annual Report:

A. Women/Maternal Health

(Preconception, Pregnancy, Postpartum Health)

Title V refers to Women/Maternal health as Preconception, Pregnancy, and Postpartum Health. This section refers to the health of womxn of child-bearing age, usually 15-44, although demographics show that this age range has been widening. Maternal health is the health of womxn during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care. The Title V Program recognizes the importance of addressing each of these stages and has renamed this area as the Preconception, Pregnancy, and Postpartum domain. Preconception health is an area that focuses on womxn's health before she becomes pregnant, health during pregnancy focuses on womxn's health beginning with conception up to the pregnancy outcome, and postpartum health is the area that focuses on womxn's health after the pregnancy outcome and up to 6 months. Preconception care is important because it reduces unwanted and mistimed pregnancies and teen pregnancy. It also has been linked with better prenatal care engagement and birth outcomes.

Priority: Improve Access to Oral Health Services

The Oral Health Program (OHP) works to achieve optimal oral health for all by eliminating oral health disparities in RI while also integrating oral health with overall health. The OHP focuses on prevention of oral disease through assurance of state-level oral health and public health leadership and enhancement of community efforts to prevent, control, and reduce oral diseases across the lifespan. In addition, the OHP works with dental providers, health professionals, community partners, and the RI Oral Health Commission to build and sustain community capacity for high-quality, culturally-sensitive oral health services. Highlights of effective ongoing interventions include the expansion of services for underserved adults through the creation of an Advanced Education in General Dentistry Residency Program, continued implementation of the school-based sealant program, Seal RI!, education to families and providers on the importance of the age one dental visit through *TeethFirst!*, provision of mobile dental programs serving Medicaid elders in nursing homes, licensure of public health hygienists, and training of providers through an annual dentistry mini-residency, academic detailing visits, and a Medicaid adult dental learning collaborative. Last year, the MCH priority of Improving Access to Oral Health Services was moved from the cross-cutting domain to the women/maternal health domain and the following strategies were developed:

Provide guidelines and professional development for healthcare (infant and perinatal medical providers), dental, and service (MCHB, HRSA, and HHS funded programs) providers on the importance of oral health for pregnant women and infants.

In 2019, the RI Oral Health Program contracted with one physician consultants to conduct academic detailing visits to pediatrician and family practice offices. Dr. Jennifer Levy, a practicing family physician, performed academic detailing visits to pediatrician and family practice provider offices. Dr. Levy was already contracting with the RIDOH Family Planning, Immunization and Family/Home Visiting Programs (FHVP) and previously provided pediatric and family physician expertise for the RI Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Advisory Board. To date, Dr. Levy has provided academic detailing services to 11 RI pediatricians and plans to continue visiting practices through July of 2019. Dr. Levy has provided support incorporating oral health into well child visits, provided tools including sample oral health risk assessments, the Smiles for Life curriculum and RI Age One Champion and Dental Safety Net lists. Dr. Levy discusses the benefits of fluoride varnish application, the benefits of prescribing fluoride, nutrition counselling and the importance of testing well water. In addition, Dr. Levy has clinical expertise in the development of *TeethFirst!* resources, the AAP Oral Health online toolkit. She has also presented at the "Dining

with the Dentist" and the RI Primary Care Pediatric meeting on the importance of oral health for young children and pregnant women.

Carol Cote, a Public Health Dental Hygienist contracted by the Department of Health, also provided dental expertise in pediatric medical practices. Ms. Cote was able to visit 12 sites during her contract. At each site she delivered education about the importance of the Age One Dental Visit, where to purchase fluoride varnish, how to apply and properly code fluoride varnish, observed workflow, and helped each practice establish a caries risk assessment through quality improvement methods. Ms. Cote used quality improvement tools to create a driver diagram that could be used as a framework for each site. All these resources and sample caries risk assessments, QI tools, and resources containing information about fluoride have been compiled into a binder that Ms. Cote brings to each new medical practice.

Pilot an electronic dental referral and data collection system between dental and medical providers. Over the past year, The RI Oral Health Program has continued to pursue the modification of the Project LAUNCH system, a web-based development screening referral case management system used by pediatricians and staff at RIDOH, to create an electronic referral system between pediatricians and dental providers. The Rhode Island Department of Education is collaborating in this multi-agency effort given their interest in empowering Pre-K educators to make various referrals, including to dentists. The IT build was given the final approval over the grant period, and the final connection with the Unite Way 2-1-1 system was completed. The Oral Health Program worked to recruit two dental practices and two pediatric practices to test the system in Cranston, RI. A Federally Qualified Health Center (FQHC) agreed to participate, but there was difficulty in finding a private medical provider office the area that was willing to a part of the pilot. The FQHC test moved forward and all were trained on the process to make referrals and respond. Unfortunately, the pilot did not move to the next phase as it was found that the United Way 2-1-1 database needed updating.

Maintain and promote oral health related resources (bilingual brochures, patient education flipbooks, toothbrushes, etc.) and prompts (Efforts to Outcomes Family Visiting case management system) within Family Visiting programs, WIC program sites, medical providers, and dentists. Building off a successful partnership in 2017, the RI Oral Health Program once again partnered with the Pawtucket Red Sox (AAA minor league baseball team located in city with high rates of child poverty) for oral health sponsorship and outreach opportunities throughout the 2019 baseball season. The RI Oral Health Program provided toothbrushes for events, had targeted messaging around sealants, brushing, and finding dental care as well as hosted the 3rd annual Oral Health Night.

Promote oral health resources and communication about early dental visits and oral health care for pregnant women through the TeethFirst! bilingual campaign for parents and families, healthcare providers, dentists, and community organizations.

The RI PIOHQI Project continues to make great progress in improving the oral health outcomes of pregnant women, infants, and toddlers. Continued success has been possible due to RIDOH internal and external partnerships including with RI PIOHQI Advisory Board members, PIOHQI Learning Lab sites, MCHB-, HRSA-, and HHS- funded projects (Family/Home Visiting programs, WIC sites, Head Start partners, etc.) and through the numerous outreach initiatives performed under the *TeethFirst!* campaign (academic detailing, community outreach events, and sporting sponsorships). Continuous learning, evaluation efforts, focus group studies, and engagement of numerous partners has generated numerous impactful proposals and strategies. Because of thoughtful and comprehensive planning as well as multi-sector collaboration and implementation, the RI PIOHQI project has seen dental utilization increases of children age two and under enrolled in Medicaid from 23.9% in 2015 to 39.9% in 2018. In addition, self-reported dental utilization among pregnant women continue remains statistically steady between 2012 (60%) to 2016 (57%). Three FHV programs now incorporate oral health questions into ETO. Moving Forward, 1,000 RI families will receive oral health counseling and have access to a referral network that did not exist before 2016 through the FHVP and

PIOHQI partnership. Additionally, 1,111 Rhode Island providers now have essential knowledge about the importance of the age one dental visit and oral health during pregnancy. Our partners and our advisory board members continue to champion oral health in their work. The RI SOHP will continue to update and recruit for the Age One Champion list. The adoption of the fluoride varnish clinical quality measure into commercial health plans will continue to encourage providers to incorporate oral health assessment, services, and referrals within their practice workflow. The development of *TeethFirst!* resources include bilingual brochures and the *TeethFirst!* Flipbook will continue to circulate at the hand of partners to Rhode Islanders. The foundation has now been laid to continue to improve utilization for pregnant women and infants in the coming years.

Priority: Improve Routine Provision of Preconception Care and Education

Support family planning at Title X agencies.

RIDOH's Family Planning Program supports twenty-seven family planning services sites, including twenty-three federally qualified community health center sites, three school-based health centers, and services at the RI Women's Division of Corrections. The family planning service sites provide comprehensive, accessible, affordable, and confidential Title X family planning services to culturally diverse, primarily low-income womxn, men, and adolescents. Family planning services include contraceptive services, preconception care, reproductive life planning, reproductive health counseling, HIV screening and referral, STI testing and treatment, and related preventive health services. The confidentiality and affordability of Title X services provide a critical safety net, particularly for low-income, uninsured individuals and minors. Family planning services are often an entry point into the healthcare system. Title X family planning clinics provide referrals to other clinical specialties and community-based supports, including prenatal care and home visiting, as appropriate. In CY2019, Title X agencies provided family planning services to over 28,000 women, men, and adolescents. Among unduplicated Title X clients served in CY2018: 22% were less than 20 years of age; 23% were male; and 12% were uninsured.

To further support preconception care, the Family Planning Program partners with the Center for Health Data & Analysis (CHDA) to provide multivitamins with folic acid to women of reproductive age at Title X family planning clinics. Folic acid supplementation reduces the likelihood of neural tube birth defects.

Title X family planning agencies adapted to continue to provide critical services during the COVID-19 pandemic, including implementation of telehealth visits, adjustments to scheduling and waiting room protocols, and prioritizing access family planning services.

Promote routine pregnancy intention screening with the OKQ.

To promote reproductive health counseling that encourages planning and empowers individuals to clarify reproductive health needs and intentions, RIDOH Family Planning has provided training and technical assistance on pregnancy intention screening. The One Key Question® (OKQ) model ("Would you/and your partner like to become pregnant in the next year?") encourages routine pregnancy intention screening. In preparation of OKQ implementation, all Title X family planning agencies received training on the OKQ model, as well as preconception care and reproductive life planning. All Title X agencies have implemented routine pregnancy intention screening with the OKQ model. RIDOH Home Visiting programs have also integrated pregnancy intention screening into their intake forms and developed protocols for routine screening.

RIDOH Family Planning has also engaged partners throughout the state and across sectors and specialties, including primary care, Head Start, Early Intervention, and substance use treatment providers, to consider integration of routine pregnancy intention screening in their practices.

Coordinate Preconception Health social marketing campaign.

RIDOH has developed social marketing materials to promote preconception care, including print ads, webpage banners, vinyl banners, and radio PSAs that includes messaging related to "Thinking about having a baby? Be

healthy. Be ready." Social marketing materials have been shared via Pawtucket Red Sox program book and game day radio announcements, RI Pride website and RI PrideFest activities, and at community outreach events throughout the state. RIDOH Family Planning and the Center for Center for HIV, Hepatitis, STD, and TB Epidemiology developed and released the Right Time app to provide sexual/reproductive health information, including where to find free condoms, family planning services, HIV/STI testing, and an "Ask the Expert" feature. RIDOH continues to actively promote the app and associate services via communications activities, including outreach at Providence Bruins hockey games, tv commercials, and partnerships with community-based agencies to promote the app.

Improve coordination of transition from OBGYN to primary care.
Medicaid coverage for pregnant women is terminated at 60-days postpartum, however RI's Medicaid 1115 waiver provides additional coverage via the "Extended Family Planning Benefit" (EFP). For women with a Medicaid covered birth, the EFP provides coverage of family planning services for two years postpartum. Access to health insurance is critical to ensure continuity of care. Although the ACA requires all individuals to have health insurance and RI has expanded Medicaid, maintaining continuity of coverage can be a challenge and many people experience instability with gaps in coverage. The EFP provides a safety net for family planning services, particularly for women the eligibility threshold for Medicaid coverage of 138% FPL and the prenatal Medicaid eligibility of 250% FPL. RIDOH academic detailing activities with OB-GYN practices included questions regarding protocols for insurance enrollment services and referrals. RIDOH worked in collaboration with RI Prematurity Task Force to review communications sent by insurers to their pregnant members regarding continuity of insurance coverage and transition to primary care.

Integrate preconception care into undergrad/graduate/continuing education and training for clinical providers and allied health professionals.
RIDOH partnered with the RI HIV & STI Prevention Coalition and the RI Prematurity Task Force to provide preconception health focused professional development opportunities with continuing education credits for physicians, nurses, social workers, and certified health education specialists.

Promote reimbursement of Long-Acting Reversible Contraceptives (LARC) during post-partum period.
RIDOH has worked in collaboration with the RI Governor's Office to explore opportunities for funding and statewide professional development programs to promote access to contraception, including LARC methods. RIDOH has work in support of the RI Governor's Office efforts to engage Upstream USA to launch an initiative in RI to improve contraceptive access, including addressing systematic barriers to access.

Other Programs/Projects Related to Women/Maternal Health

Adult Immunization Registry – During the 2019 legislative session, the Rhode Island general assembly approved a bill expanding the State's childhood immunization registry to include adults. With passage of the bill, the Immunization Program and KIDSNET moved ahead to begin development of the Rhode Island Child and Adult Immunization Registry. It is projected that the registry will begin accepting adult data in Fall of 2020 and the system will go live later in 2020 or early in 2021. Many adults receive vaccines at non-primary care sites such as pharmacies, workplace and community clinics. A vaccine registry facilitates the secure sharing of this information with the primary care and specialty care doctors who are coordinating care. A lifelong registry will help eliminate unnecessary re-vaccination that both saves health care costs and reduces inconvenience to patients. A registry is also a source of information for the public to easily obtain comprehensive immunization records that they may need for employment, education, travel, etc. A lifelong registry will further assist with

the rapid collection of vaccination status and dissemination of that data is critical to disease prevention and containment during an outbreak, such as the novel SARS-CoV-2, the virus that causes COVID-19. With a COVID-19 vaccine on the horizon, having a lifelong registry in place will be crucial. The infrastructure to monitor, track and communicate vaccination status must be in place and fully operational prior to the outbreak to appropriately target resources and contain disease spread. Lastly, to effectively achieve prevention of vaccine preventable diseases, especially among vulnerable populations such as newborns and children with special healthcare needs, a certain coverage level within the community must be maintained. This prevents the spread of disease seen in unvaccinated communities where the disease jumps from one unprotected individual to another. Having adults included in the registry allows RIDOH to monitor adults at the population level to identify communities/sub-populations at risk for spread of disease. A registry also allows targeted education and outreach to less well vaccinated populations and individuals.

Maternal Mortality Review Committee- According to the national pregnancy mortality surveillance system, during the five year period from 2012 to 2016 there were 13 pregnancy associated deaths in Rhode Island, with fewer than 10 of those deaths being pregnancy related. . Given the state's small size and small population, trends in mortality rates for certain subpopulations can be challenging to interpret and even more challenging to utilize to inform public health actions. With low numbers of cases, in depth case reviews can identify public health and other system changes that might prevent future deaths from similar causes. In addition, focusing on interventions to reduce maternal morbidity and address its root causes is important in addressing the drivers for maternal mortality that may not be gleaned from the small number of mortality case reviews.

In June 2018, the RI General Assembly passed an amendment to RIGL "An Act Relating to Health and Safety – Office of State Medical Examiners" which adds the multi-disciplinary maternal mortality review committee (MMRC) to the review of the office of the state medical examiner and extends immunities and confidentiality agreements to multidisciplinary teams. Letters of interest for committee participation were solicited. An initial meeting and subsequent practice case review were held in 2020, in collaboration with the CDC's Maternal Mortality Prevention Team, to prepare the committee for beginning case reviews later in the year.

AMCHP Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) is a multi-year national initiative supported by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Service Administration (HRSA). CoIINs are multidisciplinary teams of federal, state, and local leaders working together to tackle a common problem. Using technology to remove geographic barriers, participants with a collective vision share ideas, best practices, and lessons learned, and track their progress toward similar benchmarks and shared goals. CoIIN provides a way for participants to self-organize, forge partnerships, and take coordinated action to address complex issues through structured collaborative learning, quality improvement, and innovative activities. For the last two years, RI has participated in the Social Determinants of Health Workgroup which holds monthly technical assistance calls, webinars, and an annual in person meetings. The Disparities in Infant Mortality Advisory Committee was formed as a result of participating in this CoIIN. Two policy initiatives were pursued through this work: 1) increasing access to Doulas and 2) revising the current birth center regulations. Nearing the end of this project collaborative, the RI CoIIN team will meet with AMCHP to discuss the successes and challenges of the 3-year initiative.

Disparities in Infant Mortality (DIM) Advisory Board. - Birth Centers Regulatory Advisory Committee - The Birth Centers Regulatory Advisory Committee (BCRAC) was established in 2018 as a collaborative effort between the RIDOH MCH program and Health Facilities Regulations program. In response to requests for further discussion on revisions to the regulations, RIDOH established and convened the BCRAC, including representatives from the obstetrics/gynecology, midwifery, community health worker, and doula professions among its membership. The goal of the BCRAC was to draw together these various interested party groups, review/discuss the Regulations, receive detailed input on possible revisions to the regulations, and produce a report on the BCRAC's findings for

presentation to the Director of RIDOH. The BCRAC met 6 times during period of 5 months. The recommendations will then be implemented at the discretion of the RIDOH Director and the department's facilities regulations team. This is the first advisory committee of its kind at the department of health focused on regulations. The regulations were worked on by the RIDOH team and presented back to the BCRAC in the Fall of 2019. The regulations received extensive public input and should be finalized in late 2020. The MCH program was instrumental in recruiting a diverse cross-section of participants from the community to serve on the committee, which is a testament to its partnerships and collaborations in the community.

Maternal Psychiatry Resource Network (MomsPRN) Program - The Rhode Island Department of Health (RIDOH) is one of seven states to receive funding from the Health Resources and Services Administration's *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program,* which seeks to assist obstetrical, adult primary care, pediatric, and psychiatric providers in optimizing behavioral health care for pregnant and post-partum women. To achieve this end, the RIDOH has partnered with the Center for Women's Behavioral Health at Women and Infants Hospital (CWBH) to establish a free statewide psychiatry telephone consultation service for healthcare providers treating pregnant and postpartum women, especially those in rural and medical underserved communities. The RIDOH has also partnered with the Care Transformation Collaborative of Rhode Island (CTC) to provide intensive quality improvement coaching about behavioral health screening, treatment, and referral to contracted prenatal care practices.

The RI MomsPRN teleconsultation line is staffed by perinatal experts at the CWBH and is modeled after Rhode Island's successful Pediatric Psychiatry Resource Network (PediPRN) program. The goal of the RI MomsPRN psychiatry teleconsultation line is to empower providers in effectively managing their perinatal patients' behavioral health and substance use concerns, by initially providing treatment guidance from RI MomsPRN perinatal psychiatric specialists, and/or offering information and referral for additional supports and services in their patients' geographic area. Since its launch in September 2019, the RI MomsPRN teleconsultation line has fielded 226 teleconsultation calls, with 50 coming directly from patients and the remaining 176 calls coming from 128 unique providers (25 OBGYNs, 16 therapists, 14 midwives, 10 family visitors, 10 OBGYN nurse practitioners, 9 psychiatric nurse practitioners, 8 pediatricians, 8 family medicine doctors, 6 psychiatrists, 5 social workers, 3 OBGYN residents, 2 family medicine nurse practitioners, 1 primary care provider, 1 primary care nurse practitioners, and 10 other types of providers). In total, 176 women (including 57 pregnant women) were helped as result of their healthcare provider or RIDOH family home visitor accessing the RI MomsPRN teleconsultation line. Most of these perinatal patients have a provisional diagnosis of depression (124), anxiety (96), bipolar disorder (17), substance use disorder (15) or PTSD (14). Calling providers are increasingly looking for support with identifying individual therapy referrals (98), connecting patients to the CWBH for diagnostic evaluations (35), referrals to the CWBH's partial hospitalization program (31), medical consultations with the RI MomsPRN attending psychiatrist (30), help identifying support groups (23), or psychopharmacology guidance (12). Through a partnership with CTC, the RI MomsPRN program is also able to provide intensive quality improvement and practice transformation services to prenatal care practices seeking to implement, optimize, or spread perinatal behavioral health screening, treatment, and referral workflows and protocols. Upon soliciting and reviewing competitive applications in the fall of 2019, 4 prenatal care practices (Center for Women's Health, the Women & Infants Obstetrics and Gynecology Care Center (OGCC), Women's Care, and Women's Medicine Collaborative) were selected to join the first cohort of the RI MomsPRN perinatal behavioral health quality improvement initiative. Taken together, these 4 practices manage 32% of all RI births, serve both rural and medical underserved populations, and are affiliated with differing hospital/healthcare entities, (Care New England (OGCC and Women's Care), Lifespan (Women's Medicine Collaborative), and South County Health (Center for Women's Health)). Individual practice quality improvement teams meet monthly with CTC practice facilitators and all contracted practices jointly attend quarterly learning sessions facilitated by CTC that includes clinical advisement from CWBH staff to help them address common workflow issues and/or share promising practices. To monitor progress, RIDOH collects de-identified aggregate screening data among contracted practices. In January 2020, contracted

practices began implementing perinatal behavioral health screening protocols and the latest collected screening data show that 48% of perinatal patients have been screened for depression, 6% have been screened for anxiety, and 2% have been screened for substance use disorder at least once in January or February 2020. Practices have the remainder of the 2020 calendar year to ensure that every perinatal patient is screened at least once for depression, anxiety, and substance use disorder, which is aligned with numerous evidence-based clinical recommendations and committee opinions.

In addition to providing perinatal behavioral health teleconsultation and practice transformation services for healthcare providers, the RI MomsPRN program also collaborated with RIDOH's Family Home Visiting Program and the Women, Infants and Children (WIC) Program to create, distribute, and promote a public service campaign about perinatal depression and anxiety and the importance of seeking help by connecting with a healthcare provider. The 30 second spot featured a patient testimonial and was aired on a local news station in June 2020. To help further amplify this campaign, the RIDOH created a new mental health resource page for new moms and featured the campaign on its various digital platforms.

Community Health Network (CHN) is RI's centralized referral system for all Evidence Based Lifestyle Change Program (EBLPs) that was created in 2012 in response to data collected in 2011 through Rhode Island's Patient Centered Medical Homes Needs Assessment Survey. Since its inception, the CHN has provides a strong foundation for RI primary care practices as a referral mechanism for their patients to be able to effectively manage their chronic diseases. Managed by the Rhode Island Parent Information Network (RIPIN), the CHN utilizes Patient Navigators (PNs) to receive the referrals, contact the patients, provide program information, and place interested individuals into classes that best meet their healthcare needs. In 2017, 136 providers in 28 practice locations referred 921 to programs in the CHN. The programs currently housed under CHN are:

- Tools for Healthy Living - Chronic Disease Self-Management - This evidence-based education workshop teaches people how to manage symptoms and medications, communicate with family and doctors, relieve stress, eat well, exercise, and set attainable goals.
- Diabetes Prevention Program - This evidence-based education workshop teaches people how to lower their risk of getting Type 2 Diabetes by eating healthier, increasing physical activity and losing weight.
- Diabetes Self-Management - This evidence-based education workshop teaches people to deal with symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear, and frustration.
- Certified Diabetes Outpatient Education Program - CDOEs are Registered Nurses, Dietitians and Pharmacists who teach patients how to manage their glucose, blood pressure, cholesterol, medication, and nutrition.
- Enhance Fitness Program (YMCA) - Group exercise program that uses simple, easy to learn movements that motivate people with or without arthritis to stay active throughout their lives. The class is ideal for people who may be new to group exercise and want to have fun while exercising. People in the program experience improved physical strength, increased flexibility, better balance, enhanced cardiovascular fitness and reduced arthritic pain.
- RI Smoker's Helpline – This Program provides tobacco cessation educational training for physicians and other healthcare providers, training and support on use of fax-referral system to the Smokers' Helpline for patients who desire to quit smoking and follow up report on patient progress with Program.
- Walk w/ease - The Arthritis Foundation Walk with Ease program is designed to help people living with arthritis better manage their pain and is also ideal for people without arthritis who want to make walking a regular habit. Led by a certified leader, this program has been shown to reduce pain and increase balance and walking pace.
- Matter of Balance: Managing Concerns About Falls - Facilitated by Peer Leaders, these group workshops teach techniques to reduce fears of falling and increase activity levels among older adults.
- Chronic Pain Self-Management Program – This workshop provides you with the tools to manage medications, fatigue, frustration, proper nutrition, and communication skills, and teaches you to evaluate treatments

and make an action plan.

- Powerful Tools for Caregivers: This workshop allows caregivers to develop a wealth of selfcare tolls to reduce personal stress, change negative self-talk, communicate their needs to family members and healthcare providers, communicate more effectively in challenging situations, recognize the messages in their emotions, deal with difficult feelings, and make touch care-giving decisions.

RI WISEWOMAN Program - The Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program focuses on reducing cardiovascular disease risk factors among high-risk women. Addressing risk factors such as high blood pressure, elevated cholesterol, obesity, inactivity, diabetes, and smoking greatly reduces a woman's risk of CVD-related illness and death. The purpose of the WISEWOMAN program is to: 1) assure that cardiovascular screening is provided to women 30 and older who are eligible for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) or RI Medicaid eligible between 30-64 years; 2) work with community-based organizations to provide evidence-based prevention services to those women in need (through individualized lifestyle coaching and/or agreements with organizations such as the YMCA, Weight Watchers, and those that provide Diabetes Primary Prevention Programs); 3) improve the management and control of hypertension by integrating innovative health system-based approaches and strengthening community-clinical linkages (such as team-based care, self-measured blood pressure monitoring, and pharmacy medication management programs); and 4) gather and reporting program related evaluation data, including impact measures.
The RI WISEWOMAN Program is offered at Federally Qualified Health Centers and free clinics.
An eligible WISEWOMAN member is given a heart health assessment/screening to determine their risk factors and willingness to change. This assessment is completed with the member, health risk factors for CVD are review. Screening questions responses, clinical measures, and risk reduction counseling is written into My Heart Health Booklet and given to the member. A referral(s) is made to the Community Health Network based on the members SMART Goals. The WISEWOMAN Program has enrolled 972 unique women from June 2014 through April 2018. Of the 972 women, 1392 Screenings, Re-Screening, and Follow-Up Assessments have been completed from June 2014 through April 2018. The WISEWOMAN Programs continues to partner with community resources throughout RI and offer free memberships to our WISEWOMAN members through the CHN Referral Program. This referral system enables WISEWOMAN members to choose a health behavior support services with their health care team at the WISEWOMAN sites.
The WISEWOMAN Program has enrolled 127 unique women from June 2019 to July 2020. Of the 127 women, 177 Screenings, Re-Screening, and Follow-Up Assessments have been completed from June 2019 to July 2020. The WISEWOMAN Programs continues to partner with community resources throughout RI and offer free memberships to our WISEWOMAN members through the CHN Referral Program. This referral system enables WISEWOMAN members to choose a health behavior support services with their health care team at the WISEWOMAN sites.
From 127 unique women, 281 referrals were made through the CHN. Of the 281 referrals made to the CHN, 7 unique women were referred to LSP and participated 18 times; 167 women were referred to gyms, Jazzercise, yoga, and smoking and participated 249 times; 107 women were referred to HCP and participated 85 times.

Women's Cancer Screening Program - The Women's Cancer Screening Program (WCSP), RI Cancer Registry, and the Comprehensive Cancer Control Program implement a coordinated approach to inform policy, systems, and environmental change strategies to prevent and control cancer. The WCSP works to enhance the existing statewide infrastructure with health systems to provide breast and cervical cancer screening services to uninsured and underinsured women and to implement key evidenced-based strategies to reduce structural barriers to screening within health systems. The WCSP works collaboratively with other RIDOH programs and a network of community-based partnerships that provide services to underserved women and focus on health care systems that provide essential primary care services to the most vulnerable populations in RI. The goal of the WCSP is to decrease breast and cervical cancer incidence, morbidity, and mortality by focusing on underserved populations in RI who have

increased cancer risk. These outcomes are accomplished by implementing key evidence-based strategies to reduce structural barriers within health systems including increasing breast and cervical cancer screening services, eliminating barriers to accessing screening, and follow-up and referral for treatment. A large proportion of the work is spent partnering with the RI Federally Qualified Health Centers (FQHC) and Free Clinics to implement health systems change to drive and improve age appropriate cancer screening.

Over the past 25 years, the WCSP has provided breast and cervical cancer screening services to approximately 37,000 program eligible women including 53,404 mammograms, 47,955 Pap tests diagnosing 502 breast cancers and 39 invasive cervical cancers. Over 2,300 women have been navigated and enrolled into Medicaid through the WCSP to cover the cost of treatment related to a precancerous breast and/or cervical condition or to cover the cost of treatment needed for women with a diagnosis of breast or cervical cancer. The WCSP staff are seasoned staff serving as the backbone of the program. The staff provide ongoing support to all providers, clinicians and their office staff ensuring provider compliance with program requirements and policies. June 2019 to July 2020, 38,000 women were served by the program. 2,462 women have been navigated and enrolled into Medicaid through the WCSP. 35,377 women screened for breast cancer and 29,282 women screened for cervical cancer. Of those screened, 507 breast cancer and 40 cervical cancer diagnoses have been made.

Sustainability of Women/Maternal Priorities

Although the MCH Priority for Women's Health will be changing based on the 2020 Needs Assessment, many of the Oral Health and Family Planning strategies will continue as a component of the Pregnancy, Prenatal, and Postpartum Domain work:

- ***Work with the RI Oral Health Commission Preventive Modalities subcommittee to continue the work of the Perinatal & Infant Oral Health Quality Improvement Project (PIOHQI).*** The RI Oral Health Program will take all learnings from the 4-year PIOHQI grant to the statewide subcommittee to spread the messaging and learnings around pregnant womxn and the age one dental visit.

- ***Continue to promote oral health during pregnancy and the age one dental visit among Family/Home Visitors and WIC staff.***

The RI Oral Health Program will partner with the Family/Home Visiting Program to host two in person oral health trainings provided by the RI Dental Director. The RI Oral Health Program Manager will continue to periodically visit with Family/Home Visiting staff to review data from the MIECHV data system. The RI Oral Health Program will also continue to work with the WIC program to promote oral health in their offices. Any necessary materials, information, and training will be provided.

- ***Incorporate oral health into Community Health Worker training.***

The RI Oral Health Program will work with the Community Health Worker Association to incorporate oral health into the general curriculum for the program as well as coordinate two optional three-hour trainings throughout the year.

- ***Promote family planning and birth spacing.***

The RIDOH Family Planning will continue to support access to comprehensive, high-quality, accessible, affordable, and confidential family planning services at twenty-six services sites located throughout the state. RIDOH Family Planning will continue to provide technical assistance to support Title X family planning agencies as they scale up implementation of One Key Question® (OKQ) across their service sites. OKQ training will also be offered to community partners to support pregnancy intention screening and referrals to reproductive health services in various settings and specialties. To promote ongoing professional development, RIDOH hosts an annual Reproductive Health Summit. The Reproductive Health Summit, open to clinical and allied health professionals across RI, will share best practices within a framework of reproductive justices for contraceptive and preconception care, pregnancy intention screening, and LGBTQ inclusive care.

RIDOH will develop an issue brief on contraception including results from the contraceptive access survey of providers, as well as recommendations based upon evidence-based practice. RIDOH will also promote awareness of Medicaid's policy change for postpartum LARC reimbursement among OB-GYN and family medicine delivering providers. RIDOH will also collaborate with other agencies and community partners to identify opportunities and develop a strategic approach to improve contraceptive access, including LARCs.

APPLICATION YEAR

APPLICATION YEAR: Women/Maternal Health (Preconception, Pregnancy and Postpartum Health)

The Title V program refers to Women/ Maternal health as the Preconception, Pregnancy, and Postpartum Health section. This section refers to the health of womxn of child-bearing age, usually 15-44, although demographics show that this age range has been widening. Maternal health is the health of womxn during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care. The Title V Program recognizes the importance of addressing each of these stages and has renamed this area as the Preconception, Pregnancy, and Postpartum domain. Preconception health is an area that focuses on womxn's health before she becomes pregnant, health during pregnancy focuses on womxn's health beginning with conception up to the pregnancy outcome, and postpartum health is the area that focuses on womxn's health after the pregnancy outcome and up to 6 months. Preconception care is important because it reduces unwanted and mistimed pregnancies and teen pregnancy. It also has been linked with better prenatal care engagement and birth outcomes.

The Preconception, Pregnancy, and Postpartum Health domain section has taken into consideration that the care and outcomes of womxn, children, and families are impacted by the systemic racism, discrimination, unaddressed language barriers, and a lack of culturally responsive providers. The following quantitative, qualitative, and anecdotal information tries to tease out health disparities and the overarching healthcare needs of communities. RI's Needs Assessment took into consideration structural racism and discriminatory practices from slavery to present. In understanding the historical implications of stigma, abuse, and marginalization, healthcare institutions can better address a culture of delivering care that perpetuates harm and inequities and move forward in creating a new and unified tomorrow. One can understand black and brown communities fear of healthcare institutions in part stemming from the history of experimentation on black and brown bodies from the practices of the "father of gynecology", James Marion Sims to more recent atrocities of the Tuskegee Syphilis study or Johns Hopkins general experimentations and their creation of HeLa cells. Since September 2019, RIDOH has formed a continuing partnership with SISTA FIRE, a local RI womxn of color (WOC) organizing group that has further informed the department of the current healthcare experiences and needs of womxn of color.

Systematic racism and racial inequity occurs not only within communities and institutions but also within healthcare settings and provider practices. Title V views SISTA FIRE's key learnings through the overarching lens that discrimination and racial injustice permeate all corners of our society. Although SISTA FIRE draws on findings from Women & Infants Hospital (WIH), these issues are present within various healthcare settings, hospitals, and practices across the state. SISTA FIRE, found four overarching issues that WOC wanted birthing hospitals to address in order to develop high quality delivery and postpartum care: 1) Translation & Interpretation, 2) Trauma Informed Care, 3) Informed Consent and 4) Community Impacts. Over the next five years, the RIDOH aims to collaboratively work with SISTA FIRE and try to build out our support and strategies for these four overarching issues and strategy suggestions.

During triage, inpatient services, and discharge, WOC, especially non-English speaking WOC, felt that they were not properly communicated to, especially in their preferred language or dialect, about their condition, treatment, or about postpartum community resources and services. Even without a language barrier many WOC felt that they were not made aware of community resources and that their needs, pain, and suffering was not properly acknowledged, empathized with, and treated during their hospital stay. For instance, one respondent felt ignored when she questioned her repeated examinations. She viewed the experience as violating and invasive. She wasn't asked permission if doctors could use her as a practice patient and bring in multiple medical students at the teaching hospital. This story underlines the need for birthing hospitals to adequately communicate with their womxn of color

patients in a culturally and linguistically responsive manner about their condition.

WOC often felt judged and nervous by staff asking personal questions, under the assumption that patients weren't responsible parents. Due to this, patients often did not want home visiting services. Patients also expressed a real fear that child welfare would be contacted and that mothers would be separated from their children based on stereotypes they felt hospital staff held about womxn of color mothers. “This was my first pregnancy, so I didn't really know.... I’m asking the nurses, and they are like ‘Yeah, she’s fine, it is kind of weird that her eyes are open, but she’s good.’.... Then the doctors start asking me questions, ‘Oh do you have any kind of infection or disease that we don't know about?’ ...They kind of made it seem like I was hiding something, and this is why my daughter is not showing the typical behavior for a newborn. So I felt like they were blaming me.” This quote underlines the need for birthing hospitals and home visiting programs to create supportive and non-judgmental atmospheres that center trauma informed care of patients.

The Needs Assessment highlighted the lack of diversity in the pregnancy, prenatal and postpartum workforce. This finding was realized in family home visiting, family planning, birthing hospitals, and prenatal care providers. In addition, SISTA FIRE noted how the expansion of WIH and RIH has impacted surrounding communities. Even with such an expansion, there is a lack of representation of WOC as medical providers within the hospital and a general lack of hiring within the surrounding community or greater Providence area.

Overarchingly, SISTA FIRE, advocates for high quality trauma informed care, translation and interpretation of services, informed consent of procedures and treatments in birthing hospitals across the state, and community investment with an emphasis on community impact of birthing hospitals.

The RIDOH Disparities in Infant Mortality workgroup and SISTA FIRE also support prenatal health community based solutions such as community based doulas to support WOC during pregnancy, delivery, and postpartum. RIDOH has and will continue to support instilling doulas as an overarching support for all womxn in Rhode Island. In 2019-2020, the RIDOH supported state legislation that would strengthen medical assistance health care for expectant mothers by establishing medical assistance coverage and reimbursement rates for perinatal doula services.

Priority: Address Prenatal Health Disparities

The RIDOH believes that all pregnant individuals should have access to comprehensive and timely prenatal services across the healthcare continuum. Through the needs assessment process, stakeholders expressed a range of strategies that were broadly classified as “Prenatal Health” such as prenatal care, family planning, family home visiting, oral health care, and group prenatal care. There was also an overarching expressed desire to improve the social, environmental, and economic factors in communities where disparate perinatal outcomes are most prevalent.

While trends have been improving for all racial/ethnic populations, disparities remain in reported unintended pregnancies, with 33.1% of Non-Hispanic Whites compared to 45.6% of Hispanics 45.6%, and 61.9% Non-Hispanic Blacks. The percentage of short interpregnancy interval (< 18 months) among RI resident women in 2018 was 26.1%, which is a slight decrease from 26.8% in 2017. In 2018, Hispanic women were 40% more likely to have a short interpregnancy interval than Non-Hispanic White women. Moreover, the disparity between both groups has increased from 2014 to 2018. Vital Records data show that 2.3% of women who gave birth in 2018 reported having a previous preterm birth. Among RI-resident women who have birth in 2018, 7.6% had gestational diabetes and 8.1% had gestational hypertension/preeclampsia. Although the overall trend of cigarette smoking during the last 3 months of pregnancy has decreased from 40.0% in 2018 to 36.0% in 2018, pregnant women with disabilities has a higher percentage (13.8%) smoking during pregnancy than pregnant women with no disabilities (5.8%). The decreasing trend in cigarette smoking during pregnancy may not account the likely increasing trend in electronic cigarette use. In 2019, 84.7% of pregnant women who gave birth received prenatal care beginning in the first trimester, a slight increase from 82.7% in 2018.

Strategy: Address Prenatal Health Disparities within Prenatal Health Programs. Title V aims to partner with

community stakeholders, cultural groups, and networks, such as HEZ and SISTA FIRE, in order to address disparities within the birthing parent system of care. The intent is to provide guidance for RIDOH administered programs in family home visiting, family planning, oral health, and other preventative care on the following: trauma informed care, translation and interpretation of services, informed consent of procedures and treatments, and an emphasis on community impacts. This includes community based solutions such as community based doulas to support WOC during pregnancy, delivery, and postpartum.

Priority: Reduce Maternal Morbidity & Mortality

In 2019, 27.2% of women had cesarean delivery with a low risk first birth. The 2019 maternal morbidity rate (including blood transfusions) was 271.4 per 10,000 delivery hospitalizations, which is an increase from 242.0 per 10,000 In 2018, Black women (382.7 per 10,000 delivery hospitalizations) had a higher maternal morbidity rate than White women (224.8 per 10,000). Racial/ethnic disparities can also be seen among delivery hospitalizations regarding blood transfusions (Black women: 293.9 per 10,000; White women: 141.2 per 10,000) and hypertensive disorders (Black women: 520.4 per 10,000; White women: 288.7 per 10,000). According to the national pregnancy mortality surveillance system, during the five year period from 2012 to 2016 there were 13 pregnancy associated deaths in Rhode Island, with fewer than 10 of those deaths being pregnancy related. Given the state's small size and small population, trends in mortality rates for certain subpopulations can be challenging to interpret and even more challenging to utilize to inform public health actions. With low numbers of cases, in depth case reviews can identify public health and other system changes that might prevent future deaths from similar causes. In addition, focusing on interventions to reduce maternal morbidity and address its root causes is important in addressing the drivers for maternal mortality that may not be gleaned from the small number of mortality case reviews.

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Strategies:

(1) Rhode Island Pregnancy & Post-Partum Death Review Committee (PPDRC) is a newly established multidisciplinary committee that reviews deaths that have occurred during pregnancy or within one year of the end of pregnancy. PPDRC reviews these deaths to identify factors contributing to the deaths and to recommend public health and clinical interventions that may prevent future deaths, and also to improve systems of care.

To date, there is a 30 member committee that has been oriented by the Center for Disease Control and Prevention, established a meeting schedule, developed a data sharing relationship with the CDC, and contracted with a logistics coordinator for abstractions and recording purposes.

The Pregnancy and Postpartum Death review is conducted pursuant to RIGL §23-4-3 and Department of Public Health rules and regulations pertaining to the reporting of selected causes of mortality in Rhode Island. RI's legislation informs the composition of the PPDRC members that are appointed by the Director of Health. Per the legislation, the committee shall include:

- state agencies
- an obstetric provider from each hospital that delivers obstetrical care
- a neonatal specialist
- a perinatal pathologist
- a maternal fetal medicine specialist
- individuals or organizations that represent the populations that are most affected by pregnancy-related deaths or pregnancy-associated deaths and lack of access to maternal health care services

RI Title V intends to fully engage the perspectives expressed through the needs assessment from SISTA FIRE and Health Equity Zones to ensure systemic racism, discrimination, unaddressed language barriers, and a lack of culturally responsive providers are wholly incorporated in committee recommendations.
It is important to note that Rhode Island acknowledges the breadth of gender identity of individuals who may become pregnant (e.g. transgender, non-binary, and intersex) and named our committee the Pregnancy and Post-Partum Death Review Committee.

(2) Develop a Perinatal Quality Collaborative with diverse representation from the community. Rhode Island is the only state in the nation that does not have an active Perinatal Quality Collaborative (PQC). Hospital professionals, the Hospital Association of Rhode Island, and RIDOH are partnering to initiate a PQC in the state to improve health outcomes for women and newborns using quality improvement (QI) methods. A planning committee is underway to determine the goals of the PQC, which is expecting to formally launch in 2021 . The planning group is coordinating with the Alliance for Innovation in Maternal Health Program in RI to identify immediate needs. The RI AIM program began in 2020 with the focus on decreasing postpartum hemorrhage by implementing their AIM bundle. RIDOH seeks to 1) provide opportunities to allocate funding for operating the PQC, 2) advocate for diverse representation from the community to reduce racial/ethnic disparities in the hospital setting, and 3) coordinate efforts with the PPDRC and the AIM program in addressing maternal morbidities and mortality.

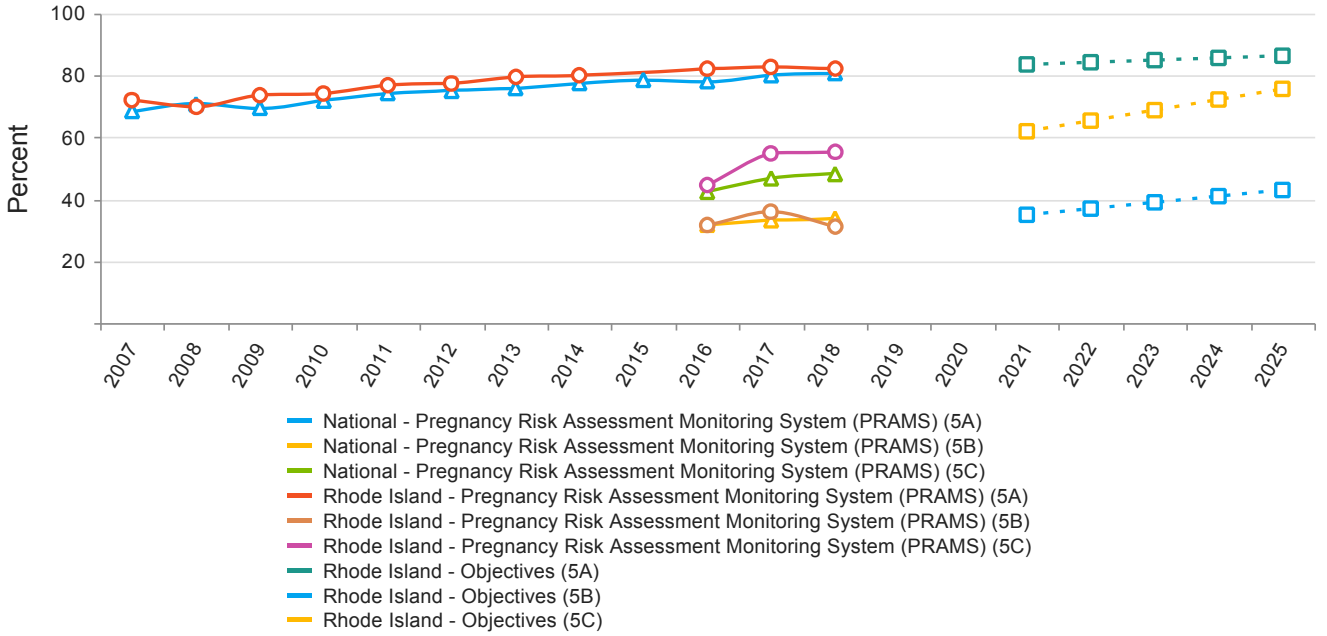
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	6.2	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.9	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	94.0	NPM 4 NPM 5

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	82.0
Numerator	7,714
Denominator	9,411
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	83.4	84.1	84.8	85.5	86.2

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	31.3
Numerator	2,813
Denominator	8,976
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	35.0	37.0	39.0	41.0	43.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	55.1
Numerator	4,947
Denominator	8,981
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	61.9	65.3	68.7	72.1	75.5

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Parent-Child Interaction

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	72.4
Numerator	417
Denominator	576
Data Source	Efforts to Outcomes Home Visiting Database
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	76.0	78.0	80.0	82.0	84.0

State Performance Measures

SPM 1 - Depression Screening for Primary Caregivers

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		80	90.9	92.3
Annual Indicator	76.2	89.6	89	85.5
Numerator	474	524	412	473
Denominator	622	585	463	553
Data Source	Family Visiting Database	Family Visiting Database	Family Visiting Database	Family Visiting Database
Data Source Year	2016	2017	FFY 2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	87.0	89.0	91.0	93.0	95.0	97.0

State Action Plan Table

State Action Plan Table (Rhode Island) - Perinatal/Infant Health - Entry 1

Priority Need
Strengthen caregiver's behavioral health and relationship with child

NPM
NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives
Increase the percent of infants placed to sleep on their backs from 82% in 2019 to 86.2% in 2025

Strategies
Tele-consultation for behavioral/mental health for caregivers and children
Postpartum depression screening

ESMs	Status
ESM 5.1 - Parent-Child Interaction	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Rhode Island) - Perinatal/Infant Health - Entry 2

Priority Need

Strengthen caregiver's behavioral health and relationship with child

SPM

SPM 1 - Depression Screening for Primary Caregivers

Objectives

Increase the percent of caregivers screened for depression in Family Visiting Programs from 85.5% in 2019 to 97% in 2025

Strategies

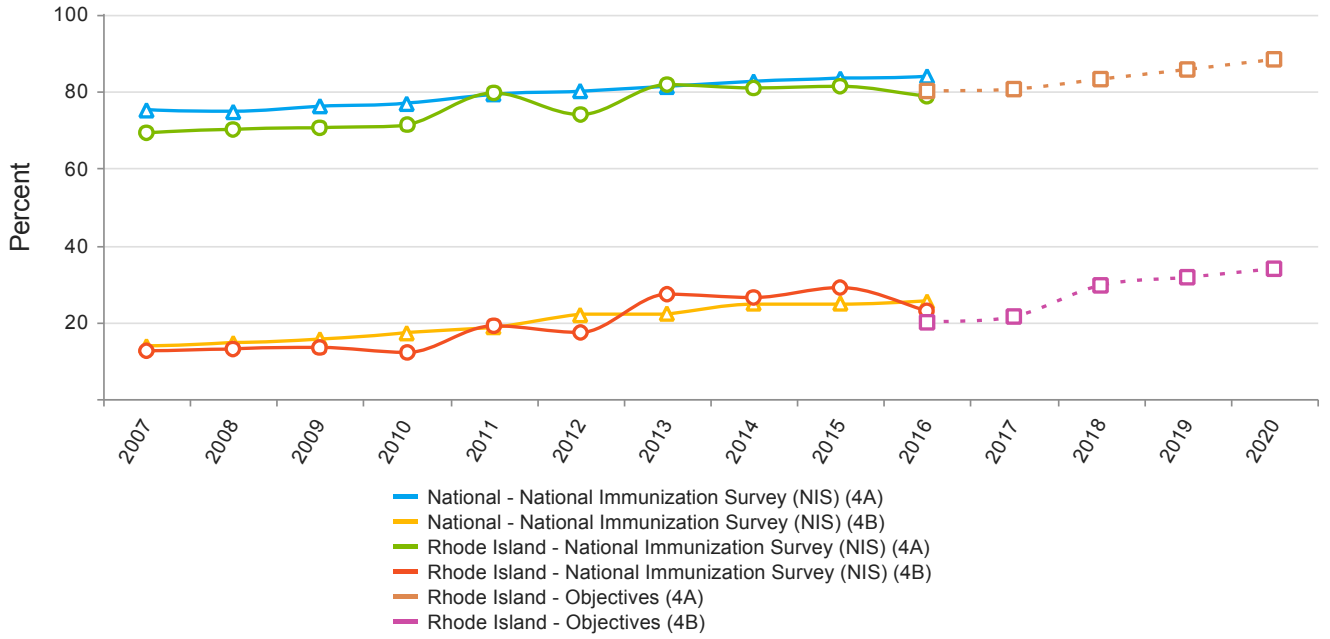
Tele-consultation for behavioral mental health among caregivers and children

Postpartum depression screening

2016-2020: National Performance Measures

2016-2020: NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Indicators and Annual Objectives



2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	80	80.5	83.1	85.6
Annual Indicator	81.8	80.6	81.4	78.8
Numerator	9,093	8,191	8,534	7,780
Denominator	11,113	10,158	10,488	9,868
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	20	21.5	29.6	31.7
Annual Indicator	27.4	26.6	28.9	23.0
Numerator	2,937	2,657	2,864	2,178
Denominator	10,738	9,975	9,912	9,488
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 4.1 - % of RI Resident Births occurring in Hospitals Designated as Baby Friendly

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		92	92	99.7
Annual Indicator	95	95.9	95.9	95.6
Numerator	9,875	9,805	9,703	9,319
Denominator	10,390	10,223	10,117	9,744
Data Source	KIDSNET	KIDSNET	KIDSNET	KIDSNET
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: State Outcome Measures

2016-2020: SOM 5 - Post-Partum Depression

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		10.5	11.6	12.8
Annual Indicator	10.9	12.6	13.6	12.3
Numerator	1,101	1,242	1,327	1,163
Denominator	10,075	9,830	9,740	9,469
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

2016-2020: SOM 6 - Black/White Infant Mortality Rate Ratio

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		2.2	3	2.5
Annual Indicator	2.4	3.8	3.8	4.2
Numerator	9.7	13.9	12.8	13
Denominator	4.1	3.7	3.4	3.1
Data Source	Vital Records	Vital Records	Vital Records	Vital Records
Data Source Year	2014-2016	2015-2017	2016-2018	2017-2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Report: Perinatal/ Infant Health

The perinatal period refers to the period immediately before and after birth. Perinatal and maternal health are closely linked. Infant health refers to the period before a child's first birthday, a very critical period in growth and development. The RI MCH Program strives to ensure that all pregnant women receive appropriate prenatal care, which can affect both maternal and infant birth outcomes. The program is focusing on the caregiver relationship between the mother and infant. Emphasis is placed on identifying pregnant and parenting families who are at high risk of negative outcomes and linking them to appropriate services, including addressing to stagnant or worsening trends in racial/ethnic disparities.

Priority: Increase Breastfeeding Awareness & Social Support

The RIDOH Breastfeeding Program works to enhance supports for pregnant and breastfeeding women and their families by building linkages between the birthing hospitals and the community, increasing awareness of breastfeeding as the optimal method of infant and young child feeding, and creating partnerships with health professionals and advocates throughout Rhode Island. The goals, objectives, strategies and vision for the program can be found in the 2015-2020 Rhode Island Breastfeeding Strategic Plan.

The WIC State Breastfeeding Coordinator maintains a seat on the Board of the RI Breastfeeding Coalition (RIBC) and represents RIDOH in the work they complete. With its current capacity, RIBC completes the biennial breastfeeding conference for professional development, and the annual community outreach zoo event held during World Breastfeeding Week in August each year, as well as partnering with RIDOH and the state WIC program to sustain the RI Baby Café and the Chocolate Milk Café at the Mount Hope WIC site in Providence.

An essential component of the Breastfeeding Program is providing quality breastfeeding support and education to all pregnant and breastfeeding women. At the program's current funding level, the program continues to staff Breastfeeding Peer Counselors in each WIC clinic, supply hospital grade breast pump rentals or manual breast pumps as needed, and staff IBCLCs to round in the birthing hospitals to provide breastfeeding support/education to all WIC active and eligible patients. This past year, efforts focused on the following strategies:

Coordinate and standardize breastfeeding messages for all RIDOH programs that work with prenatal and postpartum women.

