

**Maternal and Child
Health Services Title V
Block Grant**

Rhode Island

**FY 2020 Application/
FY 2018 Annual Report**

Created on 7/15/2019
at 2:19 PM

Table of Contents

I. General Requirements	4
I.A. Letter of Transmittal	4
I.B. Face Sheet	5
I.C. Assurances and Certifications	5
I.D. Table of Contents	5
II. Logic Model	5
III. Components of the Application/Annual Report	6
III.A. Executive Summary	6
III.A.1. Program Overview	6
III.A.2. How Federal Title V Funds Support State MCH Efforts	10
III.A.3. MCH Success Story	10
III.B. Overview of the State	11
III.C. Needs Assessment	19
FY 2020 Application/FY 2018 Annual Report Update	19
FY 2019 Application/FY 2017 Annual Report Update	23
FY 2018 Application/FY 2016 Annual Report Update	27
FY 2017 Application/FY 2015 Annual Report Update	31
Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)	34
III.D. Financial Narrative	47
III.D.1. Expenditures	49
III.D.2. Budget	53
III.E. Five-Year State Action Plan	57
III.E.1. Five-Year State Action Plan Table	57
III.E.2. State Action Plan Narrative Overview	58
<i>III.E.2.a. State Title V Program Purpose and Design</i>	58
<i>III.E.2.b. Supportive Administrative Systems and Processes</i>	60
III.E.2.b.i. MCH Workforce Development	60
III.E.2.b.ii. Family Partnership	64
III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts	66
III.E.2.b.iv. Health Care Delivery System	67
<i>III.E.2.c State Action Plan Narrative by Domain</i>	69
Women/Maternal Health	69
Perinatal/Infant Health	93

Child Health	120
Adolescent Health	139
Children with Special Health Care Needs	163
Cross-Cutting/Systems Building	187
III.F. Public Input	220
III.G. Technical Assistance	223
IV. Title V-Medicaid IAA/MOU	224
V. Supporting Documents	225
VI. Organizational Chart	226
VII. Appendix	227
Form 2 MCH Budget/Expenditure Details	228
Form 3a Budget and Expenditure Details by Types of Individuals Served	239
Form 3b Budget and Expenditure Details by Types of Services	241
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated	244
Form 5 Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V	247
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX	251
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data	253
Form 8 State MCH and CSHCN Directors Contact Information	255
Form 9 List of MCH Priority Needs	258
Form 9 State Priorities-Needs Assessment Year - Application Year 2016	259
Form 10 National Outcome Measures (NOMs)	262
Form 10 National Performance Measures (NPMs)	302
Form 10 State Performance Measures (SPMs)	309
Form 10 State Outcome Measures (SOMs)	314
Form 10 Evidence-Based or –Informed Strategy Measures (ESMs)	322
Form 10 State Performance Measure (SPM) Detail Sheets	335
Form 10 State Outcome Measure (SOM) Detail Sheets	340
Form 10 Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets	348
Form 11 Other State Data	361

I. General Requirements

I.A. Letter of Transmittal



Department of Health
Three Capitol Hill
Providence, RI 02908-5097
TTY: 711
www.health.ri.gov

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

July 1, 2019

Doctor Warren,

Thank you for the opportunity to share Rhode Island's maternal and child health accomplishments over the past year. The block grant application provides an opportunity to review how well we responded to our state priorities, reconsider our focus and direction for the upcoming year, and contemplate emerging issues impacting maternal and child health.

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, 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,

A handwritten signature in blue ink, appearing to read "Deborah Garneau".

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

State of Rhode Island and Providence Plantations

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

MCH Population Needs and Identified Title V Priorities

The Rhode Island Department of Health's (RIDOH) Maternal and Child Health (MCH) Program supports and promotes the health of all women, children, and families. RI does 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 focusing efforts on the state's most vulnerable populations. Despite these positive trends health disparities persist among age, race/ethnicity, geography, socioeconomic status, educational attainment, and health insurance coverage.

In 2014 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 over 450 individuals via surveys, facilitated discussions, large community meetings, and listening sessions. The resulting data was used to develop a list of MCH priorities for 2015-2020. They are:

1. Improve access to oral health services.
2. Improve the routine provision of preconception care.
3. Increase breastfeeding awareness and social support.
4. Address obesity, nutrition, and physical activity for children.
5. Increase the capacity and efficiency of the adolescent system of care.
6. Develop & support the implementation of the Family Home Visiting Program.
7. Improve the system of care for children and youth with special health care needs
8. Improve system coordination in communities and statewide to facilitate improved health outcomes.
9. Improve mental and behavioral health across the life course.
10. Adopt social determinants of health into public health planning and practice to improve health equity.

MCH Framework

The three leading priorities of the RIDOH are to: (1) Address the social and environmental determinants of health; (2) Eliminate disparities and promote health equity; and (3) Ensure access to quality health care for all, especially vulnerable populations. These priorities are the foundation that guides all RIDOH work, with the goal of improving the health and wellbeing of all Rhode Islanders. These priorities also provide a framework that supports RI's Title V Program. Further, 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, health care systems, clinical providers, community based organizations, and other RIDOH Programs. This work spans a variety of direct, enabling, and systems level interventions.

Health Equity Zones (HEZ)

Since 2014, the Rhode Island Department of Health has made substantial investments in place-based models that are community-led to address disparities. Rhode Island's Health Equity Zones initiative braids together funds from several sources, including the state's Title V program. In the 4 years of the program, 9 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. Each HEZ has an organization (local government or local non-profit entity) that acts as the administrator of the collaborative.

RIDOH MCH staff communicate regularly with HEZ collaboratives about the implementation of evidence-based interventions to improve the health and wellness of mothers and children in their community. Several initiatives that have been supported using this model include: a walking School Bus programs in two HEZ, including for one elementary school that has subsequently boasted the state's highest attendance rate; expansion of a Parents as Teachers program in a community that identified this as a need; the creation of Welcome Baby packets at a community hospital; a community baby shower; and community-led initiatives to increase awareness about mental health and substance use disorder. Many other MCH interventions are also supported throughout the HEZ. There is no question of the impact HEZ infrastructure is having 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 the most vulnerable communities.

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.

Partnerships

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. During 2018-2019, RIDOH MCH staff convened or participated in over 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. During 2018, the Family Visiting Program incorporated oral health screening and referral in their case management and data collection systems, the WIC Program added an oral health education model for WIC participants, and the RIDOH Lead Program began distributing bilingual oral health materials in all of the certified lead centers across the state. Significant time and resources were also invested to increasing the awareness of the importance of oral health, especially for pregnant women, among medical and dental providers. Preconception health continues to be an area of focus because of its significance in affecting perinatal health outcomes. RIDOH has supported family planning at Title X agencies for many years. Over the last several years, promotion of pregnancy intention screening, using the One Key Question (OKQ) Model, has been used to encourage reproductive health counseling that empowers individuals to clarify their health needs in accordance with their personal goals. This model is also being integrated into services among non-medical providers such as home visitors and substance use treatment providers. 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. RI has recently passed legislation to form a maternal mortality review committee, which would help inform best practices for women during pregnancy up to the postpartum period.

Perinatal/Infant Health – RI is fortunate to have breastfeeding laws that support breastfeeding and lactating mothers. These laws allow women 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 the birthing hospital, WIC offices, and through community partners that provide services to pregnant and parenting individuals; the materials were selected for inclusion in AMCHP's Implementation Toolkit for National Performance Measure 4. RIDOH oversees the implementation of four home visiting models throughout the state: First Connections, Nurse Family Partnership, Health Families America, and Parents as Teachers. The Family Visiting Program continues to identify, enroll, and provide services for families most at-risk for poor health outcomes. In FY2017, 1,646 families were served and 22,830 visits were conducted. Upon recommendation by their advisory committee, the Newborn Screening Program added three conditions to the blood spot screening panel, effective October 1, 2018.

The MCH Program has also been responsible for convening several groups that are focused on addressing perinatal health disparities; The RI Task Force on Premature Births, Disparities in Infant Mortality Work Group, Safe Sleep Interagency Work Group, and the Task Force to Support Pregnant and Parenting Families with Substance-Exposed Newborns.

Child Health - RI is a leader in several child health indicators including health care coverage and immunization rates. High immunization rates can, in part, be attributed to a state 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 (e.g. 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 children that live in low-income communities through the state. The Childhood Lead Poisoning Prevention Program pilot tested finger-stick lead screening at WIC sites for children identified in KIDSNET as needing screening.

Over the last several years, RIDOH has provided technical assistance and support to local school districts and daycare centers around nutrition and physical activity standards and guidelines. RIDOH also advocated for the General Assembly to pass a school recess law, which requires 20 consecutive minutes of unstructured free play each day in grades K – 6. RIDOH participated in a state-wide data project to collect overweight and obesity data and publish an issue brief.

Adolescent Health – 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 is an important area of work for RIDOH. Over the past several years, the MCH program has developed materials and provided technical assistance to pediatric and adult practices. For over 10 years, RIDOH has planned and sponsored the Dare to Dream high school student leadership conference. Originally intended for youth with special health care needs, because of its overwhelming successes, the annual conference has been expanded to all youth and a middle school version was created in 2017. RIDOH 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. Safety net services for family planning and STD screening and treatment are provided through contracts with community clinical providers. The Teen Outreach Program, a pregnancy prevention program, has served more than 700 youth since 2013.