In the past year, work has been completed towards coordinating and standardizing breastfeeding messages for all RIDOH programs that work with prenatal and postpartum women. Content experts from both the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Family Home Visiting programs, developed new education materials that are relevant and impactful. A distribution plan for the completed materials was developed and is being executed. Materials will be distributed through programs administered by RIDOH, as well as healthcare providers and birthing hospitals throughout the state. Electronic versions of the materials are hosted on the RIDOH Breastfeeding website for easy accessibility. The English version of the nine tear-off pads of education materials have been developed and seven of the nine materials have been translated into Spanish. These materials were distributed to WIC clinics Family Home Visiting programs, and community outreach events. Electronic versions of these materials are available on the Breastfeeding Web page at RIDOH.

Support efforts to increase access to IBCLCs & CLCs.

To increase both short- and long-term breastfeeding rates, RIDOH works to increase the public's access to skilled lactation support; numerous studies have shown the impact of both lay and professional support in increasing breastfeeding rates. RIDOH continues to partner with the RI Breastfeeding Coalition (RIBC) and the state's WIC program in supporting the sustainability of the RI Baby Café, a free, weekly support group that began in 2014 that expands access to a wide range of lactation professionals, IBCLCs, CLCs, and Peer Counselors, with no out-of-pocket cost to attendees. RIDOH and community partners continue to strategize how to increase participation

and sustain support groups (baby café) in other communities throughout the state. Staff supporting the Baby Café are volunteers except for the WIC Peer Counselors. The Chocolate Milk Café began in the Mount Hope WIC Program, in 2018. This program is staffed by a volunteer and a WIC Breastfeeding Counselor. Strategies need to be implemented to have the ability for reimbursement by insurance companies.
In April 2019, RIDOH hosted a Certified Lactation Counselor training in Providence, RI facilitated by Healthy Children Project, Inc. 50 diverse Staff from RIDOH Family Home Visiting and WIC, along with community members from Health Equity Zones completed the week-long training.

Support baby-friendly hospitals statewide.
Rhode Island aims to achieve the Baby Friendly Hospital Initiative (BFHI) designation for all five of our state's birthing hospitals. Currently, all but one facility maintains the designation. RIDOH plans to work closely with the remaining non-Baby Friendly designated hospital, as they work towards achieving the designation. RIDOH in coordination with the RI Breastfeeding Coalition will provide support in training and managing the necessary steps to move the process forward for Landmark Hospital.

To support the hospitals that are currently designated, RIDOH works with RIBC and our state's largest birthing hospital, Women & Infants Hospital of Rhode Island, to host an biennial Breastfeeding Conference, offering lactation specific continuing education credits for physicians, nurses, and lactation professionals. The 2019 conference was held on March 25th and was attended by over 100 health professionals from around RI and surrounding states. The next conference is set to take place in 2021.

Provide education on breastfeeding resources such a free breast-pumps and insurance coverage benefits.
Edits to the RIDOH breastfeeding website have been updated with the department's Communications team. These edits aim to provide a comprehensive resource for community members and professionals to access timely and accurate information on breastfeeding resources, such as education materials, and access to health and social service programs such as WIC and Family Home Visiting.

The Breastfeeding Program will support efforts to increase the number of IBCLCs and CLCs of color to address disparities in infant breastfeeding rates.
This was accomplished by offering a CLC class for WIC Peer Counselors and other individuals from the community. RIDOH also needs to better understand the breastfeeding workforce (geographic location of service, organization affiliation, race/ethnicity, etc.). The MCH Program is also working with several internal partners to explore ways to recruit and train IBCLCs of color. In April 2019, RIDOH hosted a Certified Lactation Counselor training in Providence, RI facilitated by Healthy Children Project, Inc. 50 Staff from RIDOH Family Home Visiting and WIC, along with community members from Health Equity Zones completed the week-long training. RIDOH anticipates to offer this training again Spring 2021.

RIDOH will continue to work with the RIBC's Licensing Committee to ensure licensed lactation consultants are incorporated in health insurance reimbursement policies.
Licensure was created with the intention of expanding the lactation workforce, and improving the reimbursement potential of IBCLCs, therefore making their services more accessible 1) to individuals who cannot afford to pay out of pocket for their valuable service, and 2) outside of the hospital/clinic setting.

Newport Health Equity Zone offers a "Women of Color Breastfeeding Support Group". This group meets twice a month and is facilitated by a resident of the community, who is also a doula. The goal of this program is to create a safe space for women of color to latch, encourage and support them on their journey. During these meetings the group makes appropriate referrals to other RIDOH programs, such as WIC and Family Home Visiting. We will continue to promote all of the support group offerings to the HEZs to increase participation and breastfeeding

rates/durations. 3 HEZ community members attended the CLC training in April 2019.

Priority: Support the Implementation of the Family Visiting Program

RIDOH has successfully administered evidence-based family home visiting programs since 2010. Rhode Island supports the implementation of three evidence-based models: Healthy Families America, Nurse-Family Partnership® and Parents as Teachers. In addition, RIDOH has supported First Connections, a RI grown, short-term family home visiting program, for over 20 years. Prioritized populations for the evidence-based models, as designated by HRSA/MCHB include:

- Low-income eligible families;
- families that include a pregnant woman who is younger than age 21;
- families that have a history of child abuse or neglect or have had interactions with child welfare services;
- families that have a history of substance abuse or need substance abuse treatment;
- families that have users of tobacco products in the home;
- families that have children with low student achievement;
- families with children who have developmental delays or disabilities; and
- families that include individuals who are serving or formerly served in the Armed Forces, including families that have members of the Armed Forces who have had multiple deployments outside of the United States.

RIDOH would not be able to implement evidence-based family home visiting programs without strong collaborations with key stakeholders and partners. Many of the community and state partners sit on the Family Visiting Governance Council, Governor's Children's Cabinet, Title V Maternal and Child Health Team, RI's Early Learning Council, RI's Early Intervention Interagency Coordinating Council, Successful Start Steering Committee, as well as others. The Family Home Visiting Program also continuously builds and maintains relationships with community-based social service providers, medical homes, behavioral health providers, substance use treatment providers and Health Equity Zone partners.

Furthermore, the Family Home Visiting Program collaborates with multiple programs within RIDOH.

- *WIC* – identifies and refers pregnant woman for services. WIC staff provide professional development training on infant feeding, nutrition, and breastfeeding to family visitors. WIC and family visiting work together to increase breastfeeding initiation and duration. In 2018, they worked to update breastfeeding materials and in April 2019, they co-hosted a Certified Lactation Consultant training for WIC and family visiting staff.
- *Immunization Program* - regularly attends family home visiting local implementation team meetings to discuss relevant topics including flu, T-Dap and varicella, school-based vaccination clinics. The family home visiting team regularly promotes vaccination clinics and vaccine information on the Family Visiting Facebook page and newsletter.
- *Oral Health Program* - provides ongoing training on oral health issues to family visitors. The Oral Health team created community-specific materials that family visitors use to support families' participation in oral health services. The Oral Health Program staff attend Local Implementation Team meetings to understand barriers to accessing oral health care in specific communities. The two programs share data and work to promote preventative dental car for pregnant women as well as the age 1 dental visit.
- *MomsPRN*- The family home visiting program has partnered with the MomsPRN program to support family home visitors that are working with caregivers with postpartum depression. Family home visitors are now able to access and receive support from the MomsPRN line, just as physicians and other health care providers are.

The MomsPRN team has provided support and training during the CQI initiatives to improve screening for postpartum depression and linkages to services.

Continue to use evidence-based screening tools to identify family needs and make appropriate referrals to necessary services that support positive health outcomes for all family members.

The Family Home Visiting program continues to use evidence-based screening tools. The screenings assist in guiding visits, prioritizing family needs, and planning visits around those needs. The screenings begin during the first two to three visits with a family and continue periodically throughout a family's participation in family visiting. Caregivers are screened for prenatal and postpartum depression, alcohol and substance use, and interpersonal violence. Families are offered referrals and are linked to care based on screening results. Children are also screened for developmental milestones, physical, social, and emotional health. Based on screening results, children are referred to supportive services, such as Early Intervention. With consent, family visitors also share concerns with medical providers including obstetricians and pediatricians. In the Fall of 2018, the Family Visiting program began participating in a national CQI initiative to improve screening rates and linkages to care for postpartum depression and reduce depressive symptoms in women with postpartum depression. The MCH Title V Coordinator is the CQI initiative's senior sponsor. This work will be spread to all family home visiting teams in Fall 2020.

Identify, engage, and retain more families at risk for poor outcomes.

As of June 2019, MIECHV is at 85% contracted capacity. The Family Home Visiting program remains committed to working with RI's most vulnerable families and providing support at critical points during the life course. The family home visiting program expanded the Parents as Teachers program by an additional 300 families statewide with Preschool Development Block Grant. By working with community partners such as the birthing hospitals, healthcare providers, substance use providers, Department for Children, Youth and Families (DCYF), family home visiting is able to engage pregnant women that may be at risk for poor outcomes. Through the Newborn Developmental Assessment (Level 1 screening) done for every mother and baby at time of birth, 60-65% of newborns and their families are automatically referred to First Connections at birth. First Connections works with families to refer and engage vulnerable families in long, term, evidence-based family home visiting. The family home visiting program works closely with the DCYF to identify and refer families that are involved with the child welfare system. DCYF has also increased referrals for families that are being investigated for child abuse but may not have an indicated case and open to DCYF for further services. Additionally, the Family Home Visiting program is working with RI's Department of Human Services to refer and engage families participating in TANF. Policies and procedures put in place by RIDOH's Family Home Visiting program provide clear guidelines for consistent efforts to engage and retain families, as does ongoing sub monitoring of program implementation. Family Home visiting agencies are encouraged to use continuous quality improvement to test strategies to support both initial engagement and retention in services. Family home visitors are also working with their Health Equity Zones to identify and refer families to family home visiting.

Improve the professional development system that is based on national core competencies for family visiting staff, including standardized orientation for all new staff and supervisors, including Title V priorities.

The Family Visiting Program provides a high-quality professional development opportunities to all home visitors in order to ensure a skilled workforce that is able to respond to the complex and evolving needs of families. RIDOH works closely with contracted agencies to identify additional training needs. Most recently, family visitors have been offered training on the following topics: reflective practice and supervision, working with families with substance use, safe sleep, infant feeding, breastfeeding, self-care, oral health, car seat safety, public benefits and supporting mothers with maternal depression and extensive Motivational Interview training. RIDOH is received technical assistance from HRSA on a standardized orientation processes for all new family home visitors, supervisors,

and program managers and will implement year two of the new orientation in October 2020. To support reflective practice and supervision within all contracted agencies, RIDOH has developed a framework for reflective practice and supervision and infant/early childhood mental health consultation. The Family Home Visiting Program works closely with RI's Association for Infant Mental Health to support family visitors and provide training related to behavioral health. The RIDOH family home visiting team has also connected agencies with the Rapid Response in Virtual Home Visiting webinars to support teams during the time of COVID-19 and has shifted all professional development activities to virtual offerings for the foreseeable future.

Sustain and expand the Family Visiting Program by finding additional revenue streams.
Currently, RIDOH's current capacity for evidence-based family visiting is 1,400 families statewide with MIECHV funding. However, many more vulnerable families could benefit from long term, evidence-based family visiting. While RIDOH has successfully maintained its federal funding, additional resources are needed to support the program. RIDOH was able to begin expanding Parents as Teachers in July 2020 with funding to serve 300 additional families through Preschool Development Block Grant funds. In 2018, RIDOH worked with RI Medicaid to include Healthy Families America and Nurse-Family Partnership Home Visiting Programs in RI's 115 Medicaid Demonstration Waiver. Approval by CMS was granted in December 2018. RIDOH is working closely with the Governor's office to secure state funding in FY2021. Additionally, these programs have also been added to the Medicaid State Plan Amendment and RIDOH is working to identify a state match. While it was not approved in this year, RIDOH is already beginning to build the case for it to be included it in this year's budget. RIDOH continues to work with state partners to identify opportunities for braided and blended funding. As RIDOH works to identify and engage more families in family visiting (Strategy 2), there is need to have more family visiting availability across the State.

Develop and implement a model of mental health consultation to the Family Home Visiting Program.
The Family Home Visiting Program will continue to support its 14 family visiting agencies with access to mental health consultation and similar supportive resources. With support from national experts, TA and local mental health consultants, RI has developed a tiered framework to support mental health consultation within family visiting so that family visitors, supervisors and program managers have levels of support while working with complicated families. Two levels provide for mental health consultation to family visitors and the other with families. The Family Home Visiting Program provided each family home visiting agency with dedicated funding in the agency's contract for the past few years that may be used for mental health consultation and supportive services. The Family Visiting Program will continue to do so in future contracts. There is also funding in the Preschool Development Block grant also providers funding to support mental health consultation that will begin in Fall 2020.

In addition to providing funding to each family home visiting agency, the Family Home Visiting Program has partnered with the RI Association for Infant Mental Health (RIAIMH) to provide additional support to the family home visiting workforce. The Family Home Visiting Program works with RIAIMH on training and support related to infant mental health. The Family Home Visiting Program is also supporting family visiting staff by supporting the process of Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (RI-IMH-Endorsement®). This endorsement process ensures that family home visiting staff have the competencies and skills to support the parent-child relationship and promote positive parenting practices that address the needs of infants. The family home visiting program has worked with the providers of the reflective practice and supervision trainings and groups to align the their training with the competencies for Endorsement and the training and monthly group supports now support a family visitor that is working on Endorsement.

Other Programs/Projects Related to Perinatal/Infant Health

The Rhode Island Task Force on Premature Births

RI Task Force on Premature Births is a diverse coalition of community-based organizations, government agencies, and health care partners that is currently working on a variety of strategies designed to reduce the rate of premature birth and the morbidity and mortality associated with premature birth. The overarching values of the task force include: continued emphasis on policy and advocacy; focusing on preconception, inter-conception, and postpartum time frames for intervention; linking prenatal risk assessment and screening with referral resources; recognizing social and environmental determinants of health including racism; addressing cultural awareness and competency; and using data to drive action and evaluate effectiveness. The following workgroups have been formed to work on specific areas of concern related to prematurity: 17-P, Pre and Inter-conception Health, Tobacco Cessation, Pregnancy Risk Assessment, Data.

The Rhode Island Task Force to Support Pregnant and Parenting Families with Substance-Exposed Newborns (SEN Task Force) - The SEN Task Force was re-convened by the RI Department of Health (RIDOH) during the Spring of 2016 at the request of Governor Gina M. Raimondo. The SEN Task Force reports up to the Governor's Overdose Prevention and Intervention Task Force and represents a dynamic multidisciplinary partnership across state agencies and community-based providers and stakeholders. Along with RIDOH, SEN Task Force representation includes the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH); the Rhode Island Department of Children Youth and Families (DCYF); Executive Office of Health and Human Services (EOHHS); substance use treatment providers; recovery support programs; prenatal providers; birthing hospitals; a range of family support programs; and professional and peer providers.

The mission of the SEN Task Force is to improve the health and well-being of families affected by substance use disorder through system change via the development of a comprehensive system of supports for women, newborns, and families that provide prevention and intervention to avoid or ameliorate the outcome of prenatal substance exposure across the continuum of care using the life course approach.

In 2019, the SEN Task Force began work on a strategic plan to drive the work of the Task Force for the next three years. Through the process of conducting a public needs assessment, identifying strategic priorities and desired outcomes, and conducting a national landscape analysis, and identifying strategies, the following four priorities were developed: (1) increase education and workforce development; (2) improve interdisciplinary, family-centered care coordination; (3) expand and increase access to treatment and recovery; and, (4) use data to inform program activities and improve outcomes.

RIDOH plays a key role in the leadership and administration of the SEN Task Force which met bi-monthly before the pandemic and employed a dynamic workgroup structure. Strategic planning, in the final steps, was interrupted by the COVID-19 crisis when SEN leadership was activated to RIDOH's pandemic response. Upon returning, a new structure for Task Force meetings and workgroups will be developed to support the plan's four priorities and work will begin to achieve what is an ambitious plan.

SEN 2019 Achievements:

- Nearly 100 people attended the 4th Annual SEN Conference held November 2019 in Warwick, RI. The purpose of the conference was to increase knowledge and decrease bias around families impacted by substance use disorders.
- Rhode Island participated in Year 2 of the ASTHO OMNI Learning Community. Building upon Year 1's

action plan that had a focus on increasing screening for substance use disorders and decreasing stigma, Year 2's action plan added the goal of developing a reimbursable standard-of-care to screen all women of child-bearing age for mental health and substance use disorders and ensure that intentional pregnancies are supported for all women.

- The SEN Program continues to provide support to HEZs that are addressing maternal opioid use and substance exposed newborns as part of their work under the HEZ Opioid Overdose Response Grants.
- Plan of Safe Care was launched July 1, 2018. Through April 30, 2020 48% of the 586 identified substance exposed newborns born in RI and their caregivers received a Plan of Safe Care, with a total of 588 documented new referrals.
- The First Connections NAS Program received funding for a second year to bring First Connections into Women & Infants Hospital and follow families back out into their communities. By late 2019, this program had increased the number of NAS families who received at least one home visit by 23%.

Safe Sleep – Work to decrease infant sleep-related deaths in the state continued through training, education, resources, and community outreach.

At the state level, the Interagency Safe Sleep Workgroup is comprised of representatives from the RIDOH (including Title V); Department of Children, Youth and Families (DCYF); the State's Family Visiting Program; Early Intervention; WIC; and community-based organizations that serve families at risk. The workgroup has met monthly since inception and will continue to meet quarterly in 2020.

In 2019, 13 trainings took place across the state resulting in 469 family visitors, pediatric residents, early childhood educators, childcare staff, police cadets, and DHS frontline staff receiving safe sleep training.

Another goal of the Safe Sleep Workgroup is to support Rhode Island's five birthing hospitals. Currently, RIDOH is supporting birthing hospitals' efforts to standardize their safe sleep policies by encouraging them to become Cribs 4 Kids hospitals. RIDOH and DCYF teamed up to purchase a second round of 10,000 "Sleep Baby Safe and Snug" books for hospitals to distribute to new families at discharge. NIH Safe Sleep posters and fliers in English and Spanish were also made available to hospitals.

All First Connection agencies and DCYF distribute Cribs 4 Kids safe sleep products to families in need. Approximately 100 cribettes were distributed in 2019 to families in need of a safe sleep product for their infant. Some of these cribs were provided to families with substance exposed newborns.

The Safe Sleep Program also provides safe sleep education to the community at large. A Safe Sleep PSA aired on the local ABC Channel 6 in February-March 2019, and safe sleep information is made available to the public and providers through RIDOH's Publication Center.

Linking Actions for Unmet Needs in Children's Health (LAUNCH) - The goal of LAUNCH was to ensure a system of identification (screening), recognition, and response to focus on preventing poor outcomes for children who may be at risk during early childhood, particularly for poor behavioral health. Rhode Island Project LAUNCH 2015 built on the work of LAUNCH 2008 and Successful Start to expand four activities in three identified communities in need: Woonsocket, Newport, and Washington County. The activities are (1) mental health consultation within early care and education and primary care, (2) parent education and support for children and their families age 3-8 (including 0-3 as needed), (3) screening response and referral, and (4) systems alignment related to programs and policies. LAUNCH was successful in implementing and sustaining mental health consultation to primary care in 3 practices. Mental health consultation was provided to over 12 child care programs during the course of the grant. In addition, project LAUNCH developed and piloted a training to teach

professionals how to provide mental health consultation to programs, includng child care, primary care and home visiting.

Newborn Screening Program - provides universal newborn screening for 33 core blood disorders, Critical Congenital Heart Disease, Hearing and Developmental Risk Assessment. On July 1, 2020, RI began screening for 1 new condition, Spinal Muscular Atrophy. The Newborn Screening Program assures screening and diagnosis for all infants born in the state. Abnormal results are tracked by the Newborn Screening Coordinator until resolved or a diagnosis is confirmed. Rhode Island's six specialty clinics (endocrine, metabolic, hemoglobin, cystic fibrosis, neurology, and immunology) are responsible for reporting the diagnosis and treatment plan of all infants identified with a positive screen.
In 2019, 100% of eligible infants received a newborn blood spot screening and 99.8% were screened for Critical Congenital Heart Disease (CCHD). The Newborn Screening Program and the Birth Defects Program continue to collaborate to track and identify cases of CCHD.
In 2019, the RI Newborn Screening Program applied for and received a grant from the Health Resources and Service Administration to improve evaluation of RI's newborn screening programs and to build state-level capacity to assess and report on the effectiveness of screening, including timeliness and follow-up, in reducing the morbidity and mortality caused by heritable disorders in newborns and children. This program will evaluate the effectiveness of RI's newborn screening systems by collecting data on newborn screening quality indicator information.
The Newborn Screening Advisory Committee, which advises the Newborn Screening Program on strategic planning, policies and procedures, new conditions to be added to the RI newborn screening panel, and associated services, continues to meet on a bi-monthly basis. Members include health care providers, public health experts, and people involved in delivering services, follow-up, and treatment in the state.
The Newborn Screening Program continues to train Fellows and Family Visitors to allow them to better educate parents on the urgency of newborn screening. The Newborn Screening Program will continue to work to educate more obstetrics/prenatal providers about newborn screening and increase the distribution of Newborn Screening brochures to these providers.

Rhode Island Newborn Hearing Program (RI-NBHS) - RI's NBHS program is also known as RI's Early Hearing Detection and Intervention (RI-EHDI) program. RI has a longstanding commitment to ensuring that hearing loss in newborns is detected and treated at the earliest possible point. Early detection with appropriate and timely follow-up is the best way to ensure that children with hearing loss have the opportunity to reach their full potential. The RI Department of Health (RIDOH) has worked for decades to develop and maintain a high-quality system of newborn hearing screening and follow-up based on the understanding that early support for children and their families plays a significant role in mitigating negative outcomes that can be associated with hearing loss.
Since RI passed universal newborn hearing screening legislation in the early 1990s, it has maintained consistently high screening rates. Contributing to RI's high rate of screening is the fact that newborn hearing screening is a covered benefit reimbursable by all health insurers, and RI has high rates of infants who are insured at birth. Follow-up has always been an essential component of RI's Early Hearing Detection and Intervention (RI-EHDI) program. Between 2013 and 2016, hearing screening and follow-up, supported by the Health Resources and Services Administration (HRSA) funds, focused on reducing the number of children lost to follow-up after failure to pass a newborn hearing screen. RI implemented programmatic changes and quality improvement activities to support the RI-EHDI program to reach the Joint Committee on Infant Hearing (JCIH) targets of: hearing screening by 1 month of age, audiological evaluation by 3 months of age, and intervention by 6 months of age.

RI-EHDI is a collaborative effort by design; current partners include Maternal and Child Health programs such Children with Special Health Care Needs (CSHCN), Home Visiting, Newborn Developmental and Bloodspot Screening, and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) programs at the Rhode Island Department of Health. Other partners include the Commission for the Deaf and Hard of Hearing, birthing hospitals, primary care and specialty providers, audiologists, the Part C EI Programs, RI School for the Deaf,

otolaryngologists, geneticists, parent consultants, and families. These key partners collaborate with RIDOH to develop hearing screening systems, programs, and tools for follow-up, intervention, quality assurance, and evaluation to ensure successful outcomes for children and families who are involved in the RI-EHDI program.

The RI-EHDI program is integrated into the state's system of early childhood services; this has ensured that the program is coordinated at the state and community level with other early childhood systems and supported RI to have high rates of follow-up for children who failed a newborn hearing screen. However, due to recent challenges such as reduced capacity of audiologists, changes in hospital procedures and insurance co-pays and deductibles, and expanding income disparities in the state, RI is seeing a greater need to support families of newborns and infants who do not pass a newborn hearing screen to access appropriate evaluation and intervention follow-up at the earliest possible point, consistent with the JCIH 1:3:6 guidelines.

Goals of the next four years will be accomplished by the following: 1) Engaging all EHDI system stakeholders to improve developmental outcomes of children who are deaf or hard of hearing (D/HH); 2) Ensuring that newborns are screened by 1 month of age, diagnosed by 3 months of age, and enrolled in EI by 6 months of age while reducing lost to follow-up/lost to documentation rates; 3) Identifying ways to expand state capacity to support hearing screening in young children up to 3 years of age; 4) Strengthening capacity to provide family support and engage families with children who are D/HH and adults who are D/HH throughout the EHDI system; 5) Engaging, educating, and training health professionals and service providers in the EHDI system about the 1-3-6 recommendations; and lastly 6) Facilitating improved coordination of care and services for children who are D/HH and their families. This project will strengthen and sustain the RI-EHDI system in Rhode Island and foster a supportive, comprehensive and coordinated EHDI system of care for all families with newborns, infants, and young children up to 3 years of age who are deaf or hard-of-hearing (D/HH).

The Special Supplemental Nutrition Education for Women, Infants and Children (WIC) -
The Special Supplemental Nutrition Education for Women, Infants and Children (WIC) - The mission of WIC is to assure healthy pregnancies, healthy birth outcomes and healthy growth and development for women, infants and children up to age five who are at nutritional risk, by referring to healthcare, critical social services and an array of agencies and needs identified by participants/guardians; nutrition education, breastfeeding promotion and support, provides the opportunity for participants to make informed decisions on healthy food choices, optimum feeding options, knowledge of food safety and professionals available for questions and assistance; tailored prescriptions to meet individual needs for optimal growth and development. The program serves roughly 21,000 women, infants and young children throughout Rhode Island, approximately 53% of the births in the state of RI and overall serves approximately 72% of the total WIC eligible population, based on the 2019 WIC State Plan.
A nutritionist, either BS, LDN or RD will provide client centered counselling, referrals and prescribe a food prescription based on individual needs. A care plan is developed with the participant and follow up occurs at least every quarter, some-times more frequently depending on the needs of the WIC Participant.

Prenatal women on WIC are provided education on breastfeeding and introduced to a WIC Breastfeeding Peer Counselor (BFPC). The BFPC builds rapport with the participants, provides ongoing education and promotes and supports breastfeeding. Any issues that exceed the ability of the BFPC are referred to an International Board-Certified Lactation Consultant (IBCLC). WIC IBCLC's round at the three largest hospitals in the state, provide BF education, help with latch and any other issues and see only WIC participants or WIC eligible patients. The IBCLC will send their notes to the BFPC so the BFPC can follow up either at the clinic or while the client is home.

The WIC Program provides referrals and opportunities that help positively impact the health of the women and children. WIC collaborates with the RI Breastfeeding Coalition working on many topics from licensing IBCLCs to the Baby Café in Providence RI. WIC also collaborates with the following RIDOH Programs: Healthy Homes (to address

lead exposure); PRAMS(to increase response rates); Diabetes Prevention program; Oral Health; Health Equity Zones (farmer's markets, breastfeeding promotion and support); Center for Emergency Preparedness and Reponses (community resilience); Family Home Visiting; Safe Sleep; and Tobacco cessation.

Zika Surveillance - The Center for Acute Infectious Disease Epidemiology (CAIDE) continues to conduct surveillance for Zika virus disease. Since February 2016, RI obstetricians have been instructed to call CAIDE and request testing when they identify a pregnant female who has spent time in a region with local-transmission of Zika virus or has another risk factor. When testing is requested, a public health nurse will review the CDC Zika virus testing guidelines with the provider and approve testing at the Rhode Island State Health Laboratory (RISHL), if appropriate. The nurse will then coordinate the specimen collection and educate the patient about strategies to prevent sexual transmission of Zika. If CAIDE receives any Zika virus laboratory reports from reference laboratories on females who are of childbearing age, CAIDE will follow-up with the provider to see if the female was pregnant, and if so, ensure appropriate testing was performed. If appropriate testing was not performed, testing recommendations are provided and Zika virus testing at the RISHL is offered.

Since February 2016, CAIDE has enrolled all pregnant females with laboratory evidence of possible Zika virus infection and their infants into the United States Zika Pregnancy and Infant Registry (USZPIR). Although the registry closed for new entries on March 31, 2018, CAIDE continues to follow-up on the infants born to registered mothers. Recently, the CDC received approval to receive follow-up information on infants up to 3 years of age and CAIDE will now be performing follow-up on infants at 2, 6, 12, 18, 24, 30 and 36 months of age. This is accomplished by reaching out to the infant's pediatrician and utilizing the USZPIR Infant Follow-up Form to assess developmental delays and birth defects that may not have been evident at the time of birth. No pregnant females with laboratory evidence of possible Zika virus infection have been identified since the USZPIR closed for new enrollees, but if any are identified, CAIDE will continue to provide the same support and collect the same data as prior to the closure. CAIDE continues to reinforce Zika-prevention messaging when conducting public education about mosquito-borne illness and travel.

Rhode Island's Perinatal Hepatitis Prevention Program (PHBPP) - offers comprehensive case management services to identify pregnant women infected with hepatitis B virus. The program recommends testing of all pregnant women during an early prenatal visit in each pregnancy, even if tested before or previously vaccinated. Healthcare providers are required to report all HBsAg positive pregnant women to the RIDOH. The Perinatal Hepatitis B Nurse refers for or provides HBsAg positive pregnant women with counseling, prenatal education and medical management. The purpose of educating HBsAg positive pregnant woman about hepatitis B include management of disease, prevention of transmission of disease to others and recommended prophylaxis (Hep B and HBIG) at birth, vaccination and screening for infant. The program encourages all birthing hospitals to implement a universal birth dose policy, ensure universal review of the original maternal HBsAg test results, implement standard admission orders for timely administration of Hepatitis B vaccine to all newborn infants. After delivery, the PHBPP will track and follow-up on infants born to HBV-positive women including outreach to pediatric provider to ensure appropriate hepatitis B vaccination of infant and timely Post Vaccination Serologic Testing (PVST) is completed and referral to the Pediatric Liver Clinic for follow-up care as needed.

Sustainability of Perinatal Infant Priorities

Although the MCH Priority for Perinatal Infant Health will be changing based on the 2020 Needs Assessment, the following Breastfeeding and Family Home Visiting strategies will continue as a component of RI's MCH work:

- The Breastfeeding Program will offer USDA's new Breastfeeding Curriculum***, WIC Breastfeeding Support – Learn Together, Grow Together*** to all WIC staff which includes support staff, Nutritionists and Breastfeeding Peer Counselors statewide among 12 local WIC agencies. The training content is designed to build competencies among WIC staff in supporting WIC parents. It is a skills-based approach that relies on recent science, as well as best practices adopted by State and local WIC agencies across the country.

- WIC Breastfeeding Coordinator will create and convene a RIDOH **Breastfeeding Title V subcommittee** to move strategic plan forward and increase interdepartmental program support.

- The Breastfeeding Program will continue to collaborate with local WIC agencies to promote participation in **breastfeeding support groups** such as Baby Café, Chocolate Milk and the Newport HEZ support group.

- The RIDOH Family Visiting Program will continue to **focus on the following four key priorities and goals**:
    1. Continue to use evidence-based screening tools to identify family needs and make appropriate referrals to necessary services that support positive health outcomes;
    2. Identify, engage, and retain more individuals at risk for poor outcomes;
    3. Improve the professional development system for family visiting staff, including standardized orientation for all new staff and supervisors, including Title V priorities;
    4. Sustain and expand the Family Visiting Program by finding new revenue streams

- The Family Home Visiting Program will continue to support efforts to maintain or **increase current funding levels** for the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) in 2018. The federal MIECHV legislation was reauthorized in 2018. In addition to federal funding, RIDOH continues to work with other state partners to secure funding to maintain and increase current service availability. RIDOH has engaged in dialogue with the Office of Medicaid and the Executive Office of Health and Human Services for opportunities to provide funding and/or Medicaid reimbursement.

- The Family Visiting Program will continue to **use data and input from communities** to demonstrate the need for increasing the availability of family home visiting services and the impact of reducing the current services.

APPLICATION YEAR: Perinatal/Infant Health

The perinatal period refers to the period immediately before and after birth. Perinatal and maternal health are closely linked. Infant health refers to the period before a child's first birthday, a very critical period in growth and development. The RI MCH Program strives to ensure that all pregnant women receive appropriate prenatal care, which can affect both maternal and infant birth outcomes. The program is focusing on the caregiver relationship between the mother and infant. Emphasis is placed on identifying pregnant and parenting families who are at high risk of negative outcomes and linking them to appropriate services, including addressing to stagnant or worsening trends in racial/ethnic disparities. This health domain section has taken into consideration that the care and outcomes of womxn, children, and families are impacted by the systemic racism, discrimination, unaddressed language barriers, and a lack of culturally responsive providers. The following quantitative, qualitative, and anecdotal information tries to tease out health disparities and the overarching healthcare needs of communities.

PRIORITY: Strengthen Caregiver's Behavioral Health and Relationship with Child

Title V aims to support a caregiver's behavioral health and relationship with their child. This includes supporting bonding methods between caregiver and child and also assessing the behavioral health of the caregiver and referring them to appropriate and supportive services.

In 2019, home visitors observed 72.3% of caregivers interacting with their children using a validated tool. In 2017-18, 67.6% of caregivers are able to handle the day-to-day demands of raising children very well, which increases to 73.0% when raising children ages 0-5. However, the number of caregivers able to handle the demands of raising children ages 0-17 with special healthcare needs very well is statistically lower (49.7%) than caregivers raising children without special healthcare needs ages 0-17 very well. The mental/behavioral health of a women may impact the ability to care for their child(ren). In 2018, after giving birth, 25.4% of women responded that they often or sometimes felt down, depressed, or hopeless.

All infants born in Rhode Island are screened through RIDOH's Newborn Risk Assessment Program. In 2018, 7,000 infants (63.5%) screened positive, indicating the presence of one or more risk factors associated with poor developmental outcomes. The Newborn Risk Screening Program also considers maternal risk markers. In 2018, 32.9% mothers were identified as having a history of a mental health outpatient visit, 7.2% of having history with substance abuse, 3.3% of a previous DCYF intervention, and 2.7% with a history of a chronic illness. All infants who screen positive are referred for a home visit. 2018 NIS data, 78.8% of RI infants were ever breastfed and 23.0% of RI infants were breastfed exclusively through 6 months. In 2018, PRAMS data shows that 82.0% of mothers reported that they most often place their infants to sleep on their backs.

The RIDOH community survey showed that participants chose mental health (e.g., postnatal depression or anxiety (29%) and culturally responsive pregnancy/postpartum education and care (12%) as the top issue related to pregnancy and birth that the DOH should focus on to support families. Similarly, the RIDOH & SISTA FIRE Womxn of Color survey found that participants ranked the following as the three most important things to be addressed to improve the wellbeing of newborns/infants: 1) Support new moms in caring for their infant (social, emotional, & financial) ,2) Screening newborns for health conditions and diseases , and 3) Bonding and attachment. Women of color responses for promoting the wellbeing of children (1-4 years old) were closely aligned as well. The top three answers were: 1) Parent/Caregiver Support (social, emotional financial) (70%), 2) Affordable & Quality Child Care (60%), and 3) Healthy check-ups & immunizations (56%). Overall these three surveys show's a statewide need for more comprehensive caregiver and baby support, especially in the arena of mental and emotional health.

Hospital discharge data in 2019 show that 86 newborns were discharged with neonatal abstinence syndrome. This represents a rate of 89.4 per 10,000 newborn hospitalizations, a decrease from the NAS rate of 110.6 per 10,000 in 2018. Hospital discharge data in 2019 show that 86 newborns were discharged with neonatal

abstinence syndrome. This represents a rate of 89.4 per 10,000 newborn hospitalizations, a decrease from the NAS rate of 110.6 per 10,000 in 2018. Both in HEZ SUD reports and SISTA FIRE Key Learnings parents of SENs report being stigmatized and judged by medical care providers and hospital staff. SISTA FIRE interviewee shared, “My girlfriend delivered our son, who was delivered on methadone. He had to stay in the hospital for a few days so they could wean him off the methadone. We left the hospital, but when we went home, he was having signs of detox, so we brought him back to the hospital. About two days after we brought him back...a social worker from DCF came in, and we were wondering why...A nurse had reported that she found a syringe in the bathroom of the hospital...The baby got taken from our custody. It was an agonizing year because he didn’t return home for a year, It was because they said they found a syringe in the bathroom...which was not true. I believe the nurse because we was on methadone, they felt we wasn’t worthy of having a baby.”

Next Year Strategies:

1) Teleconsultation for Behavioral Mental Health among Caregivers & Children :

Pediatric psychiatry Resource Network (PediPRN) - Rhode Island’s children and adolescents face significant challenges in accessing timely and affordable mental health care. In response to this need, the RIDOH is working in conjunction with the Emma Pendleton Bradley Hospital to expand its existing child psychiatry access program, the Pediatric Psychiatry Resource Network (PediPRN). The project’s mission is to improve access to behavioral health care for Rhode Island children and adolescents by integrating psychiatry into the state’s pediatric primary care practices. To achieve its mission, PediPRN uses a telephonic integrated care model to improve access to quality behavioral health expertise. This service is free and provides all Rhode Island pediatric primary care providers assistance with the mild to moderate mental health care needs of their patients. PediPRN focusses on creating a culture of empowerment for pediatric primary care providers. The clinical team works closely with providers offering CME opportunities, educational e-blasts, an updated website with assessment and educational resources on pediatric behavioral health topics, and ongoing support during telephonic consultations. In addition, PediPRN implemented the delivery of training, mentoring and education to PPCPs in the PediPRN Intensive Program (PIP) with the goal of creating a group of practitioners embedded in each of their home practices who will serve as local experts on various behavioral health topics. The PIP program has completed it’s first year and a second cohort of physicians has begun in 2020. Additionally, PediPRN has expanded its capacity as a resource to providers during COVID-19 an has started hosting “office hours” to physicians via zoom. Providers can speak with a staff psychiatrist, or with each other, about topics to support behavioral health treatment in their practices. This additional resource is meant to provide additional support to providers during these unprecedented times.

Maternal Psychiatry Resource Network (MomsPRN) Program - The Rhode Island Department of Health (RIDOH) is one of seven states to receive funding from the Health Resources and Services Administration’s *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program,* which seeks to assist obstetrical, adult primary care, pediatric, and psychiatric providers in optimizing behavioral health care for pregnant and post-partum women. To achieve this end, the RIDOH has partnered with the Center for Women’s Behavioral Health at Women and Infants Hospital (CWBH) to establish a free statewide psychiatry telephone consultation service for healthcare providers treating pregnant and postpartum women, especially those in rural and medical underserved communities. The RIDOH has also partnered with the Care Transformation Collaborative of Rhode Island (CTC) to provide intensive quality improvement coaching about behavioral health screening, treatment, and referral to contracted prenatal care practices.

The RI MomsPRN teleconsultation line is staffed by perinatal experts at the CWBH and is modeled after Rhode Island’s successful Pediatric Psychiatry Resource Network (PediPRN) program. The goal of the RI MomsPRN psychiatry teleconsultation line is to empower providers in effectively managing their perinatal

patients' behavioral health and substance use concerns, by initially providing treatment guidance from RI MomsPRN perinatal psychiatric specialists, and/or offering information and referral for additional supports and services in their patients' geographic area. Through a partnership with CTC, the RI MomsPRN program is also able to provide intensive quality improvement and practice transformation services to prenatal care practices seeking to implement, optimize, or spread perinatal behavioral health screening, treatment, and referral workflows and protocols.

In addition to providing perinatal behavioral health teleconsultation and practice transformation services for healthcare providers, the RI MomsPRN program also collaborated with RIDOH's Family Home Visiting Program and the Women, Infants and Children (WIC) Program to create, distribute, and promote a public service campaign about perinatal depression and anxiety and the importance of seeking help by connecting with a healthcare provider. The 30 second spot featured a patient testimonial and was aired on a local news station in June 2020. To help further amplify this campaign, the RIDOH created a new mental health resource page for new moms and featured the campaign on its various digital platforms.

2) Postpartum Depression Screening

The family home visiting program has partnered with the MomsPRN program to support family home visitors that are working with caregivers with postpartum depression. Family home visitors are now able to access and receive support from the MomsPRN line, just as physicians and other health care providers are. The MomsPRN team has provided support and training during the CQI initiatives to improve screening for postpartum depression and linkages to services. The Family Home Visiting program continues to use evidence-based screening tools. The screenings assist in guiding visits, prioritizing family needs, and planning visits around those needs. The screenings begin during the first two to three visits with a family and continue periodically throughout a family's participation in family visiting. Caregivers are screened for prenatal and postpartum depression, alcohol and substance use, and interpersonal violence. Families are offered referrals and are linked to care based on screening results. Children are also screened for developmental milestones, physical, social, and emotional health. Based on screening results, children are referred to supportive services, such as Early Intervention. With consent, family visitors also share concerns with medical providers including obstetricians and pediatricians. In the Fall of 2018, the Family Visiting program began participating in a national CQI initiative to improve screening rates and linkages to care for postpartum depression and reduce depressive symptoms in women with postpartum depression. The MCH Title V Coordinator is the CQI initiative's senior sponsor.

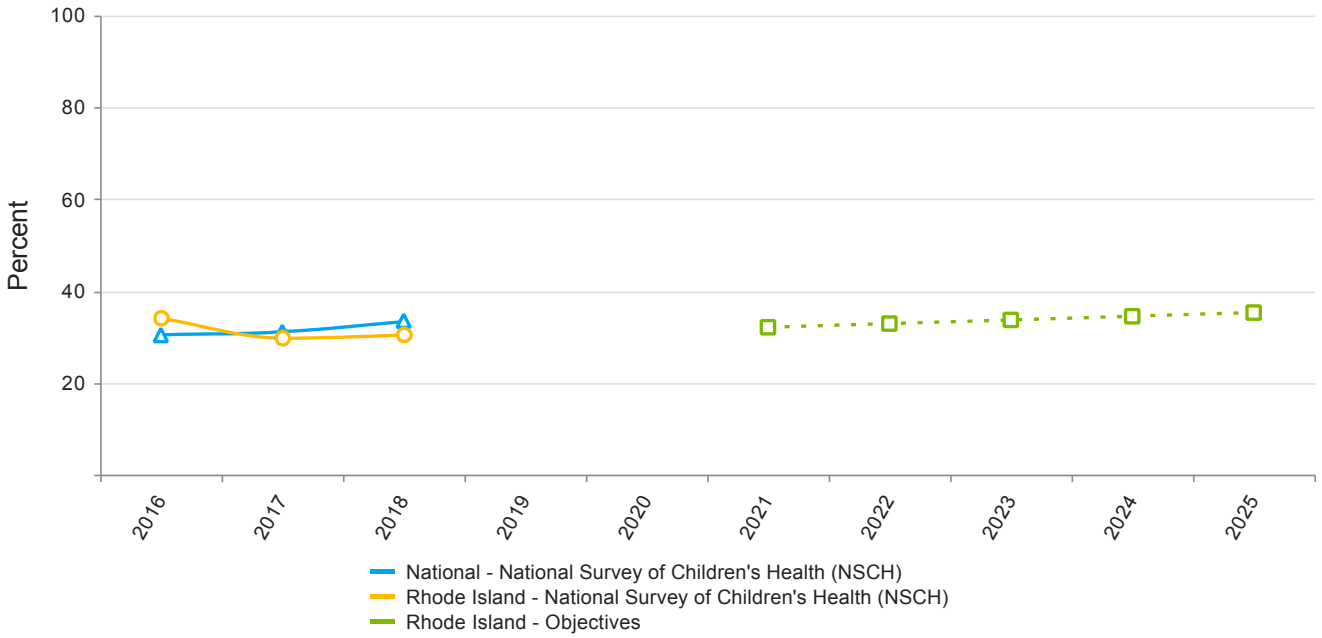
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	93.2 %	NPM 6 NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2017_2018	14.0 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2016	15.4 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	15.2 %	NPM 8.1

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	30.5
Numerator	7,940
Denominator	25,993
Data Source	NSCH
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	32.1	32.9	33.7	34.5	35.3

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Early Language and Literacy Activities

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	87.1
Numerator	1,143
Denominator	1,313
Data Source	Efforts to Outcomes Home Visiting Database
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	90.0	91.5	93.0	94.5	96.0

State Performance Measures

SPM 2 - Family member reading daily to children, ages 0-5

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	49.3
Numerator	32,768
Denominator	66,453
Data Source	NSCH
Data Source Year	2017-18
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	51.0	52.0	53.0	54.0	55.0

State Action Plan Table

State Action Plan Table (Rhode Island) - Child Health - Entry 1

Priority Need
Support school readiness

NPM
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives
Increase the percent of children screened for healthy development from 30.5% reported in 2019 to 35.3% in 2025

Strategies
Parent education and support
Improving early literacy

ESMs	Status
ESM 6.1 - Early Language and Literacy Activities	Active

NOMs
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Rhode Island) - Child Health - Entry 2

Priority Need

Support school readiness

SPM

SPM 2 - Family member reading daily to children, ages 0-5

Objectives

Increase the percentage of children, ages 0-5, who are read to daily by a family member from 49.3% in 2019 to 55% in 2025

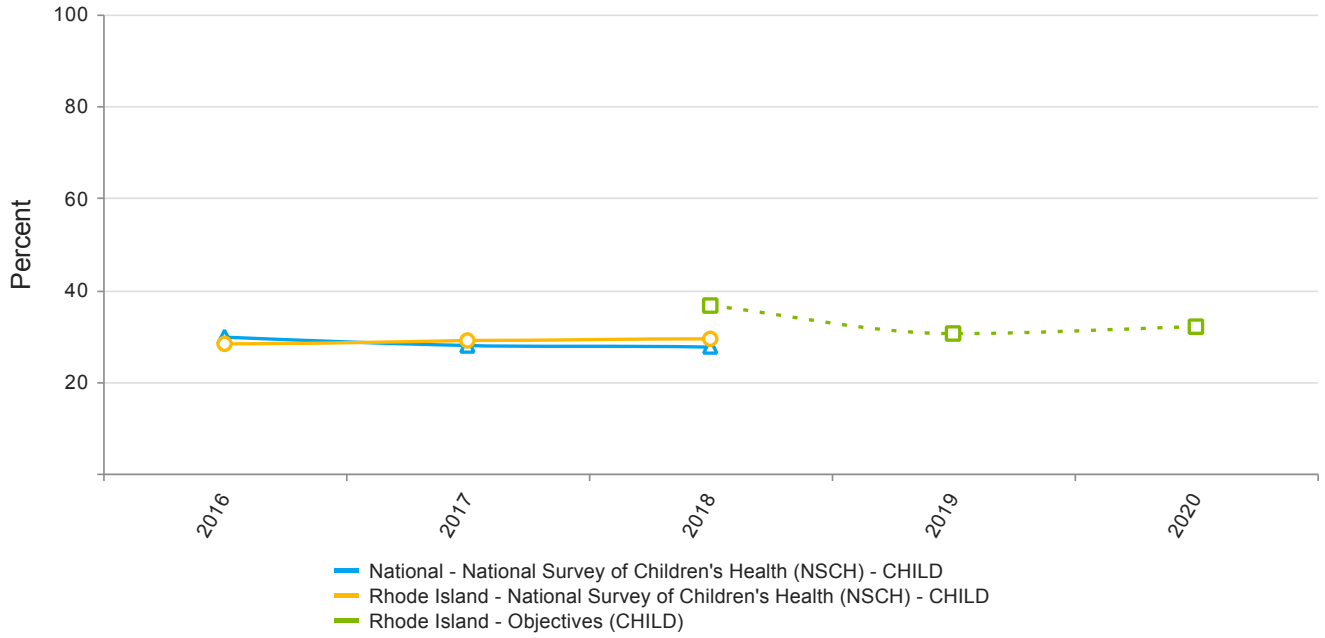
Strategies

Parent education and support

Improving early literacy

2016-2020: National Performance Measures

2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2016	**2017**	**2018**	**2019**
Annual Objective			36.6	30.5
Annual Indicator		28.2	28.9	29.4
Numerator		21,354	19,772	18,866
Denominator		75,621	68,418	64,101
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	2017	2018	2019
Annual Objective			36.6	30.5
Annual Indicator	28.2	28.2	29.7	
Numerator	21,354	21,354	18,191	
Denominator	75,621	75,621	61,215	
Data Source	NSCH	NSCH	NSCH	
Data Source Year	2016	2016	2017	
Provisional or Final ?	Final	Final	Final	

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 8.1.1 - Physical Activity and Nutrition Technical Assistance to Child Care Centers

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			7
Annual Indicator			0
Numerator			
Denominator			
Data Source			Physical Activity/Nutrition program
Data Source Year			2019
Provisional or Final ?			Final

2016-2020: ESM 8.1.2 - % children ages 5-19 impacted by improvements to the built environment

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			65
Annual Indicator			23.9
Numerator			44,151
Denominator			185,087
Data Source			Health Equity Institute/ACS 2018 Pop. estimate
Data Source Year			2019
Provisional or Final ?			Final

2016-2020: ESM 8.1.3 - # training and technical assistance opportunities provided to municipalities about master plan and land use interventions by RIDOH or it's partners

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			17
Annual Indicator			0
Numerator			
Denominator			
Data Source			Physical Activity/Nutrition program
Data Source Year			2019
Provisional or Final ?			Final

2016-2020: ESM 8.1.4 - % children (0-17) living in a HEZ community with initiatives related to physical activity and nutrition

Measure Status:		Active
State Provided Data		
	2018	**2019**
Annual Objective		
Annual Indicator		33.7
Numerator		69,069
Denominator		205,213
Data Source		Health Equity Institute/ACS 2018 Pop. estimate
Data Source Year		2019
Provisional or Final ?		Final

ANNUAL REPORT: Child Health

The health of children in RI remains an important issue to the MCH Program. Poor oral, physical, mental, and behavioral health status can have long term health consequences later in life. With the increase in childhood obesity in the United States, RI has focused on physical activity and nutrition and childhood obesity as priority issues. Childhood overweight and obesity is a major concern in RI. Not only does RI have worse rates than the national average and other New England, there are significant disparities by geography, insurance status, and race and ethnicity. The loss of over one million dollars of CDC funding for the Physical Activity and Nutrition Program has been challenging for RIDOH, as it has resulted in the loss of FTEs and a number of planned program activities. Despite these challenges, RIDOH has been able to use existing relationships with other state agencies and community organizations to continue to advocate for physical activity, nutrition, and obesity prevention.

Priority: Address Obesity, Nutrition, and Physical Activity for Children

Supporting the growth of the local food sector through meaningful regulatory and policy initiatives is critical to increasing the number of jobs, growing the local economy, and ensuring positive health outcomes. Under Rhode Island General Laws 21-36-3, the Interagency Food and Nutrition Policy Advisory Council (IFNPAC) membership is made up of the Directors of the Department of Health (RIDOH), Department of Environmental Management (DEM), and Department of Administration (DOA). Administrators and Directors from other State agencies often participate, including representation from the Department of Human Services (DHS), Office on Healthy Aging (OHA), Department of Education (RIDE), Department of Corrections (DOC), Rhode Island Commerce Corporation (CommerceRI, and the leadership of the Rhode Island Food Policy Council (RIFPC). IFNPAC was created to find ways to overcome regulatory and policy barriers to developing a strong, sustainable food economy and healthful nutrition practices. IFNPAC submits an annual activity report to the General Assembly. This report has been drafted in accordance with the requirements set forth in Chapter 36, Section 21-36-5 of the *Rhode Island Local Agriculture and Seafood Act*.

The Council met four times in 2019: on March 21, July 25, October 2, and December 18. IFNPAC members listened to and discussed presentations by public and private partners with a stake in the Rhode Island food system. IFNPAC is focused on implementing the Governor's Food Strategy, *Relish Rhody.* Agendas for meetings were set according to the Integrated Focus Areas of *Relish Rhody*. See Appendix A for meeting minutes.

The Council engaged in the five Integrated Focus Areas of *Relish Rhody*, including:

- Preserve and grow agriculture and fisheries industries in Rhode Island;
- Sustain and create markets for Rhode Island food and beverage products;
- Enhance the climate for food and beverage businesses;
- Ensure food security for all Rhode Islanders; and
- Minimize food waste and divert it from the waste stream.

Based on these focus areas, IFNPAC and the Director of Food Strategy had several major priorities in 2019. Inter-agency progress was made under each of these focus areas in 2019, with highlights of the priorities of IFNPAC detailed below.