Children and Youth with Special Health Care Needs (CYSHCN) – RIDOH has played a key role in the planning, development, and implementation of Patient Centered Medical Homes for children (PCHM-KIDS) throughout the state. Primary partners include RI's 4 health plans, the RI Chapter of the American Academy of Pediatrics, the

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 health care needs. 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. RI is 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 RI Parent Information Network (RIPIN) for the provision of the Family to Family Health Information Line, support groups, resource development, peer resource specialist (community health workers), and advocacy for CYSHCN. RIDOH oversees the Internship Program, a recently AMCHP-designated 'Promising Practice' that provides workplace experience to YSHCN that assists them with the transition to adulthood.

Cross-cutting Initiatives – In order to improve MCH systems of care, the MCH Program is working with a wide variety of internal and external partners. Over the past few years, several collaborative projects have included the Governor's Task Force for Overdose Prevention, the Task Force for Substance Exposed Newborns, The Governors Initiative to improve Third Grade Reading, Plans of Safe Care, and a Safe Sleep Campaign. Partnerships include: Rhode Island Department of Education (RIDE), Department of Children, Youth and Families (DCYF), Department of Human Services (DHS), Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH), Executive Office of Health and Human Services (EOHHS), Medicaid, Department of Corrections (DOC), and the Office of the Health Insurance Commissioner (OHIC). 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 Pediatric Patient Centered Medical Home (PCMH-Kids); Pediatric Psychiatry Referral Network (PediPRN); Community Health Teams; Screening, Brief Intervention and Referral to Treatment (SBIRT); and a workforce development.

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

The 2017 Title V investment of \$1,647,805 was only a small fraction of the overall RIDOH MCH budget of \$11,212,784. 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 RI, 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, HEZ, Accountable Entities, Hospitals, Insurers). The flexibility of Title V funds is critical as it allows RIDOH to fill gaps where reductions in other funding threatens MCH systems and services or enhance work that is already being done for greater impact.

III.A.3. MCH Success Story

RIDOH has collaborated closely with the Rhode Island Department of Children, Youth and Families on work to prevent child maltreatment. An analysis of child maltreatment fatalities in the state between 2016 and 2017 resulted in two cross-agency recommendations: to refine the existing Newborn Developmental Screen to better identify families at risk of maltreatment at birth and connect them to RIDOH's family home visiting services, and to improve data sharing between RIDOH and DCYF to ensure families who have interacted with DCYF are engaged in preventative services. This year RIDOH and DCYF have built a data-sharing process that identifies all children age 0-3 who have had a DCYF investigation and whether they have engaged in home visiting services. Family home visiting service providers follow up with any families who are not engaged to invite them to participate. RIDOH has also used predictive analytics to develop a new tool that precisely identifies children at birth who are likely to experience a DCYF investigation within the first 2 years of birth. RIDOH will be using this tool to differentiate outreach and engagement, with the goal of increasing engagement in home visiting services for the families who are most likely to become involved with DCYF.

III.B. Overview of the State

Overview of the State

Geography and Demographics

The state of Rhode Island (RI) is a small, coastal area with just over one million residents (1,057,315)^[1]. The state 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 is divided into 39 cities and towns that each govern primary and secondary education, subdivision of land and zoning, and housing code enforcement in their local community^[2]. The city of Providence is Rhode Island's capital and largest community, with an estimated 179,335 residents. Most of RI's population (636,084) lives in Providence county.

Children under 5 years of age represent 5.1% of RI's population, and 19.4% of the population is under the age of 18. Rhode Islanders age 65 and older make up 17.2% of the population. Based on the most recent Census estimates, RI's population is 83.9% White, 15.9% Hispanic or Latino, 8.4% Black or African American, 3.6% Asian, 2.8% Multiracial, and 1.3% Native American, Alaskan Native, Native Hawaiian, or Pacific Islander. Currently, 29.2% of all Rhode Islander residents are foreign-born (U.S. Census 2013-2017). The largest share of the foreign-born population in RI is from Latin America (44.7%), followed by Europe (22.6%), Asia (17.8%), and Africa (12.2%). Among RI residents over 5 years of age, 21.7% speak a language other than English at home, and Spanish is the most common of those languages (52%)¹.

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 Latino population experienced the most growth (44%), followed by Asian population (29%), and the Black, non-Latino population (28%)³. 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]. 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 children¹.

The median household income in RI between 2013 and 2017 was \$61,043, and the statewide poverty rate was 11.6%. In the city of Providence, however, the poverty rate is 26.9%⁴. Providence is considered one of Rhode Island four "core" cities, which are urban communities in the state where over 25 percent of children live in poverty^[4]. RI's "core" cities are Providence, Pawtucket, Central Falls, and Woonsocket. Within the four "core" cities, the poverty rate is over two times higher than the state average. Nearly one third of children in RI live with these "core" cities and 46% of children in the four core cities live in single-parent households⁴.

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.

In 2017, only 2.1% of RI's children under age 19 were uninsured. RI ranks third best in the U.S., with 97.9% of children having health insurance. Rhode Island does offer health coverage through HealthSource RI, RI's health insurance market place under the federal Affordable Care Act. As of October 2018, 1,749 children were enrolled in private health coverage through HealthSource RI, 52% of whom received financial assistance through a premium tax credit or a cost sharing reduction⁴. The rate of children in RI ages 19 to 35 months that were fully immunized (76%) was above the national average of 71% and 14th best in the U.S. in 2016. Rhode Island also ranked first in the U.S. for rotavirus vaccines, second for the 3-Polio vaccine, and fifth for the DTaP vaccine series in 2017. In 2014, 94% of RI's children had dental insurance that paid for routine dental care, up from 73% in 2001. Newborn screening is mandated for all babies born in Rhode Island. Rhode Island screens newborns for 31 conditions, including hearing loss.

RI also faces several challenges that impact maternal and child health. RIDOH is a close partner and data contributor to Rhode Island Kids Count - the state's children's policy organization. Every year RI Kids Count publishes one of the most comprehensive collection of data about the health and well-being of the state's children. Through the analyses in the annual RI Kids Count Factbook, many important issues are highlighted that impact RI's Maternal and Child Health populations.

RI's child poverty rate was 19% between 2013 and 2017, during which time there were 39,229 children living in families with incomes below the federal poverty threshold. In 2017, nearly one in six (17%) children in RI (a total of 33,858 children) lived in poverty, 48% of whom were children were Hispanic. Many families with incomes above the poverty level also have a difficult time meeting the high costs of housing, utilities, food, child care, and health care. Between 2013 and 2017, nearly two thirds (64%) of Rhode Island's children living in poverty lived in the four "core" cities of Providence, Central Falls, Pawtucket, and Woonsocket. In 2018, the four core cities also have 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. ⁴ Almost two-thirds (66%) of children living in poverty lived with single female caregiver. During the 2016-2017 school year, RI public school personnel identified 1,245 children as homeless. ⁴ Of these children, 65% lived with other families ("doubled up"), 27% lived in shelters, 7% lived in hotels or motels, and 2% were unsheltered. ⁴

Although progress has been made on many health indicators across 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. Black children are more likely to die in infancy than White, Hispanic, or Asian children. Hispanic and Black youth are more likely than White and Asian youth to give birth as teenagers. Black and Hispanic children in RI are more likely to be hospitalized as a result of asthma than White children⁵.

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

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; 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 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: 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. 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 of the Title V program, especially for women 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.

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. 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. This is most exemplified in the Health Equity Zone (HEZ) Initiative, a place-based initiative developed by RIDOH in 2015 with braided federal, state, and restricted funding including Title V. RIDOH has funded 9 RI non-profit organizations and local governments to support innovative approaches to preventing chronic diseases, improve MCH outcomes, and address the social and environmental determinants of health. HEZs are designed to affect change at the lowest level of the population health pyramid by increasing strategic planning and the integration of non-traditional partners to promote health and well-being within smaller geographic areas and target populations.

Rhode Island's System of Care

Infrastructure and Maternal and Child Health Services Providers

Rhode Island has several hospitals that specialize in caring for maternal and child populations. 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. Women and Infants Hospital, part of the Care New England system, specializes in care of women and newborns, and is the 9th largest stand-alone obstetrical service in the US. 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. Bradley Hospital and Butler Hospital both specialize in providing psychiatric care to children and youth. There are approximately 30 prenatal care and 60 pediatric practices throughout the state that serve pregnant women and children.

Healthcare Access, Delivery, and Financing

For decades, RIDOH has been focused on strengthening and improving the health of RI's community and health care system. From the ground-breaking RIte Track (which ensured prenatal, childbirth, and postpartum care for women), and its successor RIte Care (the state's Medicaid managed care program for children and adults) to capitated, limited network health plans, to a national focus on patient-centered medical homes, RI has pressed forward on health care innovation.