1. Preserve and Grow Agriculture and Fisheries Industries

The integrated focus area to preserve and grow agriculture and fisheries industries in Rhode Island is a cornerstone of the *Relish Rhody* food strategy. DEM and partner organizations led many of the efforts supporting our local agriculture and seafood industries. Some of the initiatives included:

- Offering technical support for compliance with the federal *Food Safety Modernization Act* to farmers across

the state – in partnership with RIDOH and the University f Rhode Island (URI).

- Several IFNPAC agencies and partners worked with dairy farmers to help ensure they could continue to operate within Rhode Island and find markets for their products.
- The Local Agriculture and Seafood Act (LASA) committee awarded $100,000 to 12 Rhode Island small businesses. This funding helped farmers and aquaculturists expand within the state by providing small grants for specific infrastructure needs. Private foundation funding for the program ended prior to grant round and resulted in a 50% reduction of available funding for regranting for fiscal year 2019. This funding loss occurred even though the Rhode Island Food Policy Council found that between 2014-2016, inclusion of just 27 recipients created 84 new jobs, increased sales by more than $5 million, and leveraged $2.5 million in additional funding. (This does not include the recent funding secured by the Rhode Island Mushroom Company, an early LASA recipient and Innovation Bond participant, that is bringing an estimated $100 million of additional investment to Rhode Island.)
- IFNPAC partnered with Polaris and Polaris provided low-cost technical assistance and LEAN training specific to food businesses. Several farmers took advantage of the program and used LEAN principles to increase efficiency and profits.
- In April, Governor Raimondo announced 12 new Real Jobs Rhode Island partnerships. This included a new food business sector partnership based at the Rhode Island Food Policy Council. The Food Policy Council, the Director of Food Strategy, and staff from the Department of Labor and Training worked with the Rhode Island Nursery and Landscape Association and consultants at KK&P to learn from their successful apprenticeship Real Jobs program to build a model for food sector jobs training and skill building. The Food Policy Council will hire a Director of Workforce Initiatives to lead this work in early 2020.
- The Food Policy Council partnered with DEM, CommerceRI, and the Commercial Fisheries Research Foundation to evaluate approaches to eliminating wastewater processing constraints that are inhibiting the growth of seafood processing in the state. The project team also looked at successful models from other parts of the country that could possibly increase wholesale/retail distribution and sales of locally processed seafood in Rhode Island. This project will be continued in 2020 and will coordinate with the efforts of DEM's Seafood Marketing Collaborative.

2. **Sustain and Create Markets for Rhode Island Food and Beverage Products**

Relish Rhody's Integrated focus area to sustain and create markets for Rhode Island food and beverage products recognizes that Rhode Island growers, harvesters, and makers are businesses that need access to appropriate markets to thrive. In this realm, IFNPAC supported four initiatives in 2019

1. Supply RI and Anchor Institution Engagement: Agencies involved in IFNPAC have continued to work to advance its goals around institutional procurement of Rhode Island food products.
    1. IFNPAC worked on a pilot project during the summer with Sodexo, with a goal that 10% of the produce procurement in three Lifespan facilities would be from local vendors. Sodexo officially launched the program in early June 2019 and purchased their produce and Rhode Island-made products from Farm Fresh RI's Market Mobile Program. Hospitals are also hosting on-site farmers markets twice a month, are labeling any Rhode-Island-grown ingredients that are available in the dining facility, and are creating locally-focused "action station" meals each week.
        1. Early numbers show that the hospitals are exceeding their goals and more than $40,000 was spent during the summer in support of local farms.
2. Partnership with the Good Food Foundation:
    1. *Relish Rhody* was a host of the 2019 Good Food Mercantile in Brooklyn. As part of its sponsorship Rhode Island food businesses received discounted rates to showcase their products at the show. Participating businesses included Granny Squib, Beth Bakes, Dave's Coffee, and Sanobe Superfoods. There was also a *Relish Rhody* table that featured food products from across the State.
    2. In June 2019, the Director of Food Strategy led a group of the Good Food Foundation Merchants' Collaborative on a tour of food producers in the state. Independent markets from across the country

(Washington, DC, Colorado, and California) and representatives from the Good Food Foundation met with Rhode Island makers, tasted their products, shared advice, and developed relationships. The Collaborative spent two days in Rhode Island.

3. Rhode Island also had a 2019 Winner of a Good Food Award: Sacred Cow Granola. Sacred Cow is a product of Munroe Dairy and a graduate of Hope & Main. They are also a participant in the Supply RI program and are currently building out a new kitchen facility in East Providence to expand their operations.

3. Wholesale readiness training for local agricultural and food processing businesses: The Food Policy Council worked closely with DEM and local organizations that serve farmers and small food processors on the development of a wholesale readiness workshop that provided technical assistance for businesses interested in selling to institutional or other wholesale buyers. The first workshop attracted about 40 attendees and content was well received. A second workshop took place in February 25 and there were more than 40 attendees.

4. Increasing local food purchases by Rhode Island public schools: The Food Policy Council worked closely with the Director of Food Strategy, DEM, RIDE, and other partners to identify ways to increase purchases of local food by public schools. This year, a workplan that detailed ways to improve RIDE's ability to accurately track local food purchases and identified ways to increase interest in purchasing local food at the district level was developed. The work plan is expected to be implemented in 2020.

3. **Enhance the Climate for food and beverage Businesses**

In alignment with the integrated focus area to enhance the climate for food and beverage businesses in Rhode Island, IFNPAC tracked and supported other agencies' initiatives in an effort to streamline regulations and update rules for food businesses. Work in this focus area included:

- The Director of Food Strategy worked with a student from Harvard to explore specific aspects of the climate for food businesses in Rhode Island. The student's work finished in April, and the findings were presented to a cross-agency team in May. The report will be distributed to all IFNPAC members and stakeholders.
- The Director of Food Strategy regularly met with businesses to provide technical assistance and guidance about troubleshooting administrative issues.

4. **Minimize Food Waste and Divert it from the Waste Stream**

Momentum continues to grow to surrounding food waste reduction and diversion within Rhode Island, and IFNPAC spent the third-quarter meeting focused on how to best support this work. This work has included:

- The *Rhode to End Hunger* continues to expand, with more than 20,000 pounds of food saved from the waste stream.
- The Center for Ecotechnology (CET) is working with DEM to conduct outreach to businesses who are not in compliance with the tonnage threshold for the state's food waste recycling law. CET offers businesses with technical assistance.
- CET, with support from the Environmental Protection Agency (EPA) and the US Department of Agriculture (USDA), offers free technical assistance to Rhode Island businesses and institutions. Since 2017, CET helped Rhode Island businesses donate three tons of edible food and divert more than 1,200 tons of food waste per year.
- CET provided compost site technical assistance to two facilities in Rhode Island. CET offered guidance and recommendations for site expansion and recipe development. This assistance supports the growth of processing capacity in the state.
- The Director of Food Strategy and representatives from DEM toured the newly constructed anaerobic digester in Johnston. The facility is currently only in its pilot phase but plans to be more fully operational in the future after testing is completed.

- DEM held a half-day information session for breweries on waste and wastewater processing and resources available to the industry from the State.
- The RIFPC created a 'Wasted Food Solutions' work group that has four major initiatives. First, it is supporting a new organization (Hope's Harvest) that is recovering grade B produce from farms around Rhode Island and delivering it to the Rhode Island Food Bank and other emergency food organizations. Around 50,000 pounds of fresh food was recovered by this effort in 2019. Second, it is supporting the work of Foodscape RI, an organization that is working in public schools to educate students and set up diversion tables that recover excess food and send it to the Food Bank. Third, it is supporting the work of composters (Earth Care Farm, The Compost Plan, and smaller urban composting organizations) to remove obstacles to increasing composting activity. Fourth, it is advocating for policies and legislation that could increase food donations, food recovery, and better organic waste management by businesses in Rhode Island.

5. **Ensure Food Security for All Rhode Islanders**

In 2017, IFNPAC created the Hunger Elimination Task Force. In October 2018, the Task Force released a set of recommendations to IFNPAC and Governor Raimondo. In 2019, the Task Force broke off into sub-groups to address specific sections of the recommendations. The work of the sub-groups included:

- The USDA released their annual *Food Insecurity Report*, showing that Rhode Island's food insecurity rate is down to 11%, from 12.4% in 2018. The Task Force aims to lower food insecurity rates to less than 10%, and with a more coordinated effort, it is expected that the goal will be attained.
- The Task Force was focused on increasing school meal participation as part of its recommendation to ensure that Rhode Island is taking full advantage of federal funds. As part of this effort, the State received grant support from Share our Strength's No Kid Hungry program. A cross-agency team, including RIDE, the Governor's Office, the Director of Food Strategy, the Food Policy Council, and the Rhode Island Healthy Schools Coalition (who is the fiscal sponsor of the grant) was selected to participate in a multi-state meeting in New Orleans and is implementing an 18-month workplan to expand innovative breakfast models for K-12 schools.
    - This Working Group will also be exploring potential policy guidance on lunch shaming and school meal balances across the state. This working group received community feedback at the July Health Equity Zone (HEZ) Learning community meeting.
    - The Task Force is moving forward on implementing other areas of its recommendations through working groups.

Supplemental Nutrition Assistance Program (SNAP) Incentive Expansion Working Group: The Rhode Island Public Health Institute (RIPHI) hired a consulting team to facilitate a stakeholder engagement and implementation process for the SNAP Incentive Expansion Project. The first phase of that work is near completion, and the next phase will be focused on advocacy and fundraising. RIPHI is partnering with DHS, and DHS Director Courtney Hawkins has agreed that DHS will become the long-term permanent administrator for this program. There is active collaboration with DHS to secure funding for 2020 through a USDA GunsNIP grant to begin a pilot program in 2022 with approximately 2,500 SNAP participants.

Transportation: The transportation subcommittee explored work to map the ways that members of the task force and the HEZ community can impact and influence transportation planning in their communities to better reflect their mobility needs to connect to food resources. The Transportation sub-committee presented at the May Hunger Elimination Taskforce (HETF) meeting and two Health Equity Zone (HEZ) Learning Community meetings.

Data: In response to the requests DHS released a SNAP client data snapshot with demographic data about how

Rhode Islanders utilize SNAP programs. Understanding the demographics of who is using the programs can help partners better tailor their services and programs.

- Jay Metzger, a RIDOH GIS Specialist, presented to the Task Force about the planned updates to the food insecurity mapping tool on RelishRhody.com. RIDOH will be updating the map based on publicly available data. Any requests for changes to the map can be shared directly with the Director of Food Strategy.

Economic Development: A cross-agency partnership of RIDOH, DHS, and DLT released shared communications materials in the fall. The Task Force identified that Rhode Islanders in need of good-paying, high-quality jobs were not getting information about programs like Real Jobs RI. This new partnership will promote awareness of these programs across agencies and to Rhode Islanders who need the information.

- Overarching:
  - For Fiscal Year 2019, the Center for Disease Control (CDC) severely restricted funding for state-level work for Physical Activity and Nutrition (PAN). CDC approved RIDOH's grant application but did not provide funding. RIDOH Associate Director Carol Hall-Walker and Director of Food Strategy Sue AnderBois attended CDC's annual meeting for all grantees as ambassadors from programs that were approved/unfunded to learn from, and connect with, PAN programs in other states. IFNPAC continues to advocate at the federal level for the reinstatement of funds for these vital programs.
  - In partnership with the Rhode Island Food Dealers Association, Governor Raimondo released a proclamation declaring September as Family Meals Month, and encouraged all families to eat at least one additional meal at home with their families each week. Family meals have been shown to improve the emotional and physical well-being of individuals.

Emergency Preparedness and Response Action Learning Collaborative - In 2019, RI also joined the AMCHP Emergency Preparedness and Response Action Learning Collaborative as a collaborative effort between Title V and the Center for Emergency Preparedness and Response. Activities include:

- Integrating MCH into state EPR Plan Reviewing sections of the state plan that pertain to MCH
- Developing strategies to gather epidemiologic/surveillance data on womxn of reproductive age and infants:
  - Describing demographic characteristics and locations of high risk MCH populations who may be particularly vulnerable to effects of an emergency
  - Assessing emergency preparedness among postpartum womxn
  - Assessing possible use of the DRH Post-Disaster Health Indicators in emergency data collection
- Establishing and promoting EPR communication about target population with clinical partners, public health and governmental partners, and with the general public.
- Identifying public health programs, interventions, and policy to protect and promote MCH health and prevent disease and injury in emergencies.

Health Equity Zones and the Built Environment

Through a contract with Grow Smart RI, RIDOH provided several HEZ Learning Community workshops on improving the built environment, especially with regard to increasing walkability and bikeability. Grow Smart also delivered on-site technical assistance and training to HEZs and municipalities (city/town councils and municipal planners) around integrating Complete Streets principles (walkability/bike ability) into comprehensive transportation policy, plans, and communications. HEZ community-level efforts include:

Cranston HEZ:

Worked with partners to develop a proposal for installation of a splash pad to provide a safe outdoor recreational space to families and children in the community

Newport HEZ:
-Greening Urban Spaces Working Group developed resident education opportunity on Zoning 101.
-Has provided input on the Newport-Pell Bridge realignment planning process, focusing on engaging North End residents.
-Transportation Working Group conducted focus groups with community members and other stakeholders.
-Has representative present on City planning/zoning board.

Central Providence HEZ:
-ONE Neighborhood builders aims to develop 150 affordable homes in Providence and surrounding areas between 2020 and 2023 .
-Supported a walking school bus programs at William D'Abate Elementary school

Pawtucket/Central Falls HEZ:
-Held a number of financial training and home education opportunities and supports. 12 participated in a Tenant/Landlord class. 37 individuals participated in Spanish Homebuyer class and 12 in the English equivalent. PCFD also partnered with Bank of America for a Homeowner class and that had 18 participants. Classes incorporated information regarding asthma risks and preventions.

-Worked closely with PCFD to make changes in their program in response to COVID and to meet the needs of their residents. Staff did outreach to their over 250 tenants ensuring they had information regarding COVID, rental and other available assistance.

-The PCF Health Equity Zone worked with GroundWorks RI to build community resilience to climate change. The partnership included GroundWorks RI, Blackstone Valley Community Action Program, Broad Street Regeneration Committee, Childhood Lead Action Project, Progreso Latino, and Southside Community Land Trust. 24 youth were employed and trained on how to grow their own food at SCLT's Galego Court farm in Pawtucket, how to process and cook their food at Harvest Kitchen and how to engage residents and gather data regarding climate resilient mitigation strategies with GroundWorks RI. Through the project 178 surveys were collected to understand residents' concerns regarding climate issues. The most common concern among surveyed residents was lack of trees (81% of the 178 respondents indicated somewhat to extreme concern). Other concerns included limited access to healthy food, lack of parks and open spaces, and flooding. Residents responded that they would like to see increased strategies around growing or buying local food, planting trees, and lastly reducing waste/preventing litter/recycling. GroundWorks RI engaged Pawtucket and Central Falls youth on home inspection for improved green infrastructure. The youth completed 25 home assessments, installed 9 raised garden beds, 7 rain barrels, conducted clean-up days, conducted tree surveys, and planted 6 trees.

-Conducted 5 lead poisoning prevention workshops at Calcutt Middle School and at Captain Hunt's Preschool, for a total of 12 families attending. 41 additional individuals were educated at the CF High School Health Fair or the Cape Verdean American Community Development Health Fair. Information, provided in English and Spanish, includes: lead/tenant's rights; lead abatement resources for homeowners; lead hazards found in paint, soil, dust and drinking water; lead safe cleaning methods and other interim controls; led safety for workers; lead testing for children and financial assistance for lead abatement for homeowners.

West Warwick HEZ:
-Collaborating with municipal officials to integrate walkability/bikeability recommendations resulting from a built environment assessment into town comprehensive plan

-Coordinating "Transportation that Works" to promote improved bus service to jobs, substance abuse recovery

services, physical activity, health care, and senior services

-Installing signage on local bike path and fitness equipment in parks and playgrounds

Child Health & Health Equity Zones

Partnering to reduce childhood lead poisoning in Pawtucket

By working with the Childhood Lead Action Project, City of Pawtucket, and community partners to implement policies to improve the enforcement of lead safety laws in Pawtucket, the Pawtucket-Central Falls Health Equity Zone contributed to a 44 percent decrease in childhood lead poisoning and the certification of approximately 200 lead-safe rental units in Pawtucket. The groups mobilized their efforts in response to data showing high levels of childhood lead poisoning in Pawtucket. For years, Pawtucket residents had struggled with insufficient local compliance with lead safety requirements for rental housing, insufficient local enforcement of lead safety laws, and unsafe housing conditions. The local Health Equity Zones infrastructure helped the diverse partners working on these issues to come together to address shared goals and helped direct flexible funding to local priorities. Working together, the partners successfully trained local officials on the enforcement of lead safety laws, implemented a City policy to require proof of compliance before issuing a building permit, and conducted community outreach and training focused on tenants' rights and lead-safe work practices. As a result, the incidence of lead poisoning dropped from 4.9 percent (104 children) in 2015 to 2.99 percent (58 children) in 2017. Continuation of this work over the last several years had contributed to further reductions in new lead poisoning cases in Pawtucket (46 children in 2019). This year, Childhood Lead Action Project conducted 5 lead poisoning prevention workshops at Calcutt Middle School and at Captain Hunt's Preschool, for a total of 12 families attending. 41 additional individuals were educated at the CF High School Health Fair or the Cape Verdean American Community Development Health Fair. Information, provided in English and Spanish, includes: lead/tenant's rights; lead abatement resources for homeowners; lead hazards found in paint, soil, dust and drinking water; lead safe cleaning methods and other interim controls; lead safety for workers; lead testing for children and financial assistance for lead abatement for homeowners.

Expansion of child health programming, and adapting to change

Several RI Health Equity Zones have implemented "Walking School Bus" programs that are improving rates of attendance and chronic absenteeism in schools – and increasing physical activity and community connectedness in the process. In 2019 to early 2020, the Central Providence HEZ enrolled an additional 150 children into the William D'Abate Elementary School Walking School Bus Program. The Walking School Bus program was suspended when schools closed in March 2020 due to COVID-19. The onset of COVID-19 in Rhode Island also led to many new needs for children and families who had to adapt to distance learning. The HEZs worked with community partners and residents to quickly identify and address urgent needs. The Woonsocket HEZ distributed over 5,000 meals to families in need. The Pawtucket Central Falls HEZ collaborated with 35 organizations in their communities to distribute over 90,000 masks to residents, and they hosted a drive-up meal distribution event that was visited by over 1,000 cars. The PCF HEZ also partnered with the Boys and Girls Club to provide groceries and youth activities to 60 families.

Developmental screening

As part of the 2012-2016 Race to the Top Early Learning Challenge grant, RIDOH assisted over 35 primary care practices in implementing standardized developmental screening to align with the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Schedule and the American Academy of Pediatrics recommendations.

RIDOH continues to work with Medicaid and insurers to support providers to screen children at 9, 18, and 30 months using a standardized tool. RIDOH is currently participating in the state's First 1,000 days initiative, which recognizes

the importance of the first three ears of life and initiative which is designed to increase Medicaid's role in things like developmental screening which can identify issues early and help increase the odds the children are able to reach their potential. In addition RIDOH participates on the PCMH-Kids planning team and supported Developmental Screening as one of the PCMH kids quality measures; in 2019 the 19, PCMH kids sites all exceeded or met the targets for Developmental Screening in RI (78% overall and 70% for Medicaid population).

Mental Health Consultation within early care and education-Through a partnership with DHS, child focused mental health consultation is available statewide. RIDOH is currently working with DHS to sustain its program focused mental health consultation to childcare as well. In 2020, several mental health professionals from Bradley Early Childhood Research Center, who are also early childhood mental health consultants, developed and delivered a training on how to become a child care mental health consultant with the goal of expanding the capacity of the system overall.

Parent education and support for children and their families: Three communities were supported to implement Incredible Years groups for families in the communities. Anticipated outcomes include, improved parenting, increased social emotional competence, and decreased behavior problems. In the longer term, RI expects to see improved school readiness, improved social-emotional functioning, and healthier families.

Immunization Program- *Universal Vaccine Purchasing Policy* - The mission of the Immunization Program is to prevent and control vaccine preventable diseases in RI by increasing immunization rates among children, adolescents and adults. This is achieved by implementing systems for efficient vaccine purchase and distribution, increasing vaccine access, decreasing cost as a barrier, quality assurance, quality improvement, public and provider education, information dissemination, surveillance, and community collaboration. Rhode Island is a universal vaccine state in which all routinely recommended vaccines are provided to healthcare providers at no cost for children, adolescents, young adults (through 26 years of age), and select vaccines for high risk adults. Influenza vaccine is provided at no cost for all Rhode Islanders aged 6 months and older.

Immunization Walk-In Clinic - The Immunization program supports a walk-in immunization clinic at St. Joseph's Health Services offering no cost vaccination for children who are uninsured/under-insured or those who are new to the country and do not yet have a doctor or are delayed in getting an appointment, and also for uninsured adults.

School Located Influenza Vaccination Clinics - The goal of the school located vaccination program is to reduce the burden of influenza in RI communities and to develop a sustainable vaccination model based on partnership among RI Department of Health (RIDOH), Department of Education (RIDE), & The Wellness Company (TWC). Vaccines are offered to all students, faculty, and staff at no cost. High school and some middle school clinics are held during the school day and elementary school clinics are held afterschool and are open to the public. Parents must provide consent for immunization and insurance information is collected for billing purposes, when available.

School Immunization Reporting - The Immunization Program continues to collect web-based reporting data to monitor school immunization coverage rates. All schools with grades kindergarten, 7th, 8th, 9th and 12th are required to report to the RIDOH annually the number of children who are fully immunized as well as those who have exemptions. All students are required to provide documentation that they are up-to-date on certain vaccines for school entry to Kindergarten, 7th, 8th, 9th, and 12th grade or provide a signed state exemption. Data include the number of students assessed, fully immunized, without an immunization record, and with an exemption certificate on file. In August 2015 additional school immunization requirements were added to the school immunization regulations under all levels pre-k through College to improve vaccination coverage with the goal of reducing the incidence of vaccine preventable disease.

Immunization Quality Improvement for Providers (IQIP) - Primary care practices enrolled in the state supplied vaccine program that see children and adolescents receive IQIP site visits from immunization program staff assessing vaccination coverage rates among children and adolescents in their practice with guidance on how to increase coverage rates and resources to help achieve that goal. IQIP is an evidence-based quality improvement tool employed by the Centers for Disease Control and Prevention to improve vaccination coverage rates. One resource that was developed is a KIDSNET tool allowing practices the access to run their own coverage rate reports on demand.

KIDSNET (Includes the state Immunization Registry) - School Nurse Immunization Reports have been developed in KIDSNET that make it easier for school nurses to use KIDSNET to evaluate the immunization status of students. These reports identify students who have met, or not met, school requirements, as well as those who have no available information in KIDSNET. The reports can be run by school, by grade, and by school district. In the event of a disease outbreak, the reports can be narrowed to look at one vaccine, identifying those who are past-due for the vaccine that prevents the outbreak disease. Contact information for the last known primary care provider appears on the reports to facilitate care coordination. Early Intervention sites have been connected to KIDSNET. First Connections, MIECHV programs, and WIC sites view KIDSNET to access children's immunization status and if a child is behind on immunizations, they link them to follow-up care. Messages about the importance of immunizations will continue to be included in KIDSNET- generated cards mailed to families of newborns as part of the State Systems Development Initiative.

The Rhode Island Asthma Control Program (RIACP) - has a strong public health foundation. It is built around home-based, school-based and health systems strategies that focus on children with asthma in Rhode Island's (RI) four high poverty "core" cities: Central Falls, Pawtucket, Providence and Woonsocket. In these four cities more than one in four children live in poverty. The Comprehensive Integrated Asthma Care System (CIACS) is the framework for aligning these strategies. The CIACS model is built upon contracts with key partners in the core cities. Three programs form the foundation of the RIACP's community-based services. These are: 1) Breathe Easy at Home (BEAH), an electronic-based -based referral system utilizing RIDOH's KIDSNET program that allows medical providers to make referrals to municipal housing code offices for asthma triggers that are code violations; 2) Home Asthma Response Program (HARP), a pediatric asthma home visiting intervention that utilizes a certified Asthma Educator (AE-C) and Community Health Worker (CHW) to provide asthma self-management education (S-ME), and in-home environmental trigger reduction to reduce asthma ED visits and inpatient admissions for children with poorly controlled asthma, and 3) Draw a Breath (DAB), an evidence-based asthma education program at Hasbro Children's Hospital that provides group asthma education classes at the hospital and at schools

Home Asthma Response Program (HARP) - In 2018, Title V contributed $55,000 to HARP. HARP is an evidence-based in-home asthma intervention that uses certified asthma educators (AE-Cs) and community health workers (CHWs) to conduct up to three intensive in-home sessions that: Assess a patient's asthma knowledge and environmental trigger exposure, provide intensive asthma self-management education, deliver cost effective supplies to reduce home asthma triggers, and improve the quality and experience of care. HARP eligibility is based on the child's age, city of residence, level of asthma control and health care use. An extensive environmental assessment is provided and involves an in-depth inspection of the family's home to identify various environmental triggers that may be exacerbating the child's asthma. Linkage to care is a component of HARP, in which children without current primary care providers at the time of the first home visit are referred to a primary care provider. All children participating in HARP are required to receive an Asthma Action Plan (AAP) from their primary care providers. The AAP ensures that all individuals caring for the child, including school nurse teachers, daycares, parents/guardians, and other caregivers understand how to recognize when the child is having asthma symptoms, environmental triggers that may exacerbate the child's asthma, how to safely administer medication, and ways to avoid asthma

attacks.
In 2017, RIACP submitted a proposal to the RI Attorney General's Office to request a $300,000 allocation from the Volkswagen (VW) Clean Air Act Civil Settlement to improve asthma outcomes for high risk pediatric asthma patients in Rhode Island. Exposure to elevated levels of nitrous oxide (NOx) emissions have pervasive negative health impacts for people with impaired respiratory systems, and especially for children with severe asthma. RIDOH is using settlement funds over the next 12-18 months to provide HARP to 200 severely asthmatic children in Central Falls, Pawtucket, Providence and Woonsocket. RIACP led the effort to conduct a pilot study to provide HARP to children with poorly controlled asthma who are enrolled in a United Medicaid Plan. The pilot is now launched with Hasbro Children's Hospital.

School Indoor Air Quality Policies: RIACP has been engaging around school indoor air quality policy issues through conducting ongoing inspections in numerous schools across the state. RIACP participated with the Fix Our Schools Now (FOS) Coalition by providing asthma data and by framing language for the policy platform around repairing school facilities. The platform supported the Governor's Executive Order and Rhode Island School Building Task Force plan to repair or replace aging school facilities across the state. In November 2018, Rhode Island voters approved a $250 million school repair bond. This is a tremendous investment that will improve indoor air quality in schools across the state.

Outdoor Air Quality Policies: RIACP participates in numerous initiatives that are working on policies relevant to childhood asthma. The RIDOH Environmental Health Risk Review group supports RIDOH's Director in reviewing environmental health concerns including ambient air quality and sources of air pollution that disproportionately impact people with asthma and other respiratory diseases. Projects reviewed include a large proposed power plant, a highway, and cumulative impacts in an industrial waterfront port. RIACP provided a Health Impact Assessment (HIA) training on May 21 and 22, 2018 with key stakeholders in Providence to begin the planning process for assessing health impacts of the Port of Providence related to air pollution and toxicants from both stationary and mobile sources. Stakeholders include community residents and organizations, Rhode Island College School of Nursing, Brown University, Johnson and Wales University, Johns Hopkins University Bloomberg School of Public Health, Kresge Foundation, the City of Providence, RI Department of Environmental Management, RI Division of Statewide Planning, RIDOH Air Quality Laboratory, and the US Environmental Protection Agency. RIACP continues to work with RIPTA, the statewide public transit agency, and shared GIS maps of asthma hot spots so that RIPTA could prioritize deployment of new zero emission electric buses in areas with a high asthma burden. The first zero emission buses were launched publicly with a well-attended press event and tour in October 2018. RIACP has also continued to collaborate with the RIDOH Lab and RI Department of Environmental Management on an EPA-funded air quality study examining the air quality impact of I-95 highway on near-road communities with elevated asthma burdens. The study results were completed by the end of 2018 with RIACP playing a lead role in engaging communities on the results and recommendations. RIACP is also engaged in ongoing close partnerships with the City of Providence on the city's Climate Justice Plan, which includes prioritizing community health, environmental justice, and resilience in environmental justice communities that are disproportionately impacted by asthma and air pollution. RIACP is updating the 2014 Asthma Claims Databook to provide the City of Providence and its community partners with asthma data and maps to supporting the development of the city's climate justice policy plan.

Oral Health Program- The OHP is located within RIDOH, Division of Community Health and Equity, Center for Preventive Services. The mission of the OHP is to achieve optimal oral health for all by eliminating oral health disparities in RI while also integrating oral health with overall health. To achieve this mission, the OHP focuses on prevention of oral disease through assurance of state-level oral health and public health leadership, documentation of the burden of oral disease in RI, and collaboration with statewide partners and the Rhode Island Oral Health Commission. In association with these partnerships, the OHP implements goals and objectives identified in the

Rhode Island Oral Health Plan to improve access to oral healthcare services, integrate the dental and medical care systems, increase oral health literacy among RI residents, sustain the oral health workforce, and inform and support productive oral health policy decisions.

Oral Health Academic Detailing – The Oral Health Program's PIOHQI Project conducted outreach to 22 sites through academic detailing about the age one dental visit and fluoride varnish application. This work resulted in 105 health care providers being trained (this includes pediatricians, medical assistants, nurses, front desk staff, office managers, and preschool staff). The RIDOH PIOHQI Project also established 5 learning lab sites that either increased the percentage of pregnant women receiving dental referrals (Thundermist, WellOne, and St. Joseph Health Center) or successfully incorporated preventive oral health services at pediatric medical practices (Costal Medial and Dr. Richard Ohmmacht). Additionally, the Age One Champion Directory continues to grow, as 6 providers were added to the list since January 2019.
The RIDOH PIOHQI Project also continued to develop and distribute an Age One Champion Directory to medical providers, community organizations, and families. This Directory is comprised of dental providers who have agreed to see very young children and is listed on the TeethFirst! website. The practices are sorted by location and include information about their hours of operation, insurances accepted, and contact information. Modifications to the RIDOH licensing system have been made so that dental providers renewing their license can indicate if they would like to be included in the Age One Champion Directory.

Oral Health & Third Grade Reading Plan - The OHP successfully incorporated an oral health measurement into the Governor's Third Grade Reading Action Plan. The number of children under two years of age with RIte Care/Medicaid coverage who have had a dental visit is now tracked quarterly within the school readiness domain of the plan and has been identified as one of the many strategies to improve reading readiness.

This past year, a dental hygienist focus group was convened to assess the knowledge and willingness of dental hygienists to promote good oral health for pregnant womxn and young children. A report was released to the RI Perinatal and Infant Oral Health Quality Improvement Project Advisory Board and representatives of the Rhode Island Dental Association, Rhode Island Dental Hygienist Association, the Rhode Island Dental Assistant Association, and the Community College of RI Dental Health Department. In total, 17 RI dental hygienists who were employed at either a general practice or at a federally qualified health center were surveyed in early June. Responses were gathered through an online survey over the course of a three-day period and respondents answering all questions received a $100 gift card for their time.

Most dental hygienists reported being comfortable providing preventive care to pregnant women, and only some expressed concerns with providing scaling and root planning with local anesthesia in the first and third trimester or taking x-rays. While most dental hygienists are comfortable treating children under age two, many reported not regularly seeing those patients as dental home establishment regularly occurs at age three. All dental hygienists reported being interested in receiving professional education about care for pregnant women and children under age two despite being well-aware of the clinical recommendations to provide such care. They also recommended more education for OB/GYNs and pediatricians on this topic and that barriers such as cost and patient education need to be addressed to improve dental utilization and outcomes. Survey respondents also expressed interest in learning more about the Age One Champion Directory and expressed that more could be done to promote its existence among dental professionals. They also noted that the decision to join such a directory would most likely be up to the dentist. For a complete overview of all focus group findings provided by Market Street Research, please click here.

Fluoride Quality Measure – Over the past year, the OHP, with the assistance of the RIDOH Medical Director, were successful in having the OHIC Developmental Measure Workgroup agree to include a fluoride varnish application

clinical quality measure for commercial medical plans about fluoride varnish application among children under age three. The OHP staff were also able to coordinate the reporting of fluoride varnish data of Rhode Island children age three and under administered by medical providers from the State's All Payer Claims Database. This data was used by the RI SOHP and RIDOH's medical director in their advocacy to gain approval from the Office of the Health Insurance Commissioner and SIM Steering Committee for the adoption of a fluoride varnish clinical quality measure for commercial medical plans.

SEAL RI! - SEAL RI! is a school-based dental program that provides exams and dental sealants to help prevent tooth decay for children ages 5-10. Currently, SEAL RI! Funds work in 11 of 39 RI communities and provide services in 56% of the schools targeted by the SEAL RI! program. Targeted schools are defined by those schools with 50% or more of the students eligible for the FRSM program. This target was designed to maximize effectiveness by targeting high-risk children living in the core cities. The primary advantage of the school-based model is a major increase in access and decrease in oral health disparities. This model is a less expensive way of providing dental care to Medicaid-eligible children than the traditional private practice dental care system. During the 2018-2019 school year, 5,757 children were screened and 1,792 of those were found to need sealants. Of those, 548 received at least one sealant. To further improve SEAL RI! impacts, OHP staff has completed research on practices to improve consent form returns. SEAL RI! data also continues to be published in a joint school report card with the Immunization and Lead Programs. Dental sealant brochures have also been distributed to elementary schools, health fairs, and lead centers throughout the state and OHP staff were successful in advocating for the inclusion of sealant benefits in state employee dental befits. OHP staff continued to host quarterly meeting with all SEAL RI! sites to discuss improvement strategies about program delivery.

Rhode Island EMS for Children Program - The purpose of RI EMSC activities is to coordinate, extend and improve upon the integration and focus of pediatric needs within the state EMS system. This involves building upon and strengthening relationships between mutually supportive pediatric-oriented programs and activities, such as those found in maternal and child health, trauma system development, disaster preparedness, and highway safety. EMSC also looks to support continued pediatric education for EMT's, paramedics and both school and emergency department nurses. EMSC will also partner with local chapters of AAP and ACEP and other professional organizations, to seek support and advice for the continued improvement of EMS care for children in Rhode Island.

In the 2018 – 2019 grant year the program recognizes that improving pediatric outcomes is not solely based on addressing pediatric issues but developing systems that include pediatric patient care as a priority. The program is focused on making gains in three areas. In the prehospital setting, the program will focus on ensuring that RI EMS agencies are submitting compliant data to the RI Center for EMS, identifying pediatric champions within EMS agencies and increasing the proportion of EMS agencies that evaluate EMS practitioner's pediatric skills at least once per year. In the hospital setting, the goal is to develop a pediatric medical recognition system that ensures that hospital facilities are prepared to care for children in medical emergencies, develop a recognition system for pediatric trauma and ensure that hospitals have compliant interfacility transfer guidelines and agreements. In the community setting, the goal is to fortify family partnerships and to increase the presence of the EMSC state partnership program within the state of Rhode Island's EMS system.

Sustainability of Child Health Priority

As a result of the 2020 Needs Assessment, RI's MCH has selected a different priority. Several of the programs and projects will be continued within RI's MCH programs or continued within the new 2020-2025 Priorities. The following programs/projects will be sustained in the following manner:

- Continue to monitor and enhance data related to BMI to better access rates of childhood overweight and obesity.
- Sponsor the Health Schools Collation breakfast. This event always includes topics related to physical activity and nutrition.
- Utilize the HEZ infrastructure to promote activities and share information and resources about physical activity and nutrition, food policy, and the built environment. HEZ collaboratives have been able to make significant gains at the local level. Title V will continue to provide technical assistance and training to the HEZ collaboratives individually and during bi-monthly Learning Network meetings.

The Title V Program will also support the following RIDOH MCH Programs related to child health: the Immunization Program, the Oral Health Program, the Early Childhood Program, the EMS for KIDS, and the Asthma Program.

APPLICATION YEAR: CHILD HEALTH

Children's health is the well-being of children from birth through adolescence, usually ages 1-11. Child health providers focus on the healthy growth and development of children to help ensure every child reaches their full potential. To support children's health, it is important to prevent and treat illnesses and injuries that can affect a child's development. It is also important to promote optimal oral health (teeth and gums) and healthy social and emotional development. The Rhode Island Department of Health (RIDOH) supports children to access healthy foods, be physically active, receive recommended immunizations, and receive timely, high-quality, culturally sensitive healthcare to help them stay healthy. RIDOH also works to foster strong family and community relationships and ensure children grow up in safe environments. This health domain section has taken into consideration that the care and outcomes of womxn, children, and families are impacted by the systemic racism, discrimination, unaddressed language barriers, and a lack of culturally responsive providers. The following quantitative, qualitative, and anecdotal information tries to tease out health disparities and the overarching healthcare needs of communities.

PRIORITY: Improve School Readiness

The health of children in RI remains an important issue to the MCH Program. Poor oral, physical, mental, and behavioral health status can have long term health consequences later in life. It is pertinent to focus on early childhood development in order to improve the physical and psychosocial well-being of RI children. The MCH Program is prioritizing school readiness, which includes the ability of children in RI to exhibit their full potential of success and the support of families and communities to meet children's needs of readiness.

Early literacy is an important precursor for developing a foundation to school readiness. In 2018, 17.9% of postpartum women reported not reading or looking at book with their baby in the past week. Disparities exist among race/ethnicity, where 25.4% of Hispanic postpartum women were not currently reading to their infant compare to 15.0% of Non-Hispanic White postpartum women. In 2017/18, 49.6% of family members were reading to their child ages 0-5 everyday. However, the disparity remains between Hispanic family members reading to their child ages 0-5 (29.6%) compared to Non-Hispanic White family members reading to their child (59.1%). Family Visiting Program in 2019 supported 2017/18 NSCH data, reporting that 49.3% of children were read, told stories, or sung songs by family members every day.

Needs assessment highlights from the community and professional surveys, ranked the following as their top issue related to education that the RIDOH can focus on to better support families: 1) Schools that are safe, healthy, and high quality, & 2) Child care that is affordable and high quality. Similarly a SISTA FIRE survey found that 50% of the womxn of color surveyed thought screening for milestones and healthy development were important to improving health and wellbeing of young children (1-4 years old). Surveyed womxn of color also ranked the following as their top three important things to improving the health and wellbeing of children (5-12 years old): 1) Social & Emotional Health (62%) , 2) Bullying (43%), and 3) Nutrition & Physical Activity (37%).

These current survey findings are further supported by prior RIDOH community engagement completed for the Preschool Development Grant. A majority of the surveyed caregivers reported access to affordable childcare as their priority (44%). Among families identified as experiencing significant stressors by the state, over 1/3 stressed a need for more "information about available programs for my family." Families with young children and special needs and/or foster care indicated a particular need for "information about available programs for my family" and "childcare close to home". Cumulatively, these surveys show that there is still a need for the state to support the overall development and social and emotional health of children, especially those at a particularly young age.

NEXT YEAR STRATEGIES:

1) Parent Education & Support

Family Home Visiting: In October 2016, HRSA revised the performance reporting requirements for MIECHV

Program state and territory awardees after a year-long process that included input from state awardees, federal partners, home visiting model developers, and other stakeholders. The update aimed to ensure accountability in demonstrating outcomes. The measures are categorized into two types: performance indicators and systems outcomes. Performance indicators are relatively proximal to the home visiting intervention or shown to be sensitive to home visiting alone. Systems outcome measures are more distal to the home visiting intervention and/or are less sensitive to change due to home visiting alone due to many factors, including confounding influences or differences in available system infrastructure at the state- or community-level. Rhode Island is focusing on the self sufficiency of primary caregivers by providing parental education and support.

2) Improving Early Literacy

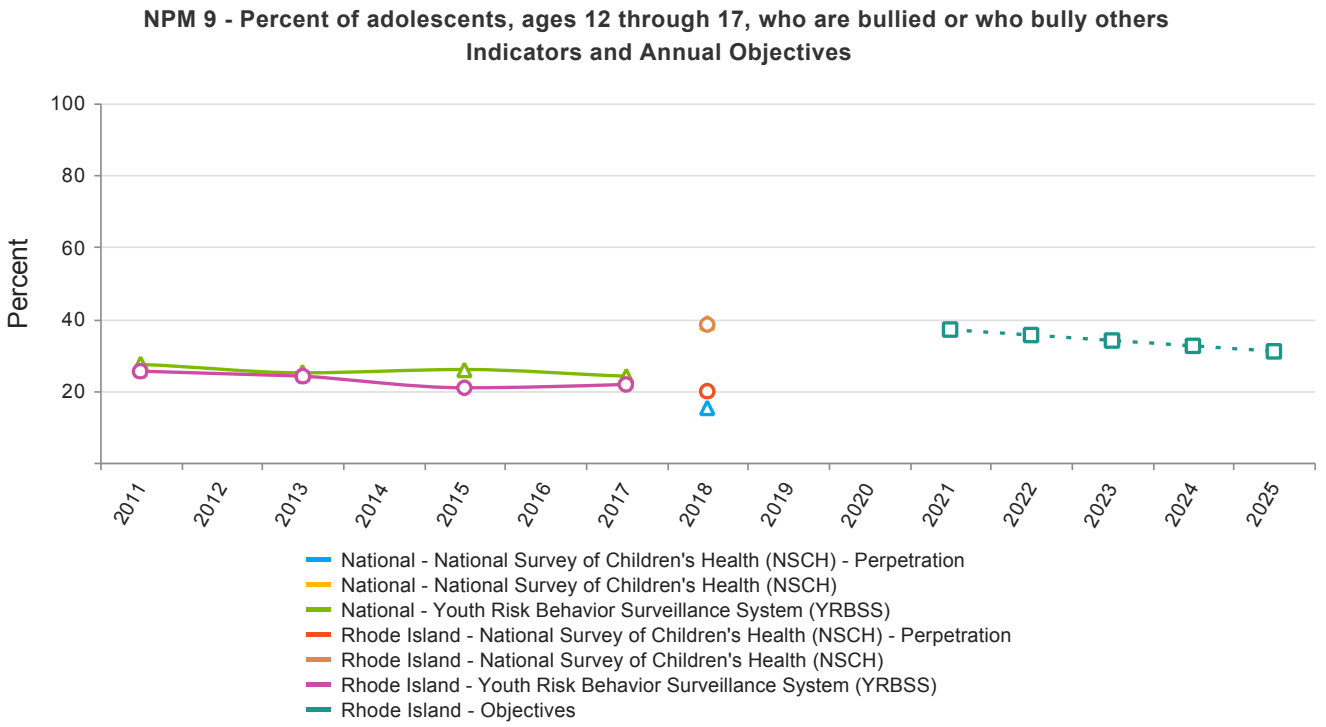
Preschool Development Grant: The Children's Cabinet oversees an interagency and the newly formed a birth to five (B-5) Steering Committee that will serve as the preschool development grant (PDG) Project Team. These structures and teams will support RI in accomplishing the goals of this grant. Over the next 3 years, RI will use results from our PDG B-5 planning period to improve system-, family-, provider-, and child-level outcomes for our most vulnerable populations. We will continue to align our B-5 systems to improve coordination and transitional supports, to expand our workforce, and to better optimize resources across agencies. We will engage families in B-5 governance, increase family knowledge through direct supports, and increase access to evidence-based services and programs. For providers, we will increase coordination, efficiency, and quality to better serve target populations. At the child level, we will increase access to high-quality Early Care and Education (ECE) programs. We will measure and evaluate our performance across all outcomes to determine effectiveness and support continuous improvement. All RI children B-5 and their families have equitable access to the high-quality services and supports they need for children to enter Kindergarten educationally and developmentally ready to succeed. This vision is founded on three integrated child-level outcome goals: **1)** Families and children B-5 are empowered to lead healthy and engaged lives through timely, targeted services that include thoughtful transitions, **2)** Children B5 equitably access high-quality early childhood care and education, and **3)** 4-year-olds participate in high-quality Pre-K.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	21.5	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	4.6	NPM 9
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	14.0 %	NPM 12

National Performance Measures



Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2019
Annual Objective	
Annual Indicator	21.8
Numerator	8,762
Denominator	40,209
Data Source	YRBSS
Data Source Year	2017

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2019
Annual Objective	
Annual Indicator	19.8
Numerator	13,784
Denominator	69,514
Data Source	NSCHP
Data Source Year	2018

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	38.5
Numerator	26,726
Denominator	69,435
Data Source	NSCHV
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	37.0	35.5	34.0	32.5	31.0

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Kids' Link Referral Network

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	66
Numerator	
Denominator	
Data Source	KIDSLINK
Data Source Year	2018-19
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	80.0	85.0	90.0	95.0

State Performance Measures

SPM 3 - ED visits for suicide ideation, ages 15-19

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	10.4
Numerator	741
Denominator	71,426
Data Source	ESSENCE syndromic surveillance, 2018 ACS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	10.2	9.9	9.6	9.3	9.0

State Outcome Measures

SOM 3 - Suicide Attempts among High School Students

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	14.7
Numerator	6,441
Denominator	43,889
Data Source	YRBS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	13.0	12.0	11.0	10.0	9.0

State Action Plan Table

State Action Plan Table (Rhode Island) - Adolescent Health - Entry 1

Priority Need
Support adolescent mental and behavioral health

NPM
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives
Reduce the percent of adolescents, ages 12 through 17, who are bullied or who bully others from 38.5% in 2019 to 31% in 2025

Strategies
Support policy and partnerships to promote youth mental or behavioral health in schools and community

ESMs	Status
ESM 9.1 - Kids' Link Referral Network	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

State Action Plan Table (Rhode Island) - Adolescent Health - Entry 2

Priority Need

Support adolescent mental and behavioral health

SPM

SPM 3 - ED visits for suicide ideation, ages 15-19

Objectives

Reduce the rate of ED visits for suicide ideation from 10.4 per 1000 adolescent (ages 15-19) ED visits in 2019 to 9 per 1000 ED visits in 2025

Strategies

Support policy and partnerships to promote youth mental or behavioral health in schools and the community

State Action Plan Table (Rhode Island) - Adolescent Health - Entry 3

Priority Need

Support adolescent mental and behavioral health

SOM

SOM 3 - Suicide Attempts among High School Students

Objectives

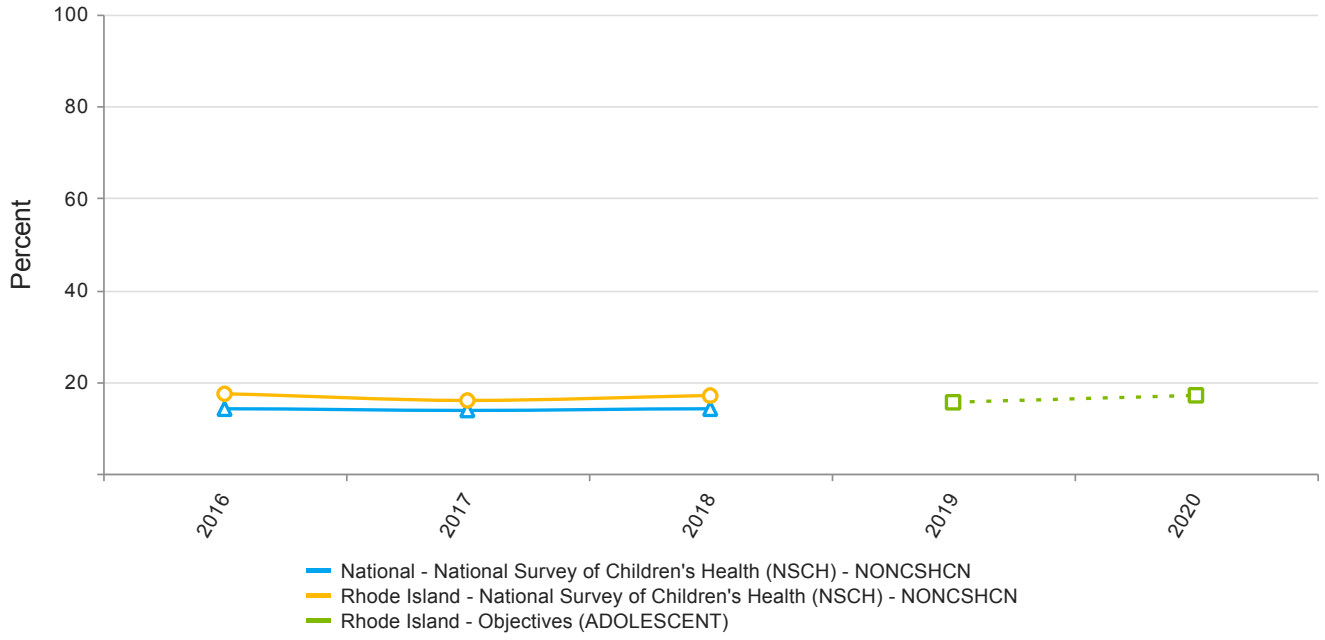
Reduce the percentage of suicide attempts among high school student from 14.7% in 2019 to 9% in 2025

Strategies

Support policy and partnerships to promote youth mental or behavioral health in schools and the community.

2016-2020: National Performance Measures

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



2016-2020: NPM 12 - Adolescent Health - NONCSHCN

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN			
	2017	**2018**	**2019**
Annual Objective			15.6
Annual Indicator	17.5	15.9	16.9
Numerator	8,345	8,049	8,912
Denominator	47,720	50,750	52,734
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2016	2016_2017	2017_2018

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			15.6
Annual Indicator	17.5	14.4	
Numerator	8,345	7,752	
Denominator	47,720	53,780	
Data Source	NSCH-NONCSHCN	NSCH-NONCSH	
Data Source Year	2016	2017	
Provisional or Final ?	Final	Final	

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 12.1 - % of medical homes with trained staff on transition

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		14	16	18
Annual Indicator	10.3	15.1	15.1	15.1
Numerator	13	19	19	19
Denominator	126	126	126	126
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 12.2 - % of practices with a transition policy

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		2	3.2	2.4
Annual Indicator	1.6	1.6	1.6	1.6
Numerator	2	2	2	2
Denominator	126	126	126	126
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 12.3 - # of youth participation in and accessing Dare 2 Dream; Self Assessments; Ready, Set, Go; HEZ; and Internships

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		1,000	1,800	1,750
Annual Indicator	1,125	1,731	1,406	1,406
Numerator				
Denominator				
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 12.4 - # of participants in Teen Outreach Program

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			240
Annual Indicator			149
Numerator			
Denominator			
Data Source			Teen Outreach Program
Data Source Year			2019-20
Provisional or Final ?			Final

2016-2020: State Outcome Measures

2016-2020: SOM 1 - Five year average birth rate among Hispanic teens (ages 15-19)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		35	33.4	31.2
Annual Indicator	38.9	35.3	32	29.6
Numerator	1,323	1,223	1,163	1,074
Denominator	34,015	34,692	36,318	36,318
Data Source	Vital Records/ACS (B01001I)	Vital Records/ACS (B01001I)	Vital Records/ACS (B01001I)	Vital Records/ACS (B01001I)
Data Source Year	2012-2016	2013-2017	2014-2018	2015-2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: SOM 2 - Five year average birth rate to Black teens (ages 15-19)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		24	14	13.5
Annual Indicator	25	14.9	12	10.5
Numerator	388	236	210	184
Denominator	15,551	15,864	17,560	17,560
Data Source	Vital Records/ACS (B01001B)	Vital Records/ACS (B01001B)	Vital Records/ACS (B01001B)	Vital Records/ACS (B01001B)
Data Source Year	2012-2016	2013-2017	2014-2018	2015-2019
Provisional or Final ?	Provisional	Final	Final	Final

2016-2020: SOM 3 - Percent LGB high school students attempting suicide

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		32	25.2	22.5
Annual Indicator	33.1	27.8	27.8	21.6
Numerator	1,160	1,114	1,114	1,050
Denominator	3,509	4,013	4,013	4,864
Data Source	YRBS	YRBS	YRBS	YRBS
Data Source Year	2015	2017	2017	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: SOM 8 - Teen Pregnancy Rate (ages 15-19) in RI core cities

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			18.4
Annual Indicator			27.2
Numerator			349
Denominator			12,847
Data Source			MCH Database/ACS 2018 5-year estimates
Data Source Year			2019
Provisional or Final ?			Final

ANNUAL REPORT: Adolescent Health

Adolescence is a critical transitional period that includes the biological changes of puberty and development to adulthood. The behavioral patterns established during these developmental periods can protect them or put them at risk for a myriad of physical and mental health conditions. Older adolescents and young adults, including those with chronic health conditions, may face challenges as they transition from the child to the adult health care system, such as changes in their insurance coverage, legal status, decreased attention to their developmental and behavioral needs. Rhode Island identified increasing the capacity and efficiency of the adolescent system of care as one its state priority needs. Even though NPM 12 (adolescent healthcare transition to adulthood) was chosen, RI monitors and addresses many other adolescent health issues including teen pregnancy, teen obesity, and behavioral mental/health.