RI is a Medicaid expansion state and 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, 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.^[5] 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.^[6] 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). Another 74,773 low-income adults without dependent children, 32,296 adults with disabilities, and 19,970 older adults were enrolled in Medicaid coverage during this time.^[7]

RI has made primary care practice transformation a center-piece of its health care reform efforts. State agencies and commercial and Medicaid insurers have embraced the Patient-Centered Medical Home model as a mechanism to improve care, improve health, and lower costs. RI is advancing medical homes as evidenced by multi-payer payments to medical homes underway, approved ACA section 2703 health home state plan amendment, and medical home payments aligned with national and state developed qualification standards. In a state with about 1,190 active primary care physicians, 443 (37%) are practicing in medical homes recognized by the National Committee for Quality Assurance (NCQA). The medical home projects underway in RI include the Pediatric Care Coordination, Community Health Teams, Chronic Care Sustainability Initiative (CCSI), Connect Care Choice, and the ACA Section 2703 Health Homes-Cedar Family Centers project.

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

Rhode Island was one of 24 states to receive a State Innovation Model (SIM) Test Grant from the federal Centers for Medicare and Medicaid Services (CMS). The state received \$20 million with the expectation that the funds would be used to transform the way healthcare is delivered and paid for – and to improve Rhode Island’s population health. RI’s SIM grant ended in June 2019 and sustainability efforts are underway to support the three categories of activities: improving the primary care and behavioral health infrastructure, engaging patients in positive health behaviors and self-advocacy, and expanding the ability of providers and policy makers to use and share data.

Services for Underserved and Vulnerable Populations

RI offers many programs and services to underserved and vulnerable populations. The Supplemental Nutrition Assistance Program (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). In 2018, 160,272 Rhode Islanders were enrolled in SNAP, 34% of whom were children. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves pregnant, postpartum, and breastfeeding women, 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 2018, 21,209 women, infants, and children were enrolled in WIC in Rhode Island, and infants and children under 4 years of age comprised 78% of the population being served by WIC.⁵ The percent of eligible enrolled of women, infants and children was 46% in 2018. There were 4,430 families who received cash assistance during 2018 with a max benefit of \$554 per month for a family of three.

As of June 2018, there were 21,488 students ages six to 21 (15% of all kindergarten through grade 12 students) receiving special education services through RI public schools. Thirty-six percent of these students had a learning disability, 18% had a health impairment, 12% had a speech/language disorder, 11% had an autism spectrum disorder, 8% had an emotional disturbance, 7% had a developmental delay, 4% had an intellectual disability, and 3% had other disabilities.⁵

In 2017, an estimated 21% of children in RI had at least one special health care need. As of June 2018, there were 2,619 children ages 3 to 21 with autism spectrum disorder receiving special education services. Likewise, as of June 30, 2018, 2,219 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* for all infants and toddlers under age three who have developmental delays, or a diagnosed physical or mental condition associated with a developmental delay. Also, as of June 30, 2018, there were 3,121 children between ages three and five who received preschool special education services. Almost 5,000 children and youth in RI under age 19 receive Medical Assistance benefits through enrollment in the federal Supplemental Security Income program. As of October 2018, there were 1,278 RI families enrolled in family home visiting programs, which are designed to reach young children and families at home to foster healthy, safe, and stimulating environments for young children in at-risk families.⁵

RI Statutes and Regulations that have an impact on MCH and CSHCN Programs

[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”.

2019 Legislative Updates – While a number of bills effecting MCH populations were introduced this legislative session, the follow bills were passed by the general assembly.

- [S409](#), [H6086](#) Requirement for all public and private schools to have Narcan onsite, including elementary schools

was codified in [RIGL 16-21-35](#).

- [S572,H5431](#)- Allows a “licensed public health dental hygienist” to conduct dental screening for children in kindergarten, third, and ninth grade.
- [S754,H5543](#)– Adds the multi-disciplinary maternal mortality review committee to the review of the office of the state medical examiner and extends certain immunities and confidentiality agreements to multidisciplinary teams.
- [S676,H5541](#)– Expands the provisions requiring the reporting of immunization status and any other relevant information to adults, not just children, and requires the department of health to include routine adult immunization in the department’s immunization program. This legislation will expand KIDSNET to include adults.

2015 – 2018 Legislative and Regulatory Updates

- [H-7644](#), [S-2669](#) – Requires any RI public school that has elementary grades K – 6 to offer students daily supervised, safe and unstructured free play recess for 20 consecutive minutes each day and was codified in [RIGL 16-22-4.2 statute](#) in 2016.
- [H-6307](#), [S-0493](#); Requires RI health care professionals to discuss the risks of developing a physical or psychological dependence prior to issuing prescriptions for a schedule II controlled dangerous substances and was codified in [RIGL 21-28-3.18](#) in 2017. This legislation aligns with the SBIRT program and other enacted pieces of legislation that seek to reducing substance use disorders in Rhode Island.
- Mental Health
 - [H-6306](#), [S-322](#) – Requires medical treatment facilities to provide discharge plans for patients with nonsubstance abuse related mental health disorders and was codified in [RIGL 23-17.26-3](#) in 2017.
 - [H-7806](#), [S-2540](#) - Requires that insurers treat behavioral health counseling and medication maintenance visits the same as primary health care visits when determining patient cost-sharing. This law also directs the Office of the Health Insurance Commissioner to work with insurers to enhance mental health parity and to report to the General Assembly on the impacts of the legislation. This legislation was codified in [RIGL 27-38.2-1](#) and [RIGL 42-14.5-3](#) statute in 2018.
 - [S-328](#) – The RI Senate passed a resolution in 2017 requesting that the Executive Office of Health and Human Services examine policies and make recommendations on improving the quality of mental health services, including those relating to maternal depression and early childhood mental health.
- [H-5953](#) ,[S-683](#) – This legislation establishes a new license that allows dental hygienists to perform dental hygiene procedures in a public health setting subject to conditions adopted by the RI board of examiners in dentistry without the immediate supervision or direction of a dentist and was codified in [RIGL 5-31-1-39](#) statute in 2015.
- [H-7220](#) , [S-2096](#) – This legislation established the RI Family Home Visiting Act within state law. The RIDOH is charged with developing and coordinating a system of early childhood visiting services to meet the needs of vulnerable families with young children. This was codified in [RIGL 23-13.7](#) in 2016.
- [H-5819](#), [S-672](#) – This legislation instructs any physician, duly certified registered nurse practitioner or other health care provider is involved in the delivery or care of infants born with or identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum disorder” to make a referral to the Department of Children, Youth, and Families for follow-up to ensure that both the mother and child have a plan of care developed for discharge. This was codified in [RIGL 40-11-6](#) statute in 2017.
- [H-5456](#), [S-0275](#) – This legislation requires infants and toddlers under two or under 30 pounds to be in car seats that face the rear of the vehicle, in a seat other than the front seat, as long as the vehicle has one. This was codified in [RIGL -31-22-22](#) statute in 2017.
- [H-5177](#), [S-0306](#) – This legislation encourages the RI Department of Elementary and Secondary Education to consult with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals for the incorporation of substance abuse prevention and suicide prevention into the health education curriculum.

Substance abuse prevention is defined as the implementation of evidence-based, age appropriate programs, practices, or curricula related to the use and abuse of alcohol, tobacco, and other drugs. Suicide prevention is defined as the implementation of evidence-based appropriate programs, practices, or curricula related to mental health awareness and suicide prevention. This was codified in [RIGL 16-22-4](#) statute in 2017.

- [H-7419](#), [S-2350](#) – This legislation prohibits the advertising of unhealthy food and beverage products in schools that do not meet minimum federal and state governmental nutrition standards. This was codified in [RIGL 16-21-7.1](#) statute in 2018.
- [S-646](#) – This joint House and Senate Resolution established a Special Legislative Commission to Study an Early Intervention System for Deaf and Hard of Hearing Children in Rhode Island” whose purpose would be to make a comprehensive study of an early intervention system for deaf or hard of hearing children in Rhode Island, and who would report back to the General Assembly.
- [H5182](#), [S175](#) – This legislation outlaws the use of any non-hands-free personal wireless communication device while operating a motor vehicle, except for public safety personnel or in emergency situations. This was codified into [RIGL 31-22-31](#) statute in 2017 and went into effect on June 1, 2018.
- [216-RICR-30-05-3](#) The RI Department of Health issued a regulation mandating that all preschool-aged children attending a preschool or daycare licensed by Department of Children, Youth and Families were required to have documentation of an annual influenza vaccine beginning August 1, 2015.
- [216-RICR-30-05-3](#) The RI Department of Health issued a regulation mandating that all childcare workers working in a preschool aged setting licensed by Department of Children, Youth and Families are required to have documentation of Tdap, Varicella, MMR vaccine, and flu vaccine beginning August 1, 2015.
- [216-RICR-30-05-3](#) The RI Department of Health issued a regulation mandating that all students entering ninth (9th) grade shall be required to have completed the HPV vaccine series (3 doses) beginning August 1, 2017.
- [216-RICR-20-05-1](#) – The RI Department of Health issued a regulation to update newborn screening rules and regulation to include three new conditions pompe, adrenoleukodystrophy, mucopolysaccharidoses beginning on October 1, 2018.
- [H-5277](#), [S 0267](#) - Prohibits licensed health care professionals from practicing conversion therapy on patients under the age of 18 years old and was codified in [RIGL 23-94-3](#) statute in 2017.