Priority: Support the Capacity & Efficiency Adolescent Systems of Care

Train & support Patient Centered Medical Homes (PCMH)-Kids and adult practices, including care coordinators, on transition resources (Got Transition, transition policies, transition readiness assessment, portable medical summary).

RI Transition Council – The Adolescent Transition Program joined the Rhode Island Transition Council (established by state law) in 2008 and continued to participate as a key partner with other state agencies, local education agencies, parents, and students to work toward the Council's goal to enable students (including those with special needs) to successfully transition to adult life in their community. The Transition Council framework focuses on five areas of transition policy development: student focused planning, student development, family involvement, program structure and interagency collaboration. These focus areas are also addressed in the State Plan developed by the RI Transition Council with support from the National Technical Assistance Center on Transition (NTACT) institute. RIDOH staff regularly attend Transition Council meeting and provide technical assistance, resources, and advise on health related topics.

Transition Materials – The Adolescent Transition Program has developed educational materials and resources to assist RI students (including those with special needs) and their support teams in transition planning. Materials include a Youth Transition Workbook and a series of transition checklists entitled Ready? Get Set! Go! The checklist series modified (with permission) by Rhode Island, provided an online fillable format as a tool to support the accomplishment of transition activities and have been incorporated into life skills programs, service care plans, and individual education programs.

Build self-determination skills among youth.

Dare to Dream Initiative: In May of 2009, the RI Department of Health (RIDOH) in collaboration with the RI Transition Council sponsored a statewide initiative and the first student leadership conference entitled "Dare to Dream" (D2D). Modeled after the Dare to Dream initiative developed by the State of New Jersey, the goal of the conference was to provide a forum for high school students (including those with special needs/disabilities) to begin to explore transition from school to adult life and develop self-determination and self-advocacy skills. Held on a college campus within the State of RI, the student led leadership conference provides youth with a forum for skill building through peer led workshops addressing topic of relevance to adolescent transition and workforce development. This past year, RIDOH launched Dare to Dream 2.0 Youth Conference on May 23, 2019 at the University of Rhode Island which was attended by over 486 students and 190 teacher/support staff from 45 different schools. The conference was supported by two (2) partner state agencies including: the RI Office of Rehabilitation Services and RI Department of Education to provide programming to address social emotional health, exploration of personal strengths, and tools for resiliency. The 2019 conference themed 'My Abilities, My Superpower', featured engaging

guest speakers, as well as an array of interactive workshops centered on knowledge and skill building. The format was designed to empower students, help them to identify and build on their strengths through teambuilding, while incorporating fun activities such as music, dance, yoga, fitness, and photography. The D2D Youth Conference scheduled for May 2020 required rescheduling due to the COVID-19 crisis and the movement of the Rhode Island School System to virtual learning. Planning for the next annual youth conference will be resumed in accordance with the scheduled return of Rhode Island schools to on-site learning.

Employment First - In 2014, Rhode Island rolled out the Employment First Initiative to promote community-based, integrated employment as the first option for employment services for individuals with special needs and disabilities. The Employment First initiative encourages youth with special needs and disabilities in transition to pursue real work experiences while working with community-based supports. Rhode Island is part of the national movement toward a greater emphasis on community employment that echoes a general shift toward services designed to integrate individuals with special needs/disabilities into their communities to afford them the same opportunities as people without special needs/disabilities. The RIDOH has supported Employment First since initial roll-out and throughout this grant reporting period through the development and implementation of youth initiatives. The RIDOH Youth Advisory Committee, Youth Internship Program, and Dare to Dream Youth Conference are included in these initiatives that provide youth with special needs and disabilities with information, resources, and experiences that promote successful transition to employment and independence.

Youth Advisory Council – In 2013, the RI Department of Health (RIDOH) implemented a Youth Advisory Council (YAC) to provide youth/ young adults, ages 14-24, with a forum for connection to other youth and an opportunity for leadership skills development. Since the inception, the YAC has advised and collaborated with various RIDOH programs affecting the health, wellness, and transition of youth (including those with special needs/disabilities).

During the last Title V reporting period, the YAC membership included sixteen (16) youth who met monthly from September 2019 through March 2020 to participate in educational and training sessions that focused on: professional development, soft skills building, and project event planning/ facilitation. Meeting agendas also included presentations from skilled professionals on topics including CPR/First Aid, strengths discovery/building, emotional resiliency/stress relief, and self-advocacy. In addition to regular meetings, Advisory youth were provided with monthly leadership opportunities through volunteer participation at various community youth events including summits, conferences and focus groups.

Despite the meeting year ending early (due to COVID) necessitating the cancellation of several significant planned events (Youth Transportation Training, Dare to Dream 2.0 Youth Conference), the YAC had a stellar year. Highlights included: "Youth Voice" presentations to the RIDOH MCH Policy Committee and a City Summer Work Readiness Program. Several members also worked on a workshop session presented at the National CityMatch Conference held in Providence, RI entitled "*Can You Hear Me Now, Ensuring Youth Voice through Youth Advisory Councils*". In addition, a YAC member was also nominated and selected to be the AMCHP Ryan Colburn Scholarship winner for her work as a youth advocate with a disability.

RIDOH Youth Internship Program - The RIDOH Youth Internship program places transition age students including those with special needs/disabilities throughout the Department in various program areas. The Internship Program is designed to assist RI high school students in career exploration and to allow them to become familiar with the expectations and norms of a real work setting. Over the past year, the RIDOH Youth Internship Program provided seven students from various Transition Programs and Academies throughout the state with opportunities to practice job skills in a real work setting. The participating Rhode Island schools included: Central Falls High School Transition Program (2) students; Lincoln High School Transition Program (1) student; Providence Autism School to Tomorrow Academy (1) student; West Bay Collaborative Transition Academy (1) student; Shea High School (1) student: and William Tolman High School (1) student. The RIDOH programs that participated in providing internship placements for the students included: Center for Preventive Services (Family Planning, Immunization, Woman Infants & Children); Center from Health

Promotion (Traumatic Brain Injury); Center for Health Data & Analysis; Center for Healthy Homes; Health Equity Institute; and the Distribution Center. A waiting list for students whose internship was scheduled to begin in March 2020 was unfortunately interrupted by the COVID 19 pandemic emergency.
The RIDOH Internship Program "*Promising Practice"* award by AMCHP and the Pulse newsletter article was utilized to promote the program and foundation to other state agencies and non-profit organization.
LINK: http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/RIDOH%20Intership%20Program.pdf
http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/JulyAugust2019/Pages/State-Internship-Program-for-CYSHCN-Pays-Dividends.aspx

Teen Outreach Program (TOP) - Teen Outreach Program (TOP) - TOP has served approximately 700 youth since 2013. The program served 149 youth in the 2019 – 2020 program and it is estimated that the program will serve at least 200 youth in 2020-2021. In terms of program success, overcoming the barriers of school district administration and accessing youth in the classrooms during the school day were quite significant. This year, youth from Tri-County Community Action's TOP club in North Providence, worked in collaboration with local and regional Substance Abuse Prevention Coalitions to organize an activity in four local liquor stores. Students placed stickers, warning about the dangers of underage drinking, on cases of alcohol. Their story was featured on the front page of The Valley Breeze, a local newspaper. Connecting for Children and Families held a donations drive for their local animal shelter at a Woonsocket Middle School. The students created signs to hang around the school and decorated donation boxes. The drive was successful, and the Facilitator was able to donate many boxes of cleaning supplies, pet toys, blankets, and dog and cat food to the local animal shelter. Many partners were able to adapt their clubs to reach students virtually during the COVID-19 pandemic. Virtual meetings allowed a space for students to discuss their concerns about COVID-19, connect with others, and continue community service-learning projects.

Princes 2 Kings (P2K) – P2K is a youth mentorship program that combines academics and tutoring in **S**cience, **T**echnology, **E**nglish, **A**rt, and **M**ath (STEAM), athletics, cultural enrichment activities, and workforce development for program participants year-round. Supported by a grant from the Federal Office of Minority Health, P2K is a collaborative effort between the RIDOH, the Boys and Girls Club of Providence, Roger Williams University, and Brown University School of Public Health. The primary objective of P2K is to address low high school graduation rates (a key social determinant of health), among Hispanic, Black, and Southeast Asian males 12 to 18 years of age. Low graduation rates are associated with a number of poor economic and health outcomes (e.g., poverty, poor mental health, teen pregnancy, and chronic disease).
P2K is divided into two components: Academic Year Program and Summer Enrichment Program. The Academic Year Program coincides with the Providence Public School District's calendar. The summer program consists of a Civil Discourse program where P2K youth engage with local activists, lawyers, and environmental specialists to discuss the impact of environmental justice issues on the local community. The Academic Year Program is held at the Boys & Girls Clubs of Providence South Side Clubhouse where activities take place three days per week (Tuesday, Wednesday, and Thursday) with optional Saturday field trips. During the week, activities run from 4:00 PM to 8:00 PM with an optional teen hour from 8:00 PM – 9:00 PM. Due to COVID-19, programming has shifted to virtual engagement and food delivery to program participants.

Initial evaluations efforts have found that P2K has high levels of acceptability from program participants and their families as well as strong support from community members and organizations. Further findings suggest that P2K is meeting the academic, emotional, and social needs of program participants. Further evaluation efforts will determine how the program supports achievement of improved grades and behavior. Currently, there are 64 participants in the P2K program.

Girls Empowerment Mentoring Support (RI-GEMS) – RIDOH seeks to reduce the impact and prevalence of violence and trauma among at-risk young women of color through opportunities to learn skills and gain experiences that contribute to positive social environments and healthy life choices. RI-GEMS is an *innovative* approach to empower young women of color to achieve academically and become leaders in their community. This year RI-GEMS provides year-round mentoring, academic support, and leadership development programming to a cohort of 62 young women of color who attend two middle schools in Providence, RI. The academic-year component of the program emphasizes academic performance and developing social and non-violent skills. The six-week summer component of the program focuses on summer learning loss prevention, community building, and social and emotional learning. This work builds on the successful RIDOH funded P2K program.

Develop a Web-based resources (ri.medicalhomeprotal.org) to provide a consumer-friendly way to navigate the CYSHCN system of care that includes robust transition resources.

The Medical Home Portal(MHP) - www.medicalhomeportal.org is an online resource established by the RI Department of Health (RIDOH) to provide a one-stop-shop for comprehensive diagnostic, education, specialty care, social service, and resource information to improve the system of care and health outcomes for CYSHCN. The MHP addresses specific informational areas for: Diagnosis and Conditions; Physicians and Professionals; and Parents and Families. The MHP was developed in 2016 through a partnership between the RIDOH and the University of Utah and has been an on-going contractual collaboration since to build the RI Resource component of the portal directory that includes state specific provider and service information. As of June 2020, the number of listings in the RI Service directory was 755.

The RIDOH convenes an Advisory Committee comprised of families, partner state agencies, community stakeholders, health professionals, and advocates to provide guidance and oversight of the MHP. In addition to the Advisory Committee, the RIDOH also participates as a member of the Medical Home Portal 's State Partners' Advisory Board to ensure content integrity, an improved avenue for resource navigation, and a mechanism for user feedback/utilization tracking. The MHP recently benefitted from a collaboration with experienced families of CYSHCN for enhancement of the RI Emergency Preparedness section of the MHP to provide *Crisis Preparedness Tips for Families of Individuals with Special Needs/Disabilities* and a *Crisis Preparation Passport*.

Resulting from the 2020 pandemic crisis, a Covid-19 Section was incorporated into the MHP to share vetted information on health insurance, safety guidelines, community supports, and tools to help families and professionals caring for CYSHCN.
The past grant reporting period showed a dramatic increase in users among families and professionals and has been visited over 13, 000 times. Data collection is captured through google analytics for monthly reporting on number of users, type of device used, and top twenty (20) viewed pages and state locations.

Adolescent Health & Health Equity Zones

Youth and Young Adult Leadership in Health Equity Zones (HEZs)

At the start of the 2019-2020 reporting year HEZs were surveyed to assess their interest and needs around youth/young adult development and leadership (Y/YALD). The results indicated a need to train adults in authentic youth engagement while furthering opportunities for youth leadership and development across the HEZ Initiative. A HEZ wide Youth Advisory was formed, and all agreed that what was needed was funding for a Youth Engagement Consultant (YEC) to elevate youth voice in all priority areas within the HEZ network by providing assessments and recommendations. The HEZ YEC would also be responsible for collaborating with the HEZ youth engagement

advisory to assess HEZ strategies concerning youth engagement. It was also agreed that the HEZ YEC would assist in developing a resource library of best practices and tools to initiate/improve youth engagement, maintain consistent communication with the Rhode Island Department of Health (RIDOH) HEZ leadership and other relevant staff, implement quality improvement measures to improve HEZ efficiency and outcomes in relation to youth voice, and will assist in youth engagement policies and programs as appropriate. The work of this group was put on hold in early March due to COVID-19.

Engaging Youth in Community Planning

In 2018-2019 the RIDOH Youth Advisory Council (YAC) collaborated with the Pawtucket/Central Falls HEZ (PCFHEZ) evaluation team to recruit participants for a young adult focus group "Community Conversations: Help solve the substance use in Central Falls and Pawtucket." Youth leaders from the community participating in this project identified opioid education and awareness as a need, and became part of the PCF HEZ Opioid Action Plan. This plan incudes substance use education for youth, and positive social opportunities and employment opportunities for youth and young adults. The PCFHEZ offered substance use education programs that reached 216 students at local schools. In a post-presentation survey, 91% of students reported that the presentation helped them understand how opioids affect the body, and 92% of students reported feeling very or somewhat confident that they would be able to help someone in the case of an overdose. The PCF HEZ also developed plans to strengthen their collaborative by establishing a youth engagement taskforce (work group) to identify specific needs for youth and youth serving organizations in PCFHEZ.

Engaging Adolescents in Community Assessments

The Cranston Health Equity Zone, a new HEZ in their first year of development, engaged youth and young adults in their initial community assessment process. They developed a teen focused survey and collaborated with a middle school within their target area to administer the survey to students. This resulted in incorporating teen input around education, safety, and health for their community into the Cranston HEZ 2020-2021 workplan to bring trauma informed training to schools in the Cranston HEZ.

The East Providence Health Equity Zone, another new HEZ, also engaged youth and young adults in their initial community assessment process. In response to their findings, the EP HEZ plans to establish a Youth Health and Wellness workgroup to further explore and to develop plans to address areas of concern identified by the youth, including bullying and substance misuse.

Engaging Adolescents in Health/Wellness

The Woonsocket Health Equity Zone continues to provide sex education curriculum to all ninth grade students at Woonsocket High School and ongoing, open-door support from the sex education provider. Additionally, the HEZ has partnered with a local school-based community organization and the RIDOH Adolescent Health Program to develop Family Planning messaging via social media. The local school-based CBO also provides a holistic health and wellness curriculum with a leadership component requiring students to develop a health or wellness related leadership strategy to present to their community or school. The program awards .25 credit when students complete the program. This ongoing work in the HEZ has contributed to a 30% reduction in teen pregnancy since 2014.

Statewide Adolescent Health Strategic Plan – Rhode Island's Adolescent Health Strategic Plan utilizes Healthy People 2020 and Maternal and Child Health's Title V performance measures as a guide in identifying these health priorities. This plan discusses each health priority by presenting an overview of the issue and providing a snapshot on how it is affecting different segments of the adolescent population. The Adolescent and School Health program at RIDOH identified overarching goals and guiding principles that support the plan. The eight key areas each have specific goals and objectives needing action to improve the health status of adolescents in RI through 2022. The goals and objectives were developed based upon existing data, current research, identified gaps, and by integrating

initiatives supported by collaborating partners. Best practice strategies for achieving the goals and objectives will be discussed in the strategic plan to address the unique health needs of adolescents. Currently the version is in its final draft, and circulated for editing and final comments.

Social Media Marketing and RIghtTime App – In 2019-2020, the Center for HIV, Viral Hepatitis, STD and TB Epidemiology (CHHSTE) continued its collaboration with RIDOH's Family Planning Program to promote the RIghtTime app. The mission of this app is to help adolescents and people of all ages and genders to navigate an increasingly complicated landscape of information surrounding sexual health. In 2019-2020, we continued promotion of the app and raised awareness about HIV/STD prevention, testing, and treatment through social media, as well as through tabling at athletic and community events (such as Pawtucket Red Sox and Providence Bruins games, the Rhode Island All-State High School Sports Awards, Rhode Island Pride, and the Washington County Fair). We have also continued building partnerships with healthcare providers, community organizations, and educator organizations such as the Rhode Island Healthy Schools Coalition, the Rhode Island School Nurse Teacher Association, and the Rhode Island Association for Health, Physical Education, Recreation, and Dance and presented workshops and training opportunities promoting RIghtTime as a sexual health resource for youth, educators, and parents.

RIDOH Partnership with RI Healthy Schools Coalition - During 2019-2020, RIDOH continued to work with the RI Healthy Schools Coalition (RIHSC) to engage school districts in assessing and implementing positive change related to Adolescent Sexual Health (ASH). Efforts continued to focus on raising greater awareness of Adolescent Sexual Health as a part of comprehensive health education, developing policy, and providing school committee members, administrators, educators and nurses with tools and resources to improve education and access to services in their schools. During the past 12 months, RIHSC:

- Presented an Adolescent Sexual Health workshop for RI School Committee members, in coordination with the RI Association of School Committees (RIASC), with 24 highly engaged attendees, representing 19 RI school districts, which served as an introduction to the need and urgency of improving adolescent sexual health. Attendees returned to their district school and wellness committees to secure support for next steps.
- Developed an Adolescent Sexual & Reproductive Health Assessment Tool, based on the National School Health Index and RI specific regulations and data points, to help districts self-assess policy, practice and professional development around this topic.
- Developed accompanying Resource Sheets for the Tool to provide information and possible action steps for improvement.
- Created ASH in the Schools: The Basics for district stakeholders, a document that explains/reinforces the importance of adolescent sexual health in schools and introduces the Assessment Tool.
- Provided technical assistance to two school district wellness committees (Pawtucket and Smithfield) as they completed the self-assessment and identified next steps.
- Created a RI Sexual Health Education Requirements Summary document for districts to more easily see provisions pertaining to ASH, with information extracted from the 3 extensive documents that dictate all health education standards, requirements and educational outcomes for RI schools.

Vaccinate Before You Graduate (VBYG) – RI has conducted school located vaccination (SLV) clinics every year since 2001 through our Vaccinate before You Graduate (VBYG) program. VBYG is a "catch-up" school-based vaccination program initially targeting high school seniors but has expanded in recent years to include all students in middle school and high school. The goal of the program is to ensure that students have access to all routinely recommended vaccines and are fully immunized before graduating from high school and entering college and/or the workforce. All vaccines recommended for adolescents by CDC's Advisory Committee on Immunization Practices (ACIP) including influenza are available through the VBYG program. The program has been acknowledged for its

innovative approach to improving adolescent access to vaccines and has helped in our work towards reaching state and national immunization goals. In 2018, RI was recognized for achieving the highest adolescent immunization coverage rates compared nationally at the National Immunization Conference. During school year 2019-2020, a total of 95 schools participated in VBYG program. A total of 1,825 students received one or more vaccines through the program and 3,776 vaccine doses were administered. With the early closure of schools due to the COVID-19 response, less clinics were held and therefore less students were vaccination than previous years.

Conference on Youth Sexual Health Education - In partnership with the RI HIV & STI Prevention Coalition, RIDOH hosted the seventh annual RI Conference on Youth Sexual Health Education (CYSHE) on May 10, 2019. CYSHE reached over 100 youth serving providers to improve professional capacity to address the sexual health needs of youth in a positive, safe and supportive environment with improved knowledge, comfort, skills, and resources. The key note speaker was Lorena Olvera Moreno, PhD, MEd, MPsT, is an educator and Fulbright awardee with more than 10 years of experience within the fields of sexuality education, reproductive justice, and reproductive health. Her talk *"Honoring Marginalized Communities through Intersectional Sexuality Education"* recognized the complexities of oppressed young people's sexual and reproductive lives, and described the framework of intersectional sexuality education as it applies to youth.

The Violence and Injury Prevention Program (VIPP) -
collaborates with RI Student Assistance Services to implement a 12-session emotional regulation pilot program in two middle schools. This intervention targeted students who were referred by school professionals. In addition, the MCH Program supported work with the Brain Injury Association of RI to provide ImPACT Neuropsychological Baseline Testing to high school youth who participated in school sports and youth athletic leagues. This program also provides concussion recognition and brain safety informational presentations to athletic trainers, coaches, parents, school professionals and middle and high school age youth who participated in school sports and youth athletic leagues.

The VIPP in collaboration with Day One, the states only rape crisis center, has created two initiatives for college professionals and students. The RI Cross Campus Collaborative on Sexual Assault Prevention consists of Title IX and Sexual Assault Prevention professionals from the 11 colleges and universities in Rhode Island. The collaborative meets monthly to share best practices, conduct process and outcome evaluation trainings, and has participated in an American Public Health Association (APHA) training on on-campus sexual assault prevention planning. The second initiative created is the RI Student Collaborative on Sexual Violence, which includes undergraduate and graduate students from the 11 colleges in Rhode Island. The student collaborative hosted sexual assault prevention fundraisers and implemented a student led sexual assault prevention rally.

Youth Sport Concussion Prevention Program (YSCPP) – Title V provided Venture Capital funding to offer neuropsychological baseline testing (NBT) to middle and high school age youth ages 11-18 who participate in school sports and youth athletic leagues. This project proposes the use of the ImPACT neuropsychological baseline test to capture a baseline for youth athletes. ImPACT is a web-based 20-minute test that measures attention span memory, problem solving, and reaction time that can reveal a wide range of deficits in neuropsychological functioning. This test is easy to administer by computer, is relatively inexpensive to administer, and provides a database that can be used to monitor youth who are affected. In addition, the program provides concussion safety informational presentations to athletic trainers, coaches, parents, school professionals and middle and high school age youth ages 11-18 who participate in school sports and youth athletic leagues. Between October 1st, 2019 through June 31st, 2020. The Youth Sport Concussion Prevention Program was implemented in 18 schools in a variety of ways. Six out of the eighteen schools only participated school in concussion education presentation activities. 508 students aged 11-18 completed baseline ImPACT testing. The Program is working on implementing a universal return to learn

protocol called REAP which focuses on concussion management for schools. By implementing REAP the Youth Sport Concussion Prevention Program will be able to help not only student athletes but any student who suffers a concussion.

Pediatric Psychiatry Resource Network (PediPRN) -

Pediatric psychiatry Resource Network (PediPRN) - Rhode Island's children and adolescents face significant challenges in accessing timely and affordable mental health care. In response to this need, the RIDOH is working in conjunction with the Emma Pendleton Bradley Hospital to expand its existing child psychiatry access program, the Pediatric Psychiatry Resource Network (PediPRN). The project's mission is to improve access to behavioral health care for Rhode Island children and adolescents by integrating psychiatry into the state's pediatric primary care practices. To achieve its mission, PediPRN uses a telephonic integrated care model to improve access to quality behavioral health expertise. This service is free and provides all Rhode Island pediatric primary care providers assistance with the mild to moderate mental health care needs of their patients. PediPRN focusses on creating a culture of empowerment for pediatric primary care providers. The clinical team works closely with providers offering CME opportunities, educational e-blasts, an updated website with assessment and educational resources on pediatric behavioral health topics, and ongoing support during telephonic consultations. In addition, PediPRN implemented the delivery of training, mentoring and education to PPCPs in the PediPRN Intensive Program (PIP) with the goal of creating a group of practitioners embedded in each of their home practices who will serve as local experts on various behavioral health topics. The PIP program has completed it's first year and a second cohort of physicians has begun in 2020. Additionally, PediPRN has expanded its capacity as a resource to providers during COVID-19 an has started hosting "office hours" to physicians via zoom. Providers can speak with a staff psychiatrist, or with each other, about topics to support behavioral health treatment in their practices. This additional resource is meant to provide additional support to providers during these unprecedented times.

Emotional Regulation Intervention Project –The Rhode Island Department of Health Violence and Injury Prevention Program in conjunction with the Rhode Island Student Assistance Program (SAP) aim to provide a wide range of prevention and early intervention services to high risk adolescents. The intervention will be implemented by master's-level counselors who will provide a Prevention Education Series (PES); individual and group counseling for students enrolled in; and referral to community-based social service and mental health agencies. The intervention was piloted during the '17-'18 school year in which SAP counselors were trained in Project TRAC, a developmentally tailored emotion regulation training program designed for middle school students. The focus of the program is to help students 1) become aware of the connection between emotions and behaviors (especially risk behaviors), 2) improve recognition of when one is having a strong emotion, and 3) learn strategies for managing emotions in moments when they are making decisions.

The 2018 Title V MCH Venture Capital Funding allowed the Violence and Injury Prevention Program (VIPP) to scale up the implementation of the Emotional Regulation Intervention Project from two to five schools. During the 18-19 school year the SAP hosted a two-day emotional regulation intervention training for five counselors returning and new who showed interest in the Emotional Regulation Intervention Project. The Emotional Regulation Intervention Project implemented five 12 session workshops in five different school districts in Rhode Island. The number of students who participated varied between three and eight students per group. The Emotional Regulation Intervention Project served 31 students but the pre and post surveys were only completed by students who received parental approval before the start of the workshop. The evaluator will analyze the pre-post survey data and develop a report by September 2019. In efforts to sustain the intervention the VIPP will work with the Emotional regulation consultant to adapt the 12-session workshop into strategies that can be implemented by teachers in the classroom. In addition, the VIPP was able to obtain additional funding through the Rape Prevention Education grant to implement seven

workshops in the 19-20 school year.

Mental Health Consultation within early care and education-Through a partnership with DHS, child focused mental health consultation is available statewide. RIDOH is currently working with DHS to sustain its program focused mental health consultation to childcare as well. In 2020, several mental health professionals from Bradley Early Childhood Research Center, who are also early childhood mental health consultants, developed and delivered a training on how to become a child care mental health consultant with the goal of expanding the capacity of the system overall.

Parent education and support for children and their families: Three communities were supported to implement Incredible Years groups for families in the communities. Anticipated outcomes include, improved parenting, increased social emotional competence, and decreased behavior problems. In the longer term, RI expects to see improved school readiness, improved social-emotional functioning, and healthier families.

The Rhode Island Youth Suicide Prevention Project (RIYSPP) - works with a broad range of partners to implement a combination of strategies aligned with the 2012 National Strategy for Suicide Prevention that are focused on lowering youth (10-24) suicide death and attempt rates. The three primary interventions associated with this project are: 1. Training youth and adults across the State in evidence-based gatekeeper training programs, 2. Training counselors/school crisis team members from schools across the state in a novel streamlined crisis evaluation assessment tool/protocol and connecting them to clinicians (via the Kids' Link line at Bradley Hospital) who can help them triage and connect students in crisis with a local mental health provider, and 3. Implementing RI's first systemic linkage of non-health organizations with mental health using various strategies in order to coordinate and share resources for the assessment, referral, treatment, and provision of follow-up care with wrap around services for at-risk youth, including sharing de-identified data. Also, the project maintains a statewide Youth Suicide Prevention Coalition with representation from all priority populations and funded/non-funded partners and works to promote suicide prevention principles to all Rhode Island residents. VIPP is currently working to rollout the SPI Youth Suicide Prevention work to every public-school district in the state. The VIPP has also implemented the Emotional Regulation program in one Health Equity Zone middle school (Westerly). The VIPP has also participated in the HRSA funded Collaborative Office Rounds grant, whereby the HEZ has received the funding and training is targeted to local pediatricians. The VIPP also participates with the Bristol Health Equity Zone through their suicide prevention subcommittee.

Statewide Plan for Improving Behavioral Health - The Governor signed an executive order (Executive Order 18-03) which charges state agencies with "develop[ing] an action plan to guide improvements to RI's adult and pediatric behavioral healthcare systems" and reporting back to the Governor by November 30, 2018. To do this work, the Governor's Office has asked to convene a small group of liaisons from RI State agencies to develop this action plan, in collaboration with their agencies, agency directors, and the Governor's Office.

PCHM-Kids SBIRT Learning Collaborative- The PCMH-Kids is an initiative of the Care Transformation Collaborative of Rhode Island (CTC-RI) which is a statewide multi-payer patient centered medical home initiative. CTC-RI is co-convened by the Executive Office of Health and Human Services and the Office of Health Insurance Commissioner. RIDOH MCH leadership participates PCMH-Kids leadership planning activities, committee meetings, and work groups. PCMH-Kids was founded in 2015 as a pediatric primary care patient-centered medical home initiative that is driven by data, quality care and collaboration. Practices receive financial support and technical assistance to achieve NCQA recognition as a patient-centered medical home, meet state established clinical quality measures, and participate in quality improvement activities on important child and youth health topics. Cohorts of practices enroll for three years. In January 2019, the third cohort of pediatric practices signed on. Currently there are 37

pediatric and family medicine practices participating in the PCMH-Kids initiative, including 260 primary care providers and trainees, covering over 110,000 lives, and representing more than 80% of the state's pediatric Medicaid population. PCMH-Kids successes include:

- Improved developmental screening of all children age 9-30 months from a baseline of 41% screened to 85.9% screened which is fundamental to the Governor's Children's Cabinet third grade reading readiness initiative
- Improved obesity screening and counseling from a baseline of 55% to 85.8%
- Developed and implemented a pediatric specific high-risk framework to identify children and families that would benefit from care coordination services
- Reduced Emergency Department usage by 2.5% compared with non-PCMH practices

Practices have also embraced a pediatric vision of care coordination and integrated behavioral health, using a model that includes practice-based social workers as care coordinators. Accomplishments in integrating behavioral health services into primary care include:

- ADHD screening, diagnosis and treatment plans
- Maternal post-partum depression screening: baseline of 22% to 87% with implementation of referral protocols for intervention
- Screening, Brief Intervention, Referral, and Treatment (SBIRT) in the adolescents with 75 providers with a total pediatric population of ~34,000

In 2020, RIDOH will continue collaborating with the CTC to support PCMH-Kids practices in integrating Family Home Visiting within the Medical Home and doing joint care coordination for families facing adversity.

RIDOH MCH programs work closely with PCMH-Kids to support medical home efforts. KIDSNET, the state's integrated child health information system, works with providers to create reports that practices can use for patients care. Practices can utilize this centralized database to identify children in need of newborn hearing screening, immunizations, lead screening, developmental screening, Kindergarten readiness screening as well as participation in other early childhood programs such as WIC, Family Home Visiting Programs, and Early Intervention. KIDSNET recently worked with PCMH-Kids to develop a new practice report to identify newborns and young children with medical and family risk factors that would benefit from care coordination and referrals for supports. In March 2019, the RIDOH Family Home Visiting program and PCMH-Kids collaborated in applying for a *Healthy Tomorrows Partnership for Children* grant to improve communication between primary care and home visiting programs and implement a process for integrated care coordination. Funds will be awarded in March 2020 for this five-year project.

RIDOH Healthy Summer Toolkit for Youth Program Leaders - Between late spring and fall of 2019, multiple RIDOH programs contributed health information and links to health resources as part of a new bi-weekly newsletter. Multiple issues disseminated health information and resources about **insect and animal bite disease prevention,** youth mental health resources, emergency preparedness for youth, smoking/vaping/substance use prevention, and sun/extreme heat safety, among others. Later summer/early fall editions also served as back-to-school resource editions.

Sustainability of Adolescent Priorities

As a result of the 2020 Needs Assessment, RI's MCH has selected a different priority. Several of the programs and projects will be continued within RI's MCH programs or continued within the new 2020-2025 Priorities. The following programs/projects will be sustained in the following manner:

Got Transition - RIDOH will continue using best practice and guidance from GotTransition and the National Collaborative on Workforce and Disability-Youth (NCWD-Youth) and the National Academies of Sciences, Engineering, and Medicine recommendations in the Promise of Adolescence: Realizing Opportunity for All Youth, will continue to collaborate with partner state agencies - RI Department of Education (RIDE), Office of Rehabilitation Services (ORS), Department of Children, Youth, and Families (DCYF), and Behavioral Health and Developmental Disabilities Hospitals (BHDDH), the Health Equity Zones (HEZ), and other community stakeholders to promote and implement the following for transition age youth:

- Forums focused on building youth leadership, development, and mentoring skills in the areas of social and emotional well-being and the Dare to Dream Student Leadership Conference.
- Increase the statewide presence of the RIDOH Youth Advisory Council (YAC) and promote youth engagement in the HEZ.
- Provide transition education and resources to PCMH-Kids/PCMC-Adults
- Youth Resource and Opportunity Mapping
- Promoting youth participation on State Agency Advisories and Councils- focusing on statewide systems i.e. Children's Cabinet, Healthy Transitions, Transition Council, RI Special Education Advisory Council

Dare 2 Dream 2.0 - RIDOH will continue to build on past success of the 12th annual Dare to Dream Conference. Through a continued collaborative effort with the University of Rhode Island Center for Student Leadership and Development and partner state agencies, the RIDOH plans to design a conference program that will promote social/emotional health, well-being, and resiliency skill building for a second year in a row.

RIDOH Youth Internships - RIDOH will continue to provide internship opportunities for students with special needs/disabilities (ages 16-21) to provide work exploration/experiences in public health programs for students enrolled in RI Transition Academies, District High School Transition Programs, and vocational learning programs that include pre-employment transition services and community work placement. The RIDOH will also increase efforts to expand the Department programs that will provide internship placements within their program areas for students who need to have the opportunity to become familiar with the norms of a work setting and explore various job skills. Prior to the start of the 2019/2020 school year, the RIDOH Internship Program will conduct internship orientation sessions to identify potential students for participation in the program.

Youth Advisory Council (YAC)- RIDOH will continue to expand the opportunity for youth to participate with the Department in an advisory role. Monthly meeting address 3 focus areas: professional development and training, group soft skills building, and project/event planning and facilitation. Members of the Youth Advisory Council will participate in the RIDOH Title V Needs Assessment planning for incorporation of the youth. The YAC will continue to have significant role in the 2020 Dare 2 Dream 2.0 Student Leadership Conference.

Sexual Health - During the next year RIDOH plans to continue the collaboration with RIDE and encourage sexual health education in schools. The adolescent sexual health workgroup is in the process of assessing the current landscape of adolescent sexual health services in Rhode Island and prioritizing additional topics to focus on. RIDOH plans to continue the relationship with Providence Community Health Centers to improve STD screening among adolescents as well as extend the relationship through the Rhode Island Health Center Association.

Youth Engagement - The RI-GEMS initiative will adapt three locally and nationally recognized evidence-based and promising practice models: Girls Circle Afterschool Program; Upward Bound Summer Enrichment Academy; and Racial Justice Training to achieve the program objectives outlined in this grant. Each of these three models is connected to three core components of RI-GEMS:

1. Girls Circle Afterschool program & other enrichment activities
2. RI-GEMS Summer Enrichment Academy (Similar to Upward Bound)

3. Racial Justice Training and Adult Education

Violence and Injury Prevention - RIDOH plans to continue its work to address distracted and impaired driving policies; improve the implementation of return to learn protocols; and continue to implement the middle school emotional regulation pilot program. Second, the program plans to continue its groundbreaking work with school crisis teams and diversion of youth from hospital ED's when proper screening and consultation indicate it can be safely done through a community mental health center. In collaboration with *Day One,* RIDOH will continue to implement the Your Voice, Your View bystander intervention workshops in middle and high schools in Rhode Island.

Positive Youth Leadership/Development and Youth Involvement in the HEZ

To build on the momentum of the RIDOH Youth Advisory Council and to advance the necessity for meaningful engagement of youth as experts about their needs and priorities, RIDOH is exploring strategies to increase the youth involvement through the HEZ Initiative. Plans include: "Community of Practice" models for Youth Engagement, HEZ Youth Advisory Councils, Statewide Youth Engagement Opportunities mapping, and forums for youth investment via the Dare to Dream Initiative and other events.

APPLICATION YEAR: Adolescent Health

Adolescence (age 12-17) is a critical period of transition between childhood and adulthood. It includes the biological changes of puberty and development to adulthood. The behavioral patterns established during these developmental years can protect children or put them at risk for many different physical and behavioral health conditions. Older adolescents and young adults, including those with chronic health conditions, may face challenges as they transition from the pediatric to the adult healthcare system. This includes changes in their health insurance coverage and legal status. It may also include decreased attention to their developmental and behavioral needs. The Rhode Island Department of Health (RIDOH) strives to ensure that all adolescents and young adults receive timely, high-quality, culturally sensitive healthcare. This health domain section has taken into consideration that the care and outcomes of womxn, children, and families are impacted by the systemic racism, discrimination, unaddressed language barriers, and a lack of culturally responsive providers. The following quantitative, qualitative, and anecdotal information tries to tease out health disparities and the overarching healthcare needs of communities.

Priority: Support Mental & Behavioral Health

The overall Title V priority for adolescent health is to comprehensively support mental and behavioral health. There was a slight decrease in bullying in school property among high school students from 17.3% in 2017 to 16.4% in 2019. LGB high school students continue to be more likely to be bullied on school property (37.2%) than heterosexual high school students (13.0%), as well as more likely to be electronically bullied (LGB HS students: 26.5%; heterosexual HS students: 10.9%). Suicide ideation is an important issue which the MCH Program monitors. YRBS 2019 data report a slight decrease among high school teens who seriously considered committing suicide from 13.6% in 2017 to 12.1% in 2019, but a statistically significant increase from 9.9% in 2013. Disparities exist between 16.6% of Non-Hispanic Black teens who seriously considered committing suicide compared to 10.6% of Non-Hispanic White teens in 2017. In 2019, the prevalence of having attempted suicide was higher among gay, lesbian, and bisexual students (36.5%) than heterosexual (9.7%) students. The percentage of binge drinking (11.2%) among high school teens in 2017 has dropped slight in 2019 (10.7%).

In 2019, RIDOH Title V and Adolescent Reproductive Health staff outlined and administered a youth survey. Youth ranked the following as their top four priorities that should be addressed to improve the health and well-being of teens: 1) Mental Health (54%), 2) Safe & Healthy Schools (53%), 3) Suicide Prevention (37%), and 4) Healthy Relationships (with adults, friends, and partners) (36%).

Similarly, 32% of teens ranked Mental health(Anxiety, depression, etc.) as one of their top four things that concerned them on a day to day basis. Rhode Island and SISTA FIRE collaboratively distributed a survey that asked womxn of color the top three important things that need to be addressed to improve the health and well-being of adolescents (12-17 years old). The top priorities that rose to the top are as follows: 1) Sexual Health (58.9%), 2) Mental Health (45.4%), and 3) Social & Emotional Health (40.2%). Womxn of color ranked the top three important things needed to be addressed for the health and well-being of young adults (18-24 years old). The following three priorities were overwhelmingly chosen: 1) Mental Health (64.2%), 2) Social & Emotional (44.9%), and 3) Sexual Health (42.6%).

All three surveys overwhelming align to show that there is a need to support the mental and behavioral health and development of youth. This theme was further fleshed out during a youth focus group the Title V needs assessment team held with the Youth Advisory Council (YAC). The youth agreed that mental health was an immense issue among their peers that encompassed substance and drug use and mental illness. Youth participants did see substance use, vaping, and drug use occurring within social scenes and gatherings. However, all agreed that much of the persistent drug use, substance use, and vaping they saw was tied to youth masking or self-treating underlying social and emotional issues. In all, Youth focus group participants emphasized that mental illness should be destigmatized and schools and providers should find more educational and supportive avenues to help bolster youth mental health.

Strategy: Support Policy and Partnerships to Promote Youth Mental or Behavioral Health in Schools and the Community

The Rhode Island Youth Suicide Prevention Project (RIYSPP) - works with a broad range of partners to implement a combination of strategies aligned with the 2012 National Strategy for Suicide Prevention that are focused on lowering youth (10-24) suicide death and attempt rates. The three primary interventions associated with this project are: 1. Training youth and adults across the State in evidence-based gatekeeper training programs, 2. Training counselors/school crisis team members from schools across the state in a novel streamlined crisis evaluation assessment tool/protocol and connecting them to clinicians (via the Kids' Link line at Bradley Hospital) who can help them triage and connect students in crisis with a local mental health provider, and 3. Implementing RI's first systemic linkage of non-health organizations with mental health using various strategies in order to coordinate and share resources for the assessment, referral, treatment, and provision of follow-up care with wrap around services for at-risk youth, including sharing de-identified data. Also, the project maintains a statewide Youth Suicide Prevention Coalition with representation from all priority populations and funded/non-funded partners and works to promote suicide prevention principles to all Rhode Island residents. VIPP is currently working to rollout the SPI Youth Suicide Prevention work to every public-school district in the state. The VIPP has also implemented the Emotional Regulation program in one Health Equity Zone middle school (Westerly). The VIPP has also participated in the HRSA funded Collaborative Office Rounds grant, whereby the HEZ has received the funding and training is targeted to local pediatricians. The VIPP also participates with the Bristol Health Equity Zone through their suicide prevention subcommittee.

Children with Special Health Care Needs

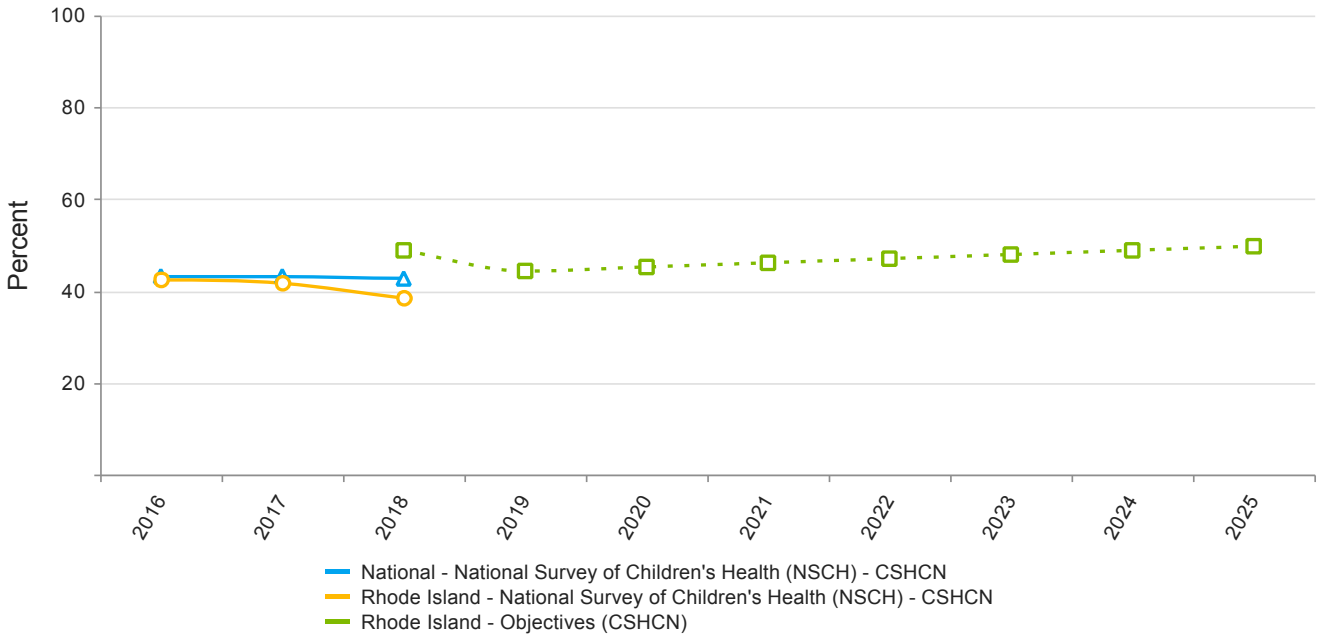
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	14.0 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	54.2 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	93.2 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2017_2018	2.8 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			48.8	44.3
Annual Indicator		42.5	41.6	38.4
Numerator		19,360	18,320	16,137
Denominator		45,543	44,071	41,977
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	2017	2018	2019
Annual Objective			48.8	44.3
Annual Indicator	42.5	42.5	40.6	
Numerator	19,360	19,360	17,280	
Denominator	45,543	45,543	42,599	
Data Source	NSCH	NSCH	NSCH	
Data Source Year	2016	2016	2017	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	45.2	46.1	47.0	47.9	48.8	49.7

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - # of web hits on the Medical Home Portal

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			5,000
Annual Indicator		4,737	14,098
Numerator			
Denominator			
Data Source		CSHCN Program - Med Home Portal Google Analytics	CSHCN Program - Med Home Portal Google Analytics
Data Source Year		StateFY19	StateFY20
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	15,000.0	16,000.0	17,000.0	18,000.0	19,000.0	20,000.0

ESM 11.2 - Pediatric Practices Trained on Care Coordination

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	28.1
Numerator	36
Denominator	128
Data Source	Care Transformation Collaborative/CSHCN Program
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	44.0	52.0	60.0	68.0	76.0

State Performance Measures

SPM 4 - Percent of parents of CSHCN reporting effective care coordination for their child

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	50.4
Numerator	21,112
Denominator	41,913
Data Source	NSCH
Data Source Year	2017-18
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	52.0	53.0	54.0	55.0	56.0

State Action Plan Table

State Action Plan Table (Rhode Island) - Children with Special Health Care Needs - Entry 1

Priority Need

Ensure effective Care Coordination for CSHCN

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

Increase the percent of children with SHCN, ages 0 through 17, who have a medical home from 44.3% in 2019 to 49.7% in 2025

Strategies

Promote patient centered medical homes

Promote a web-based application to address effective care coordination in the Medical Home Portal

ESMs	Status
ESM 11.1 - # of web hits on the Medical Home Portal	Active
ESM 11.2 - Pediatric Practices Trained on Care Coordination	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

State Action Plan Table (Rhode Island) - Children with Special Health Care Needs - Entry 2

Priority Need

Ensure effective Care Coordination for CSHCN

SPM

SPM 4 - Percent of parents of CSHCN reporting effective care coordination for their child

Objectives

Increase the percent of parents of CSHCN reporting effective care coordination for their child from 50.4% in 2019 to 56% in 2025

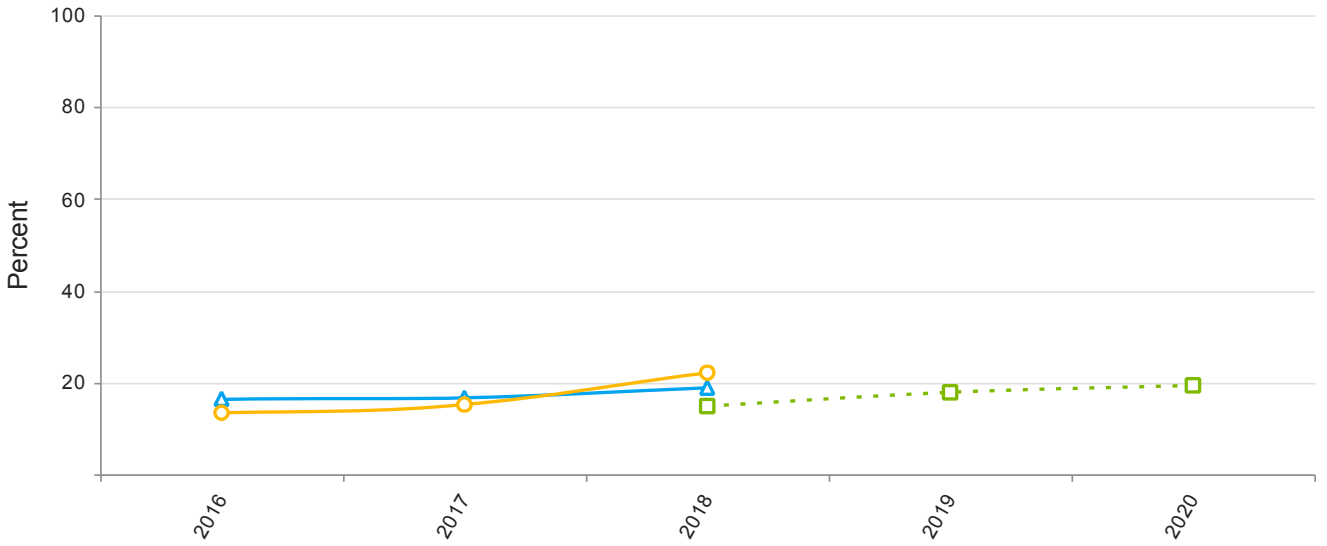
Strategies

Promote patient centered medical homes for CSHCN

Promote a web-based application to address effective care coordination in the Medical Home Portal

2016-2020: National Performance Measures

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



National - National Survey of Children's Health (NSCH) - CSHCN
Rhode Island - National Survey of Children's Health (NSCH) - CSHCN
Rhode Island - Objectives (CSHCN)

2016-2020: NPM 12 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			14.9	17.9
Annual Indicator		13.4	15.1	22.3
Numerator		2,540	3,136	4,528
Denominator		18,916	20,735	20,335
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			14.9	17.9
Annual Indicator	13.4	13.4	16.5	
Numerator	2,540	2,540	3,731	
Denominator	18,916	18,916	22,553	
Data Source	NSCH	NSCH	NSCH	
Data Source Year	2016	2016	2017	
Provisional or Final ?	Final	Final	Final	

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 12.1 - % of medical homes with trained staff on transition

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		14	16	18
Annual Indicator	10.3	15.1	15.1	15.1
Numerator	13	19	19	19
Denominator	126	126	126	126
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 12.2 - % of practices with a transition policy

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		2	3.2	2.4
Annual Indicator	1.6	1.6	1.6	1.6
Numerator	2	2	2	2
Denominator	126	126	126	126
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 12.3 - # of youth participation in and accessing Dare 2 Dream; Self Assessments; Ready, Set, Go; HEZ; and Internships

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		1,000	1,800	1,750
Annual Indicator	1,125	1,731	1,406	1,406
Numerator				
Denominator				
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 12.4 - # of participants in Teen Outreach Program

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			240
Annual Indicator			149
Numerator			
Denominator			
Data Source			Teen Outreach Program
Data Source Year			2019-20
Provisional or Final ?			Final

2016-2020: State Outcome Measures

2016-2020: SOM 4 - Percent High School Students with Special Health Care Needs attempting suicide

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		23	22.5	22
Annual Indicator	23.1	24.4	24.4	19.8
Numerator	1,671	1,845	1,845	1,907
Denominator	7,249	7,567	7,567	9,640
Data Source	YRBS	YRBS	YRBS	YRBS
Data Source Year	2015	2017	2017	2019
Provisional or Final ?	Final	Final	Final	Final

ANNUAL REPORT: Children with Special Health Care Needs

The Maternal and Child Health Bureau (MCHB) defines Children with Special Health Care Needs (CSHCN) as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." (mchb.hrsa.gov) Children and youth with special health care needs (CYSHCN) are a diverse group of children, ranging from children with chronic conditions to those with more medically complex health issues, to children with behavioral or emotional conditions. Health care needs may be physical, developmental, behavioral or emotional and may manifest in children of any age. CSHCN are often diagnosed with more than one condition, and frequently experience several functional difficulties, learning or behavior problems, difficulty with gross or fine motor skills, chronic pain or difficulty in making and keeping friends. [D(1]

Priority: Improve the System of Care for Children With Special Health Care Needs

- ***Support the enhancement of care coordination with the PCMH-Kids practices, with emphasis on CYSHCNs.***

Care Transformation Collaborative - Launched in 2008 by the Office of the Health Insurance Commissioner, the Care Transformation Collaborative of Rhode Island (CTC) formally the RI Chronic Care Sustainability Initiative (CSI-RI) brought together key health care stakeholders to promote care for patients with chronic illnesses through the patient-centered medical home (PCMH) model. Practices were supported through contract agreements negotiated between the health plans to provide per member per month payments to drive practice transformation and quality improvements (care coordinators, electronic medical records etc.). The successful CTC adult PCMH initiative served as the pilot for the CTC implementation of a model for pediatric practices (PCMH-Kids) to provide children/youth including those with special health care needs with a medical home to enhance the system of care to improve health outcomes.

PCMH-Kids – The Patient Centered Medical Home Kids (PCMH-Kids) project, a multi-payer, primary care payment and delivery system reform was convened in 2013 to extend the transformation of primary care to practices that serve children across Rhode Island. PCMH-Kids. The RI Department of Health (RIDOH) participated in this initiative along with project partners: RI's 4 major health plans; RI American Academy of Pediatrics (RIAAP); Executive Office of Health and Human Services (EOHHS); and the Care Transformation Collaborative (CTC) of RI to engage providers, payers, patients, parents, and policy makers to develop high quality patient-centered medical homes for this population. During the last Title V reporting period, RIDOH partnered with the CTC to support continued implementation of PCMH-Kids and facilitation of the expanded initiative to include 28 practices. The RIDOH collaboration supports technical assistance for practice learning sessions, care coordination, practice reporting, and stakeholder meetings.

Cedar Program Collaboration with PCMH-Kids - During the summer of 2015, the Executive Office of Health and Human Services (EOHHS) underwent a transformation regarding Medicaid service delivery changes as part of the initiative - Reinventing Medicaid. These changes focused on 1) Improving integration and coordination of care; 2) Improving outcomes for children/youth and their families; and 3) Increasing efficiency of care/coverage. The Medicaid transformation also resulted in a redesign of the Cedar Program to improve service access/system navigation for families of CYSHCN. With the expanded role of primary care as an element of practice transformation, care coordination became an enhanced component of the patient-centered medical home (PCMH)) model. The PCMH-Kids practice care coordination component was further enhanced through the integration of the Cedar Program to support the practices through implementation of a referral process for eligible CYSHCN.

- ***Support a comprehensive system of family leadership.***

Rhode Island Parent Information Network - The RI Department of Health (RIDOH) contracts with the Rhode Island Parent Information Network (RIPIN) for Peer Resource Support Services to support the Title V Program in ensuring a quality system of health care for Children and Youth with Special Health Care Needs (CYSHCN). Through the employment of families of CYSHCN, RIPIN provides training to individuals who have actual life experience to assist other families of CYSHCN. Specific areas of Peer Resource Specialist support include the administration of a comprehensive resource, information, and referral system; training, education, peer support, and system navigation. In addition, the Peer Resource Specialists promote the values of cultural diversity, family-centered systems, and family and professional partnerships. The RI Parent Information Center is also the federally designated Family to Family (F2F) Health Information Center for the State of Rhode Island. Currently, all RIPIN employees are certified or working toward Community Health Worker certification.

Family Voices - The RI Department of Health (RIDOH) ensures the incorporation of family leadership through contractual support the Family Voices (FV) program which is housed within the RI Parent Information Network (RIPIN). Family Voices is a national grassroots network of families representing Children and Youth with Special Health Care Needs (CYSNCN) with a chapter in each state. The Family Voices program fulfills the Title V CYSHCN mandate to provide opportunities for parent engagement, leadership development, and policy advocacy to address the uninsured and underinsured CYSHCN. Family representation and/or input is incorporated into the following: task forces, advisories, and councils for CYSHCNs; communications development/distribution; parent/caregiver support groups; community outreach; and legislative policy development/advocacy.

Family Voices Leadership Team - RIDOH contracts with RIPIN to convene The Family Voices Leadership Team, an advisory body comprised of state agencies, healthcare providers, and community stakeholders, to provide expertise and input on a variety of issues effecting the system of care for CSHCN. Current members include:

- The Autism Project
- Bayada Home Health Care
- Bradley Hospital - (Children's Behavioral Health)
- The Governor's Commission on Disabilities
- Parent Support Network of RI
- Protect our Health Care Coalition of RI
- RI Behavioral Health, Developmental Disabilities, and Hospitals
- RI Department of Health, Office of Special Needs, Birth Defects, and Emergency Medical Services for Children's Programs
- RI Executive Office of Health and Human Services
- RI Kids Count
- RI Parent Information Network
- United Health Care
- United Way

RIDOH staff also participate in the FV Leadership Team and provide heavy input on agenda topics and planned activities. During the past year, the group completed a fact sheet that is being used to inform legislative advocacy efforts to improve the quality of life for CYSHCN. A Policy Forum, "Families as Partners Shaping Systems Change," was held and families shared their experiences with RI's behavioral health care system, getting their children evaluations and diagnosis, and lack of in-home services and supports from respite to skilled nursing.

Family to Family Health Information Center (F2FHIC) - RIPIN is also the Rhode Island's HRSA funded F2FHIC, which is housed within Family Voices. This program provides families of CSHCNs with support, resource referral, training workshops, advocacy, and relevant information via newsletters/publications/websites. The National Center of Leadership for Family and Professional Partnerships provides technical assistance, training, and connections to F2FHICs. Title V dollars are utilized to provide staffing support.

RIPIN Peer Resource Specialists – Through a contract with RIDOH, RIPIN employs Peer Resource Specialists to strengthen Rhode Island's capacity to plan and deliver effective services to special needs, disability, and vulnerable populations. The Peer Resource Specialists bring the perspective of parents, youth, and consumers into the programs where they are placed. In addition to employment within the RIDOH, Peer Resource Specialists are employed throughout the CYSHCN service system, assist healthcare professionals, community stakeholders, and policy leaders in providing support to CYSHCN and their families. RIPIN has developed and registered an apprenticeship program with RI Department of Labor and Training, to further support the development of certified community health workers (CCHWs) utilizing employed Peer Resource Specialists. RIPIN has aligned its professional development programming to the domains of the certification standards. RIPIN employees are expected to earn certification within their first 18 months of employment. During the last year, Peer Resources Specialist have worked with the following RIDOH programs: Special Needs, Birth Defects, Oral Health, Emergency Preparedness, Home Visiting, Health Information Line, Chronic Disease, WIC, and Immunization.

Parent Support Groups - Family Voices hosts a monthly Peer Support Group for families and caregivers of CYSHCN, entitled Peer-to-Peer Connections. This group is facilitated by RIPIN staff members, who are also parents of CYSHCN. The goal of the support group is to foster guidance and support from peers who share their same experiences. Each month's meeting focuses on a relevant topic common to all families supporting children and youth with special needs. Additionally, facilitators seek family input regarding trending issues that families experience and use that input to inform the work of Family Voices and the Family Voices Leadership Team. In order to keep the group fluid and encourage new participants, crafts and icebreakers are incorporated into the meetings. During the last year, FV facilitated eleven (11) monthly support group meetings that engaged a total of eighteen families, with six of them being new to RIPIN.

- ***Support and enhance the medical home portal.***

The Medical Home Portal (MHP) - www.medicalhomeportal.org is an online resource established by the RI Department of Health (RIDOH) to provide a one-stop-shop for comprehensive diagnostic, education, specialty care, social service, and resource information to improve the system of care and health outcomes for CYSHCN. The MHP addresses specific informational areas for: Diagnosis and Conditions; Physicians and Professionals; and Parents and Families. The MHP was developed in 2016 through a partnership between the RIDOH and the University of Utah and has been an on-going contractual collaboration since to build the RI Resource component of the portal directory that includes state specific provider and service information. As of June 2020, the number of listings in the RI Service directory was 755.

The RIDOH convenes an Advisory Committee comprised of families, partner state agencies, community stakeholders, health professionals, and advocates to provide guidance and oversight of the MHP. In addition to the Advisory Committee, the RIDOH also participates as a member of the Medical Home Portal 's State Partners' Advisory Board to ensure content integrity, an improved avenue for resource navigation, and a mechanism for user feedback/utilization tracking. The MHP recently benefitted from a collaboration with experienced families of CYSHCN for enhancement of the RI Emergency Preparedness section of the MHP to provide *Crisis Preparedness Tips for Families of Individuals with Special Needs/Disabilities* and a *Crisis Preparation Passport*.

Resulting from the 2020 pandemic crisis, a Covid-19 Section was incorporated into the MHP to share vetted information on health insurance, safety guidelines, community supports, and tools to help families and professionals caring for CYSHCN.

The past grant reporting period showed a dramatic increase in users among families and professionals and has

been visited over 13, 000 times. Data collection is captured through google analytics for monthly reporting on number of users, type of device used, and top twenty (20) viewed pages and state locations.

Governor's Commission on Disabilities Annual Public Forums - The Governor's Commission on Disabilities was designated by law in Rhode Island in 1992 as the agency with the responsibility for state government compliance with the ADA and all other state/federal laws protecting the rights of people with disabilities. In 2003, the Commission also assumed the responsibility to investigate complaints of discrimination based on disability, allegedly caused by physical inaccessibility of facilities. The Commission conducts public forums statewide on the concerns of people with disabilities and their families during the week of the anniversary of the signing of the Americans with Disabilities Act. The forums, held through the state, have led to a broader legislative agenda and highlight the fact that individuals with disabilities often need services from multiple agencies at the same time. Testimony is documented for submission to state policy makers and planners to address current service status, unmet needs, and suggestions for systems improvement and expanding opportunities. The RI Department of Health (RIDOH) and other state agencies participate in forums held every year during July and August. This year (2020) marked the 30th Anniversary of ADA. Celebratory events to acknowledge this important anniversary will be provided though virtual platforms due to COVID -19 safety adherence requirements. The use of the Forums to provide a venue for the voice of individuals with special needs/disabilities and their families have resulted in significant policy and systems changes some of which include:
Medicaid Managed Care option for adults with disabilities that assists families in navigating through the chronic health care systems

- Cost of living adjustment for (Medicaid) personal care attendants
- A crisis intervention service for adults with severe impairments who have been abused or assaulted by a care giver
- Comprehensive instate transitional services for individuals with traumatic brain injury;
- Accessory family dwelling unit in a single-family residence as a reasonable accommodation for family-members with disabilities in any residential area;
- A network of wheelchair accessible taxicabs, funded by the federal New Freedom Initiative;
- RI Pharmaceutical Assistance for the Elderly; co-payments to people on SSDI between 55 and 65 through the Neighborhood Opportunities Program to create more affordable and accessible housing;
- Medicaid Buy-In Program for persons with disabilities who are eligible for Medicaid allowing them to return to work while retaining Medicaid coverage
- The installation of curb cuts and/or ramps at both ends of any pedestrian crosswalk
- A community living option to all persons who have a disability and are sixty-five (65) years of age or younger in order to allow those individuals the choice to live in a less restrictive community-based environment or their own home environment
- The RI Pharmaceutical Assistance for the Elderly to include state co-payments to people on SSDI between 55 and 65
- The Secretary of State to utilize "state-of-the-art" voting technology to expand special ballot services to a wide range of voters with disabilities
- Zoning ordinances to provide standards and requirements for the review and approval of drive-through windows (of any type), including taking into account pedestrian safety and access for people with disabilities;

New England Regional Genetic Network (NERGN) - RIDOH contracts with RIPIN to support families of children with rare genetic conditions to increase awareness of available services and supports. In this role, RIPIN has become a member of NERGN which serves as conduit to share information and research. Over the past year, RIPIN recruited another staff member to support this work. Through this partnership, RIPIN assisted 15 families with children or youth diagnosed with genetic conditions to identify physicians in RI and provided over 400 families and professionals with resources and information. In April 2020, RIPIN staff members virtually attended the annual NERGN Conference. We are also participating

in quarterly meetings with NERGN and the five other Family Voices organizations to share best practices and resources that are useful to both families and professionals.

RIDOH Youth Internship Program - The RI Department of Health (RIDOH) Internship Program for youth with special needs/disabilities provided internships to seven students within various Department Programs during the 2019-2020 school year. The Internship Program utilized the Promising Practice recognition designated by the Association of Maternal and Child Health Programs (AMCHP) to promote the program within RI schools including Transition Academies and Transition Programs. The goal of the Internship Program is to provide students with special needs/disabilities with the opportunity to practice job skills in a real work environment to prepare them for the eventual transition to work and independence. Since there are many factors that impact successful employment for youth with special needs/disabilities, the RIDOH Internship Program provides students with a venue to become familiar with office norms, social behaviors, and daily work routine expectations.

Family Voices Integration with HEZ - The RIDOH contracts with RIPIN to support a quality system of care for CYSHCN and their families *in communities and statewide. This effort includes fostering community connections to provide education, resources, and supports to address systems barriers and gaps at the local level.* RIPIN staff collaborate with each HEZ to build partnerships among professionals and families. RIPIN staff attend monthly collaborative meetings for each HEZ and participated in 3 HEZ statewide learning community meetings where they facilitated panel discussions that addressed education disparities, social determinants of health, and the community health worker role. RIPIN is also utilizing the HEZ collaboratives to recruit respondents for a "Children with Special Health Care Needs Caregiver Survey" that will help identify areas of needs for future policy development.

In collaboration with other state agencies, stakeholders, community-based organizations, and families, RIDOH will continue to ensure that CYSHCN have access to needed programs and services for them to achieve optimal health outcomes and reduce inequalities. Ongoing work includes identifying system gaps and barriers, including clinical, social, and financial, that hinder a coordinated service delivery system for CYSHCN. RIDOH will continue to monitor the special needs service delivery system specific to care coordination services (Cedar Programs) to ensure adequate access, quality standard oversight, and effective collaboration with other systems of care including PCMH.

Sustainability of CSHCN Priorities

During the next year, RIDOH will maintain contractual agreements with RIPIN for the following:

- Family Voices - resource education and dissemination of materials and brochures; support families with referrals and system navigation; ensure family representation at all tables and committees relevant to CSHCNs.
- FV Leadership Team – convene advisory committee that works on systems and policy issues. This group will play a key role in the planning and facilitation of the Caregivers Summit which will connect families and professionals to their legislative representatives to address service needs/gaps identified resulting from the family survey conducted in early 2019.
- Employment of Peer Resource Specialists in various capacities within RIDOH Programs including: Special Needs, Oral Health, Early Hearing Detection & Intervention, Health Promotion, Family Visiting Program, and Emergency Preparedness.
- Represent RI in the New England Regional Genetic Network (NERGN) and provide information and service to families in RI with children with rare genetic conditions.
- Family-to-Family Health Information Center to provide families raising CYSHCN in RI with access to a resource for assistance, training workshops, advocacy, and relevant informational materials.
- Increased involvement and connection with the HEZ through participation in community collaborative meetings and HEZ learning community events.
- Convene and facilitate parent support groups

RIDOH will also continue to collaborate with the CTC to support the expanded the PCMH-Kids Initiative that will provide 17 additional practices (Cohort 3). Efforts will include technical assistance in the support of existing and new participating practices. RIDOH will also partner with the CTC in the planning and facilitation of the annual larger learning collaborative conference to be entitled: *Advancing Integrated Primary Care: Innovations at Work* which is scheduled to be held during October 2019.

The RI Medical Home Portal (MHP) https://ri.medicalhomeportal.org/ will continue to be updated and populated with a variety of new clinical, social, and wrap around support services. RIOH will continue to collaborate with the University of Utah, RIPIN, and the Autism Project, to improve the MHP. The MHP advisory committee will continue to provide oversight and direction on the development of this local resource. A new quality improvement project has been identified for the coming year, it will update and add comprehensive resources for non-clinical supports important to families with CSHCNs such a behavioral health, early childhood services, programs for school aged children, transitions, insurance, and support groups. Outreach and demonstration trainings will also be provided in different venue to increase utilization of the MHP. On-going evaluation efforts will include regular review of the content, website analytics, and participant feedback.

Lastly, RIDOH will provide representation at all Governor's Commission on Disabilities Public Forums scheduled to be held over a two-week period during July and August 2019. As a member of the Commission, the RIDOH will also participate in the review and development of the Public Forum Summary Report for legislatures, policy makers, and state planners.

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In RI, according to 2017/18 NSCH, 20.3% of RI children ages 0-17 years have at least one special health care need, compared to 18.5% in the nation. Among children 3-17 years old, the prevalence of ADD/ADHD is 10.0%. It is also estimated that the current prevalence of autism, Asperger's Disorder, or other ASD in RI is 2.2%.

Medical Home

Several essential criteria are required to be considered a medical home. It includes being accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. In RI, NSCH 2017/18 data report that 38.4% of children with special healthcare needs (CSHCN) had a medical home, compared to 53.1% of children without special health care needs. This RI CSHCN measure does not meet the Healthy People 2020 target objective of 54.8%. In 2017/18, only 40.5% of CSHCN received effective care coordination. In 2017/18, 68.2% of CSHCN are continuously and adequately insured in RI.

Impact on Families

RI continues to study and monitor the financial impact that many families with CSCHN experience. The NSCH 2017/18 reports that 8.7% of families with CSHCN have had problems paying for any of the child's medical or health care bills in RI, compared to 18.1% of families with CSHCN nationwide. NSCH also reports that 14.9% of RI families of CSHCN had a family member stop working or cut down hours of work because of the child's health or health conditions, compared to 1.5% families of children without special health care needs in 2017/18.

Qualitatively, the RIDOH in collaboration with the Rhode Island Parent Information Network (RIPIN) surveyed, interviewed, collected stories, published a issue brief, and held a conference that centered the voices of parents of CSHCNs. Surveyed parents and caregivers reported the following three overarching areas where they felt were challenges to accessing care:

1) Mental & Behavioral Healthcare,

2) Neurology & Neuropsychology, and

3) In-home Nursing and Respite Care.

Overall, parents/guardians reported that they struggled to obtain timely services for their children, especially as it pertained to these three key areas. A CSHCN parent, Amy, stated, “There are so few providers in the state that appointments are more than 5 months out. By the time we get there, another issue has developed or the condition has progressed to the point that my child needs hospitalization; hospitalization seems at times the only way to expedite the ‘availability’ of appointments.” Families, especially those on Medicaid, were frustrated by the limited rate of insurance acceptance by providers and programs in RI. Some families do report trying to explore and access more timely services out of state but face significant resistance from insurance providers.

Additionally, many noted that it was hard to hire qualified home-based caregivers and therapists due to the general applicant pool lacking expertise related to complex pediatric conditions. These home-based providers also have a high turnover rate due to low and noncompetitive salaries and insurance reimbursement rates. Families also were exasperated by the limited hours of home-based services their insurance covered. During listening sessions, caregivers reported that they frequently performed a variety of medical procedures, like catherization, for their children due to limited access to home-based nursing support. This issue is further underlined by the RIDOH and SISTA FIRE survey showing the following answers, assistance with the activities of daily life (46%) and parent support and respite care (39%), as their top two for improving the health and wellbeing of children with special health care needs.

Overall, parents/guardians highlighted that increased coordination of care across agencies and programs is essential to better address the needs of children with special healthcare needs and their families. In general, they agreed there are some high-quality providers in the state, but limited connection and communication between programs. For instance, a desire for better coordination between the RIDOH and RI Department of Education came up as a way to help make services more seamless for CSHCNs. Caregivers expressed frustration that they receive recommendations from doctors which cannot be followed in many schools. One parent noted, “Doctors tell you what is best. Then I bring the paper to school and the school can’t do it. Doctors and schools don’t talk.” Caregivers expressed frustration that they were sometimes on their own to identify potential resources, especially as children grew older. One parent noted, “There are lot of good programs but no interconnection. You have to navigate it yourself.” Overall, there was consensus that better coordination between agencies and programs would reduce the travel burden on families. Some parents reported traveling unnecessarily far distances to access services because they did not have support coordinating care or identifying geographically convenient options. One parent asked, “Why don’t agencies communicate with each other? Why do I have to go to an agency in Warwick when I’m in Cumberland?” In all, interviewed and surveyed caregivers desired a more coordinated and accessible system of care for the needs of their children.

APPLICATION YEAR: Children with Special Healthcare Needs

The Maternal and Child Health Bureau (MCHB) defines Children with Special Healthcare Needs (CSHCN) as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." This includes a diverse group of children younger than 18 (about 20% of children in Rhode Island). It includes children with chronic conditions, children with medically complex health issues, and children with behavioral or emotional conditions. These children may have physical, developmental, behavioral, or emotional healthcare needs. These needs may appear in children of any age. CSHCN are often diagnosed with more than one condition. They also frequently experience difficulties in several areas, such as learning, behavior, gross or fine motor skills, chronic pain, and making and keeping friends. The Rhode Island Department of Health (RIDOH) strives to ensure that all children with special healthcare needs receive timely, high-quality, culturally sensitive healthcare.

Priority: Ensure Effective Care Coordination for Children with Special Healthcare Needs

Priority Overview:

Several essential criteria are required to be considered a medical home. It includes being accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. In RI, NSCH 2017/18 data report that 38.4% of children with special healthcare needs (CSHCN) had a medical home, compared to 53.1% of children without special health care needs. This RI CSHCN measure does not meet the Healthy People 2020 target objective of 54.8%. In 2017/18, only 40.5% of CSHCN received effective care coordination. A larger combined sample size is needed to better understand families and CSHCN in receiving effective care coordination. In 2017/18, 68.2% of CSHCN are continuously and adequately insured in RI.

The RIDOH in collaboration with the Rhode Island Parent Information Network (RIPIN) surveyed, interviewed, collected stories, published a issue brief, and held a conference that centered the voices of parents of CSHCNs. Surveyed parents and caregivers reported the following three overarching areas where they felt were challenges to accessing care:

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Strategies:

1) Promote Patient Centered Medical Homes for CSHCN

The RIDOH aims to support a patient centered medical home (PCMH) for CSHCNs through the Patient Centered Medical Home Kids (PCMH-Kids) project. PCMH-Kids is a multi-payer, primary care payment and delivery system reform was convened in 2013 to extend the transformation of primary care to practices that serve children across Rhode Island. PCMH-Kids. The RI Department of Health (RIDOH) participated in this initiative along with project partners: RI's 4 major health plans; RI American Academy of Pediatrics (RIAAP); Executive Office of Health and Human Services (EOHHS); and the Care Transformation Collaborative (CTC) of RI to engage providers, payers, patients, parents, and policy makers to develop high quality patient-centered medical homes for this population. There are currently 28 pediatric practices participating in PCMH-Kids. A main tenant of the PCMH-Kids practice support surrounds training on and ensuring effective care coordination. MCH will promote practice learning sessions, care coordination, practice reporting, and stakeholder meetings.

2) Promote a Web-Based Application to Address Effective Care Coordination in the Medical Home Portal (MHP)

The Medical Home Portal (MHP) www.medicalhomeportal.org is an online resource established by the RI Department of Health (RIDOH) to provide a one-stop-shop for comprehensive diagnostic, education, specialty care, social service, and resource information to improve the system of care and health outcomes for CYSHCN. The MHP addresses specific informational areas for: Diagnosis and Conditions; Physicians and Professionals; and Parents and Families. The MHP was developed in 2016 through a partnership between the RIDOH and the University of Utah and has been an on-going contractual collaboration since to build the RI Resource component of the portal directory that includes state specific provider and service information. As of June 2020, the number of listings in the RI Service directory was 755.

The RIDOH convenes an Advisory Committee comprised of families, partner state agencies, community stakeholders, health professionals, and advocates to provide guidance and oversight of the MHP. In addition to the Advisory Committee, the RIDOH also participates as a member of the Medical Home Portal 's State Partners' Advisory Board to ensure content integrity, an improved avenue for resource navigation, and a mechanism for user feedback/utilization tracking. The MHP recently benefitted from a collaboration

with experienced families of CYSHCN for enhancement of the RI Emergency Preparedness section of the MHP to provide *Crisis Preparedness Tips for Families of Individuals with Special Needs/Disabilities* and a *Crisis Preparation Passport*.

Resulting from the 2020 pandemic crisis, a Covid-19 Section was incorporated into the MHP to share vetted information on health insurance, safety guidelines, community supports, and tools to help families and professionals caring for CYSHCN.

The past grant reporting period showed a dramatic increase in users among families and professionals and has been visited over 13, 000 times. Data collection is captured through google analytics for monthly reporting on number of users, type of device used, and top twenty (20) viewed pages and state locations.

Cross-Cutting/Systems Building

State Performance Measures

SPM 6 - High School Graduation Rate

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	83.9
Numerator	9,457
Denominator	11,272
Data Source	Rhode Island Department of Education
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	85.0	85.5	86.0	86.6	87.0

State Outcome Measures

SOM 1 - Percent of Children Living in Poverty

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		20	18.4	15.5
Annual Indicator	20.4	19.4	16.6	18
Numerator	43,282	40,675	33,818	36,036
Denominator	212,038	209,667	203,723	200,202
Data Source	ACS Population estimate (B17001)	ACS 2016 Population estimate (B17001)	ACS 2017 Population estimate (B17001)	ACS 2018 Population Estimate (B17001)
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	17.5	17.0	16.5	16.0	15.5	15.0

State Action Plan Table

State Action Plan Table (Rhode Island) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Adopt social determinants of health in MCH planning and practice to improve health equity

SPM

SPM 6 - High School Graduation Rate

Objectives

Increase the percent of 9th graders graduating in 4 years with a regular diploma from 83.9% in 2019 to 87% in 2025

Strategies

Youth Advisory Council

Health Equity Zones

State Action Plan Table (Rhode Island) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Adopt social determinants of health in MCH planning and practice to improve health equity

SOM

SOM 1 - Percent of Children Living in Poverty

Objectives

Reduce the percent of children living in poverty from 18% in 2019 to 15% in 2025

Strategies

Youth Advisory Council

Health Equity Zones

2016-2020: State Performance Measures

2016-2020: SPM 2 - Rhode Island youth suicide rate ages 10-24

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		4.2	7.8	5
Annual Indicator	5.2	8.5	2.9	1.5
Numerator	11	18	6	3
Denominator	212,216	210,752	206,863	206,863
Data Source	RI Vital Records, 2016 ACS Population Estimates	RI Vital Records, 2017 ACS Population Estimates	RI Vital Records, 2018 ACS Population Estimates	RI Vital Records, 2018 ACS Population Estimates
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

2016-2020: SPM 6 - Number of Certified Community Health Workers

Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			258
Annual Indicator			186
Numerator			
Denominator			
Data Source			RI Certification Board
Data Source Year			2019
Provisional or Final ?			Final

2016-2020: SPM 7 - MCH Priority Areas with at least 50% of HEZ engaged in related MCH funded activities

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			8
Annual Indicator			7
Numerator			
Denominator			
Data Source			Health Equity Institute
Data Source Year			2018
Provisional or Final ?			Final

ANNUAL REPORT: Cross/Cutting Systems Building

Public health research and data show that generations-long social, economic, and environmental inequities, including structural racism and other forms of discrimination and their consequences, have resulted in adverse health outcomes. For example, segregation in housing and education and racist mortgage lending and zoning policies have historically advantaged white Americans and disadvantaged communities of color. Together, these policies and practices have a greater influence on health outcomes than individual choices or access to healthcare. These inequities have been shaped by the distribution of power, money, and resources at the global, national, and local levels. Reducing health inequities through policies, practices, and organizational systems can help improve opportunities for every Rhode Islander.

Priority: Improve System Coordination

Continue implement and support of Health Equity Zone (HEZ) Initiative.

The MCH Program is committed to addressing health disparities and improving population health in underserved communities. One promising initiative is the Rhode Island's Health Equity Zones. With a mission to "encourage and equip neighbors and community partners to collaborate to create healthy places for people to live, learn, work, and play" the Health Equity Zones have directed more than $10.4 million in public health funding towards community-led projects, increasing the impact and productivity of efforts to build healthier and more resilient communities. The MCH Program has invested in maternal and child health initiatives in 9 Health Healthy Zones throughout the state over the past four years.

HEZs are contiguous geographic areas, that are small enough to have a significant impact on improving health outcomes, reducing health disparities and improving the social and environmental conditions of the neighborhood, yet large enough to impact a significant number of people. HEZs can be defined by political boundaries (e.g., cities, wards) or by less defined boundaries (e.g., neighborhoods). The geographically-defined HEZ community must have a target a population of at least 5,000 people, demonstrate economic disadvantage, and demonstrate poor health outcomes. The HEZ are administered by a "Backbone Agency" which may be a municipality or a public not-for-profit community-based organization. Backbone Agencies must be supported by a HEZ Collaborative to achieve project goals. Existing Health Equity Zone Collaboratives include residents, diverse community-based organizations, youth-serving organizations, educators, business leaders, health professionals, transportation experts, and people in many other fields who are coming together to address the most pressing health concerns in their neighborhoods.

In June 2019, RIDOH expanded support and funding to three new communities to establish Health Equity Zones. The communities were chosen through a competitive process that drew nearly 20 applicants from communities across the state. Throughout July 2019 to June 2020, the 3 new Health Equity Zones conducted comprehensive community needs assessments and developed action plans based on their findings. At the same time, the 7 existing HEZs reassessed their communities' needs to ensure their action plans aligned with emerging needs in their communities. In March 2020, when the COVID-19 pandemic reached Rhode Island, the Health Equity Zones worked to rapidly identify and respond to emergent needs in their community. For example, HEZs coordinated food delivery, distribution of PPE, and social and educational supports for families with children. During COVID-19, HEZs have been an essential factor in response efforts, serving as a liaison between the community and the Department of Health, and coordinating resources and services at the community level.

Develop certification process & core competencies for MCH workforce statewide through Community Health Worker workforce development initiatives.

RI has benefited from a Certification Program for Community Health Workers since 2016. To date, there are 284 Certified Community Health Workers in RI, each with demonstrated competency in the following domains:

Domains

- Engagement Methods and Strategies
- Individual and Community Assessment
- Culturally and Linguistically Appropriate Responsiveness
- Promote Health and Well-Being
- Care Coordination and System Navigation
- Public Health Concepts and Approaches
- Advocacy and Community Capacity Building
- Safety and Self-Care
- Ethical Responsibilities and Professional Skills

Standards

1. Experience: Six months or 1000 hours of paid or volunteer work experience within five years
2. Supervision: 50 hours specific to the domains
3. Education: 70 hours relevant to the domains
4. Portfolio: Demonstrated competency through approved portfolio. The portfolio is a collection of personal and professional activities and achievements. This part of the requirement for the Community Health Worker is highly personalized and no two applicants will submit the same documentation. Components of the portfolio include documentation and requirements of at least three of these categories: Community Experience & Involvement; Research Activities; College Level Courses / Advanced or Specialized Training; Community Publications; Presentations & Projects; Statement of Professional Experience; Achievements / Awards; Resume / Curriculum Vitae (CV); Performance Evaluation

Training and Development - RI MCH Program partners with the following training entities for CHW education and preparation:

- Community Health Innovations of RI provides ongoing training and apprenticeship opportunities especially for CHWs based in the community through health Equity Zones;
- Rhode Island College Healthy Jobs offers ongoing CHW courses at Central Falls Parent College, Rhode Island College campus in Providence throughout the academic term, and in a centralized Warwick location;
- RIDOH Chronic Disease Programs offers core community health worker training and modules specific to patient navigators working in chronic disease.
- Dorcas International Institute offers a training for CHW working with refugees through funding by RI Foundation;
- Rhode Island Parent Information Network provides ongoing training opportunities for Resource Specialist including parents of children with special healthcare needs;
- Clinica Esperanza sponsors ongoing Navagante trainings for Bilingual / Bicultural CHWs.

All of these training programs have aligned their curriculum with Rhode Island's Certified Community Health Worker standards meeting the certification requirements. RI MCH Program also partners with the Department of Labor & Training in supporting the Community Health Worker Association of Rhode Island (CHWARI) at the Rhode Island College. CHWARI is an organization to provide CHWs resources around trainings and other professional development opportunities. The Community Health Worker Association of Rhode Island (CHWARI) actively supports frontline healthcare workers who work in underserved communities to improve high quality healthcare access for people in need. CHWARI envisions a state in which all Rhode Island communities receive high quality, equitable health and social services in order for all individuals to realize their optimal state of health and well-being. The mission of CHWARI is to Increase the power of Rhode Island's Community Health Workers to promote health equity through increasing access to quality healthcare and social services and conducting advocacy.

Facilitate Interdepartmental, interagency, and statewide discussion to improve the health care delivery system.

EOHHS - RI MCH Leadership plans for and conducts a monthly stakeholder engagement meeting with the Executive Office of Health and Human Services (EOHHS) called the EOHHS Partnership meeting. This meeting draws

between 50-75 advocates, consumers, providers, and state agency representatives to review Medicaid policy and program, grant opportunities, Medicaid re-design initiatives, barriers to coordinated care, Medicaid budget and spending, and Medicaid legislative proposals. Many of these topics affect MCH populations, especially children and youth with special needs.

Children's Cabinet - The RI Children's Cabinet provides overarching leadership and a comprehensive, strategic approach necessary to improve the well-being of RI's children and youth. Its members engage in shared planning and decision making, interagency agreements to implement policy or programs and appropriate data-sharing to improve services and outcomes for children and youth. The Cabinet is comprised of the Secretary of the Executive Office of Health and Human Services, the Commissioner of Elementary & Secondary Education, the Director of the Dept. of Health, the Child Advocate, the Director of the Dept. of Human Services, the Director of the Dept. of Administration, Director of the Dept. of Labor and Training, the Director of the Dept. of Children, Youth & Families, the Director of Dept. of Behavioral Healthcare, Developmental Disabilities & Hospitals, and the Commissioner of Post-Secondary Education.

The overall goals of the Cabinet are to:

1. Improve the health, education, and well-being of all children and youth in RI.
2. Increase the efficacy, efficiency, and coordination of service delivery.
3. Improve data-driven, evidence-based decision-making through strengthened data sharing capacities among agencies and research partners, while adequately protecting the privacy rights of children.

In 2019, RIDOH worked with the Children's Cabinet to write a competitive grant for Preschool Development Funding. This grant was received and RIDOH received funding for two primary scopes of work. 1) to fund Health Equity Zones to implement evidence-based parent education and support programs and to imbed family navigators into early childhood programs. The goal of the navigators is to help families understand and access services that they need. The second scope of work was to expand the parents as Teachers program, RIDOH is in the process of funding new agencies to expand PAT by 300 slots.

Patient Centered Medical Home-Kids (PCMH-Kids) - PCMH-Kids is an initiative of the Care Transformation Collaborative of Rhode Island (CTC-RI) which is a statewide multi-payer patient centered medical home initiative. CTC-RI is co-convened by the Executive Office of Health and Human Services and the Office of Health Insurance Commissioner. RIDOH MCH leadership participates PCMH-Kids leadership planning activities, committee meetings, and work groups. PCMH-Kids was founded in 2015 as a pediatric primary care patient-centered medical home initiative that is driven by data, quality care and collaboration. Practices receive financial support and technical assistance to achieve NCQA recognition as a patient-centered medical home, meet state established clinical quality measures, and participate in quality improvement activities on important child and youth health topics. Cohorts of practices enroll for three years. In January 2019, the third cohort of pediatric practices signed on. Currently there are 37 pediatric and family medicine practices participating in the PCMH-Kids initiative, including 260 primary care providers and trainees, covering over 110,000 lives, and representing more than 80% of the state's pediatric Medicaid population. PCMH-Kids successes include:

- Improved developmental screening of all children age 9-30 months from a baseline of 41% screened to 85.9% screened which is fundamental to the Governor's Children's Cabinet third grade reading readiness initiative
- Improved obesity screening and counseling from a baseline of 55% to 85.8%
- Developed and implemented a pediatric specific high-risk framework to identify children and families that would benefit from care coordination services
- Reduced Emergency Department usage by 2.5% compared with non-PCMH practices

Practices have also embraced a pediatric vision of care coordination and integrated behavioral health, using a model that includes practice-based social workers as care coordinators. Accomplishments in integrating behavioral

health services into primary care include:

- ADHD screening, diagnosis and treatment plans
- Maternal post-partum depression screening: baseline of 22% to 87% with implementation of referral protocols for intervention
- Screening, Brief Intervention, Referral, and Treatment (SBIRT) in the adolescents with 75 providers with a total pediatric population of ~34,000
- In 2020, RIDOH will continue collaborating with the CTC to support PCMH-Kids practices in integrating Family Home Visiting within the Medical Home and doing joint care coordination for families facing adversity.

RIDOH MCH programs work closely with PCMH-Kids to support medical home efforts. KIDSNET, the state's integrated child health information system, works with providers to create reports that practices can use for patients care. Practices can utilize this centralized database to identify children in need of newborn hearing screening, immunizations, lead screening, developmental screening, Kindergarten readiness screening as well as participation in other early childhood programs such as WIC, Family Home Visiting Programs, and Early Intervention. KIDSNET recently worked with PCMH-Kids to develop a new practice report to identify newborns and young children with medical and family risk factors that would benefit from care coordination and referrals for supports. In March 2019, the RIDOH Family Home Visiting program and PCMH-Kids collaborated in applying for a *Healthy Tomorrows Partnership for Children* grant to improve communication between primary care and home visiting programs and implement a process for integrated care coordination. Funds will be awarded in March 2020 for this five-year project.

Aligning MCH research to impact system development - To support Rhode Island in achieving its goal that 75% of 3rd graders will read at grade level by 2025, the Rhode Island Department of Health (RIDOH), in collaboration with the Executive Office of Health and Human Services (EOHHS), leveraged the RIDOH Academic Center, a partnership between the Department and the academic colleges/universities throughout Rhode Island. To foster research driven approach to improving early childhood health to support the third grade reading goal, Rhode Island can capitalize on its small geography, high-level interagency coordination efforts (e.g., Children's Cabinet), and research strengths (e.g., Brown University and University of Rhode Island) to understand and address the causes of poor outcomes, and improve the health and education outcomes for children. RIDOH supports the following areas of work

Investing in Knowledge – Hassenfeld Birth Cohort Study funded by Hassenfeld Foundation
This project will serve as a pilot for collecting, analyzing, and evaluating data associated with this prenatal, maternal and child health population. Doing so will provide the state with lessons learned for any other related projects or potential scale-ups of existing projects.

Investing in Practice – Working Across Sectors to Accelerate the Delivery of Evidence-Based Programs
To accelerate near-term implementation of action steps, RIDOH proposes to dedicate efforts and energy to address already known recommendations within and between existing child- and family-serving programs. This will involve an array of service provision efforts – both "scaling up" current evidence-based efforts and introducing new approaches for families between birth and 3rd grade. For example, implement the action steps for school readiness in FY20: increase referrals to Child Outreach Screens for at-risk children, including DCYF-connected children and other children receiving home-visiting services.

Engage community members, CHWs, and consumers in all areas of program, policy, and systems change.
Commission for Health Advocacy and Equity – RIDOH, Health Equity Institute convenes the Commission for Health Advocacy and Equity (CHAE). The CHAE is a legislatively mandated commission created to address the social determinates of health and eliminate health disparities. The CHAE is represented by diversity of RI as individuals of

or representing racial / ethnic minorities (Latino, Native American, and Black), persons with disabilities, LGBTTQQ, and people with limited English proficiency. Members also represent a variety of disciplines including consumers / residents, academia, housing, substance use, advocacy, medicine, public health, business, child welfare, local government, community development, planning, commerce, transportation, and social services.

The Commission is required to complete a Disparities Impact and Evaluation legislative report every two years. The first report was published in January 2015 and it identified disparities in 5 areas (nutrition and physical activity, asthma, infant mortality, chronic illnesses and oral health) that needed to be addressed. In addition to the five focus areas, the report identified global recommendations for addressing health disparities in RI. The second report released in December 2017, established definitions of equity terminology including health, health equity, determinants of health, and health disparities; and identified 2 priority areas that the Commission's work will focus on for the next two years. These priority areas are (1) increase minimum wage to $15 per hour, and (2) increase high school graduation rates. The Commission actively engages with community organizations, members of the public, and legislators to impact these two priority areas. The third report was published in January 2020 and highlighted RI's Statewide Health Equity Indicators. This report provides data related to these measures to help educate the Rhode Island General Assembly, State agencies, and partner organizations on health inequities in Rhode Island. For each measure, the report also includes examples of programs and policies in Rhode Island and across the country that are showing promise for reducing inequities.

Health Equity Institute – Special Needs - A main tenant of the MCH Program is supporting, empowering, training, hiring, and promoting parents and family partners at all levels of decision making, policy development, service provision, and community development. RIDOH partners with the RI Parent Information Network, Parent Support Network, Sherlock Center on Disabilities (RI's UCEDD), the Autism Project of RI, and other disease specific family organizations. Parent leaders are cultivated and supported to lead policy initiatives, make systems improvements and champion principles of parent-professional partnerships. Parent support groups are organized throughout the state. RIDOH has contracted with RIPIN (Family Voices) to maintain a calendar of support groups based on topic, age, and language. Through the Family Voices Leadership Team, RIDOH has addressed systems barriers and developed a parent policy team to provide peer-to-peer support in addressing statewide policy, especially health reform. Throughout RI over 1850 parents have been trained in navigating the special needs service delivery system such as basic rights, college success for students with disabilities, options for medical assistance, and transition planning.

Peer Resource Specialists – Peer Resource Specialists are culturally diverse family members with experience accessing MCH services and are assigned to various RIDOH programs based on the program's need for parent and consumer participation. Peer resource specialists are full partners in policymaking, outreach, and program quality assurance and evaluation. Currently, resource specialists are assigned to WIC, Immunization, Birth Defects, Diabetes Prevention, Wise Woman, Integrated Chronic Disease, Health Communications, Family Visiting, EDHI, Emergency Preparedness, and the Health Equity Institute.

Youth Resource Specialists - Since 2014, the Health Equity Institute has invested in hiring and supporting Youth Resource Specialists. Their input into the transition process and generation of self-determination resources has been invaluable. Youth Resource Specialists are engaged in planning and leading the Dare to Dream Student Leadership event, represent RI at national youth forums, and promote inclusion in RI's youth serving organizations. In 2019, youth resource specialists led a monthly Youth Advisory Council where an average of 35 students with disabilities served as advisors to RIDOH programs and policies; presented at the national AMCHP Conference; organized the Dare to Dream conference attended by 450 students; and presented at the Turn Up Rhode Island Conference featuring career exploration for 300 students of color. Unfortunately, youth conferences expected to take place in the Spring of 2020 were cancelled due to Covid.

Health Equity Zones (HEZ*)* – Each of the 10 funded Health Equity Zones has a lead organization (local government

or local non-profit entity), that acts as a backbone on behalf of the coalition of key community stakeholders and residents in the proposed geographic area. One of the key requirements of HEZ funding is heavy stakeholder and resident engagement. This ensures that individuals who are experiencing poor health outcomes and health disparities are represented and are included in the decision-making process.

RI Asthma Control Program - The RI Asthma Control Program (RIACP) is working closely with families and seeking to develop family leadership in multiple areas including but limited to: improving indoor air quality at home and in schools; asthma and chronic disease self-management skills; healthy housing policies; and training and support for development of advocacy skills. The RI Asthma Control Coalition, in partnership with RI Parent Information Network, helped RIACP initiate "Asthma Advocates in Action," to help people with asthma and their caregivers build advocacy and leadership skills.

Priority: Improve Mental/Behavioral Health

Increase the number of programs implemented in Rhode Island that support healthy social/emotional development and address behavioral health issues.

RI has as a goal, to move toward implementing evidence-based programs to address issues that result in poor outcomes for families. Over the several years, RIDOH has continued to fund expanded behavioral health interventions across the life course.

Maternal Psychiatry Resource Network (MomsPRN) - The Rhode Island Department of Health (RIDOH) is one of seven states to receive funding from the Health Resources and Services Administration's *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program,* which seeks to assist obstetrical, adult primary care, pediatric, and psychiatric providers in optimizing behavioral health care for pregnant and post-partum women. To achieve this end, the RIDOH has partnered with the Center for Women's Behavioral Health at Women and Infants Hospital (CWBH) to establish a free statewide psychiatry telephone consultation service for healthcare providers treating pregnant and postpartum women, especially those in rural and medical underserved communities. The RIDOH has also partnered with the Care Transformation Collaborative of Rhode Island (CTC) to provide intensive quality improvement coaching about behavioral health screening, treatment, and referral to contracted prenatal care practices.

The RI MomsPRN teleconsultation line is staffed by perinatal experts at the CWBH and is modeled after Rhode Island's successful Pediatric Psychiatry Resource Network (PediPRN) program. The goal of the RI MomsPRN psychiatry teleconsultation line is to empower providers in effectively managing their perinatal patients' behavioral health and substance use concerns, by initially providing treatment guidance from RI MomsPRN perinatal psychiatric specialists, and/or offering information and referral for additional supports and services in their patients' geographic area. Since its launch in September 2019, the RI MomsPRN teleconsultation line has fielded 226 teleconsultation calls, with 50 coming directly from patients and the remaining 176 calls coming from 128 unique providers (25 OBGYNs, 16 therapists, 14 midwives, 10 family visitors, 10 OBGYN nurse practitioners, 9 psychiatric nurse practitioners, 8 pediatricians, 8 family medicine doctors, 6 psychiatrists, 5 social workers, 3 OBGYN residents, 2 family medicine nurse practitioners, 1 primary care provider, 1 primary care nurse practitioners, and 10 other types of providers). In total, 176 women (including 57 pregnant women) were helped as result of their healthcare provider or RIDOH family home visitor accessing the RI MomsPRN teleconsultation line. Most of these perinatal patients have a provisional diagnosis of depression (124), anxiety (96), bipolar disorder (17), substance use disorder (15) or PTSD (14). Calling providers are increasingly looking for support with identifying individual therapy referrals (98), connecting patients to the CWBH for diagnostic evaluations (35), referrals to the CWBH's partial hospitalization program (31), medical consultations with the RI MomsPRN attending psychiatrist (30), help identifying support groups (23), or psychopharmacology guidance (12). Through a

partnership with CTC, the RI MomsPRN program is also able to provide intensive quality improvement and practice transformation services to prenatal care practices seeking to implement, optimize, or spread perinatal behavioral health screening, treatment, and referral workflows and protocols. Upon soliciting and reviewing competitive applications in the fall of 2019, 4 prenatal care practices (Center for Women's Health, the Women & Infants Obstetrics and Gynecology Care Center (OGCC), Women's Care, and Women's Medicine Collaborative) were selected to join the first cohort of the RI MomsPRN perinatal behavioral health quality improvement initiative. Taken together, these 4 practices manage 32% of all RI births, serve both rural and medical underserved populations, and are affiliated with differing hospital/healthcare entities, (Care New England (OGCC and Women's Care), Lifespan (Women's Medicine Collaborative), and South County Health (Center for Women's Health)). Individual practice quality improvement teams meet monthly with CTC practice facilitators and all contracted practices jointly attend quarterly learning sessions facilitated by CTC that includes clinical advisement from CWBH staff to help them address common workflow issues and/or share promising practices. To monitor progress, RIDOH collects de-identified aggregate screening data among contracted practices. In January 2020, contracted practices began implementing perinatal behavioral health screening protocols and the latest collected screening data show that 48% of perinatal patients have been screened for depression, 6% have been screened for anxiety, and 2% have been screened for substance use disorder at least once in January or February 2020. Practices have the remainder of the 2020 calendar year to ensure that every perinatal patient is screened at least once for depression, anxiety, and substance use disorder, which is aligned with numerous evidence-based clinical recommendations and committee opinions.

In addition to providing perinatal behavioral health teleconsultation and practice transformation services for healthcare providers, the RI MomsPRN program also collaborated with RIDOH's Family Home Visiting Program and the Women, Infants and Children (WIC) Program to create, distribute, and promote a public service campaign about perinatal depression and anxiety and the importance of seeking help by connecting with a healthcare provider. The 30 second spot featured a patient testimonial and was aired on a local news station in June 2020. To help further amplify this campaign, the RIDOH created a new mental health resource page for new moms and featured the campaign on its various digital platforms.

Pediatric psychiatry Resource Network (PediPRN) - Rhode Island's children and adolescents face significant challenges in accessing timely and affordable mental health care. In response to this need, the RIDOH is working in conjunction with the Emma Pendleton Bradley Hospital to expand its existing child psychiatry access program, the Pediatric Psychiatry Resource Network (PediPRN). The project's mission is to improve access to behavioral health care for Rhode Island children and adolescents by integrating psychiatry into the state's pediatric primary care practices. To achieve its mission, PediPRN uses a telephonic integrated care model to improve access to quality behavioral health expertise. This service is free and provides all Rhode Island pediatric primary care providers assistance with the mild to moderate mental health care needs of their patients. PediPRN focusses on creating a culture of empowerment for pediatric primary care providers. The clinical team works closely with providers offering CME opportunities, educational e-blasts, an updated website with assessment and educational resources on pediatric behavioral health topics, and ongoing support during telephonic consultations. In addition, PediPRN implemented the delivery of training, mentoring and education to PPCPs in the PediPRN Intensive Program (PIP) with the goal of creating a group of practitioners embedded in each of their home practices who will serve as local experts on various behavioral health topics. The PIP program has completed it's first year and a second cohort of physicians has begun in 2020. Additionally, PediPRN has expanded its capacity as a resource to providers during COVID-19 an has started hosting "office hours" to physicians via zoom. Providers can speak with a staff psychiatrist, or with each other, about topics to support behavioral health treatment in their practices. This additional resource is meant to provide additional support to providers during these unprecedented times.

Emotional Regulation Intervention Project – The Rhode Island Department of Health Violence and Injury Prevention

Program in conjunction with the Rhode Island Student Assistance Program (SAP) aim to provide a wide range of prevention and early intervention services to high risk adolescents. The intervention will be implemented by master's-level counselors who will provide a Prevention Education Series (PES); individual and group counseling for students enrolled in; and referral to community-based social service and mental health agencies. The intervention was piloted during the '17-'18 school year in which SAP counselors were trained in Project TRAC, a developmentally tailored emotion regulation training program designed for middle school students. The focus of the program is to help students 1) become aware of the connection between emotions and behaviors (especially risk behaviors), 2) improve recognition of when one is having a strong emotion, and 3) learn strategies for managing emotions in moments when they are making decisions.

The 2018 Title V MCH Venture Capital Funding allowed the Violence and Injury Prevention Program (VIPP) to scale up the implementation of the Emotional Regulation Intervention Project from two to five schools. During the 18-19 school year the SAP hosted a two-day emotional regulation intervention training for five counselors returning and new who showed interest in the Emotional Regulation Intervention Project. The Emotional Regulation Intervention Project implemented five 12 session workshops in five different school districts in Rhode Island. The number of students who participated varied between three and eight students per group. The Emotional Regulation Intervention Project served 31 students but the pre and post surveys were only completed by students who received parental approval before the start of the workshop. The evaluator will analyze the pre-post survey data and develop a report by September 2019. In efforts to sustain the intervention the VIPP will work with the Emotional regulation consultant to adapt the 12-session workshop into strategies that can be implemented by teachers in the classroom. In addition, the VIPP was able to obtain additional funding through the Rape Prevention Education grant to implement seven workshops in the 19-20 school year.

Mental Health Consultation within early care and education- Through a partnership with DHS, child focused mental health consultation is available statewide. RIDOH is currently working with DHS to sustain its program focused mental health consultation to childcare as well. In 2020, several mental health professionals from Bradley Early Childhood Research Center, who are also early childhood mental health consultants, developed and delivered a training on how to become a child care mental health consultant with the goal of expanding the capacity of the system overall.

Parent education and support for children and their families- Three communities were supported to implement Incredible Years groups for families in the communities. Anticipated outcomes include, improved parenting, increased social emotional competence, and decreased behavior problems. In the longer term, RI expects to see improved school readiness, improved social-emotional functioning, and healthier families.

Offer training to support providers who may be caring for families who may be experiencing toxic stress.
RI continued to make progress toward developing systems and strategies of recognition and response for families with young children who are experiencing, or at risk of experiencing, toxic stress and/or trauma. Over the past year RI focused on continuing to support First Connections home visiting to implement the Experience Screen to identify Toxic Stress as well as to offering training to providers who are caring for children and families who experience toxic Stress and/or trauma. RI is conducting ongoing research with the Experience Screen to ascertain if risk for Toxic Stress can be determined at birth.