^[1] U.S. Census, July 2018 estimates <https://www.census.gov/quickfacts/RI>

^[2] RI Department of Labor and Training Census Statistics <http://www.dlt.ri.gov/lmi/census.htm>

^[3] PolicyLink and The USC Program for Environmental and Regional Equity
http://www.policylink.org/sites/default/files/RHODE_ISLAND_PROFILE.pdf [policylink.org]

^[4] RI Kids Count Factbook, 2019 <http://www.rikidscount.org/Portals/0/Uploads/Documents/Factbook%202018/2018%20Factbook.pdf>
[rikidscount.org]

^[5] HealthSource RI Open Enrollment 2016 http://healthsourceri.com/wp-content/uploads/2016/07/OE3Report_Final_07212016.pdf
[healthsourceri.com]

^[6] Health Equity Zones Rhode Island Department of Health 2019 http://www.health.ri.gov/programs/detail.php?pgm_id=1108

^[5] HealthSource RI Open Enrollment 2018 Report
https://healthsourceri.com/wp-content/uploads/2018HSRI_OE5Report_02182019.pdf

^[6] HealthSource RI Open Enrollment 2018 Report
https://healthsourceri.com/wp-content/uploads/2018HSRI_OE5Report_02182019.pdf

^[7] HealthSource RI Open Enrollment 2018 Report

https://healthsourceri.com/wp-content/uploads/2018HSRI_OE5Report_02182019.pdf

III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

Data Collection and Analysis

The MCH Program uses administrative and population-based data to describe the health of the MCH population. Routine data collection and analysis is performed to evaluate state MCH priority needs, monitor key national and state performance and outcome measures, and generate hypotheses for analytical studies. The MCH team regularly meets with data partners to ensure routine, quality data collection. The MCH Program builds data capacity through ongoing linkages within and outside of RIDOH. As part of the SSDI initiative to expand direct access capacity to data systems, the MCH Program has built direct access to birth and death data for ongoing data management, collection, and quality assurance. The MCH Program also works with other state agencies to link data systems to report key health indicators.

State Priority Needs

RI monitors Title V national and state measures as they related to identified priorities and strategies to determine the effectiveness of RIDOH's response.

1. RI has made efforts to increase preconception care and education among women of child-bearing age in Title X agencies and other settings through the use of the One Key Questions (OKQ). In addition, the MCH program has begun to monitor family planning methods among Title X clients to assess the preconception care and education.
2. RI has improved its breastfeeding rates. This can be attributed in part to the number of child born at Baby-Friendly Hospitals, health insurance reimbursement lactation support, and breastfeeding education and support at WIC clinics.
3. RIDOH has been challenged with the loss of its Physical Activity and Nutrition Program earlier this year, which would have introduced 3 new ESMS regarding this state priority. The MCH Program will continue to monitor outcomes for childhood obesity and physical activity to determine if current trends improve, while evaluating current strategies.
4. The increase in Title X client enrollment and the expansion of the Teen Outreach Program demonstrates improvement in building systems of care for adolescents. A decrease in teen pregnancy, and a continued increase in adolescent immunization and physical activity are positive trends for the health of RI's adolescents.
5. The Family Visiting Program continues to reach targeted infant and maternal populations, with particular emphasis placed on identifying, engaging, and retaining individuals most at risk for poor outcomes. Family Visiting has implemented depression screening for its clients within the first three months of enrollment, of which the proportion of screenings completed have increased since the starting year.
6. Although the proportion of CSHCN who report having a medical home remains low compared to the target of 55%, RIDOH has now developed a medical home portal where families with CSHCN can navigate systems of care, which the MCH Program will assess by monitoring web use. The MCH Program is still pending evaluation for assessing adolescent transition among the CSHCN population.
7. RI demonstrates an improvement among pregnant women with a preventive dental visit and an improvement among children ages 0-17 with a preventive dental visit. RI developed a state oral health strategic plan for CSHCN in 2017. RI also plans to increase training among providers for oral health.
8. RI has seen an increasing number of certified community healthcare workers (CHWs). This is included as a new state performance measure (SPM). The MCH Program, along with the RI Certification Board, have developed a certification process that includes eligibility for recertification after two years.
9. RI currently has mixed results regarding the improvement of mental behavior across the life course. Youth suicide ideation and suicide rates have increased. However, postpartum depression has decreased since 2012. To

further address mental/behavioral health issues across the life course, the MCH Program is overseeing the MomsPRN initiative which assists providers in improving behavioral health care for pregnant and postpartum women through a consult line.

0. RIDOH identified the need to develop a statewide surveillance system to monitor the State's progress towards improving the social, economic, and environmental conditions that impact health. RIDOH developed a set of 12 indicators across 4 domains that will be used to measure the impact of changes to the SDOH.

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".