The Family Visiting Program will continue to use the experience screen in First Connections home visiting programs. RI will also continue to focus efforts around ensuring that the highest risk children and their families are linked to comprehensives services. RI will also pursue targeted funding streams to increase the capacity to mitigate toxic stress. Ri will also continue to offer training to groups of multi-disciplinary providers on caring for children and

families who experience toxic stress and/or trauma. Three trainings are planned for the coming year. RI will also continue to try to encourage primary care providers to screen for toxic stress. Finally, RI will begin to re-design its First connections screening and response home visiting program so that different levels of intensive outreach and services can be embedded with the goal of reaching families with greater challenges and engaging them in services.

Develop and implement a model of mental health consultation to the Family Home Visiting Program.
The Family Home Visiting Program will continue to support its 14 family visiting agencies with access to mental health consultation and similar supportive resources. With support from national experts, TA and local mental health consultants, RI has developed a tiered framework to support mental health consultation within family visiting so that family visitors, supervisors and program managers have levels of support while working with complicated families. Two levels provide for mental health consultation to family visitors and the other with families. The Family Home Visiting Program provided each family home visiting agency with dedicated funding in the agency's contract for the past few years that may be used for mental health consultation and supportive services. The Family Visiting Program will continue to do so in future contracts. There is also funding in the Preschool Development Block grant also providers funding to support mental health consultation that will begin in Fall 2020.

In addition to providing funding to each family home visiting agency, the Family Home Visiting Program has partnered with the RI Association for Infant Mental Health (RIAIMH) to provide additional support to the family home visiting workforce. The Family Home Visiting Program works with RIAIMH on training and support related to infant mental health. The Family Home Visiting Program is also supporting family visiting staff by supporting the process of Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (RI-IMH-Endorsement®). This endorsement process ensures that family home visiting staff have the competencies and skills to support the parent-child relationship and promote positive parenting practices that address the needs of infants. The family home visiting program has worked with the providers of the reflective practice and supervision trainings and groups to align the their training with the competencies for Endorsement and the training and monthly group supports now support a family visitor that is working on Endorsement.

Implement suicide prevention programs
The Rhode Island Youth Suicide Prevention Project (RIYSPP) - works with a broad range of partners to implement a combination of strategies aligned with the 2012 National Strategy for Suicide Prevention that are focused on lowering youth (10-24) suicide death and attempt rates. The three primary interventions associated with this project are: 1. Training youth and adults across the State in evidence-based gatekeeper training programs, 2. Training counselors/school crisis team members from schools across the state in a novel streamlined crisis evaluation assessment tool/protocol and connecting them to clinicians (via the Kids' Link line at Bradley Hospital) who can help them triage and connect students in crisis with a local mental health provider, and 3. Implementing RI's first systemic linkage of non-health organizations with mental health using various strategies in order to coordinate and share resources for the assessment, referral, treatment, and provision of follow-up care with wrap around services for at-risk youth, including sharing de-identified data. Also, the project maintains a statewide Youth Suicide Prevention Coalition with representation from all priority populations and funded/non-funded partners and works to promote suicide prevention principles to all Rhode Island residents. VIPP is currently working to rollout the SPI Youth Suicide Prevention work to every public-school district in the state. The VIPP has also implemented the Emotional Regulation program in one Health Equity Zone middle school (Westerly). The VIPP has also participated in the HRSA funded Collaborative Office Rounds grant, whereby the HEZ has received the funding and training is targeted to local pediatricians. The VIPP also participates with the Bristol Health Equity Zone through their suicide prevention subcommittee.

Other Programs/Projects Related to Mental/Behavioral Health

Statewide Plan for Improving Behavioral Health - The Governor signed an executive order (Executive Order 18-03) which charges state agencies with "develop[ing] an action plan to guide improvements to RI's adult and pediatric behavioral healthcare systems" and reporting back to the Governor by November 30, 2018. To do this work, the Governor's Office has asked to convene a small group of liaisons from RI State agencies to develop this action plan, in collaboration with their agencies, agency directors, and the Governor's Office.

PCHM-Kids SBIRT Learning Collaborative- The MCH Medical Director was involved with this initiative that was designed to train groups of pediatric primary care providers and trainees in SBIRT and integrate substance use and abuse screening and brief intervention into practices through a pediatric learning collaborative. Combining efforts and resources with RI PCMH-kids, the RI State Innovation Model primary care initiative, eleven pediatric practices representing a heterogeneous mix of patients throughout the state joined the learning collaborative. The practices worked regularly with experts in adolescent substance use who coached pediatricians and helped them develop referral networks. Practice workflow was also addressed. Specific educational sessions both didactic and simulation were held to cover specific topics including; confidentiality issues when caring for adolescents with substance abuse, opioid use in adolescents, and intervention techniques when managing concerning adolescent substance use A substance abuse referral resource guide for pediatric practice is being developed by medical students as part of a collaborative initiative with the intent to distribute the resource to all pediatric providers in the region. All of the 11 practices involved in the initiative enhanced their knowledge about the role and impact of recreational substance use in the lives of their adolescent patients and about adolescent decision making related to substance use. All of the participating pediatric providers found the initiative beneficial and successfully integrated substance use screening into their practices. They reported and demonstrated increased knowledge of motivational techniques to discuss substance use with adolescents and were more comfortable assessing and managing adolescents with substance use and abuse. They all exceeded their initial screening goals and established ongoing quality metrics that will be sustained in practices. They expressed needs for ongoing assistance with sustainment as they navigate increasing screening in practices and also start to address how to provide early intervention to patients with risks for substance use disorder and in particular opioid abuse and chronic cannabis use. They identified gaps in services and designed specifically for youth and expressed need for local resources for referral. The practices will continue to make progress and grow during the 2019 sustainment period when they will receive additional coaching to help them further integrate SBIRT into their practices.

Healthy Transitions Grant – RIDOH assisted the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH), with the implementation of the Healthy Transitions (HT) Grant, a grant program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The goal being to improve life trajectories for youth and young adults with, or at risk for, serious mental health conditions. Through this work, a Youth MOVE chapter (a behavioral health youth leadership group) was established within the Parent Support Network of RI. The RIDOH Youth Advisory Council collaborated with BHDDH to represent the voice of youth with complex medical and/or behavioral health conditions. In 2018, the RIDOH advised BHDDH on the development a transition resource for youth involved with the child welfare system entitled "Take Charge of Your Behavioral Health: A Guide for Young Adults in Rhode Island's Behavioral Health System".

Governor's Commission on Behavioral Health - The RIDOH Adolescent Transition Program provided on-going technical assistance to the BHDDH and the Healthy Transitions Statewide Advisory Council (SAC) in the implementation of the "Now is the Time" Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with, or at Risk for, Serious Mental Health Conditions, a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to develop and sustain a system of services for youth and young adults ages 16-25

who have serious mental health conditions and co-occurring disorders. The RIDOH Transition Program provided best practice and guidance regarding the process and scope of transition and transfer of youth and young adults to augment the knowledge of BHDDH staff and sub-contracted organizations.

Drug Overdose Prevention Program - The mission of the Drug Overdose Prevention Program is to decrease drug overuse, misuse and abuse and to decrease nonfatal and fatal drug overdoses in RI. The PDO PfS Program educates prescribers and pharmacists on the responsible prescribing of opioids, connects people struggling with substance use disorder (SUD) to community health navigator services, evaluates public health polices relevant to drug overdose prevention, improves access to drug overdose data, and engages diverse stakeholders to facilitate multi-agency collaboration and partnerships. The Program works very closely with and supports the Governor's Task Force on Overdose Prevention and is responsible for overseeing the Prescription Drug Monitoring Program (PDMP).

Overdose Prevention Task Force - The Governor's Task Force on Overdose Prevention and Intervention was created by executive order in August 2015. It is co-chaired by the Director of the Rhode Island Department of Health (RIDOH) and the Director of BHDDH (the state substance abuse agency). The task force meets on a monthly basis and includes state police, local police, healthcare providers, Emergency Medical Services (EMS), the Department of Corrections, the PDMP, recovery and treatment community centers, CBOs, and individuals in active recovery. In November 2015, the Task Force published a Strategic Plan and in May 2016, the Task Force released an Action Plan that outlines how the Strategic Plan will be implemented. The Strategic Plan includes four strategic initiatives: (1) expanding access to medication assisted treatment (MAT), (2) saturating high risk populations with naloxone, (3) preventing high risk prescribing of opioids, and (4) increasing access to peer-based recovery services. Each strategy has a statewide working group committed to development, implementation, and evaluation of the respective strategy. The plan is a rapid response to the overdose epidemic in RI and commits to reducing the number of overdose death by one-third within three years. This is a multi-agency, volunteer-based approach that leverages existing resources and partnerships to stop the overdose epidemic in RI.

Peer Recovery Specialists - RIDOH partners with the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (the state substance abuse services authority) to fund Peer Recovery Coaches in three settings; Emergency Rooms, the Department of Corrections, and through targeted street outreach. A certified peer recovery specialist helps individuals navigate treatment and recovery resources, provides education on overdose prevention, and the use of naloxone, and acts as a contact for additional recovery support. RIDOH has also hosted trainings for individuals to be trained as Perinatal Peer Recovery Specialists.

Priority: Adopt Social Determinants of Health in Public Health Planning

Continue to implement & support the Health Equity Zone (HEZ) Initiative.

RI's Health Equity Zone initiative is an innovative, place-based approach that brings communities together to build the infrastructure needed to achieve healthy, systemic changes at the local level. Health Equity Zones are geographic areas where existing opportunities emerge and investments are made to address differences in health outcomes. Through a collaborative, community-led process, each Health Equity Zone conducts a needs assessment and implements a data-driven plan of action to address the unique social, economic, and environmental factors that are preventing people from being as healthy as possible. Our approach recognizes that communities have different needs and assets to build upon. By aligning strategic investments with existing resources across sectors, each community can address their unique needs, reduce disparities, and stimulate economic growth. Listed below is a description of MCH activities that took place in each HEZ this past year. Additional projects have also been included

in specific domains reports as well.

Bristol

In the Bristol Health Equity Zone, an Engagement Navigator at Mt. Hope High School offered one-on-one counseling to students with immediate need for a variety of support services, including housing resources, food access, and more. This position offers students and families immediate assistance and prescreening services, and referrals to a variety of wrap around programs. The long-term goal of this effort is to decrease the number of students and families accessing emergency rooms for mental health support services.

Last year, the Bristol HEZ also continued the Parents As Teachers program, which offers free family visiting to any family with a child between prenatal and kindergarten entry. This program provides knowledge for parents regarding age-appropriate skills and activities to promote school readiness, and increases families' connections to various education, employment, family, and physical and mental health resources in the community. Last year, 54 families, including 68 children, received a total of 335 visits, and 9 group sessions were offered.

A group of residents and community stakeholders, including representatives from the School Department, the Bristol Police Department, Bayside YMCA, Roger Williams University, and the National Alliance on Mental Illness, and more, meet monthly toward a community-wide suicide prevention plan. This group initiated the Kindness Rocks campaign to spread kindness and compassion and increase the sense of community connectedness.

Central Providence

In 2019, the Olneyville Health Equity Zone expanded its efforts to additional adjacent neighborhoods in Providence to create the Central Providence Health Equity Zone. With the addition of new areas of the community, the Central Providence HEZ conducted a needs assessment in those areas to determine what the HEZs action plan should be for those neighborhoods. Lack of affordable childcare was identified as a community need, and the HEZ developed a plan for establishing a new resident-led childcare center and for improving existing childcare centers in the area.

The Central Providence HEZ's main focus is on economic opportunity, and those efforts included the development of internship opportunities for teens, and a computer science skill-building program for middle school girls. The HEZ also utilizes community health workers to connect residents to social services and to keep a pulse on the needs of the community. Community Health Workers also work with families to increase enrollment in Family Home Visiting programs. The CP HEZ's CHWs have been an integral part of their response to COVID-19, by allowing efficient communication of residents' needs to the HEZ, which was able to leverage its relationship with RIDOH and other agencies to direct resources to families with urgent needs during COVID-19.

East Providence

As a new HEZ, East Providence conducted a comprehensive community assessment this year, which included a youth focused survey that received almost 200 responses. In response to the findings of their needs assessment, the EP HEZ plans to establish a Youth Health and Wellness focus group, hire a Family Navigator to engage families in Home Visiting programs, and to develop a program for families using the evidence based Parents As Teachers (PAT) model.

Newport

In addition to continuing to support ongoing maternal and child health work throughout their community, the Newport HEZ began focusing on key target populations most in need of health equity work. For example, they are working with community partners and healthcare providers to improve healthcare access and improve healthcare

experiences for LGBTQ+ teens.

The Newport HEZ has also focused intensively on racial equity and racial justice. One of the Newport HEZ's leading priorities is to eliminate disparities in black maternal and child health outcomes. In efforts to improve racial equity, the HEZ participated in and hosted several racial equity trainings throughout the year, reaching hundreds of attendees in the Newport community and beyond. The Newport HEZ conducts all of their work through a resident-centered, racial justice lens.

Pawtucket/Central Falls

The Childhood Lead Action Project (CLAP) continued to provide lead poisoning prevention and education to the Pawtucket and Central Falls communities. CLAP facilitated five lead poisoning prevention workshops at local schools. In previous years, the HEZ's partnership with CLAP has contributed to achieving a 44% decrease in childhood lead poisoning in Pawtucket, and the HEZ continues to support work to decrease childhood lead poisoning throughout the community.

The Pawtucket Central Falls HEZ also developed an Opioid Action Plan this year, which includes plans for substance use education for youth, and the creation of positive social opportunities and employment opportunities for youth and young adults. The PCF HEZ's substance use education programs reached 216 students at local schools this year, and they plan to continue these efforts in the future. In a post-presentation survey of those students, 91% reported that the presentation helped them understand how opioids affect the boy, and 92% reported feeling very or somewhat confident that they would be able to help someone in the case of an overdose.

Through their partnership with the Boys and Girls Club, the PCF HEZ engaged families and youth in a family swim program, anti-bullying and conflict resolution programming, and fitness and wellness classes. The Boys and Girls Club also helped serve 60 families with groceries, gift cards, and activities for youth during COVID-19. Another HEZ partner, Progreso Latino, provided over 100 individuals with birth control options and information regarding pre-natal and post-natal care.

Washington County

Maternal and child health is a primary focus of *South County Health Bodies Health Minds* (HBHM), which serves as the backbone for the Washington County Health Equity Zone. HBHM implements 5-2-1-0 to prevent childhood obesity and promote healthy habits, by encouraging families to be more physically active and eat healthier, while engaging community partners to create healthier environments for children. The 5-2-1-0 program promotes eating 5 fruits and vegetables, engaging in no more than 2 hours of recreational screen time, getting 1 hour of exercise, and drinking 0 sugary drinks per day. To date, the Washington County HEZ has reached over 11,000 children and adolescents with their 5-2-1-0 programming. Ten K-12 schools implemented policy, systems, or environmental changes including offering a new grab-n-go breakfast option, eliminating chocolate milk for breakfast, and starting advisory committees for students to work with food service providers to give input on school nutrition.

Through Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), the Washington County HEZ implemented 3 key prevention and promotion strategies : (1) conducting Incredible Beginnings training with 19 early care & education providers, including home visitors (2) partnering with schools and Head Start to conduct 4 Incredible Years Parenting groups (to promote family strengthening and positive parenting skills), and (3) integrating behavioral health services into primary care settings by providing mental health consultation in 4 small pediatric practices. To date, 337 children have received developmental screenings, and 101 children have received mental health consultations through Project LAUNCH.

West Elmwood

As a new HEZ, West Elmwood spent most of the year conducting a comprehensive community assessment. Part of their assessment focused specifically on teens, including a teen survey. The HEZ identified chronic absenteeism, lack of after school and extracurricular activities, and lack of resources to attain post-secondary education as key issues facing teens in their community. In response, they developed an action plan to address these issues, as well as additional community needs, which will be implemented over the next several years.

West Warwick

West Warwick Public Schools Implemented a 3-tier trauma-informed high school initiative and trained teachers and staff throughout the school department. This year, the West Warwick school department became the state's first trauma-informed school district. West Warwick has the highest rate of foster and kinship care in the state, which led a West Warwick resident and HEZ ambassador establish the Grands Flourish program to support the experience of grandparents raising grandchildren due to the opioid epidemic and other trauma. Grands Flourish piloted a peer-to-peer grandparent support and resource group at the West Warwick HEZ Hub, and West Bay CAP implemented a part-time case manager solely dedicated to supporting grandparents raising grandchildren in West Warwick. Throughout the year, the West Warwick HEZ continued to support these efforts and others to support families with children impacted by substance use.

Woonsocket

Teen Health continues to be a key focus area of the Woonsocket HEZ. Throughout the year, The HEZ continued to support a Family Planner and Sexuality Educator in Woonsocket High School and continued to implement an inclusive, medically accurate, comprehensive, and evidence-based health curriculum for high school students. Since baseline in 2014, the HEZ's work has contributed to a 30% reduction in birth to teens in Woonsocket.

Develop certification process & core competencies for the MCH workforce statewide through a Community Health Worker workforce development initiative.

RI has benefited from a Certification Program for Community Health Workers since 2016. To date, there are 284 Certified Community Health Workers in RI, each with demonstrated competency in the following domains:

Domains

- Engagement Methods and Strategies
- Individual and Community Assessment
- Culturally and Linguistically Appropriate Responsiveness
- Promote Health and Well-Being
- Care Coordination and System Navigation
- Public Health Concepts and Approaches
- Advocacy and Community Capacity Building
- Safety and Self-Care
- Ethical Responsibilities and Professional Skills

Standards

1. Experience: Six months or 1000 hours of paid or volunteer work experience within five years
2. Supervision: 50 hours specific to the domains
3. Education: 70 hours relevant to the domains
4. Portfolio: Demonstrated competency through approved portfolio. The portfolio is a collection of personal and professional activities and achievements. This part of the requirement for the Community Health Worker is highly personalized and no two applicants will submit the same documentation. Components of the portfolio include documentation and requirements of at least three of these categories: Community Experience & Involvement; Research Activities; College Level Courses / Advanced or Specialized Training; Community

Publications; Presentations & Projects; Statement of Professional Experience; Achievements / Awards; Resume / Curriculum Vitae (CV); Performance Evaluation

Training and Development - RI MCH Program partners with the following training entities for CHW education and preparation:

- Community Health Innovations of RI provides ongoing training and apprenticeship opportunities especially for CHWs based in the community through health Equity Zones;
- Rhode Island College Healthy Jobs offers ongoing CHW courses at Central Falls Parent College, Rhode Island College campus in Providence throughout the academic term, and in a centralized Warwick location;
- RIDOH Chronic Disease Programs offers core community health worker training and modules specific to patient navigators working in chronic disease.
- Dorcas International Institute offers a training for CHW working with refugees through funding by RI Foundation;
- Rhode Island Parent Information Network provides ongoing training opportunities for Resource Specialist including parents of children with special healthcare needs;
- Clinica Esperanza sponsors ongoing Navagante trainings for Bilingual / Bicultural CHWs.

All of these training programs have aligned their curriculum with Rhode Island's Certified Community Health Worker standards meeting the certification requirements. RI MCH Program also partners with the Department of Labor & Training in supporting the Community Health Worker Association of Rhode Island (CHWARI) at the Rhode Island College. CHWARI is an organization to provide CHWs resources around trainings and other professional development opportunities. The Community Health Worker Association of Rhode Island (CHWARI) actively supports frontline healthcare workers who work in underserved communities to improve high quality healthcare access for people in need. CHWARI envisions a state in which all Rhode Island communities receive high quality, equitable health and social services in order for all individuals to realize their optimal state of health and well-being. The mission of CHWARI is to Increase the power of Rhode Island's Community Health Workers to promote health equity through increasing access to quality healthcare and social services and conducting advocacy.

Continue to support a comprehensive system of engagement & leadership development for vulnerable populations.

Health Equity Institute – Health Equity Institute (HEI) was created by Director Nicole Alexander-Scott, MD, MPH in 2016 as a strategy to promote RIDOH's three leading priorities. The priorities include: 1) addressing the social and environmental determinants of health; 2) eliminating the disparities of health and promote health equity; and 3) ensuring access to quality health services for Rhode Islanders, including our vulnerable populations. The mission of the HEI is to address systemic inequities so that all Rhode Islanders achieve their ideal life outcome regardless of their race, geography, disability status, education, gender identity, sexual orientation, religion, language, age, or economic status. HEI recognizes that achieving health equity requires action, leadership, inclusion, cross-sectoral collaboration and shared responsibility throughout RIDOH, and communities across the state. HEI has substantial expertise in providing communities and policymakers with data, technical assistance, and evidence-based programs to address health disparities in vulnerable populations. Several large programs are housed within the HEI, including: Disability & Health, Minority Health, Refugee Health, Maternal and Child Health and the Health Equity Zones (HEZ). HEI also provides collaborative support to all of RIDOH's equity initiatives including: the Social Justice Roundtable, Sexual Orientation and Gender Identity Workgroup, Vulnerable Populations Data Collection Workgroup, Disparities in Population Health Goals, Social Determinants of Health Workgroup, Community Health Assessment Group, Commission for Health Advocacy & Equity, Community Health Resiliency Project, and the Kresge Initiative.

Healthy Equity Communication Trainings -

RIDOH received a Kresge Foundation Applied Learning Resource Grant through the Emerging Leaders in Public

Health (ELPH) initiative to support agency transformation to integrate social justice into RIDOH's practices and create a new role for public health to advocate for social and environmental justice policies. As part of this work, RIDOH partnered with The Praxis Project and Berkeley Media Studies Group (BMSG) to host two full-day trainings to help us communicate more effectively about social justice and health equity. The ELPH Initiative provided critical support that has helped RIDOH transform the way we communicate about health equity and social justice. Funding and support made available through this initiative enabled RIDOH to obtain technical assistance and training for staff across the department from leading experts in the health equity and health communications field, including The Praxis Project[1] and Berkeley Media Studies Group[2]. With this assistance, RIDOH held an initial training in July 2018 for staff in its Center for Public Health Communication and additional staff from Centers and Divisions across the Department. This training helped build staff capacity to apply a health equity and social justice lens to their work and included hands-on practice to develop communications strategies and messages to drive narrative change and effect related changes in policies, systems, and environments affecting health. In March 2019, RIDOH held a follow-up training with the same expert consultants, this time for a more focused group of communications staff and other staff dedicated to health equity initiatives. This second in-person training was supplemented by a series of conference calls to dig into specific questions raised by RIDOH staff and help staff immediately apply new principles to their work.

As a result of this training, RIDOH has developed new messaging to help make the case for advancing health equity and social justice, and garner support for specific health equity initiatives, like its Health Equity Zone model. RIDOH has also begun applying a stronger racial equity lens to its messaging, explicitly calling out racism as a barrier to health and advocating for approaches that advance racial equity. To encourage further engagement in health equity work across the Department, RIDOH has started a regular health equity series in its employee newsletter, called "Health Equity Now," and has created a page on its intranet to share health equity resources and training opportunities with employees. RIDOH is also exploring how to better highlight stories about how employees are advancing health equity in their work, and how the lived experiences of employees motivate them to do this work.

In addition, with the support of ELPH project consultants Human Impact Partners and Berkeley Media Studies Group, RIDOH's Health Equity Institute (HEI) created a guide, "Building a Shared Language around Health Equity," to foster shared understanding about terms and concepts including social justice, institutional racism, and structural inequities.

Commission for Health Advocacy and Equity – RIDOH, Health Equity Institute convenes the Commission for Health Advocacy and Equity (CHAE). The CHAE is a legislatively mandated commission created to address the social determinates of health and eliminate health disparities. The CHAE is represented by diversity of RI as individuals of or representing racial / ethnic minorities (Latino, Native American, and Black), persons with disabilities, LGBTTQQ, and people with limited English proficiency. Members also represent a variety of disciplines including consumers / residents, academia, housing, substance use, advocacy, medicine, public health, business, child welfare, local government, community development, planning, commerce, transportation, and social services. The Commission is required to complete a Disparities Impact and Evaluation legislative report every two years. The first report was published in January 2015 and it identified disparities in 5 areas (nutrition and physical activity, asthma, infant mortality, chronic illnesses and oral health) that needed to be addressed. In addition to the five focus areas, the report identified global recommendations for addressing health disparities in RI. The second report released in December 2017, established definitions of equity terminology including health, health equity, determinants of health, and health disparities; and identified 2 priority areas that the Commission's work will focus on for the next two years. These priority areas are (1) increase minimum wage to $15 per hour, and (2) increase high school graduation rates. The Commission actively engages with community organizations, members of the public, and legislators to impact these two priority areas. The third report was published in January 2020 and highlighted RI's Statewide Health Equity Indicators. This report provides data related to these measures to help
educate the Rhode Island General Assembly, State agencies, and partner organizations on health inequities

in Rhode Island. For each measure, the report also includes examples of programs and policies in Rhode Island and across the country that are showing promise for reducing inequities.

Refugee Health Program (RHP) - The responsibilities of the RI-RHP include tracking new refugees who enter the state via the Centers for Disease Control and Prevention's (CDC) Electronic Disease Notification (EDN), assuring that all new refugees receive an initial health assessment within 30 days (in compliance with ORR State Letter 12-09 guidelines), tracking refugee health status through the completion of the Rhode Island version of the refugee health screening form, holding refugee network stakeholder meetings to connect stakeholders, sharing information with community agencies and health care providers, and assisting in the completion of the I-693 report of medical examination and vaccination form, which accompanies refugee green card applications. The ORR Refugee Health Promotion Program Grant enables the RI-RHP to assist refugee resettlement agencies and health clinics in building on their health promotion activities for refugees who are recent arrivals. Rhode Island arrivals in 209 totaled 89 with refugees largely from the following countries: Burundi, United Republic of Tanzania, Democratic Republic of Congo, Ukraine, Somalia, Syria, and Colombia, and Eritrea. The mean age of refugees is 21 years old with a range of 3 to 65 years. All newly arrives adult refugees attend community orientation that covers a multitude of topics geared to helping the newly arrived refugees adjust to their new environment. The major areas of focus include the following: Medical and Health issues, Rights and Responsibilities of Refugees, Employment Counseling, Housing, Financial Literacy, Social Guidelines, School Registration, Education, and Cultural Adjustment. Within this framework, more detailed discussions are dedicated to topics that are immediately relevant to the lives of each family. All the newly arrived refugees are connected to the local healthcare providers for medical screenings and vaccinations. The medical case management services include navigation of the health care system beyond primary care providers to include pharmacies, dentists, ophthalmologists, immunologists, audiologists, obstetricians, imaging specialists, insurance providers, billing offices, and others. Newly arrived refugees attend four sessions within the first 3 weeks after arrival. Interpreters are provided as needed.

Culturally Linguistic Appropriate Services (CLAS) –
The Rhode Island Health Equity Institute (HEI) has been actively developing and implementing CLAS throughout Rhode Island through a multi-faceted approach.

- *CLAS Trainings* - RIDOH conducts CLAS trainings for RIDOH staff as well as community partners to enhance the implementation of culturally and linguistically appropriate services. These trainings include practical ways of improving language access and creating an environment that is welcoming of diverse cultural backgrounds. Examples of community partners that have received training include: college students, refugee service providers, case workers for child protective services, state agencies and more.
- *CLAS Materials* - In addition to the CLAS trainings for community partners, RIDOH distributes "I Speak Cards" which are durable, bilingual wallet-sized resources that educate the public about their rights regarding language access. There are efforts underway to evaluate the use of these cards.
- *CLAS Complaints* - RIDOH has revamped the process for tracking and handling CLAS related complaints. CLAS related complaints are now handled through the centralized customer service line, and there has been an improvement in the coordination between the customer service staff, health facilities regulation staff, and the Health Equity Institute regarding addressing complaints.
- *Facilitating Training of Bilingual Staff* - RIDOH is working to compile a repository of state and web-based programs that enable staff of RIDOH and any other facility to become a certified interpreter/translator. This initiative is designed to rectify the common practice in the community of non-certified bilingual staff serving as translators or interpreters.
- *CLAS Champion Program* - RIDOH runs a CLAS Champion elective for physicians who are working under a J1 Visa. Doctors working under a J1 Visa are required to engage in one of three options of meaningful public service-oriented work one of which is becoming a CLAS champion. This involves undergoing CLAS training and

championing CLAS at their respective institutions thereafter. In 2019 RIDOH had 27 doctors in the J1 Visa program complete CLAS training. There are efforts to better engage the CLAS champions regularly and better understand how they are serving as ambassadors for CLAS at their respective institutions.

Sexual Orientation and Gender Identity (SOGI) workgroup - The Rhode Island Department of Health (RIDOH) has formed a large, multidisciplinary team which is working to improve LGBTTQQ (Lesbian, Gay, Bisexual, Trans, Two-Spirit, Queer and Questioning) public health policies, systems, and environmental change. LGBTTQQ individuals often face a variety of healthcare challenges, including identifying and accessing providers knowledgeable about their health risks and behaviors and who provide culturally affirming care. LGBTTQQ health is also intersectional — sexual orientation and gender identity/expression are important parts of a person's identity, but there are often other demographic factors influencing access to care. The group is working to ensure that our health surveillance systems include questions about sexual orientation and gender identity, offer training to staff to improve our ability to respond to LGBTTQQ health inquiries, and build relationships with other organizations to improve LGBTTQQ health equity statewide. Current initiatives include:

- ***Data and Surveillance -*** In 2016, RIDOH began including the Centers for Disease Control and Prevention (CDC) optional module on Sexual Orientation and Gender Identity in RI's adult Behavioral Risk Factor Surveillance System (BRFSS) survey. RIDOH also began including a gender identity question in RI's high school Youth Risk Behavior Survey (YRBS) in 2017. RIDOH is currently analyzing findings from these surveys related to gender identity, with the goal of releasing these data later this year.
- ***H 7765 – An Act Relating to Health and Safety – Vital Records -*** RIDOH Director Nicole Alexander-Scott, MD, MPH submitted a letter of support for H 7765, legislation which aims to ensure that gender markers on death certificates are correctly aligned with the decedent's identified gender if it does not correlate with sex assigned at birth. RIDOH has also been working with GLBTQ Legal Advocates & Defenders (GLAD) on an amendment to include "any additional document as authorized by the Rhode Island Department of Health" to the list of qualifying documents that can be presented to memorialize a decedent's identified gender.
- ***LGBTTQQ+ Health Resources -*** RIDOH has developed a list of resources that RI LGBTTQQ+ community members may find helpful in accessing culturally proficient healthcare. To view these resources, visit www.health.ri.gov/lgbt.
- ***RI Pride Sponsorship*** RIDOH has been a proud sponsor of RI's Pride Festival since 2016, distributing public health resources and standing with LGBTTQQ+ Rhode Islanders to celebrate their many contributions to our wider community.
- ***Listening Forum on Health and Public Safety -*** RIDOH held a listening forum with the City of Providence in 2016 to learn more about ways to improve health and public safety for LGBTTQQ+ community members. RIDOH is planning to hold another listening forum later this year.
- ***All-Access Restroom at RIDOH's Cannon Building -*** As part of planned renovations to modernize its public restrooms, RIDOH is installing an all-access bathroom on the lower level of the Cannon Building. These facilities will ensure a more welcoming and private space for gender non-conforming visitors and staff, as well as families, caregivers, individuals with disabilities, individuals with atypical bodies and physical presentations, and others.

RI Department of Health Information Line - The RIDOH Information Line (HIL) is the Department of Health's single point of entry for telephone inquiries. The HIL answers an average of 6800 calls per month on behalf of the Department's programs and the Director's office. When there is a Health emergency within the Department or the State (e.g. COVID-19) the HIL will setup a separate line for the specific emergency. (since March 2, 2020 – July 20, 2020 we have received 73,192 calls just for COVID-19 The office hours on the HIL are from 8:30-4:30pm, Monday through Friday. There are at least two individuals on the phone line at all times. The telephone system used by the

HIL is a Uniform Call Distribution (UCD) system. This system allows all calls coming into RIDOH, to come into a single number. From there HIL staff will answer the calls and route them to the appropriate program/division, if they cannot be answered by staff. The HIL phone number is 401-222-5960. The HIL maintains a call database. All staff have access to the database through their own computer with a personal login. Once a call is received, it is logged into the HIL call database. There is a Database Input Sheet that is used when logging in calls. There are currently 38 programs listed on the input sheet, for which calls are taken. The HIL maintains three voicemail boxes; an English voicemail, a Spanish voicemail and an emergency voicemail. There is also a central e-mail account for anyone wishing to contact RIDOH with questions, which is also answered by HIL staff. The HIL also manages the complaint intake for Health Professionals and Facilities Regulation. The complaints are received via telephone, e-mail, e-fax or walk-in. They are processed and forwarded to the respective programs. RIDOH also has the ability to stand up an Emergency Information Line (EIL) as needed to respond to a high volume of calls during emergencies and other crisis response scenarios. RIDOH is currently utilizing the EIL to respond to inquiries from the public related to the Coronavirus Disease 2019 (COVID-19) response.

Family to Family Health Information Center **-** RIPIN is also the Rhode Island's HRSA funded F2FHIC, which is housed within Family Voices. This program provides families of CSHCNs with support, resource referral, training workshops, advocacy, and relevant information via newsletters/publications/websites. The National Center of Leadership for Family and Professional Partnerships provides technical assistance, training, and connections to F2FHICs. Title V dollars are utilized to provide staffing support.

RIREACH **-** RIREACH is an initiative under the RI Parent Information Network (RIPIN) umbrella that works in partnership with the Office of the Health Insurance Commissioner (OHIC) and HealthSource RI. RIREACH helps Rhode Islanders with any type of health insurance including: Medicaid, Medicare, commercial coverage (provided by an employer or purchased through HealthSource, RI) and the uninsured. Using a diverse team of advocates through a peer to peer support model, RIREACH provides assistance on the phone or in person in both consumer's homes or multi-program expertise that is critical to their ability to solve complex issues. Together with RI Family Voices, RIREACH provides valuable information and support to families of CYSHCN and transitioning youth in navigating and utilizing health insurance.

Develop "data-to-action" initiatives to build internal and interagency support and action.

Statewide Health Equity Indicators – Over the past two years, the Health Equity Institute (HEI) went through an extensive community engagement process where the Community Health Assessment Group examined more than 180 potential indicators to measure Rhode Island's progress in advancing health equity. This process led to the selection, in 2018, of a core set of 15 health equity indicators in 5 domains: integrated healthcare, community resiliency, physical environment, socioeconomics, and community trauma. Data comes from various sources. When possible, data are reported by geographic location, race/ethnicity, disability status, income level, or other demographic characteristics. The selected measures are intended to help communities assess the impact of health equity initiatives, such as RI's Health Equity Zones, by providing baseline data and supporting outcomes evaluation. They also provide a way to measure our shared progress. *A complete list of Rhode Island's Statewide Health Equity Indicators can be found in the Appendix.*

MCH Data Dashboard - The SSDI Program developed an MCH data "dashboard" that is available internally to MCH program management on a shared computer drive. The dashboard is an Excel spreadsheet that includes all state and federal Title V outcome, performance and evidence-based strategy measures, as well as the SSDI minimum and core data set, with separate tabs for each. Definitions and descriptions of the numerator and denominators for each measure are presented, along with historical data up to 10 years back and future targets through the year 2023. Where relevant, national averages and Healthy People 2020 objectives are presented for comparison. These data

can be used to inform program planning, policy decisions, needs assessment and grant writing. Next steps include connecting the dashboard, using Power BI software, to the RIDOH website to display selected MCH data measures for the public.

KIDSNET - is a population-based integrated child health information system that facilitates the collection and appropriate sharing of preventive health services data for the provision of timely and appropriate follow-up. KIDSNET began in 1997 with funding from a Robert Wood Johnson Foundation All Kids Count grant and has continued to grow since that time. It contains information on children's preventive health services for all RI children born on or after January 1, 1997. KIDSNET also serves as Rhode Island's childhood immunization registry for children up to age 19. Currently it links data related to the following: *newborn screening (bloodspot, hearing and developmental screening), vital records, family visiting, immunization, lead screening, WIC, Early Intervention, early childhood developmental screening, Asthma (Breathe Easy at Home), Cedar (Medicaid Care Coordination), Head Start, and insurance as well as having connections to birth defects and foster care data*. State-wide data systems for Child Outreach and Dental Sealant programs are built into KIDSNET. Also collected are enrollment data from major health insurers (including all Medicaid Managed Care plans), as well as developmental screening from participating primary care providers and Cedar Family Centers. Three of seven Head Start agencies provide enrollment data, with a fourth planning to begin sending data soon.. Because of the integrated nature of KIDSNET and easy on-line access, medical homes, child health programs, Early Intervention (Part C), specialty care providers, Head Start, School Nurse Teachers, home visitors, and other authorized users can access information necessary for case management, care coordination, and tracking of children with who are missing or need follow-up from various preventive health services such as newborn hearing screening, lead screening, and immunization. KIDSNET data managers support MCH programs by responding to numerous data requests for program development, quality assurance, and quality improvement activities. For example, the Newborn Hearing Screening and Early Childhood Programs work with the Early Intervention (EI) Program to reduce the number of families who do not consent to share data in KIDSNET and to reduce the number of children where consent is missing. These programs use KIDSNET to identify when children are enrolled in EI so complete data are important. Another example is KIDSNET is working with WIC, Family Visiting, Cedar, Head Start, and Early Intervention to promote the running of reports to assure clients receive preventive services and follow-up. This has become even more critical as there is a state-wide effort to reverse the declines in lead screening and immunization associated with the COVID-19 pandemic. Expansion of the immunization registry component of KIDSNET to include all ages is underway, and in the future will provide data on the immunization status of pregnant womxn.

RITRACK migration to KIDSNET - The newborn hearing screening database (RITRACK) was developed in the early 1990's as a stand-alone system. At the time, it met the needs of the newborn hearing screening program. Over time, data transfer between RITRACK and KIDSNET has improved its functionality but it is inefficient and no longer meets the needs of the program, requires Women & Infant IT department support and is unavailable to RIDOH staff. This project will migrate the functionality of RITRACK directly into KIDSNET to resolve these issues. Programming has been completed and is being tested prior to release into production when all newborn hearing screening data functions will be integrated into KIDSNET. Title V funding was blended with other sources to cover the overall project costs. This project improves the efficiency of data management and reduces the time for data to become available to partners serving children and families. These partners assist RIDOH to ensure that all infants (approximately 11,000 per year) receive newborn hearing screen and appropriate follow-up. The data system provides PCPs, audiologists, Early Intervention, home visitors, WIC, and other community partners access to run reports on their patients/clients to help reduce loss to follow-up from newborn hearing

PRAMS data & infant safe sleep recommendations - The RI Safe Sleep Work Group aims to reduce infant sleep-

related deaths in the state. Two-thirds of RI infant sleep-related deaths from 2012-2017 have occurred while an infant was sharing a bed or other surface with another person. PRAMS data from 2012-2015 reveals that 57% of new mothers report that their baby sleeps in the same bed with someone else and 19% report that this occurs always or often. The Interagency Safe Sleep Work Group designed a two-hour training program for early childhood professionals to learn about the American Academy of Pediatrics *Updated 2016 Recommendations for a Safe Infant Sleeping Environment* and strategies for effective conversations about safe sleep. The trainings include infant sleep-related PRAMS data which highlights that bedsharing with infants is not uncommon and that early childhood professionals are important messengers of safe sleep recommendations including the key message, *Share a room, not a bed*. Since January 2017, 430 early childhood professionals in WIC, Early Intervention, and Family Home Visiting have been trained. Additionally, nearly 300 DCYF employees have been trained. Of the professionals trained, 57.8% reported feeling an increase in their confidence to provide guidance on SIDS and safe sleep to their families after the training session. RIDOH is including PRAMS infant sleep data in other high-profile presentations to leadership and policy groups throughout the state and in media interviews and articles. The Safe Sleep Work Group will continue to monitor trends in PRAMS responses which will inform future professional education activities and public health communications promoting infant safe sleep recommendations.

RIDOH has benefited from an increased use of RI PRAMS for public health action and from students providing preliminary analyses for Rhode Island's MCH strategic objectives, many of which have been published as RIDOH Issue Briefs, presented to practitioners locally and nationally, and published in peer-reviewed journals. Since its inception in 2016, the collaboration received national recognition with the CDC PRAMS 2018 1st place award for Unique Partnerships and Collaborations. More recently the Brown School of Public Health applied for a Health Resource and Services Administration (HRSA) grant to establish a MCH Centers of Excellence with the purpose to: 1) strengthen and expand the MCH workforce, both in Rhode Island as well as nationally, by training graduate and post-graduate public health students in MCH and 2) advance MCH science, research, practice, and policy through a well-trained MCH public health workforce that has benefited from a "learning public health by doing public health" approach to education.

This past year, RI PRAMS program and the Brown University School of Public Health continued to strengthen the partnership to use RI PRAMS data in the biostatistics and data analysis education of Brown University Master of Public Health students. In each year that this has been a part of the introductory biostatistics course sequence more students have applied to be a part of the collaboration than there are spots available. Based on these successes, the collaboration expanded in 2019 to include additional databases and issues from the RIDOH.

During the academic year 2019/2020 six students worked with RI PRAMS 2016 – 2018 dataset. Students meet monthly in a small group setting, led by Karine Monteiro, the RI PRAMS Coordinator and two to three times with identified RIDOH program staff. Issue brief analysis topics are aligned with ongoing RIDOH initiatives from brainstorming sessions held with the MCH Policy group and the PRAMS Steering Committee members. The issues focused on during the academic year 2019/2020 include adverse childhood experiences (ACEs), nicotine substance use, preterm birth, maternal depression, physical activity during pregnancy, and safe sleep. The partnership will continue in academic year 2020/2021 through distance learning due to the COVID-19 pandemic.

PRAMS data & maternal depression – The Rhode Island Maternal Psychiatry Resource Network (RI MomsPRN) Program continues to actively collaborate with RIDOH's Center for Health Data, Analysis, and Public Health Informatics Unit to collect and analyze related maternal depression and behavioral health data within the PRAMS survey. This past year staff from both units collaborated to create a report and related poster for the RI Prematurity Task Force Summit that explored the connection between maternal mental health and preterm birth. Both the publication and related poster were distributed and highlighted to 125 attending prenatal care staff on 11/14/19. The Summit also featured a panel discussion that included RI MomsPRN clinical staff and a related keynote address by Dr. Jennifer Payne, Director of the Women's Mood Disorder Center from Johns Hopkins School of Medicine that further reinforced and explored findings in the PRAMS data report. In addition, the two RIDOH units continue to analyze related phase 8 PRAMS data (2016-2018) and are actively partnering with a Brown University Public Health School Graduate Student to create a maternal depression during pregnancy report. Covid staff re-assignment at

RIDOH has delayed the finalization of this brief, but it will be completed in the near future as RIDOH staff return to their normal job functions. This partnership also resulted PRAMS behavioral health data being included in a new Title V perinatal mental health factsheet, which is being used to guide stakeholder strategic discussions. Finally, RI MomsPRN funds continue to support the administration of the RI PRAMS survey and the fielding of substance use disorder related modules and questions that will be reportable in the near future.

Behavioral Risk Factor Surveillance System (BRFSS) –
BRFSS is an annual state-based telephone survey assessing the health status and behavioral risk factors of the non-institutionalized adult population 18 years of age and older. The BRFSS survey provides valuable information on health trends, chronic disease risks, and data for monitoring the effectiveness of policies, programs, and interventions. Subject areas include self-reported health status, access to health care, health awareness, use of preventive services, as well as knowledge and attitudes of health care and health care practices.
BRFSS data collection, analysis and reporting is a critical component of the 5-year needs assessment, and BRFSS results are used by the MCH program, other RIDOH programs, state agencies, academic institutions, non-profit organizations and others to develop and evaluate programs that promote the health of Rhode Island residents. About one half of the questions asked on the 2020 survey were recommended by the Rhode Island Department of Health.

BRFSS collects data related to 17 of the 23 Population Health Goals of RIDOH's Strategic Framework, including:

1. Reduce obesity in children, teens, and adults
2. Reduce chronic illnesses, such as diabetes, heart disease, asthma, and cancer
3. Promote the health of mothers and their children
4. Promote senior health to support independent living
5. Promote behavioral health and wellness among all Rhode Islanders
6. Support Rhode Islanders in ongoing recovery and rehabilitation for all aspects of health
7. Increase access to safe, affordable, healthy food
8. Reduce environmental toxic substances, such as tobacco and lead
9. Improve access to care including physical health, oral health, and behavioral health systems
10. Expand models of care delivery and healthcare payment focused on improved outcomes
11. Increase patients' and caregivers' engagement within care systems
12. Reduce communicable diseases, such as HIV and Hepatitis C
13. Reduce substance use disorders
14. Minimize exposure to traumatic experiences, such as bullying, violence, and neglect
15. Ensure that quality public health data are collected consistently using current technology
16. Analyze public health data to monitor trends, identify emerging problems, and determine populations at risk
17. Provide public health data to support program planning, policy development, and surveillance needs

BRFSS also provides data to inform some of RIDOH's Health Equity Indicators, which addresses RIDOH's three leading priorities:

- Integrated Healthcare - Healthcare Access (percentage of adults who reported not seeking medical care or dental care due to cost
- Community Trauma - Discrimination (percentage of adults reporting racial discrimination in healthcare settings)

The Youth Risk Behavior Survey (YRBS) - i
is a collaboration between CDC, RIDOH, RIDE, and BHDDH. The survey, which is administered every two years, is implemented through anonymous questionnaires in a random sample of Rhode Island public high schools and

middle schools. Rhode Island is currently designing the 2021 high school survey in collaboration with the RI YRBS Advisory Committee. The survey will be fielded between February – May 2021 and will include state added questions related to the following topics: prescription drugs, maternal and child health priorities, oral health, homelessness, food insecurity, transportation safety, gender expression, transgender status, and assets. The data are used to help policy makers, school administrators, social service workers, and public health professionals understand trends in the health behaviors of young people across the state and to create health-related policies that will impact those behaviors. At RIDOH, data from the Youth Risk Behavior Survey are used to develop health programs for adolescents throughout Rhode Island and to understand how students are disproportionately affected by different health issues. Understanding these disparities allows an opportunity to address the factors at the community-level that affect students' decisions and behaviors. Covid – 19 staff re-assignment at RIDOH has delayed YRBS data products planned for 2020. Despite these barriers we have been able to accomplish the following:

- The 2019 YRBS data are available for analysis and summary tables are posted on the Rhode Island Department of Health (RIDOH) website.
- A Health by Number article entitled “Sleep Deprivation among Rhode Island High School Students” published in the March 2020 issue of the Rhode Island Medical Journal.
- The YRBS Survey Coordinator gave an oral presentation at the RI Conference on Youth Sexual Education in May 2019, and to orient community health educators about the questions on the Rhode Island High School Youth Risk Behavior Survey that pertain to sexual identity, gender identity and gender expression, and provide results of the prevalence of health-related behaviors by sex, race ethnicity, sexual identity, gender expression and disability.
- The MCH Program continues to support the administration of YRBS and advocates for several state-added questions be included on the high school and middle school surveys. Disability and drinking water questions address MCH state priority needs. Questions on social support, community connectedness, and homelessness will help address issues regarding measuring social determinants of health.
- The YRBS Survey Coordinator also participated in the All Students Count Coalition (ASCC), webinar entitled, Measuring What Matters: Leveraging YRBSS Data to Improve the Health & Well-Being of Transgender & Nonbinary Students.
- Work is ongoing to review and update YRBS/Profiles 5-year Communication Plan and develop analysis plans for 2019 data.
- Partnerships with a variety of stakeholders continue to be integral component of the YRBS project. For the 2019 YRBS survey, three new partners were identified to provide input. The partners included RIDOH Health Equity Institute’s Girls Empowerment Mentoring Support Program and Princes to Kings Program, RIDE Title 1 Homelessness Program and the RI Department of Transportation.

Rhode Island Department of Health (RIDOH) Academic Center - was created in 2015 to enhance RIDOH’s capacity to integrate scholarly activities into public health policy and practice by establishing and facilitating collaborations with academic and research colleagues across the state, and build upon internal and external partnerships and synergy to establish the RIDOH Culture of Learning at the department. The RIDOH Academic Institute supports three areas of engagement to achieve these goals: Public Health Education and Research, Workforce and Career Development, and Research Integrity and Accreditation.

Public Health Education and Research

Through the work of the RIDOH Academic Institute, RIDOH has become an Academic Health Department that looks forward to having formal affiliations with all of Rhode Island’s colleges and universities. Formal affiliations currently exist with: Brown University School of Public Health, Community College of Rhode Island, Johnson and Wales University, New England Institute of Technology, Providence College, Rhode Island College, Roger Williams University, and University of Rhode Island. Collaboration between RIDOH programs and academic faculty is

encouraged based on RIDOH's public health policy and practice, and similar research and teaching interests of academic faculty. These partnerships drive development of collaborative research ideas that create experiential learning opportunities for RIDOH Public Health Scholars, who are undergraduate, graduate, professional or clinical students currently enrolled in courses of study that relate to public health.

RIDOH's utilization of a health equity lens for public health program planning and policy development provides multidisciplinary opportunities for collaboration with faculty and students in programs of study such as public health, healthcare, communications, graphic design, technology, housing, finance, law, urban planning, architecture, etc.

Collaborative state-academic forums and partnerships are developed to enhance statewide research and outcomes in public health-related topic areas. These research-based groups include multiple researchers from various academic institutions as well as state agencies and community partners.

Workforce and Career Development

The knowledge, skills and abilities of RIDOH staff and healthcare and health-related professionals across Rhode Isl are enhanced through assessment of career planning and continuing education needs, thoughtful engagement, a development of initiatives to address Rhode Island's health workforce needs utilizing collaborative and innovat methods.

Research Integrity and Accreditation

To facilitate appropriate use of RIDOH data, public health research is reviewed by the RIDOH Institutional Review Bo to ensure ethical use of human subject research in compliance with federal laws. Additionally, RIDOH's quality a performance is advanced through measurement and comparison with nationally recognized, practice-focus evidence-based standards to improve and protect the public's health.

Between June 2019 – June 2020, RIDOH staff authored the following MCH related journal articles:

1. Money EB, Williams J, Zelek M, Amobi A. Engaging the Power of Communities for Better Health. N C Med J. 2020 May-Jun;81(3):195-197.

2. Brousseau EC, Clarke JG, Dumont D, Stein LAR, Roberts M, van den Berg J. Computer-assisted motivational interviewing for contraceptive use in women leaving prison: A randomized controlled trial. Contraception. 2020 May;101(5):327-332.

3. Werner EF, Schlichting LE, Grobman WA, Viner-Brown S, Clark M, Vivier PM. Association of Term Labor Induction vs Expectant Management With Child Academic Outcomes. JAMA Netw Open. 2020 Apr 1;3(4):e202503.

4. Jackson TL, Cooper T. Sleep Deprivation among Rhode Island High School Students. R I Med J (2013). 2020 Mar 2;103(2):49-52.

5. Orr M, Rajotte J, Jackson T, Cooper T, Clyne A. E-cigarette Use and Rhode Island High School Students: What Providers Need to Know about the Characteristics of Initiation of E-cigarettes and Related Risk Behaviors. R I Med J (2013). 2020 Feb 3;103(1):51-54.

6. Monteiro K, Kim HH, Arias W, High P. How Many Parents are Reading with their Young Infants in Rhode Island? R I Med J (2013). 2019 Dec 2;102(10):57-60.

7. Sheldrick RC, Schlichting LE, Berger B, Clyne A, Ni P, Perrin EC, Vivier PM. Establishing New Norms

for Developmental Milestones. Pediatrics. 2019 Dec;144(6):e20190374.

8. Zheng T, Zhu C, Bassig BA, Liu S, Buka S, Zhang X, Truong A, Oh J, Fulton J, Dai M, Li N, Shi K, Qian Z, Boyle P. The long-term rapid increase in incidence of adenocarcinoma of the kidney in the USA, especially among younger ages. Int J Epidemiol. 2019 Dec 1;48(6):1886-1896.

9. Amobi A, Plescia M, Alexander-Scott N. The Business Case for Investing in Place-Based Public Health Initiatives. J Public Health Manag Pract. 2019 Nov/Dec;25(6):612-615.

10. Clements E, Schlichting LE, Clyne A, Vivier PM. Underlying Causes and Distribution of Infant Mortality in a Statewide Assessment from 2005 to 2016 by Infant, Maternal, and Neighborhood Characteristics. R I Med J (2013). 2019 Nov 1;102(9):15-22.

11. Amobi A, Lewis M, Novais A, Alexander-Scott N. ASTHO President's Challenge: Core Principles for Building Community Resilience. Am J Public Health. 2019 Sep;109(S4):S277-S278.

12. St John K, Viner-Brown S. Maternal Obesity and Birth Defects in Rhode Island. R I Med J (2013). 2019 Aug 1;102(6):50-52.

13. Amobi A, Plescia M, Alexander-Scott N. Community-Led Initiatives: The Key to Healthy and Resilient Communities. J Public Health Manag Pract. 2019 May/Jun;25(3):291-293.

Sustainability of Crosscutting Priorities

RIDOH and the MCH Program will continue to have a leadership role in system, interdepartmental, and interagency coordination to improve the overall healthcare delivery system across the state for MCH populations. Through involvement in the Executive Office of Health and Human Service, RIDOH will continue to represent MCH policy direction and leadership on the state's population health plan and participate in the following initiatives: State Improvement Model (SIM); Patient Centered Medical Home-Kids (PCMH-K); Care Transformation Collaborative (CTC); and interdepartmental advisory groups. Specific MCH SIM initiatives include the Rhode Island Child Psychiatry Access Program (RICPAP) and the RI Screening, Brief Intervention, and Referral to Treatment Project (SBIRT). RIDOH will also continue to be heavily involved in the Children's Cabinet and Governor's Taskforce on 3rd grade reading. RIDOH will continue to assist on implementing the Global Compact Medicaid Waiver with CMS and State Medicaid.

Over the coming year the Children's cabinet will continue to focus on supporting activities that will improve RI's 3rd grade reading proficiency. This is a multi-state agency effort which also includes community partners and focuses on supporting children and their families beginning at birth to be proficient readers by 3rd grade. There is a state agency staff level Governor's Taskforce on 3rd Grade Reading, that was convened in 2016 to ensure that specific activities to improve 3rd grade reading are implemented. The Cabinet is also focused on interagency collaboration activities that will both support families to reduce involvement in the child welfare agency as well as improve outcomes for children who are currently involved with the child welfare agency.

RIDOH and the MCH Program will continue to implement and support the 10 Health Equity Zones throughout RI. This includes utilizing Title V block grant funding to support MCH work in the HEZ, as long as it aligns with MCH State Priorities. The Program will work collaboratively with each HEZ to provide support and guidance, ensure fidelity to evidence-based programs, and create alignment and synergy at the local level. This will be achieved through attendance at monthly HEZ Collaborative meetings, reviewing quarterly reports, regular communication, and an annual site visit. MCH staff will continue to serve on the HEZ policy team will participate in collective impact evaluation of the HEZ.

Community Health Workers (CHW) are frontline public health workers who liaise between health, social services, and the community to facilitate access to services and improve the quality and cultural competence of service delivery. RIDOH is advancing the CHW profession through facilitating a certification process, building the research base, and developing reimbursement pathways. The use of CHWs in health prevention programs has been associated with improved healthcare access, prenatal care, pregnancy and birth outcomes, client health status, health-seeking behaviors, and reduced health care costs. RIDOH will continue to develop and support peer CHWs through the RI Parent Information Network, Pediatric Practice Enhancement Project, and RIREACH Program. RIDOH will continue to engage community members, CHWs, and consumers in all areas of program, policy and systems change through existing advisory boards, consumer groups, Health Equity Zones, and community contracts.

RIDOH will continue to implement evidence based program to address mental and behavioral including MomsPRN and PediPRN. RI will continue to be involved with statewide initials that support mental and behavioral health. RI will also collect and analyze data on gaps in services particularly as its related to mental/behavioral health.

The Family Visiting Program will continue to use the experience screen in First Connections home visiting programs. RI will also continue to focus efforts around ensuring that the highest risk children and their families are linked to comprehensives services. RI will also pursue targeted funding streams to increase the capacity to mitigate toxic stress. The program will continue to track the positive responses to questions on the experience screen. There are clear income disparities in who experiences toxic stress. The experience of toxic stress is strongly related to poverty and therefore is correlated with a myriad of health disparities. RI's work around toxic stress is focused on linking families to community based programs that meet their needs, and to make systems changes among systems that serve children at high risk for toxic stress such as those involved in the child welfare system, or infant born with Neonatal Abstinence Syndrome and their families. RI's work is also focused on ensuring that all family members are connected to necessary services.

RIDOH will continue to implement suicide prevention programs. In the coming year, the RI Youth Suicide Prevention Programs (RIYSPP) plans to continue rolling out the Suicide Prevention Initiative (SPI) protocol and training adults and students in additional RI school districts. High-risk districts (those with higher reported youth suicide completions/attempts) are prioritized first, but if they decline the program staff will quickly move to establish partnerships with other school districts. In addition to the work done in schools, RIYSPP will continue to work with partners (South County Health Equity Zone, Washington County Coalition for Children, etc.) to train local community leaders (faith leaders, youth leaders, community organizers, etc.) in suicide prevention principles. RIYSPP staff will also continue to provide technical assistance to schools who have implemented the SPI protocol. Lastly the RIYSPP will work to provide suicide prevention resources/services to the 18-24 years old population group in RI through the various colleges/institutions of higher learning located throughout the State.

Overdose prevention will be supported by maintaining a leadership role in the Overdose Prevention Task Force, the Neonatal Abstinence Syndrome Task Force, and funding a network of Peer Recovery Coaches.

RIDOH aims to achieve health equity for all MCH populations by eliminating health disparities, assuring healthy child development, preventing and controlling disease and disability, and working to make the environment healthy. RI will continue to support health equity as the social determinants of health are adopted into public health planning and practice. RIDOH will do this by continuing to use a comprehensive, integrated approach to supporting health. RIDOH will continue to focus on improving outcomes for its most vulnerable populations, taking a life course approach through systems that support identification of risk and response at the earliest possible point. It is through taking this approach that RI will support all of its citizens to achieve optimal health.

RIDOH will continue to represent and provide advocacy for vulnerable populations. The Health Equity Institute (HEI) will continue to provide programmatic support concerning the best practice in eliminating health disparities in RIDOH programs through addressing the social determinants of health including transportation (providing bus passes for consumer engagement), interpreting (access to language bank for assistance), housing (providing technical assistance concerning Medicaid home stabilization and Home Locator services), engage community

partners (Green and Healthy Housing Initiative, Healthy Communities, Health Food at School, Dare to Dream, Social Justice Workgroup, Employment First, Project SEARCH) and implementation of the Health Equity Zones. HEI will continue to provide education and technical assistance on Culturally Linguistic Appropriate Services (CLAS) standards to advance health equity, improve quality and helps to eliminate health disparities. It will also continue to convene the LGBTQ workgroup and the social justice roundtable.

The MCH Program will continue to actively participate in committees and workgroups that address the social and environmental determinants of health such as the Commission for Health Advocacy and Equity, the LGBT workgroup. Community Assessment Group, the Social Justice Roundtable among others. RIDOH will continue to collect, analyze and disseminate data to build internal and interagency support for MCH issues. The MCH Program will maintain its involvement in the PRAMS, BRFSS and YRBS advisory boards to ensure that the data needs of the Program are represented. For example, the MCH Program is advocating for the addition of a race and discrimination module in the PRAMS survey.

APPLICATION YEAR: Crosscutting

RI's Cross Cutting Priority attempts to address health inequities that are systemic, avoidable, unfair, and unjust differences in health status across population groups. RIDOH recognizes that the conditions in which people are born, grow, live, learn, work, and play affect health in powerful ways. Public health research and data show that many adverse health outcomes have resulted from generations-long social, economic, and environmental inequities. These inequities include poverty, discrimination, racism, and their consequences. For example, segregation in housing and education and racist mortgage lending and zoning policies have affected communities differently and have had a greater influence on health outcomes than genetics, individual choices, or access to healthcare. Removing obstacles to health and improving access to good jobs with fair pay, quality education and housing, safe environments, and healthcare can help reduce health inequities and improve opportunities for every Rhode Islander.

Priority: Adopt Social Determinants of Health in MCH Planning & Practice to Improve Health Equity

The Title V program aims to collaborate across the RIDOH and with other state and local stakeholders to adopt SDoH into MCH planning and practice in order to improve health equity. RI has adopted 15 Health Equity Indicators as statewide measures to overarchingly assess health equity in the state. These indicators span across five domains (integrated healthcare, community, physical environment, socio-economics, and community trauma), which are further broken down in measuring key determinants of health that can be reported by city/town and race/ethnicity and monitored annually using various state agency, census, and survey data. The MCH Program is interested in incorporating these measures to address social determinants of health that are related to the MCH populations. Overall, the goal is to increase health equity and access across the entire state. Please reference the appendix for a comprehensive breakdown of health equity indicators.

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BRFSS 2018 data show that 78.3% of Hispanics report visiting their doctor in the past year compared to 86.0% of Non-Hispanic Whites. The community resilience indicator measures Health in All Policy by calculating the percentage of low- and moderate-income housing. This indicator shows that cities such as Woonsocket (15.9%), Providence (14.9%), and Central Falls (11.2%) in 2016 had a higher percentage of low- and moderate-income housing than the statewide estimate (8.2%). Housing burden, a socioeconomic indicator, is calculated by identifying the percentage of cost-burdened renters and owners for RI cities and towns. This composite metric from 2019 HousingWorks RI Factbook's data showed that the communities with the highest total burden are Central Falls (55%), Providence (45%), and Pawtucket (42%). In 2018, nearly 4,000 women, men, and children experiencing homelessness sought shelter in RI. This number does not include those using RI's recently implemented coordinated entry system, which aims to triage households experiencing housing insecurity and "divert them from ending up in limited shelter beds; and the more than 1,500 RI students, who are measured by a different standard, but do not have a place to call home—a nearly 24 percent increase from the prior school year."[1] In 2019, the graduation rate among high school students who completed 4 years (2015/16 freshman class) was 83.9%, which is an increase from 2016 (2012/13 freshmen class) with 82.8%.

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Throughout the Title V Needs Assessment the state has collected quantitative, qualitative, and anecdotal information on how social determinants of health and structural inequities impact the outcomes of all Rhode Islanders. The SISTA FIRE Maternal Child Health Survey found that WOC ranked the following as what they were most concerned on a daily basis: not enough jobs that pay a living wage or have a career path (52%), paying monthly bills (41%), and wealth creation (34%). These daily stressors and needs of WOC do contribute to emotional, mental, and toxic stress. SISTA FIRE Survey found that 8% of Womxn of Color (WOC) responded always experiencing racism in the healthcare setting and 49% WOC experienced racism sometimes. Additionally, there were a higher unawareness of certain types of state programming and services such as: free breastfeeding support (41% unaware), free insurance during pregnancy (43% unaware), and home visiting (45% unaware).

Additionally, the 2017 SISTA FIRE community survey brought up barriers and hardships among WOC. For instance, WOC struggle to attain higher education degrees due to a lack of financial resources and supports. 68% of WOC reported having to work part or full time to afford basic needs and tuition. Overall, 50% of the approx. 300 women who took the survey earned less than $30K. The survey showed WOC work across a variety of industries (food, hospitality, healthcare, education, etc.) but still almost a quarter (23.3%) of respondents made an annual income of $10k or less. Homeownership is low as well with only 18% of respondents reporting ownership of their house. A majority of WOC (66%) rented their homes. A significant percentage of WOC also reported struggling to afford food (31%), housing (48%), and to pay off debt (79%). 49% reported that they were unable to save for future or emergency expenses and 23% were unable to make payments towards their debt. High rates of debt are indicators of stress and instability. Debt and credit issues limit access to housing and ability to afford housing, as well as other basic needs like food, healthcare, childcare and transportation. These findings are further grounded by most respondents residing in Providence where there have been steep increases in rents with the average household needing to earn an annual income of $70k in order to afford a two bedroom apartment.

Young mothers of SENs interviewed by the Pawtucket & Central Falls HEZ also reported poor treatment when going to prenatal checkups, when arriving in the hospital to give birth, at the hospital after birth, and when visiting their baby if s/he is going through withdrawal. One woman shared her experiences of giving birth twice at Women and Infants Hospital. The first time she successfully hid her addiction to opioids and alcohol from hospital staff. She remarked that she was treated “like a princess” and given a special birthing suite. The second time she gave birth, she was “deep in the throes of her addictions” and It showed on her face, her body, and in her comportment. She arrived at the ED at Rhode Island Hospital and was left alone on a gurney in the waiting room for hours. When she was finally attended to she was fully dilated and ready to give birth. She was supposed to have had a C section but by then it was too late. Overall, these experiences show a need for a reduction of stigma and more comprehensive and compassionate care for substance using mothers giving birth.

The Title V Program solicited feedback on community needs at the recent Health Equity Zone (HEZ) Professional Learning Community Event on February 28, 2020. Several cross-cutting themes emerged as part of the HEZ event focus groups. HEZ participants repeatedly highlighted the importance of mental health and the need for more mental health care providers, resources and supports. This was supported by the poll results, with 73% of respondents saying this was the top priority for RIDOH to address in the well-being category. HEZ participants focused on the prevalence of health disparities across all of the Title V domains. They repeatedly indicated the need for more staff and providers who share similar cultural and linguistic backgrounds with the families and communities they serve. Participants felt that there needs to be more community education and outreach so that individuals and families are more aware of the existing resources and services available in their communities. Additionally, HEZ participants spoke to the need for more comprehensive sex and health education to help prevent unintended

pregnancies, reduce the rates of sexually transmitted infections, and promote positive social and emotional development.

Strategies:

1) Youth Advisory Council

The RIDOH aims to promote health equity through the input of youth advisory councils. The RIDOH Youth Advisory Council is comprised of youth and young adults who have demonstrated leadership through their involvement with Dare to Dream or other statewide youth initiatives and have an interest in helping their peers who want to improve their school and communities. The Council provides feedback and collaborates with the Office of Special Needs on a variety of activities, programs, policies, and resources that affect the health, wellness, and transitional needs of youth in the State.

2) Health Equity Zones

The Health Equity Institute at the Rhode Island Department of Health (RIDOH) collaborates with RIDOH staff, state leaders, and community partners to ensure every Rhode Islander has a fair and just opportunity to be healthy. This work directly supports and provides leadership to RIDOH's signature initiative: Rhode Island Health Equity Zones, a community-led model that brings people together to create healthy places to live, learn, work, and play. Rhode Island's Health Equity Zone initiative is an innovative, place-based approach that brings communities together to build the infrastructure needed to achieve healthy, systemic changes at the local level. Health Equity Zones are geographic areas where existing opportunities emerge and investments are made to address differences in health outcomes. Through a collaborative, community-led process, each Health Equity Zone conducts a needs assessment and implements a data-driven plan of action to address the unique social, economic, and environmental factors that are preventing people from being as healthy as possible. Funds aim to support neighborhoods and localities in establishing and maintaining programs identified by each community that address social determinants of health. HEZs are supported by public and private funding, braided together at the state-level, including substantial resources from the Title V Maternal and Child Health Grant Program.

[1] 2019 HousingWorks RI Factbook. https://www.housingworksri.org/Portals/0/Uploads/Documents/2019%20Pages/HFB2019_compressed.pdf

III.F. Public Input

Public Input

The mission of the Rhode Island Department of Health (RIDOH) Title V MCH Program is to build integrated systems that support health, growth, and development for MCH populations, including children with special health care needs (CSHCN). RI has regular mechanisms in place to obtain input and feedback on MCH programs through advisory and other groups (coalitions, collaboratives etc.) charged with addressing specific public health programs and initiatives. Some of these groups are administered by RIDOH and others are administered by external partners, including other state agencies. Input related to state MCH needs, capacity and priorities are collected at these meetings from participating stakeholders, other state agencies, providers, and consumers which include families with CSHCN and incorporated into program planning and development. (Please see appendix for full list of committees)

During the Title V Needs Assessment Title V leaders organized an efficient and strategic plan for community and workforce engagement. The initial step was to get a sampling of what population needs were present within each domain. RIDOH engaged in the following list of surveys and community and stakeholder input events:

Population & Professional Surveys:

-Statewide Community Health Survey (476 responses) distributed by the RIDOH
-Statewide Professional Survey (449 responses) distributed by the RIDOH
-2019 Youth Survey (188 responses) in collaboration with Adolescent, School & Reproductive Health Programs
-2019 Parents of CSHCNs Survey (117 responses) distributed by RIPIN
- 2020 Womxn of Color Survey (200 responses) distributed by SISTA FIRE

Community & Stakeholder Input

-2019 Youth Advisory Council Focus Group
-2019 Womxn of Color Birthing Stories key learnings (approx. 300 responses) collected and summarized by SISTA FIRE
-2020 Parents of CSHCNs Focus Group
-2020 Health Equity Zone Collaborative Conference Focus groups: Conference members (statewide Health Equity Zone leads, local organizations, community activists, and constituents) were split into smaller focus groups and assigned MCH populations to cover that aligned with their organizational focus.
-RIPIN Conference: RIPIN survey findings were shared and Parents of CSHCNs shared their personal stories and gave policy recommendations to stakeholders.

Title V Public Comment Period

RIDOH gained feedback from the community on the 2019/2020 Title V application and annual report. Following the submission of the application and annual report to HRSA on September 15th, the MCH Program plans to disseminate the document to MCH stakeholders and community members. Initial plans include posting it on the RIDOH Title V webpage and sharing electronically to Health Equity Zone Collaboratives, MCH committees and advisory boards, and through MCH staff professional networks. Comments and recommendations will be received through August 30, 2021 and will be incorporated into the final document that will be submitted to HRSA at the end of September 2021.

Strategic Planning & Needs Assessment

Family Visiting Program

In 2018-2019, RI's Family Visiting MIECHV Program went through a strategic planning process and, in 2019-2020, MIECHV engaged in a federally mandated needs assessment process. During both processes, RIDOH staff worked with the 12 Local Implementing Agencies to identify staff and families to participate in surveys, workshops, and focus groups. The Successful Start Steering Committee serves as the statewide advisory body for family home visiting and Project LAUNCH and is being led by staff from each program. Together, the two programs are working on strategies to engage families at different systems levels and are receiving technical assistance from HRDA and guidance from states that have successfully engaged parents and families at different systems levels.

SEN Task Force

The Rhode Island Task Force to Support Pregnant and Parenting Families with Substance-Exposed Newborns

(SEN Task Force) has begun a facilitated strategic planning/ visioning process. The outcome of this work will be a road map to shape and guide the task force's efforts for the next five to 10 years. Through this process, collective priorities will be established with diverse stakeholder input to focus energy and resources, strengthen operations, and ensure that stakeholders and state agencies are working toward common goals, intended outcomes, and results. The strategic plan will incorporate short-term plans that we can support through our limited resources, as well as a collective long-term vision we are poised to advocate for when additional federal or local funding is available to support the SEN work.

III.G. Technical Assistance

1. Technical Assistance

The following information represents a preliminary plan for technical assistance requests by RI's Title V Program.

TA #1: Incorporating the Voices of RI Women of Color in RI MCH Program– The Center for Community Transformation

RIDOH and The Center for Community Transformation will develop strategy regarding outreach and facilitation to reach women of color across different cities and towns (Providence, Pawtucket and Central Falls) and in regard to language. The Center for Community Transformation Team will synthesize information and provide a formal narrative of the key findings and recommendations from the discussion, including short stories if applicable. The scope of this work will advise RI's racial disparities work in Infant Mortality, Maternal Mortality, and general social environmental determinants of health.

TA: #2 Delivering Special Education in a Virtual Environment - Consultant TBD

RI's Title V partner Rhode Island Parent Information Network surveyed over 400 parents of children with disabilities who attend school in Rhode Island, asking them about their experiences with distance learning. RIPIN released the results of this survey, highlighting the following three key policy recommendations for Rhode Island schools: School reopening plans should include targeted solutions for students with disabilities; on distance learning days, schools should consider enhanced in-person support for students with disabilities who are able to participate; and on in-person school days, schools should make high-quality distance learning options available for students with disabilities who need it. RI Title V requests technical assistance for RI's special education providers and districts to implement these recommendations.

TA: #3 Operationalizing and measuring social, environmental, and economic determinants of health in MCH - Consultant TBD

Addressing social determinants of health is one of RIDOH's 3 leading priorities. Additionally, the MCH Program has identified incorporating SDOH into public health planning and practice as one of its ten priority areas. While the MCH Program has used traditional health outcomes to measure disparities, it has yet to incorporate measures addressing the SDOH, such as transportation, housing, toxic stress, disability, safety, education, etc. In early 2020, RIDOH released the Rhode Island Health Equity Measures. This technical assistance will be to prepare a specific MCH report to understand, operationalize and measures SDOH that affect maternal and child health outcomes using the Health Equity Indicators.

TA: #4 Improving the experience of women of color at Women & Infants Hospital – Dr. Joia Crear- Perry, Birth Equity Solutions

Located in Providence, Women & Infants Hospital (WIH) is RI's largest birthing hospital. Approximately 80% of the babies born in RI are delivered at WIH. While the hospital has an outstanding clinical reputation for being one of the busiest hospitals it the country, it has struggled at times to meet the diverse needs and cultural differences that are reflected in its patient population. During the Spring of 2019, the hospital experienced a black maternal death that received national attention, including from the Black Mama's Matter Alliance. This event further damaged the hospitals' relationship with the community. Afterwards, WIH leadership engaged RIDOH in an effort to find ways to collaborate around improving the experiences of women of color across the state who receive obstetric care at Women and Infants Hospital. Building off of the success of a recent Kaizen event (rapid CQI) event that examined the continuity of care and community supports offered to families, RIDOH feels that WIH hospital could benefit from the expertise of Dr. Joia Crear-Perry, who has provided birth equity consulting services to other hospitals throughout the country.

2. Medicaid Memorandum of Understanding - uploaded

3. Supporting Documents- uploaded
    1. 2020 RIDOH MCH Partnerships and Collaborations
    2. Health Equity Zones Project Description & Outcomes
    3. RI's Statewide Health Equity Indicators
    4. RI Home Visiting Strategic Plan
    5. 2020 Rhode Island Commission for Health Advocacy and Equity Legislative Report

11. Organizational Charts – uploaded
    1. EOHHS
    2. RIDOH
    3. Health Equity Institute
    4. Maternal and Child Health

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - RIDOH EOHHS ISA Agreement signed.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - V. Appendix Title V MCH Populations Issue Briefs.pdf

Supporting Document #02 - V. Health Equity Zones Community Overviews.pdf

Supporting Document #03 - V. RIDOH MCH Partnerships and Collaborations.pdf

Supporting Document #04 - V. APPENDIX STATE REGULATIONS (2).pdf

Supporting Document #05 - HealthEquityIndicators.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - OrgCharts_RI_2020.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Rhode Island

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,900,000	
A. Preventive and Primary Care for Children	$ 621,672	(32.7%)
B. Children with Special Health Care Needs	$ 688,750	(36.2%)
C. Title V Administrative Costs	$ 84,142	(4.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,394,564	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 2,192,023	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 2,517,587	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 36,320,104	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 41,029,714	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,875,000		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 42,929,714	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 55,910,645	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 98,840,359	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 262,365
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)	$ 554,286
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 292,837
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)	$ 538,487
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose: Prevention for States Program	$ 4,386,071
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 791,738
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 182,767
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 541,356
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	$ 207,829
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 178,304
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 115,036
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 286,117
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 158,790
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,091,570
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 99,936
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 23,170,148

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Lead	$ 171,999
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Radon	$ 148,674
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Toxic Substance	$ 85,039
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 901,613
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 499,751
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 198,213
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 399,198
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	$ 575,000
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Asbestos	$ 175,208
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	$ 1,144,045
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 14,087,271
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 153,000
Department of Health and Human Services (DHHS) > Other > OMH STATE PARTNERSHIP	$ 217,824
Department of Health and Human Services (DHHS) > Other > OSHA	$ 478,734
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Climate Change	$ 264,829
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Improving Arthritis	$ 312,493
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PPHF Tobacco Quitline	$ 50,020

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Family Outreach	$ 502,850
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Health promotion	$ 95,415
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PPHF Women's Cancer Screening Program	$ 1,518,182
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid	$ 953,710
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Cash and Medical Assistance	$ 119,940

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,900,000		$ 1,646,441	
A. Preventive and Primary Care for Children	$ 619,643	(32.6%)	$ 497,031	(30.1%)
B. Children with Special Health Care Needs	$ 689,048	(36.3%)	$ 677,606	(41.1%)
C. Title V Administrative Costs	$ 66,542	(3.5%)	$ 134,949	(8.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,375,233		$ 1,309,586	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 2,167,896		$ 1,936,929	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 2,643,619	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 34,000,771		$ 30,645,189	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 36,168,667		$ 35,225,737	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,875,000				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 38,068,667		$ 36,872,178	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 68,380,364		$ 73,964,022	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 110,601,918		$ 110,836,200	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 274,467	$ 187,356
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)	$ 627,317	$ 645,027
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 155,454	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 253,867	$ 238,669
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)	$ 545,200	$ 492,513
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose: Prevention for States Program	$ 2,724,318	$ 22,763,567
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 771,936	$ 263,873
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 154,190	$ 150,593
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 232,030	$ 326,203
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	$ 2,280,440	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 15,811,957	$ 13,422,973
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	$ 183,948	$ 208,911

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	$ 175,000	$ 153,395
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 197,946	$ 166,357
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 90,111	$ 114,157
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,884	$ 240,291
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,119,764	$ 1,337,454
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 822,920	$ 775,997
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Youth Suicide Prevention	$ 967,592	$ 764,374
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 25,409,176	$ 22,471,245
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Asbestos	$ 209,678	$ 148,524
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Lead	$ 182,975	$ 156,978
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Radon	$ 132,163	$ 136,907
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Toxic Substance	$ 136,147	$ 1,244
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 769,477	$ 836,356
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 495,483	$ 78,497

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 405,453	$ 281,075
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 846,108	$ 113,601
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 321,913	$ 182,197
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 171,186	$ 117,485
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 1,563,017	$ 1,521,160
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement	$ 96,164	$ 92,414
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,471,963	$ 369,512
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 5,698,401	$ 2,898,449
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PPHF Tobacco Quitline	$ 1,081	$ 51,374
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Family Outreach	$ 501,962	$ 458,121
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhancing Cancer Registry	$ 132,507	$ 152,260
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Improving Arthritis	$ 270,984	$ 242,960

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Climate Change	$ 234,252	$ 251,593
Department of Health and Human Services (DHHS) > Other > OMH State Partnership	$ 201,900	$ 231,491
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Home Visiting Co-op	$ 164,000	$ 164,000
Department of Health and Human Services (DHHS) > Other > OSHA	$ 524,047	$ 475,421
US Department of Housing and Urban Development (HUD) > Community Planning and Development > Hurricane Sandy	$ 38,154	$ 0
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid	$ 762,832	$ 279,448

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: 1,646,441 was the final amount awarded to RI Department of Health.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: the amount of the expenditures is relative to the amount of the award received	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Administrative cost expended is 8.2% of the total award	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Newborn screening actual expenditures are lower than projected	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: primary Care State Medicaid match account actual expenditures are greater than projected	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Rhode Island

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 300,306	$ 188,771
2. Infants < 1 year	$ 312,124	$ 214,617
3. Children 1 through 21 Years	$ 309,548	$ 282,414
4. CSHCN	$ 688,750	$ 677,606
5. All Others	$ 205,130	$ 148,084
Federal Total of Individuals Served	$ 1,815,858	$ 1,511,492

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 537,308	$ 461,758
2. Infants < 1 year	$ 2,617,773	$ 2,308,097
3. Children 1 through 21 Years	$ 16,021,186	$ 14,254,136
4. CSHCN	$ 2,510,667	$ 2,245,515
5. All Others	$ 19,014,811	$ 14,831,457
Non-Federal Total of Individuals Served	$ 40,701,745	$ 34,100,963
Federal State MCH Block Grant Partnership Total	$ 42,517,603	$ 35,612,455

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Children 1-21 years does not equal Preventive and Primary Care for Children and Preventive and Primary for Children includes Infants <1 year	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Does not include Admin cost	
3.	**Field Name:**	**IB. Non-Federal MCH Block Grant, Non Federal Total of Individuals Served**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Does not include Admin cost of $327,969	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Children 1-21 years does not equal Preventive and Primary Care for Children and Preventive and Primary for Children includes Infants <1 year	
5.	**Field Name:**	**IB. Non-Federal MCH Block Grant, Non Federal Total of Individuals Served**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Does not include Admin cost of $340,715	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Rhode Island

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 0	$ 23,900
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 19,359
C. Services for CSHCN	$ 0	$ 4,541
2. Enabling Services	$ 916,383	$ 650,683
3. Public Health Services and Systems	$ 983,617	$ 971,858
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Post-Traumatic Healing program		$ 23,900
Direct Services Line 4 Expended Total		$ 23,900
Federal Total	$ 1,900,000	$ 1,646,441

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 1,642,572	$ 1,296,542
3. Public Health Services and Systems	$ 39,387,142	$ 33,145,136
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 41,029,714	$ 34,441,678

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Rhode Island

Total Births by Occurrence: 10,708 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	10,635 (99.3%)	83	40	40 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis
Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)
Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy			

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Critical Congenital Heart Disease	10,647 (99.4%)	150	10	10 (100.0%)
Newborn Hearing Screening	10,615 (99.1%)	245	16	16 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Children with blood spot or CCHD presumptive positive screens are referred to the appropriate Hasbro Children's Hospital clinic for diagnosis and follow-up and followed until they have been seen at a specialty clinic. Families not connecting for specialty care may be referred to Family Visiting for assistance. Specialty clinics will make referrals to Early Intervention if appropriate and continue with long-term follow-up until adulthood. Children with diagnosed hearing loss are followed until enrollment in Early Intervention is confirmed or refused by parents. Early Intervention monitors development until age 36 months.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Rhode Island

Annual Report Year 2019

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	5	78.2	0.0	18.2	0.0	3.6
2. Infants < 1 Year of Age	549	69.7	0.0	28.4	0.5	1.4
3. Children 1 through 21 Years of Age	3,408	64.4	0.0	19.8	15.5	0.3
3a. Children with Special Health Care Needs	703	67.8	0.0	11.3	14.9	6.0
4. Others	456	55.3	0.0	43.2	1.5	0.0
Total	4,418					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	10,506	No	12,529	100	12,529	5
2. Infants < 1 Year of Age	11,063	No	10,708	100	10,708	549
3. Children 1 through 21 Years of Age	262,049	Yes	262,049	100	262,049	3,408
3a. Children with Special Health Care Needs	56,419	Yes	56,419	100	56,419	703
4. Others	784,709	No	798,007	54	430,924	456

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**
	Field Note: 55 women received First Connections prenatal home visits, 8.9% (5 women) of the contract budgets were paid by Title V.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**
	Field Note: # of unduplicated children under age one who had at least one First Connections home visit in 2019 plus # level 1 risk positives born who were not seen but got some kind of outreach.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: # served in the following programs (multiplied by % of program budget from Title V): First Connections, Seal RI, RIPIN RIREACH, Youth Sports Concussion Program, and Teen Outreach Program.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: # children (1-21) served times 20.3% (the percent of children with special healthcare needs from National Survey of Children's Health). CSHCN receive the same services as all children but also from initiatives including RIPIN, Family Voices, Medical Home Portal, shared plans of care, Dare to Dream, patient centered medical home and adolescent transition to adult care.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: # births not receiving a home visit that got some kind of outreach plus adults over 21 receiving RIREACH services, times the percent of those budgets paid by Title V.	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2019**
	Field Note: Lower numbers in 2019 are in part due to cancellation of the Dare to Dream conference and discontinuation of SealRI services by two agencies.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**
	Field Note: Includes occurrence births, fetal deaths and pregnancy terminations. Deliveries occur in hospitals that Title V works with for baby-friendly hospitals, safe sleep policies, and substance exposed newborns plans of safe care. Insurance coverage for prenatal and postpartum care, educational materials. Some pregnant women also receive WIC, family-visiting, KIDSNET. Referrals to Family Visiting may include women whose pregnancy resulted in fetal death.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**
	Field Note: All infants born in Rhode Island, including home births, receive newborn screening (blood spot, CCHD, hearing) or outreach to document parent refusal. Those born in hospitals (>99%) receive a developmental risk assessment with referral to family visiting, safe sleep and baby friendly hospitals. All infants born are enrolled in KIDSNET which is used to ensure they had newborn screening and additional preventive healthcare such as immunizations. Some infants are enrolled in WIC.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: All Rhode Island children are enrolled in KIDSNET, an integrated child health information system, that includes newborn screening, immunization, Early Intervention, developmental screening, family visiting, WIC, lead screening, asthma, Cedar (Medicaid care coordination), and Head Start. KIDSNET is used to ensure they have preventive healthcare such as immunizations and lead screening or receive services for which they are eligible such a WIC, EI, etc. Many children also receive services from a wide variety of MCH programs.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: see note for #3. Reference data used for # CSHCN estimate.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: The Rhode Island Health Equity Zones represent community that are home to approximately 52.4% of the state population. Title V investments in these communities benefit all ages. Also included were non-pregnant women and men serve by Family Planning and women who received home visits but did not deliver in 2109. To de-duplicate, the total number was reduced by the number of women over age 21 delivering babies in 2019.	

Data Alerts:

1.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Rhode Island

Annual Report Year 2019

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	10,708	5,944	801	2,931	46	521	3	276	186
Title V Served	10,708	5,944	801	2,931	46	521	3	276	186
Eligible for Title XIX	5,067	1,713	526	2,324	40	164	3	173	124
2. Total Infants in State	10,165	5,174	768	2,856	41	471	3	260	592
Title V Served	9,738	5,174	768	2,856	41	471	3	260	165
Eligible for Title XIX	4,925	1,632	514	2,286	37	159	3	173	121

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2019**
	Column Name:	**Total**

Field Note:
Race/ethnicity data for OOS RI-resident births are unknown

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Rhode Island

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(401) 222-5960	(401) 222-5960
2. State MCH Toll-Free "Hotline" Name	Health Information Line	Health Information Line
3. Name of Contact Person for State MCH "Hotline"	Margarita Jaramillo	Margarita Jaramillo
4. Contact Person's Telephone Number	(401) 222-5981	(401) 222-5981
5. Number of Calls Received on the State MCH "Hotline"		139,241

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://health.ri.gov/programs/detail.php?pgm_id=1126	https://health.ri.gov/programs/detail.php?pgm_id=1126
4. Number of Hits to the State Title V Program Website		1,206
5. State Title V Social Media Websites	https://www.facebook.com/HealthRI	https://www.facebook.com/HealthRI
6. Number of Hits to the State Title V Program Social Media Websites		10,336

Form Notes for Form 7:

Number of Hits to the State Title V Program Social Media Websites is the number of individuals who follow the RIDOH facebook page

Form 8
State MCH and CSHCN Directors Contact Information

State: Rhode Island

1. Title V Maternal and Child Health (MCH) Director	
Name	Deborah Garneau
Title	MCH/CSHCN Director
Address 1	RI Department of Health
Address 2	3 Capitol Hill
City/State/Zip	Providence / RI / 02908
Telephone	(401) 222-5929
Extension	
Email	deborah.garneau@health.ri.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Deborah Garneau
Title	MCH/CSHCN Director
Address 1	RI Department of Health
Address 2	3 Capitol Hill
City/State/Zip	Providence / RI / 02908
Telephone	(401) 222-5929
Extension	
Email	deborah.garneau@health.ri.gov

3. State Family or Youth Leader (Optional)	
Name	Kathy Kuiper
Title	Community Health Worker
Address 1	RIPIN
Address 2	3 Capitol Hill
City/State/Zip	Providence / RI / 02908
Telephone	(401) 222-5887
Extension	
Email	kathleen.kuiper@health.ri.gov

Form Notes for Form 8:

None

Form 9
State Priorities – Needs Assessment Year

State: Rhode Island

Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Reduce maternal morbidity/mortality	New
2.	Address prenatal health disparities	New
3.	Strengthen caregiver's behavioral health and relationship with child	New
4.	Support school readiness	New
5.	Support adolescent mental and behavioral health	New
6.	Ensure effective Care Coordination for CSHCN	New
7.	Adopt social determinants of health in MCH planning and practice to improve health equity	Revised

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Rhode Island

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

Due to small numbers, Child Mortality and RI maternal mortality are not reportable.

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	84.4 %	0.4 %	8,597	10,180
2017	83.6 %	0.4 %	8,512	10,183
2016	84.9 %	0.4 %	8,677	10,221
2015	83.6 %	0.4 %	8,177	9,781

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	84.1
Numerator	8,235
Denominator	9,795
Data Source	Vital Records
Data Source Year	2019

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	104.7	9.9	113	10,794
2016	80.2	8.6	88	10,969
2015	46.7	7.5	39	8,345
2014	58.5	7.3	64	10,943
2013	72.1	8.1	79	10,952
2012	73.8	8.2	82	11,108
2011	70.7	8.0	79	11,169
2010	55.9	7.1	63	11,262
2009	55.3	6.9	64	11,575
2008	39.5	5.7	48	12,164

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2019
Annual Indicator	74.4
Numerator	72
Denominator	9,680
Data Source	Hospital Discharge Data
Data Source Year	2019

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2018	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	7.6 %	0.3 %	801	10,500
2017	7.5 %	0.3 %	795	10,627
2016	8.0 %	0.3 %	858	10,791
2015	7.6 %	0.3 %	833	10,989
2014	7.1 %	0.3 %	765	10,813
2013	6.9 %	0.2 %	746	10,797
2012	8.0 %	0.3 %	877	10,920
2011	7.4 %	0.3 %	813	10,948
2010	7.7 %	0.3 %	862	11,173
2009	8.0 %	0.3 %	913	11,434

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	7.7
Numerator	786
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	9.0 %	0.3 %	943	10,504
2017	8.3 %	0.3 %	882	10,631
2016	9.3 %	0.3 %	1,008	10,789
2015	8.6 %	0.3 %	947	10,985
2014	8.6 %	0.3 %	932	10,815
2013	8.7 %	0.3 %	937	10,770
2012	9.7 %	0.3 %	1,053	10,897
2011	9.0 %	0.3 %	987	10,921
2010	9.6 %	0.3 %	1,065	11,144
2009	10.0 %	0.3 %	1,137	11,405

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	9.4
Numerator	959
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	24.7 %	0.4 %	2,593	10,504
2017	23.5 %	0.4 %	2,497	10,631
2016	23.5 %	0.4 %	2,531	10,789
2015	23.7 %	0.4 %	2,606	10,985
2014	24.2 %	0.4 %	2,621	10,815
2013	22.7 %	0.4 %	2,450	10,770
2012	22.7 %	0.4 %	2,472	10,897
2011	22.6 %	0.4 %	2,471	10,921
2010	23.8 %	0.4 %	2,647	11,144
2009	24.4 %	0.4 %	2,781	11,405

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	25.1
Numerator	2,554
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	4.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	4.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	7.0 %			
2013/Q3-2014/Q2	7.0 %			
2013/Q2-2014/Q1	8.0 %			

Legends:

State Provided Data	
	2019
Annual Indicator	1.3
Numerator	4
Denominator	305
Data Source	CMS Hospital Compare, 2018/Q4 - 2019/Q3
Data Source Year	2018/19

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	6.7	0.8	71	10,668
2016	7.1	0.8	77	10,834
2015	6.1	0.8	67	11,018
2014	5.6	0.7	61	10,849
2013	7.0	0.8	76	10,843
2012	7.2	0.8	79	10,957
2011	7.9	0.9	87	11,002
2010	7.0	0.8	79	11,209
2009	6.4	0.8	73	11,467

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	5.5
Numerator	59
Denominator	10,668
Data Source	Vital Records
Data Source Year	2019

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	6.2	0.8	66	10,638
2016	5.6	0.7	60	10,798
2015	5.9	0.7	65	10,993
2014	4.4	0.6	48	10,823
2013	6.5	0.8	70	10,809
2012	6.5	0.8	71	10,926
2011	6.4	0.8	70	10,960
2010	7.2	0.8	80	11,177
2009	5.9	0.7	67	11,442

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2019
Annual Indicator	5.6
Numerator	57
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	4.3	0.6	46	10,638
2016	4.4	0.6	47	10,798
2015	4.5	0.6	50	10,993
2014	3.8	0.6	41	10,823
2013	4.3	0.6	46	10,809
2012	4.9	0.7	54	10,926
2011	4.5	0.6	49	10,960
2010	5.3	0.7	59	11,177
2009	4.8	0.7	55	11,442

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2019
Annual Indicator	4.2
Numerator	43
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	1.9	0.4	20	10,638
2016	1.2	0.3	13	10,798
2015	1.4	0.4	15	10,993
2014	NR	NR	NR	NR
2013	2.2	0.5	24	10,809
2012	1.6	0.4	17	10,926
2011	1.9	0.4	21	10,960
2010	1.9	0.4	21	11,177
2009	1.0	0.3	12	11,442

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2019
Annual Indicator	1.4
Numerator	14
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	291.4	52.4	31	10,638
2016	277.8	50.8	30	10,798
2015	282.0	50.7	31	10,993
2014	184.8	41.4	20	10,823
2013	249.8	48.1	27	10,809
2012	338.6	55.8	37	10,926
2011	301.1	52.5	33	10,960
2010	304.2	52.3	34	11,177
2009	270.9	48.7	31	11,442

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2019
Annual Indicator	295.1
Numerator	30
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	94.0 ϟ	29.7 ϟ	10 ϟ	10,638 ϟ
2016	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2015	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2014	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2013	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2012	91.5 ϟ	29.0 ϟ	10 ϟ	10,926 ϟ
2011	127.7 ϟ	34.2 ϟ	14 ϟ	10,960 ϟ
2010	89.5 ϟ	28.3 ϟ	10 ϟ	11,177 ϟ
2009	87.4 ϟ	27.7 ϟ	10 ϟ	11,442 ϟ

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	98.4
Numerator	10
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019

NOM 9.5 - Notes:

SUID - numerator less than 20 should be interpreted with caution

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.9 %	0.9 %	894	10,090
2013	11.3 %	1.0 %	1,140	10,054
2012	7.4 %	0.8 %	756	10,183
2011	10.5 %	1.0 %	1,082	10,263
2010	10.7 %	1.0 %	1,127	10,555
2009	8.9 %	0.9 %	949	10,715
2008	9.5 %	1.0 %	1,060	11,163
2007	10.2 %	1.0 %	1,179	11,569

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2019
Annual Indicator	9.2
Numerator	95
Denominator	1,034
Data Source	PRAMS
Data Source Year	2015

NOM 10 - Notes:

2015 is most recent data available. Question was not asked on RI PRAMS since 2015.

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	11.5	1.1	121	10,502
2016	9.1	0.9	97	10,691
2015	9.1	1.1	74	8,105
2014	9.3	0.9	98	10,584
2013	7.2	0.8	76	10,580
2012	7.5	0.8	81	10,754
2011	8.0	0.9	90	11,209
2010	5.6	0.7	64	11,371
2009	6.4	0.7	75	11,760
2008	5.8	0.7	71	12,343

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	8.8
Numerator	85
Denominator	9,625
Data Source	Hospital Discharge Data
Data Source Year	2019

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	9.3 %	1.4 %	17,849	192,159
2016_2017	8.5 %	1.4 %	16,400	193,898
2016	7.6 %	1.3 %	14,830	196,256

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	11.1	3.4	11	98,696
2017	NR	NR	NR	NR
2016	12.0	3.5	12	99,695
2015	14.9	3.8	15	100,929
2014	9.8	3.1	10	101,717
2013	NR	NR	NR	NR
2012	16.3	4.0	17	103,978
2011	NR	NR	NR	NR
2010	14.0	3.6	15	106,929
2009	14.9	3.7	16	107,497

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

Child Mortality numerator is <10, thus is non-reportable

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	21.5	4.1	28	130,247
2017	21.2	4.0	28	131,892
2016	18.0	3.7	24	132,964
2015	20.1	3.9	27	134,195
2014	19.1	3.8	26	135,786
2013	22.8	4.1	31	135,989
2012	16.6	3.5	23	138,552
2011	20.6	3.8	29	140,731
2010	19.5	3.7	28	143,870
2009	29.4	4.5	43	146,457

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	15.4
Numerator	20
Denominator	130,247
Data Source	Vital Records/ACS
Data Source Year	2019

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	6.5 ϟ	1.7 ϟ	14 ϟ	217,002 ϟ
2015_2017	5.9 ϟ	1.6 ϟ	13 ϟ	219,235 ϟ
2014_2016	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2013_2015	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2012_2014	6.2 ϟ	1.7 ϟ	14 ϟ	225,834 ϟ
2011_2013	7.0 ϟ	1.7 ϟ	16 ϟ	229,317 ϟ
2010_2012	6.8 ϟ	1.7 ϟ	16 ϟ	234,659 ϟ
2009_2011	7.5 ϟ	1.8 ϟ	18 ϟ	240,035 ϟ
2008_2010	8.6	1.9	21	244,085
2007_2009	12.2	2.2	30	246,316

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	4.7
Numerator	10
Denominator	214,968
Data Source	Vital Records/ACS
Data Source Year	2019

NOM 16.2 - Notes:

Adolescent Motor Vehicle Fatality - 3 year average, numerator is <20 so interpret with caution

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	4.6	1.5	10	217,002
2015_2017	6.4	1.7	14	219,235
2014_2016	5.0	1.5	11	221,339
2013_2015	5.4	1.6	12	222,933
2012_2014	NR	NR	NR	NR
2011_2013	4.4	1.4	10	229,317
2010_2012	4.7	1.4	11	234,659
2009_2011	5.4	1.5	13	240,035
2008_2010	5.3	1.5	13	244,085
2007_2009	4.5	1.4	11	246,316

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	20.3 %	1.6 %	41,977	206,900
2016_2017	21.1 %	1.6 %	44,071	209,097
2016	21.6 %	1.9 %	45,543	210,415

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	14.0 %	2.6 %	5,896	41,977
2016_2017	16.9 %	2.5 %	7,464	44,071
2016	18.6 %	3.4 %	8,486	45,543

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	2.2 %	0.5 %	3,669	169,592
2016_2017	2.7 %	0.5 %	4,594	170,633
2016	3.8 %	0.9 %	6,526	170,670

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	10.0 %	1.3 %	16,627	166,377
2016_2017	10.3 %	1.3 %	17,289	168,179
2016	12.0 %	1.8 %	20,553	171,083

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	54.2 %	5.7 %	12,793	23,592
2016_2017	55.2 %	5.5 %	13,886	25,167
2016	59.0 %	6.4 %	16,520	28,007

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	93.2 %	1.3 %	192,277	206,236
2016_2017	90.5 %	1.4 %	188,371	208,096
2016	89.7 %	1.7 %	188,144	209,741

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	15.4 %	0.4 %	1,075	6,984
2014	16.3 %	0.4 %	1,447	8,853
2012	16.7 %	0.4 %	1,678	10,031
2010	16.4 %	0.4 %	1,764	10,783
2008	17.3 %	0.4 %	1,643	9,504

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	15.2 %	1.3 %	5,801	38,206
2015	12.0 %	1.1 %	4,636	38,669
2013	10.6 %	0.6 %	4,344	40,796
2011	10.7 %	1.1 %	4,455	41,581
2009	10.2 %	1.0 %	5,037	49,272
2007	10.7 %	1.0 %	4,968	46,404
2005	12.8 %	0.8 %	5,873	45,959

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	14.0 %	2.4 %	13,000	93,023
2016_2017	16.8 %	2.5 %	15,559	92,733
2016	19.2 %	3.3 %	16,507	85,972

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

State Provided Data	
	2019
Annual Indicator	18.1
Numerator	740
Denominator	4,092
Data Source	KIDSNET (ages 2-4 WIC data)
Data Source Year	2019

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.2 %	0.6 %	4,391	203,553
2017	2.0 %	0.5 %	4,107	206,423
2016	1.7 %	0.4 %	3,583	208,694
2015	3.1 %	0.6 %	6,643	211,249
2014	3.3 %	0.6 %	6,986	211,655
2013	5.9 %	0.8 %	12,619	212,402
2012	5.1 %	0.7 %	11,019	217,152
2011	3.9 %	0.6 %	8,506	218,727
2010	4.8 %	0.8 %	10,694	223,688
2009	4.9 %	0.6 %	11,118	226,634

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	2.7
Numerator	5,631
Denominator	206,469
Data Source	National Survey of Childrens Health
Data Source Year	2017/18

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	75.1 %	3.2 %	12,026	16,017
2017	74.4 %	3.1 %	11,602	15,601
2016	75.5 %	3.4 %	12,066	15,974
2015	77.2 %	3.1 %	12,594	16,313
2014	75.6 %	3.7 %	12,146	16,074
2013	82.1 %	3.4 %	12,938	15,766
2012	72.5 %	3.3 %	11,623	16,039
2011	67.3 %	3.4 %	11,676	17,343
2010	56.6 %	4.1 %	9,925	17,542
2009	29.2 %	3.6 %	5,739	19,629

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	78.0 %	1.6 %	151,665	194,367
2017_2018	76.2 %	1.8 %	149,068	195,535
2016_2017	74.2 %	2.1 %	146,499	197,358
2015_2016	77.9 %	1.6 %	157,355	201,944
2014_2015	78.6 %	1.8 %	159,729	203,244
2013_2014	74.5 %	2.2 %	154,658	207,665
2012_2013	81.6 %	2.2 %	168,118	206,069
2011_2012	73.8 %	2.4 %	156,961	212,569
2010_2011	79.3 %	2.1 %	166,555	210,031
2009_2010	57.8 %	2.6 %	143,204	247,757

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	89.3 %	2.1 %	53,589	60,010
2017	88.6 %	2.3 %	53,699	60,605
2016	88.9 %	1.9 %	54,185	60,939
2015	84.2 %	2.0 %	51,886	61,643

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	96.3 %	1.2 %	57,797	60,010
2017	94.6 %	1.4 %	57,336	60,605
2016	95.4 %	1.2 %	58,144	60,939
2015	97.1 %	0.8 %	59,855	61,643
2014	92.4 %	1.8 %	57,201	61,899
2013	95.5 %	1.5 %	61,178	64,058
2012	94.0 %	1.5 %	61,130	65,020
2011	87.5 %	1.8 %	58,019	66,335
2010	79.5 %	2.6 %	53,076	66,797
2009	60.1 %	3.1 %	41,529	69,099

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	98.7 %	0.6 %	59,204	60,010
2017	94.1 %	1.6 %	57,018	60,605
2016	96.4 %	1.2 %	58,759	60,939
2015	97.7 %	0.8 %	60,242	61,643
2014	94.1 %	1.7 %	58,242	61,899
2013	92.0 %	1.8 %	58,920	64,058
2012	94.3 %	1.5 %	61,342	65,020
2011	88.9 %	2.1 %	58,964	66,335
2010	83.5 %	2.4 %	55,748	66,797
2009	75.7 %	2.6 %	52,313	69,099

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	11.5	0.6	411	35,887
2017	11.4	0.6	414	36,449
2016	12.9	0.6	474	36,750
2015	14.3	0.6	530	37,041
2014	15.8	0.7	590	37,310
2013	17.5	0.7	659	37,583
2012	19.8	0.7	760	38,343
2011	21.4	0.7	831	38,857
2010	22.4	0.8	891	39,736
2009	25.8	0.8	1,051	40,776

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2019
Annual Indicator	9.7
Numerator	357
Denominator	36,835
Data Source	Vital Records, US Census 5 - 2018 year estimate
Data Source Year	2019

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	12.3 %	1.2 %	1,163	9,469
2017	13.6 %	1.2 %	1,327	9,740
2016	12.6 %	1.1 %	1,242	9,830
2014	10.9 %	1.0 %	1,101	10,075
2013	11.9 %	1.0 %	1,190	10,014
2012	13.9 %	1.1 %	1,408	10,100

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	2.8 %	0.8 %	5,783	206,150
2016_2017	2.0 %	0.7 %	4,262	208,387
2016	1.3 %	0.5 %	2,800	209,890

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Rhode Island

NPM 2 - Percent of cesarean deliveries among low-risk first births

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2019
Annual Objective	
Annual Indicator	27.8
Numerator	988
Denominator	3,556
Data Source	NVSS
Data Source Year	2018

State Provided Data	
	2019
Annual Objective	
Annual Indicator	27.2
Numerator	826
Denominator	3,041
Data Source	Vital Records
Data Source Year	2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	25.0	24.0	23.0	22.0	21.0

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	82.0
Numerator	7,714
Denominator	9,411
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	83.4	84.1	84.8	85.5	86.2

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	31.3
Numerator	2,813
Denominator	8,976
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	35.0	37.0	39.0	41.0	43.0

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	55.1
Numerator	4,947
Denominator	8,981
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	61.9	65.3	68.7	72.1	75.5

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	30.5
Numerator	7,940
Denominator	25,993
Data Source	NSCH
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	32.1	32.9	33.7	34.5	35.3

Field Level Notes for Form 10 NPMs:

None

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2019
Annual Objective	
Annual Indicator	21.8
Numerator	8,762
Denominator	40,209
Data Source	YRBSS
Data Source Year	2017

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2019
Annual Objective	
Annual Indicator	19.8
Numerator	13,784
Denominator	69,514
Data Source	NSCHP
Data Source Year	2018

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	38.5
Numerator	26,726
Denominator	69,435
Data Source	NSCHV
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	37.0	35.5	34.0	32.5	31.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			48.8	44.3
Annual Indicator		42.5	41.6	38.4
Numerator		19,360	18,320	16,137
Denominator		45,543	44,071	41,977
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			48.8	44.3
Annual Indicator	42.5	42.5	40.6	
Numerator	19,360	19,360	17,280	
Denominator	45,543	45,543	42,599	
Data Source	NSCH	NSCH	NSCH	
Data Source Year	2016	2016	2017	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	45.2	46.1	47.0	47.9	48.8	49.7

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2019
Annual Objective	
Annual Indicator	5.5
Numerator	567
Denominator	10,346
Data Source	NVSS
Data Source Year	2018

State Provided Data	
	2019
Annual Objective	
Annual Indicator	4.7
Numerator	479
Denominator	10,166
Data Source	Vital Records
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	4.5	4.3	4.1	3.9	3.7

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Rhode Island

2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	80	80.5	83.1	85.6
Annual Indicator	81.8	80.6	81.4	78.8
Numerator	9,093	8,191	8,534	7,780
Denominator	11,113	10,158	10,488	9,868
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
No provisional data are available, hope to have data before September deadline for updating data.

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	20	21.5	29.6	31.7
Annual Indicator	27.4	26.6	28.9	23.0
Numerator	2,937	2,657	2,864	2,178
Denominator	10,738	9,975	9,912	9,488
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
No provisional data are available, hope to have data before September deadline for updating data.

2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2016	**2017**	**2018**	**2019**
Annual Objective			36.6	30.5
Annual Indicator		28.2	28.9	29.4
Numerator		21,354	19,772	18,866
Denominator		75,621	68,418	64,101
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			36.6	30.5
Annual Indicator	28.2	28.2	29.7	
Numerator	21,354	21,354	18,191	
Denominator	75,621	75,621	61,215	
Data Source	NSCH	NSCH	NSCH	
Data Source Year	2016	2016	2017	
Provisional or Final ?	Final	Final	Final	

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			14.9	17.9
Annual Indicator		13.4	15.1	22.3
Numerator		2,540	3,136	4,528
Denominator		18,916	20,735	20,335
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			14.9	17.9
Annual Indicator	13.4	13.4	16.5	
Numerator	2,540	2,540	3,731	
Denominator	18,916	18,916	22,553	
Data Source	NSCH	NSCH	NSCH	
Data Source Year	2016	2016	2017	
Provisional or Final ?	Final	Final	Final	

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Adolescent Health - NONCSHCN

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN			
	2017	**2018**	**2019**
Annual Objective			15.6
Annual Indicator	17.5	15.9	16.9
Numerator	8,345	8,049	8,912
Denominator	47,720	50,750	52,734
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2016	2016_2017	2017_2018

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			15.6
Annual Indicator	17.5	14.4	
Numerator	8,345	7,752	
Denominator	47,720	53,780	
Data Source	NSCH-NONCSHCN	NSCH-NONCSH	
Data Source Year	2016	2017	
Provisional or Final ?	Final	Final	

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	61	62.5	64.2	58.5
Annual Indicator	58.4	58.4	57.7	55.6
Numerator	5,897	5,897	5,697	5,390
Denominator	10,093	10,093	9,869	9,692
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2014	2017	2018

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective	61	62.5	64.2	58.5
Annual Indicator	56.6	57.7	55.6	
Numerator	5,628	5,697	5,390	
Denominator	9,947	9,869	9,692	
Data Source	PRAMS	PRAMS	PRAMS	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Provisional	

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Rhode Island

SPM 1 - Depression Screening for Primary Caregivers

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		80	90.9	92.3
Annual Indicator	76.2	89.6	89	85.5
Numerator	474	524	412	473
Denominator	622	585	463	553
Data Source	Family Visiting Database	Family Visiting Database	Family Visiting Database	Family Visiting Database
Data Source Year	2016	2017	FFY 2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	87.0	89.0	91.0	93.0	95.0	97.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Only includes participants who reached the 3 month mark during the reporting period - the same familiy is not reported on in subsequent years. (note: if participants were enrolled less than 3 months but still recieved their assessment they have been added to the numerator and denominator)

SPM 2 - Family member reading daily to children, ages 0-5

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	49.3
Numerator	32,768
Denominator	66,453
Data Source	NSCH
Data Source Year	2017-18
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	51.0	52.0	53.0	54.0	55.0

Field Level Notes for Form 10 SPMs:

None

SPM 3 - ED visits for suicide ideation, ages 15-19

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	10.4
Numerator	741
Denominator	71,426
Data Source	ESSENCE syndromic surveillance, 2018 ACS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	10.2	9.9	9.6	9.3	9.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of parents of CSHCN reporting effective care coordination for their child

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	50.4
Numerator	21,112
Denominator	41,913
Data Source	NSCH
Data Source Year	2017-18
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	52.0	53.0	54.0	55.0	56.0

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Effective Family Planning Methods among Title X Clients

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			64.5
Annual Indicator			64.5
Numerator			12,870
Denominator			19,939
Data Source			Title X Data System
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	66.0	67.0	68.0	69.0	70.0	71.0

Field Level Notes for Form 10 SPMs:

None

SPM 6 - High School Graduation Rate

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	83.9
Numerator	9,457
Denominator	11,272
Data Source	Rhode Island Department of Education
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	85.0	85.5	86.0	86.6	87.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - Rhode Island youth suicide rate ages 10-24

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		4.2	7.8	5
Annual Indicator	5.2	8.5	2.9	1.5
Numerator	11	18	6	3
Denominator	212,216	210,752	206,863	206,863
Data Source	RI Vital Records, 2016 ACS Population Estimates	RI Vital Records, 2017 ACS Population Estimates	RI Vital Records, 2018 ACS Population Estimates	RI Vital Records, 2018 ACS Population Estimates
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Indicator has a numerator <20 and should be interpreted with caution	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: SPM2: Indicator has a numerator <20 and should be interpreted with caution	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: SPM2: 2018 Indicator has a numerator <10 and should not be reported	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: SPM2: 2019 Indicator has a numerator <10 and should not be reported	

2016-2020: SPM 6 - Number of Certified Community Health Workers

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			258
Annual Indicator			186
Numerator			
Denominator			
Data Source			RI Certification Board
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 7 - MCH Priority Areas with at least 50% of HEZ engaged in related MCH funded activities

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			8
Annual Indicator			7
Numerator			
Denominator			
Data Source			Health Equity Institute
Data Source Year			2018
Provisional or Final ?			Final

Field Level Notes for Form 10 SPMs:

None

Form 10
State Outcome Measures (SOMs)

State: Rhode Island

SOM 1 - Percent of Children Living in Poverty

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		20	18.4	15.5
Annual Indicator	20.4	19.4	16.6	18
Numerator	43,282	40,675	33,818	36,036
Denominator	212,038	209,667	203,723	200,202
Data Source	ACS Population estimate (B17001)	ACS 2016 Population estimate (B17001)	ACS 2017 Population estimate (B17001)	ACS 2018 Population Estimate (B17001)
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	17.5	17.0	16.5	16.0	15.5	15.0

Field Level Notes for Form 10 SOMs:

None

SOM 2 - Postpartum Hemorrhage Rate

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	984.1
Numerator	955
Denominator	9,704
Data Source	Hospital Discharge Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	970.0	955.0	940.0	925.0	910.0

Field Level Notes for Form 10 SOMs:

None

SOM 3 - Suicide Attempts among High School Students

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	14.7
Numerator	6,441
Denominator	43,889
Data Source	YRBS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	13.0	12.0	11.0	10.0	9.0

Field Level Notes for Form 10 SOMs:

None

Form 10
State Outcome Measures (SOMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SOM 1 - Five year average birth rate among Hispanic teens (ages 15-19)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		35	33.4	31.2
Annual Indicator	38.9	35.3	32	29.6
Numerator	1,323	1,223	1,163	1,074
Denominator	34,015	34,692	36,318	36,318
Data Source	Vital Records/ACS (B01001I)	Vital Records/ACS (B01001I)	Vital Records/ACS (B01001I)	Vital Records/ACS (B01001I)
Data Source Year	2012-2016	2013-2017	2014-2018	2015-2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

None

2016-2020: SOM 2 - Five year average birth rate to Black teens (ages 15-19)

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		24	14	13.5
Annual Indicator	25	14.9	12	10.5
Numerator	388	236	210	184
Denominator	15,551	15,864	17,560	17,560
Data Source	Vital Records/ACS (B01001B)	Vital Records/ACS (B01001B)	Vital Records/ACS (B01001B)	Vital Records/ACS (B01001B)
Data Source Year	2012-2016	2013-2017	2014-2018	2015-2019
Provisional or Final ?	Provisional	Final	Final	Final

Field Level Notes for Form 10 SOMs:

None

2016-2020: SOM 3 - Percent LGB high school students attempting suicide

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		32	25.2	22.5
Annual Indicator	33.1	27.8	27.8	21.6
Numerator	1,160	1,114	1,114	1,050
Denominator	3,509	4,013	4,013	4,864
Data Source	YRBS	YRBS	YRBS	YRBS
Data Source Year	2015	2017	2017	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Not all students answer the suicide questions. Those who didn't answer have been excluded from both numerator and denominator.

2016-2020: SOM 4 - Percent High School Students with Special Health Care Needs attempting suicide

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		23	22.5	22
Annual Indicator	23.1	24.4	24.4	19.8
Numerator	1,671	1,845	1,845	1,907
Denominator	7,249	7,567	7,567	9,640
Data Source	YRBS	YRBS	YRBS	YRBS
Data Source Year	2015	2017	2017	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Not all students answer the suicide questions. Those who didn't answer have been excluded from both numerator and denominator.

2016-2020: SOM 5 - Post-Partum Depression

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		10.5	11.6	12.8
Annual Indicator	10.9	12.6	13.6	12.3
Numerator	1,101	1,242	1,327	1,163
Denominator	10,075	9,830	9,740	9,469
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

None

2016-2020: SOM 6 - Black/White Infant Mortality Rate Ratio

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		2.2	3	2.5
Annual Indicator	2.4	3.8	3.8	4.2
Numerator	9.7	13.9	12.8	13
Denominator	4.1	3.7	3.4	3.1
Data Source	Vital Records	Vital Records	Vital Records	Vital Records
Data Source Year	2014-2016	2015-2017	2016-2018	2017-2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The numerator used to calculate Black infant mortality rate was 10. This indicator should be interpreted with caution. SOM 6: Ratio reflects a 3 year average	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: SOM 6: Ratio reflects a 3 year average	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Does not include race data on out-of-state resident deaths.	

2016-2020: SOM 8 - Teen Pregnancy Rate (ages 15-19) in RI core cities

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			18.4
Annual Indicator			27.2
Numerator			349
Denominator			12,847
Data Source			MCH Database/ACS 2018 5-year estimates
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 SOMs:

None

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Rhode Island

ESM 2.1 - AIM Provider Education

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	40.0	60.0	80.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 2.2 - AIM Nurse Education

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	40.0	60.0	80.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - Parent-Child Interaction

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	72.4
Numerator	417
Denominator	576
Data Source	Efforts to Outcomes Home Visiting Database
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	76.0	78.0	80.0	82.0	84.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - Early Language and Literacy Activities

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	87.1
Numerator	1,143
Denominator	1,313
Data Source	Efforts to Outcomes Home Visiting Database
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	90.0	91.5	93.0	94.5	96.0

Field Level Notes for Form 10 ESMs:

None

ESM 9.1 - Kids' Link Referral Network

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	66
Numerator	
Denominator	
Data Source	KIDSLINK
Data Source Year	2018-19
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	80.0	85.0	90.0	95.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - # of web hits on the Medical Home Portal

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			5,000
Annual Indicator		4,737	14,098
Numerator			
Denominator			
Data Source		CSHCN Program - Med Home Portal Google Analytics	CSHCN Program - Med Home Portal Google Analytics
Data Source Year		StateFY19	StateFY20
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	15,000.0	16,000.0	17,000.0	18,000.0	19,000.0	20,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - Pediatric Practices Trained on Care Coordination

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	28.1
Numerator	36
Denominator	128
Data Source	Care Transformation Collaborative/CSHCN Program
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	44.0	52.0	60.0	68.0	76.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.1.1 - Tobacco Cessation Community Resources

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	68.3
Numerator	43
Denominator	63
Data Source	Efforts to Outcomes MIECHV
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	70.0	72.0	74.0	76.0	78.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.1 - % of RI Resident Births occurring in Hospitals Designated as Baby Friendly

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		92	92	99.7
Annual Indicator	95	95.9	95.9	95.6
Numerator	9,875	9,805	9,703	9,319
Denominator	10,390	10,223	10,117	9,744
Data Source	KIDSNET	KIDSNET	KIDSNET	KIDSNET
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: All but one maternity hospital in RI are Baby Friendly. Once that one get the designation (target by 2018), only home births and non-maternity hospital births will be excluded.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: One RI birthing hospital remains that has not achieved Baby Friendly status. Once that is achieved, this measure can be retired and another breastfeeding measure will be selected after reviewing the MCH Evidence Center and other sources.	

2016-2020: ESM 8.1.1 - Physical Activity and Nutrition Technical Assistance to Child Care Centers

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			7
Annual Indicator			0
Numerator			
Denominator			
Data Source			Physical Activity/Nutrition program
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This ESM has been retired due to loss of Federal Physical Activity and Nutrition Grant

2016-2020: ESM 8.1.2 - % children ages 5-19 impacted by improvements to the built environment

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			65
Annual Indicator			23.9
Numerator			44,151
Denominator			185,087
Data Source			Health Equity Institute/ACS 2018 Pop. estimate
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.1.3 - # training and technical assistance opportunities provided to municipalities about master plan and land use interventions by RIDOH or it's partners

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			17
Annual Indicator			0
Numerator			
Denominator			
Data Source			Physical Activity/Nutrition program
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This ESM has been retired due to loss of Federal Funding for Physical Activity and Nutrition

2016-2020: ESM 8.1.4 - % children (0-17) living in a HEZ community with initiatives related to physical activity and nutrition

Measure Status:	**Active**	
State Provided Data		
	2018	**2019**
Annual Objective		
Annual Indicator		33.7
Numerator		69,069
Denominator		205,213
Data Source		Health Equity Institute/ACS 2018 Pop. estimate
Data Source Year		2019
Provisional or Final ?		Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.2 - % of Practices using Shared Plans of Care

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		8	15	19
Annual Indicator	7.9	15.1	15.1	28.1
Numerator	10	19	19	36
Denominator	126	126	126	128
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.3 - % of medical homes with trained staff

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		14	16	19
Annual Indicator	10.3	15.1	15.1	28.1
Numerator	13	19	19	36
Denominator	126	126	126	128
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.1 - % of medical homes with trained staff on transition

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		14	16	18
Annual Indicator	10.3	15.1	15.1	15.1
Numerator	13	19	19	19
Denominator	126	126	126	126
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Trainings for Medical Homes postponed until 2021.

2016-2020: ESM 12.2 - % of practices with a transition policy

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		2	3.2	2.4
Annual Indicator	1.6	1.6	1.6	1.6
Numerator	2	2	2	2
Denominator	126	126	126	126
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Trainings for Medical Homes postponed until 2021.

2016-2020: ESM 12.3 - # of youth participation in and accessing Dare 2 Dream; Self Assessments; Ready, Set, Go; HEZ; and Internships

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		1,000	1,800	1,750
Annual Indicator	1,125	1,731	1,406	1,406
Numerator				
Denominator				
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	Health Equity Institute
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Dare to Dream was canceled due to COVID-19 Pandemic

2016-2020: ESM 12.4 - # of participants in Teen Outreach Program

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			240
Annual Indicator			149
Numerator			
Denominator			
Data Source			Teen Outreach Program
Data Source Year			2019-20
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 13.1.1 - Number of healthcare providers trained on Oral Health

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			250
Annual Indicator			230
Numerator			
Denominator			
Data Source			Oral Health Program
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Rhode Island

SPM 1 - Depression Screening for Primary Caregivers
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Increase the number of primary caregivers who are screened for depression within 3 months for those enrolled in home visiting
Definition:	**Numerator:** If not enrolled prenatally, number of primary caregivers enrolled in home visiting who are screened for depression within 3 months of enrollment; if enrolled prenatally, the number of primary caregivers screened within 3 months of delivery **Denominator:** For those not enrolled prenatally, the number of primary caregivers enrolled in home visiting for at least 3 months; for those enrolled prenatally, the number of primary caregivers enrolled in home visiting for at least 3 months post delivery **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH - 34 Decrease the proportion of delivering a live birth who experience postpartum depressive symptoms
Data Sources and Data Issues:	Efforts to Outcomes Home Visiting Database
Significance:	Undetected and untreated parental depression places Rhode Island children at risk each day. Parental depression can be especially damaging for the growth and healthy development of very young children, who depend heavily on their caregivers for nurture and care. Treating parental depression and addressing its negative effects early in a child's life could improve that child's development. Family Visiting will continue to collect benchmark data on maternal depression and use continuous quality improvement strategies to improve screening and referral rates.

SPM 2 - Family member reading daily to children, ages 0-5
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of children read to daily by a family member
Definition:	**Numerator:** # of children, ages 0-5, read to daily by a family member **Denominator:** # of children, ages 0-5 **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	EMC-2.3 Increase the proportion of parents who read to their young child
Data Sources and Data Issues:	NSCH
Significance:	Reading to young children improves school readiness and reading and educational outcomes. In 2014, the American Academy of Pediatrics recommended that pediatric providers promote early literacy experiences, which include shared reading for families with young children starting at birth and continuing at least until the age of kindergarten entry.

SPM 3 - ED visits for suicide ideation, ages 15-19
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To reduce the number of emergency department visits among adolescents due to suicide ideation
Definition:	**Numerator:** Emergency department visits among adolescents ages 15-19 with suicidal ideation syndrome **Denominator:** Adolescent population, ages 15-19 **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	MHMD-2 Reduce suicide attempts by adolescents
Data Sources and Data Issues:	ESSENCE syndromic surveillance, US Census
Significance:	While syndromic surveillance is not considered absolute in confirming suicide ideation syndrome, they can provide timely detection and self-directed violence trend information that targets vulnerable adolescent populations.

SPM 4 - Percent of parents of CSHCN reporting effective care coordination for their child
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percent of parents of CSHCN reporting effective care coordination for their Child
Definition:	**Numerator:** # children with special healthcare needs who received needed care coordination **Denominator:** # children with special healthcare needs **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems; MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
Data Sources and Data Issues:	NSCH
Significance:	Care coordination bridges medical and non-medical disciplines to address medical, social, educational, and behavioral needs of the families and children with special healthcare needs to achieve optimal health outcomes.

SPM 5 - Effective Family Planning Methods among Title X Clients
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase the percentage of Title X female clients who use a most to moderately effective family planning methods from 61% (2017) to 66% by 2020
Definition:	**Numerator:** Females served at Title X clinics with a primary contraceptive method reported as intrauterine device, hormonal implant, hormonal patch, hormonal injection, vaginal ring, oral contraception, or sterilization. **Denominator:** Females served at Title X clinics, excluding those who are pregnant or seeking pregnancy **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	FP-1 Increase the proportion of pregnancies that are intended
Data Sources and Data Issues:	Title X Data System
Significance:	Forty-four percent of all pregnancies in Rhode Island are unintended (mistimed or unwanted). Increasing access to contraception is a proven strategy for reducing unintended pregnancy and achieving healthy spacing of births. Contraception is a highly effective clinical preventive service that can help women achieve their personal reproductive health goals. Women and teens need to have access to the full range of contraceptive methods to choose the method best suited to their needs in order to be successful in delaying or preventing pregnancy. These performance measures for contraceptive care reflect the fact that some contraceptive methods are more effective than others at preventing unintended pregnancy, and are designed to encourage providers to offer the full range of most and moderately effective methods. Effectiveness is only one of many important aspects to consider in comparing contraceptive methods, but it has been shown to be of great important to women who use contraception. A 2016 study asked 1,783 women in family planning and abortion clinics across the United States what characteristics of contraceptive methods were “extremely important” to them. Of 23 total items, the method’s effectiveness at preventing pregnancy was the item that most (89%) women said was “extremely important.” The next most important characteristics were the method is easy to get (81%), affordable (81%), and easy to use (80%).[1] . In 2017, 11,721 of 19,245 (61%) of female Rhode Island Title X clients used the most to moderately effective contraceptive methods. Title X family planning sites play a critical role in ensuring access to comprehensive, high quality, confidential, and affordable family planning services. [1] Jackson, A.V., Karasek, D., Dehlendorf, C., and Foster, D.G. (2016). Racial and ethnic differences in women’s preferences for features of contraceptive methods. Contraception, 93(5), 406-11.

SPM 6 - High School Graduation Rate
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the rate of high school students graduating with a regular diploma in four years
Definition:	**Numerator:** Number of high school students receiving a diploma within four years **Denominator:** Number of students who entered 9th grade four years prior **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	AH-5.1 Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade
Data Sources and Data Issues:	Rhode Island Department of Education - these data represent the academic school year of entry four years prior
Significance:	Dropping out of high school and not receiving a diploma is linked to a number of negative health impacts, such as fewer employment opportunities, low wages, and poverty.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - Rhode Island youth suicide rate ages 10-24
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Reduce the Rhode Island youth suicide rate to 3.9 per 100,000 by FY2020
Definition:	**Numerator:** Number of youth suicides in RI ages 10-24 **Denominator:** RI population ages 10-24 **Unit Type:** Rate **Unit Number:** 100,000
Healthy People 2020 Objective:	Healthy People 2020 targets 10.2 per 100,00 for all populations suicide rate. Current national average rate for teens 12-17 is 5.2 and young adults aged 18-24 is 13.2.
Data Sources and Data Issues:	National Vital Statistics System-Mortality [NVSS-M], CDC
Significance:	According to the Centers for Disease Control and Prevention, Suicide is the 2nd leading cause of death in youth ages 15-24, both nationally and in Rhode Island. From 2004-2015, over 100 Rhode Island young people, ages 10-24 died by suicide. For every one of these suicide deaths in this age group, there are approximately 100-200 suicide attempts. Every year in Rhode Island, about 500 youth are seen in the emergency department for a suicide attempt. In the last ten years there have been over 1,100 suicide deaths in Rhode Island. The number of suicide deaths in Rhode Island 1 person every three days, and occurs four times more often than homicide. For RI youth its 1 every 20 days. Yet, suicide is preventable. Knowing the risk factors and recognizing the warning signs for suicide can help reduce the suicide rate. RI baseline: youth suicide rate 4.3 per 100,000 for 2010-2014.

2016-2020: SPM 6 - Number of Certified Community Health Workers
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the number of certified community health workers from 218 in 2018 to 238 in 2020
Definition:	**Numerator:** # of RI Certified Community Health Workers **Denominator:** N/A **Unit Type:** Count **Unit Number:** 300
Healthy People 2020 Objective:	PHI-6.1Increase the number of public health or related sub-baccalaureate certificates and associate degrees awarded
Data Sources and Data Issues:	Rhode Island Certification Board
Significance:	Community health workers are frontline, public health professionals who often have similar cultural beliefs, chronic health conditions, disability, or life experiences as other people in the same community. As trusted leaders, they often serve as a link between their community and needed health or social services. Community health workers help to improve access to, quality of, and cultural responsiveness of service providers.

2016-2020: SPM 7 - MCH Priority Areas with at least 50% of HEZ engaged in related MCH funded activities
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the number of MCH Priority Areas with at least 50% of HEZ engaged in related MCH funded activities from 4 of 10 in 2018 to 6 of 10 in 2020
Definition:	**Numerator:** Number of MCH Priority Areas with at least 50% of HEZ engaged in related MCH funded activities **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Healthy People 2020 Objective:	Healthy People 2020 has several objectives addressing social determinants of health including health, education, childcare, housing, business, law, media, community planning, transportation, and agriculture.
Data Sources and Data Issues:	Health Equity Zones
Significance:	HEZ is RIDOH's place based initiative to identify ways to create social and physical environments that promote good health for all members of 9 communities throughout RI. HEZ activities ensure that Rhode Islanders have an opportunity to be healthy and well by addressing inequities in health care, education, childcare, housing, business, law, media, community planning, transportation, and agriculture. HEZ activities focused on improving the social and economic condition of MCH populations including women of reproductive age and their families will be tracked for this state performance measure.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Rhode Island

SOM 1 - Percent of Children Living in Poverty
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Reduce the percent of children living in poverty to no more than 18%
Definition:	**Numerator:** # of children living below the federal poverty threshold **Denominator:** # of children **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	SDOH-3.2Proportion of children aged 0-17 years living in poverty Baseline: 20.7 percent of children ages 0 to 17 were living below the poverty threshold in 2010 Target: Not applicable Target-Setting Method: This measure is being tracked for informational purposes. If warranted, a target will be set during the decade.
Data Sources and Data Issues:	US Census, American Community Survey
Significance:	ACS 2010-2014 data indicate that 20.1% of RI children under age 18 lived in households with incomes below the federal poverty threshold. Poverty has a direct impact on health, with life long impact.

SOM 2 - Postpartum Hemorrhage Rate
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Reduce the rate of postpartum/obstetric hemorrhages during delivery
Definition:	**Numerator:** # of postpartum hemorrhage diagnoses during delivery hospitalization **Denominator:** # of delivery hospitalizations **Unit Type:** Rate **Unit Number:** 10,000
Healthy People 2020 Objective:	MICH-6 Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery)
Data Sources and Data Issues:	Hospital Discharge data
Significance:	Rapid blood loss can cause a severe drop in the mother's blood pressure and may lead to shock and death. Quickly detecting and treating the cause of bleeding can lead to a full recovery. In Rhode Island, Non-Hispanic Black women are more likely to experience postpartum hemorrhage than Non-Hispanic White women.

SOM 3 - Suicide Attempts among High School Students
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Reduce the percentage of high school students attempting suicide
Definition:	**Numerator:** High school students reporting attempting suicide in the past 12 months **Denominator:** High school students responding to the YRBS question **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MHMD-2 Reduce suicide attempts by adolescents
Data Sources and Data Issues:	YRBS
Significance:	Not addressing suicide behavior leads to adolescents who are more likely to attempt suicide. Although the percentage of high school students who attempted suicide dropped slightly from 15.9 in 2017 to 14.7 in 2019, there was significant increasing trend from 2007 with 12.1. Non-Hispanic Black and Hispanic students are more likely to attempt suicide than Non-Hispanic White students

Form 10
State Outcome Measure (SOM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SOM 1 - Five year average birth rate among Hispanic teens (ages 15-19)
Population Domain(s) – Women/Maternal Health, Adolescent Health

Measure Status:	Active
Goal:	Reduce the birth rate disparity between Hispanic and non-Hispanic teens in Rhode Island.
Definition:	**Numerator:** Number of births to Hispanic teens ages 15-19 for past five years **Denominator:** ACS population estimates for RI Hispanic teens ages 15-19 for past five years **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	FP-8.1Reduce pregnancies among adolescent females aged 15 to 17 years Baseline: 40.2 pregnancies per 1,000 females aged 15 to 17 years occurred in 2005 Target: 36.2 pregnancies per 1,000 FP-8.2Reduce pregnancies among adolescent females aged 18 to 19 years Baseline: 116.2 pregnancies per 1,000 females aged 18 to 19 years occurred in 2005 Target: 105.9 pregnancies per 1,000
Data Sources and Data Issues:	Vital Records US Census, American Community Survey
Significance:	Despite declines among all racial and ethnic groups, disparities still exist in teen birth rates. In RI between 2010 and 2014, the teen birth rate for Hispanics (45.9) and Black (33.2) teens were higher than the rate of their White (11.6) and Asian (11.5) peers.

2016-2020: SOM 2 - Five year average birth rate to Black teens (ages 15-19)
Population Domain(s) – Women/Maternal Health, Adolescent Health

Measure Status:	Active
Goal:	Reduce the birth rate disparities between Black teens and other races in Rhode Island.
Definition:	**Numerator:** # births to Black teens ages 15-19 for past five years **Denominator:** ACS population estimates for RI Black teens ages 15-19 for past five years **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	FP-8.1Reduce pregnancies among adolescent females aged 15 to 17 years Baseline: 40.2 pregnancies per 1,000 females aged 15 to 17 years occurred in 2005 Target: 36.2 pregnancies per 1,000 FP-8.2Reduce pregnancies among adolescent females aged 18 to 19 years Baseline: 116.2 pregnancies per 1,000 females aged 18 to 19 years occurred in 2005 Target: 105.9 pregnancies per 1,000
Data Sources and Data Issues:	Vital Records US Census, American Community Survey
Significance:	Despite declines among all racial and ethnic groups, disparities still exist be teen birth rates. In RI between 2010 and 2014, the teen birth rate for Hispanics (45.9) and Black (33.2) teens were higher than the rate of their White (11.6) and Asian (11.5) peers.

2016-2020: SOM 3 - Percent LGB high school students attempting suicide
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Reduce suicides among LGB students
Definition:	**Numerator:** # LGB high-school students attempting suicide **Denominator:** # LGB high-school students **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Healthy People 2020 targets 10.2 per 100,00 for all populations suicide rate and 1.7 suicide attempts per 100 youth population.
Data Sources and Data Issues:	YRBS
Significance:	Previous analyses have shown that LGBU students were twice as likely to be depressed and 4 times more likely to have attempted suicide compared to their heterosexual peers. 2015 YRBS Data for LGB high-schoolers indicate 33.1% attempted suicide compared to 10.5% overall.

2016-2020: SOM 4 - Percent High School Students with Special Health Care Needs attempting suicide
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Reduce suicide among youth with special health care needs
Definition:	**Numerator:** # High School Students with Special Health Care Needs attempting suicide **Denominator:** # High School Students with Special Health Care Needs **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Healthy People 2020 targets 10.2 per 100,00 for all populations suicide rate and 1.7 suicide attempts per 100 youth population.
Data Sources and Data Issues:	YRBS
Significance:	The 2015 Youth Risk Behavior Survey showed higher rates of high school students reporting feeling sad or hopeless among youth with special needs (54.6%) compared to overall (26.4%), 35.6% considered suicide and 23% attempted suicide compared to 10.5% overall.

2016-2020: SOM 5 - Post-Partum Depression
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Reduce post-partum depression</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td># post-partum women reporting symptoms of depression</td></tr>
<tr><td>Denominator:</td><td># post-partum women</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>MICH-34 (Developmental) Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>PRAMS</td></tr>
<tr><td>Significance:</td><td>According to 2013 PRAMS survey results, 10.5% of women reported experiencing depression during their pregnancy, and 11.9% reported post-partum depression. Mental well being impacts the health of both the mother and her children.</td></tr>
</table>

2016-2020: SOM 6 - Black/White Infant Mortality Rate Ratio
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Reduce the Black/White Infant Mortality Ratio
Definition:	**Numerator:** Infant Mortality Rate among Black Infants **Denominator:** Infant Mortality Rate among White Infants **Unit Type:** Ratio **Unit Number:** 1
Healthy People 2020 Objective:	MICH-1.3 Reduce the rate of all infant deaths (within 1 year) Baseline: 6.7 infant deaths per 1,000 live births occurred within the first year of life in 2006 Target: 6.0 infant deaths per 1,000 live births Target-Setting Method: 10 percent improvement
Data Sources and Data Issues:	Vital Records
Significance:	Although overall infant mortality rates have decreased, racial disparities persist. For example, in 2014 the RI Black infant mortality rate (7.9 per 1000 births) was 2.3 times higher than for Whites (3.4 per 1000).

2016-2020: SOM 8 - Teen Pregnancy Rate (ages 15-19) in RI core cities
Population Domain(s) – Women/Maternal Health, Adolescent Health

Measure Status:	Active
Goal:	Reduce the rate of teen (ages 15-19) pregnancy in RI core cities from 22 per 1000 in 2015 to 20.5 per 1000 by 2020
Definition:	**Numerator:** # of teen (ages 15-19) pregnancies in RI core cities **Denominator:** # of teen (ages 15-19) residing in RI core cities **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	FP-8 Reduce pregnancies among adolescent females
Data Sources and Data Issues:	Vital Records and American Community Survey
Significance:	Rhode Island rates of teen pregnancy, teen birth, and repeat teen pregnancy are the highest in New England. The rate of teen births in RI Core Cities was selected as a measure because teen birth rates in the core cities are higher than in the remainder of the state. Rates are notably the highest in the core cities of Central Falls, Pawtucket, Providence, and Woonsocket. The five-year average rate of teen pregnancy (ages 15-19) for 2010-2014 was 32.7 in the core cities compared to 10.6 in the rest of Rhode Island. This may in part be due to higher teen birth rates for Hispanic teens (45.9 per 1000 for 2010-2014) and Black teens (33.2 per 1000) who are more likely to live in core cities than for White (11.6 per 1000) teens.Teen pregnancy and parenting puts both the teenager and the child at risk for poor outcomes. Future prospects for teenagers decline significantly if they have a baby, such as low rates of high school completion, serious health risks, in addition to the close linkage to poverty and single parenthood. Children born to teen mothers experience higher rates of low birth weight and related health problems, are more likely to have insufficient health care, receive inadequate parenting, more likely to fall victim to abuse and neglect, and are more likely to suffer from poor school performance.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Rhode Island

ESM 2.1 - AIM Provider Education
NPM 2 – Percent of cesarean deliveries among low-risk first births

Measure Status:	Active
Goal:	Increase the proportion of OB physicians and midwives who completed the education program on obstetric hemorrhage
Definition:	**Numerator:** Number of OB physicians and midwives from participating hospitals in the AIM program who completed (within the last two years) an education program on obstetric hemorrhage **Denominator:** Number of OB physicians and midwives affiliated with participating hospitals in the AIM program **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	AIM Program
Significance:	According to the CDC, obstetric emergencies, like severe bleeding and amniotic fluid embolism cause most deaths at delivery and in the week after delivery, severe bleeding, high blood pressure and infection are most common. Provider training has been show to improve provider assessment and treatment of obstetric hemorrhage and reduce preventable factors related to policies and procedures (Am J Perinatol 2017; 34(01): 74-79).

ESM 2.2 - AIM Nurse Education
NPM 2 – Percent of cesarean deliveries among low-risk first births

Measure Status:	Active
Goal:	Increase the proportion of OB nurses who completed the education program on obstetric hemorrhage
Definition:	**Numerator:** Number of OB nurses from participating hospitals in the AIM program who completed (within the last two years) an education program on obstetric hemorrhage **Denominator:** Number of OB nurses affiliated with participating hospitals in the AIM program **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	AIM Program
Significance:	According to the CDC, obstetric emergencies, like severe bleeding and amniotic fluid embolism cause most deaths at delivery and in the week after delivery, severe bleeding, high blood pressure and infection are most common. A Joint Commission literature review found prevention, early recognition and timely treatment had the most impact on reducing maternal morbidity and mortality and as a result added 13 elements of performance in these areas including provision of role-specific education to all staff and providers who treat pregnant and postpartum patients about the organization's hemorrhage procedure (R3 Report, The Joint Commission, Issue 24, August 21, 2019).

ESM 5.1 - Parent-Child Interaction

NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the number of families that have an annual parent-child interaction assessment
Definition:	**Numerator:** Primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool **Denominator:** Primary caregivers enrolled in home visiting **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Efforts to Outcomes Home Visiting Database
Significance:	MIECHV provides evidence-based home visiting services to at-risk women and caregivers with young children to improve the lives of children and families. Healthy Families America used the CHEERS Check-In tool- that is a tool developed by the national Healthy Families America office that has been tested and validated. Nurse-Family Partnership uses the DANCE and similar to HFA that is a tool that the Nurse-Family Partnership National Service Office requires NFP sites to use. Parents as Teachers uses the Infant/Toddler Home Observation Measurement of the Environment (HOME).

ESM 6.1 - Early Language and Literacy Activities
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of families that read, tell stories, sing to their (child)ren every day during a typical week
Definition:	**Numerator:** Children enrolled in family visiting with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with child, every day **Denominator:** Children enrolled in family visiting **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Efforts to Outcomes Home Visiting Database
Significance:	Studies have shown that children that are spoken to frequently by their caregivers have larger vocabulary and literacy skills. Home visitors teach parents about the importance early literacy, and help them learn skills to incorporate them in their regular routine.

ESM 9.1 - Kids' Link Referral Network
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To increase the number of adolescents screened for suicide ideation to KIDSLINK for appropriate referrals and supports
Definition:	**Numerator:** Students at-risk of non-suicidal self-harm, suicidal ideation, or having risk factors that may influence suicidal ideation or non-suicidal self-harm referred to Kids' Link **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Kids' Link RI; incomplete referrals may vary (reporting schools only needed clinical consultation, parents couldn't be reached, parents declined services)
Significance:	Many school districts transported all children who expressed suicide ideation to the nearest ED, regardless of the severity crisis. The Suicide Prevention Initiative (SPI) is a collaboration of RIDOH and Rhode Island Student Assistance Services, and Bradley Hospital's Kids Link RI hotline. SPI protocol provides guidelines for determining if a student is in immediate danger of killing her/himself and needs to be transported to a local hospital, or if the child's mental health/behavioral needs can be met outside of an emergency department.

ESM 11.1 - # of web hits on the Medical Home Portal
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the number of web hits on medical home portal from 1781 to 20,000 by 2025
Definition:	**Numerator:** # web hits on RIDOH medical home portal https://ri.medicalhomeportal.org/ **Denominator:** N/A **Unit Type:** Count **Unit Number:** 30,000
Data Sources and Data Issues:	RIDOH CSHCN Program
Significance:	A 2017 NCQA report (https://www.ncqa.org/wp-content/uploads/2018/08/20171017_PCMH_Evidence_Report.pdf) presents evidence for the value of patient centered medical homes "that PCMHs are saving money ..., and improving patient outcomes." The Rhode Island Medical home Portal https://ri.medicalhomeportal.org/ is a unique source of reliable information about children and youth with special healthcare needs(CYSHCN) offering a “one stop shop” for families, physicians and the medical home team, care coordinators and community partners. Once on the site, a visitor can research diagnoses, find linkages to Rhode Island pediatric specialists, design a custom care notebook, and create a Rhode Island Service Provider list that automatically updates when there is a change in the listing. This information is available 24/7 and is beneficial to both families and providers. If a visitor would rather speak to someone, the help page will direct the visitor to the RIPIN Call Center. Patient centered medical homes can trust the MHP to provide timely resources and materials while the patient is still in the office

ESM 11.2 - Pediatric Practices Trained on Care Coordination
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the proportion of PCMH-Kids practices with staff trained in care coordination
Definition:	**Numerator:** Number of Patient Centered Medical Home-Kids practices **Denominator:** Number of pediatric practices in state **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Care Transformation Collaborative RI / KIDSNET
Significance:	Care coordination is an essential component of services for patient and family-centered medical homes (PCMH). The PCMH is a critical part of the integrated care model for children with special needs. The PCMH model is being promoted and implemented in Rhode Island through the PCMH-Kids initiative of the Care Transformation Collaborative. A curriculum on care coordination has been developed to build capacity of the diverse team of healthcare professionals and families through effective implementation of care coordination components.

ESM 14.1.1 - Tobacco Cessation Community Resources
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
Goal:	Increase the percentage of primary caregivers who report using tobacco or cigarettes at Family Visiting enrollment and received information on and/or were referred to tobacco cessation counseling or services within 3 months of enrollment
Definition:	**Numerator:** # of primary caregivers who report using tobacco/cigarettes at Family Visiting enrollment and received information on and/or were referred to tobacco cessation counseling or services within 3 months of enrollment (excludes those already in services) **Denominator:** # of primary caregivers who report using tobacco/cigarettes at Family Visiting enrollment **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Efforts to Outcomes Database
Significance:	Smoking is a known risk factor for both preterm birth and maternal morbidity, thus impacting both the mother and infant's health.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.1 - % of RI Resident Births occurring in Hospitals Designated as Baby Friendly
2016-2020: NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	100% of RI Residents Born in Hospitals Designated as Baby Friendly Hospitals
Definition:	**Numerator:** Number of RI Resident Births Occurring in Hospitals Designated as Baby Friendly **Denominator:** Number of RI Resident Occurrence Births **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	RI WIC Program
Significance:	“Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers.” -World Health Organization’s Global Strategy on Infant and Young Child Feeding Breastfeeding saves lives; Breastfeeding saves money; Breastfeeding contributes to a more productive workforce; and Breastfeeding is better for the environment

2016-2020: ESM 8.1.1 - Physical Activity and Nutrition Technical Assistance to Child Care Centers
2016-2020: NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of childcare centers that receive training and/or technical assistance in physical activity and nutrition practices from 7 to 232 by 2023
Definition:	**Numerator:** # of childcare centers who received technical assistance or training to improve physical activity and nutrition practices from RIDOH or it's partners **Denominator:** N/A **Unit Type:** Count **Unit Number:** 250
Data Sources and Data Issues:	RIDOH Physical Activity and Nutrition Program
Significance:	Childcare centers play an integral role of obesity modulation throughout childhood. By having childcare staff that are competent in the areas of physical activity and nutrition, staff can partake in role-modeling behaviors educational activities to support both nutrition and physical activity for children. Through ongoing training and technical assistance opportunities, staff can increase knowledge, and practice concepts learned in childcare settings to improve health of children.

2016-2020: ESM 8.1.2 - % children ages 5-19 impacted by improvements to the built environment
2016-2020: NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the percent of children impacted by changes to the built environment from 60% to 81% by 2023
Definition:	<table><tr><td>**Numerator:**</td><td># children ages 5-19 living in municipalities where improvements to the built environment occurred</td></tr><tr><td>**Denominator:**</td><td># children ages 5-19 living in Rhode Island</td></tr><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr></table>
Data Sources and Data Issues:	American Community Survey, Physical Activity and Nutrition Program
Significance:	Understanding how many children live in areas that have taken measures to improve the built environment to encourage physical activity is essential for understanding the reach of interventions, and to understand municipalities to target in the state to achieve greatest impact. According to a recent review article "Street connectivity, physical activity, and childhood obesity: A systematic review and meta-analysis" by Jia, et al, (https://onlinelibrary.wiley.com/doi/epdf/10.1111/obr.12943), found a positive association between street connectivity and physical activity but that more evidence is needed to confirm the causal association between street connectivity and weight status.

2016-2020: ESM 8.1.3 - # training and technical assistance opportunities provided to municipalities about master plan and land use interventions by RIDOH or it's partners
2016-2020: NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of training and technical assistance opportunities provided to municipalities to improve master plan or land use interventions from 14 to 28 by 2023
Definition:	**Numerator:** # training and technical assistance opportunities provided to municipalities about master plan and land use interventions by RIDOH or it's partners **Denominator:** N/a **Unit Type:** Count **Unit Number:** 30
Data Sources and Data Issues:	RIDOH Physical Activity and Nutrition Program
Significance:	Living in a neighborhood or an environment that is safe, walkable and connects everyday locations such as schools, parks, and corner stores is essential to promote physical activity where people live. Training and technical assistance provided to municipalities about how to design their streets and neighborhoods in ways to promote and reduce barriers for physical activity, will increase competency and encourage implementation of policy and strategies to improve built environment conditions.

2016-2020: ESM 8.1.4 - % children (0-17) living in a HEZ community with initiatives related to physical activity and nutrition
2016-2020: NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	100%
Definition:	<table><tr><td>**Numerator:**</td><td># children (0-17) living in a HEZ community with initiatives related to physical activity and nutrition</td></tr><tr><td>**Denominator:**</td><td># children (0-17) living in a HEZ community</td></tr><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr></table>
Data Sources and Data Issues:	Health Equity Institute / ACS Population Estimates
Significance:	Childhood overweight and obesity rates continue to increase in Rhode Island and they exceed national averages. Rates are high statewide, and racial and ethnic disparities are present. The Health Equity Zones are an opportunity for communities to promote policies and programs that could reduce childhood overweight and obesity (for example, bike paths, school breakfast programs, community gardens, walking school bus, etc.)

2016-2020: ESM 11.2 - % of Practices using Shared Plans of Care
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase % of Practices using Shared Plans of Care by 2020
Definition:	**Numerator:** Number of Practices using Shared Plans of Care **Denominator:** Total Number of Practices **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Health Equity Institute; Office of Special Needs
Significance:	The Medical Home approach to caring for children focuses on the patient, his/her family, and their community and aims to improve outcomes related to health, relationships, education, and abilities. The Medical Home Portal is a unique source of reliable information about children and youth with special health care needs (CYSHCN), offering a “one-stop shop” for their: •Families •Physicians and Medical Home teams •Other Professionals and Caregivers (medicalhomeportal.com) According to the National Association of Medical Home Implementation "Research has shown that the use of a shared plan of care can • Improve family-clinician relationships. • Support provision of family-centered care. • Provide information that enhances the planning and delivery of health care services that meet the medical and social needs of children, youth, and their families...In addition, the “National Standards for Systems of Care for Children and Youth with Special Health Care Needs” cites a shared plan of care as a critical and inherent component of a health care system that improves health for all CYSHCN".

2016-2020: ESM 11.3 - % of medical homes with trained staff
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	% of medical homes with trained staff by 2020
Definition:	**Numerator:** Number of medical homes with trained staff **Denominator:** Total number of medical homes **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Health Equity Institute; Office of Special Needs
Significance:	The Medical Home approach to caring for children focuses on the patient, his/her family, and their community and aims to improve outcomes related to health, relationships, education, and abilities. The Medical Home Portal is a unique source of reliable information about children and youth with special health care needs (CYSHCN), offering a “one-stop shop” for their: •Families •Physicians and Medical Home teams •Other Professionals and Caregivers (medicalhomeportal.com) According to the National Association of Medical Home Implementation "Research has shown that the use of a shared plan of care can • Improve family-clinician relationships. • Support provision of family-centered care. • Provide information that enhances the planning and delivery of health care services that meet the medical and social needs of children, youth, and their families...In addition, the “National Standards for Systems of Care for Children and Youth with Special Health Care Needs” cites a shared plan of care as a critical and inherent component of a health care system that improves health for all CYSHCN"

2016-2020: ESM 12.1 - % of medical homes with trained staff on transition
2016-2020: NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase % of medical homes with trained staff on transition by 2020
Definition:	**Numerator:** Number of medical homes with trained staff on transition **Denominator:** Total Number of medical homes **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Health Equity Institute; Office of Special Needs
Significance:	The Medical Home approach to caring for children focuses on the patient, his/her family, and their community and aims to improve outcomes related to health, relationships, education, and abilities. The Medical Home Portal is a unique source of reliable information about children and youth with special health care needs (CYSHCN), offering a “one-stop shop” for their: •Families •Physicians and Medical Home teams •Other Professionals and Caregivers (medicalhomeportal.com)

2016-2020: ESM 12.2 - % of practices with a transition policy
2016-2020: NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase % of practices with a transition policy</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of practices with a transition policy</td></tr>
<tr><td>Denominator:</td><td>Total number of practices</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Health Equity Institute; Office of Special Needs</td></tr>
<tr><td>Significance:</td><td>According to a study on the U.S. performance with transitions, most CYSHCN do not receive needed transition preparation. Although most providers are encouraging CYSHCN to assume responsibility for their own health, far fewer are discussing transfer to an adult provider and insurance continuity.
Healthcare transition is a critical part of the Medical Home concept. The goal of this transition for young adults with special healthcare needs is “to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate healthcare services that continue uninterrupted as the individual moves from adolescence to adulthood.”</td></tr>
</table>

2016-2020: ESM 12.3 - # of youth participation in and accessing Dare 2 Dream; Self Assessments; Ready, Set, Go; HEZ; and Internships
2016-2020: NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase # of youth participation in and accessing Dare 2 Dream; Self Assessments; Ready, Set, Go; HEZ; and Internships
Definition:	**Numerator:** Number of youth participation in and accessing Dare 2 Dream; Self Assessments; Ready, Set, Go; HEZ; and Internships **Denominator:** N/A **Unit Type:** Count **Unit Number:** 44,800
Data Sources and Data Issues:	Health Equity Institute; Office of Special Needs
Significance:	Healthcare transition, the process of change from child and family-centered healthcare to adult healthcare, is a critical part of the Medical Home concept. The goal of this transition for young adults with special healthcare needs is “to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate healthcare services that continue uninterrupted as the individual moves from adolescence to adulthood."

2016-2020: ESM 12.4 - # of participants in Teen Outreach Program
2016-2020: NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase the number of Teen Outreach Program participants to 215 by 2020
Definition:	**Numerator:** Number youth ages 11-18 served by Teen Outreach Program **Denominator:** N/A **Unit Type:** Count **Unit Number:** 300
Data Sources and Data Issues:	RIDOH Adolescent Health Program
Significance:	The Teen Outreach Program has served approximately 400 youth since 2013. Likewise, it has increased the number of youth participating in the TOP program from 186 in 2014-2015 school year to over 200 in 2017-2018 school year. The curriculum is based on a youth development approach and has a broad sexuality and family life component that aligns with current Rhode Island state requirements for a comprehensive sex education program. TOP has consistently demonstrated reductions in suspension rates, reduction in course failure rates, and reduction in pregnancy rates. There have also been observed reductions in school drop-out rates.

2016-2020: ESM 13.1.1 - Number of healthcare providers trained on Oral Health
2016-2020: NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Train 100 RI healthcare providers on Oral Health by 2020
Definition:	**Numerator:** Number of healthcare providers trained on Oral Health by the RIDOH Oral Health Program **Denominator:** N/A **Unit Type:** Count **Unit Number:** 550
Data Sources and Data Issues:	RIDOH Oral Health Program
Significance:	Healthcare providers play a pivotal role in promoting dental visits. This is especially true during pregnancy as women are more open to attending to their health and are more susceptible to oral health issues. Training more healthcare providers on this topic, as well as referral mechanisms, is intended to increase the number of pregnant women having a preventive dental visit.RI PRAMS data show that 82.7% of women who had a healthcare worker speak to them about oral health during pregnancy had a preventive dental visit compared to only 30.3% of women who did not talk to a healthcare provider. This is consistent with a Maryland PRAMS study which found that “receipt of oral health counseling during pregnancy was positively related to teeth cleaning during pregnancy”1. At the national level, in a consensus statement, a 2012 Oral Health Care During Pregnancy Expert Workgroup of the National Maternal and Child Oral Health Resource Center concluded it is essential for healthcare providers to “provide pregnant women with appropriate and timely oral health care, which includes oral health education”2 and a 2013 American College of Obstetricians and Gynecologists (ACOG) Oral Health Care During Pregnancy Advisory Committee Opinion states: “To potentiate general health and well-being, women should routinely be counseled about the maintenance of good oral health habits throughout their lives as well as the safety and importance of oral health care during pregnancy”3 1 Thompson TA, Cheng D, Strobino D. Dental cleaning before and during pregnancy among Maryland mothers. Matern Child Health J 2013;17:110–8 2 Oral Health Care During Pregnancy Expert Workgroup. 2012. Oral Health Care During Pregnancy: A National Consensus Statement. Washington, DC: National Maternal and Child Oral Health Resource Center 3 Oral health care during pregnancy and through the lifespan. Committee Opinion No. 569. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;122:41

Form 11
Other State Data

State: Rhode Island

The Form 11 data are available for review via the link below.

Form 11 Data