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. The Chronic Care and Disease Management Team is responsible for reducing the incidence, burden, and associated risk factors related to asthma, arthritis, heart disease and stroke, diabetes, and cancer to improve health outcomes. The Health Promotion and Wellness Team is responsible for strategies that support and reinforce healthy living through the life course. The Perinatal and Early Childhood Health Team is responsible for supporting healthy birth outcomes, positive early childhood development, and school readiness by providing and assuring mothers and children have access to quality services. The Preventive Services and Community Practices Team is responsible for improving the quality of preventive and community services by increasing access and availability to vulnerable populations. The Special Needs Team is responsible for assuring the systems of care is accessible and equipped to handle CSHCN. The Healthy Homes and Environment Team is responsible for protecting the health and safety of children, workers, and the general public by identifying and decreasing environmental hazards. RIDOH is also home to the Center for Health Data and Analysis and Vital Records. CHDA leads, supports, and coordinates the collection, analysis, and dissemination of public health data that informs and drives program and policy development. All RIDOH's programs work together to ensure a statewide system of services that reflect the principles of comprehensive, coordinated, community-based, family-centered care which are essential for effectively fostering and facilitating MCH activities and goals.

Emerging Public Health Issues

Drug Overdose

Rhode Island is experiencing an epidemic of drug overdose. The rapid increase in drug overdose deaths (over

110% since 2009,) has been driven in part by an extraordinarily high prevalence of illicit substance use, combined with a high rate of opioid prescribing. In August 2015, the Governor of RI passed an executive order to convene a “Governor’s Task Force on Overdose Prevention and Intervention”. The Task Force meets on a monthly basis and includes appointed members from the state and local police, clinicians, researchers, Emergency Medical Services (EMS), the RI Department of Corrections (RIDOC), the Prescription Drug Monitoring Program (PDMP), recovery and treatment community centers, and individuals in active recovery. 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.

Substance Exposed Newborns (SEN)

RI continues to see an increasing rate of infants born with opioid withdrawal called neonatal abstinence syndrome (NAS). The rate has increase from 9.1 per 1,000 newborn hospitalizations in 2013 to 10.6 per 1,000 in 2017. RI is also experiencing an increasing rate in all drug-related diagnoses (cocaine, marijuana, and other drug exposures) among newborns, from 11.7 per 1,000 newborn hospitalizations to 17.0 per 1,000. This broader category is referred to as Substance Exposed Newborns (SEN). The RI Task Force to Support Pregnant and Parenting Families with Substance-Exposed Newborns (SEN Task Force), was formed as part of the Governor’s Task Force on Drug Overdose. Members of the SEN Task Force include representatives from RIDOH, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, the Department of Children Youth and Families, local drug treatment providers, perinatal medical providers from the major birthing hospitals specializing in NAS, and others. The goal of the SEN Task Force is to improve a coordinated system for early identification and plans of safe care for impacted women, children and families, with an emphasis on comprehensive, family-focused, cross sector, care coordination to support the best health and social outcomes. RIDOH staff plays a key role in the leadership and administration of the SEN Task Force which meets on a quarterly basis. This past year, an SEN data workgroup was established with the goal of improving data collection and surveillance and to guide the development of a database for plans of safe care in RI.

Maternal Mortality/Severe Morbidity

Across the US, maternal mortality has become a major public health concern. The five year maternal mortality rate in RI for 2013-2017 was 11.2 per 100,000 live births. Given the state’s small numbers, analysis by race/ethnicity and other risk markers is challenging to interpret and inform public health. In June 2019, the general assembly passed legislation making it possible to stand up a maternal mortality review committee. RIDOH will be the lead agency on this project and will work to get a functioning committee in place by the end of 2019. The severe maternal morbidity rate in RI for 2017 was 240.5 per 10,000 delivery hospitalizations, a significant increase from 184.5 per 10,000 in 2013. RI severe maternal morbidity data revealed disparities among non-Hispanic Black women (344.6 per 10,000) compared to non-Hispanic White women (183.0 per 10,000), and among women living in RI core cities (239.1 per 10,000) compared to non-core cities (179.7 per 10,000). RIDOH is working to better understand this data and bring stakeholders together to discuss potential strategies to address the disparities, including the possible formation of a maternal health task force.

Reproductive Privacy Act

Proposed federal level changes to the Title X program may have significant impacts on healthcare access and provision of high-quality, evidence-based care. Changes to Title X rule include prohibition on referral to abortion services, even if specifically requested by a patient. It will also permit, but no longer require, nondirective pregnancy options counseling. In addition to longstanding clear financial separation between Title X projects and abortion services, the revised rule will require physical separation from abortion providing facilities. Additional requirements of the rule include family involvement and sexual coercion prevention counseling, clarification on compliance with state reporting laws, and increased reporting requirements. Many of the proposed updates to the Title X rule do not align with standards of care or evidence-based best practice. These revisions can impact a providers' ability to provide comprehensive and timely care to patients in need. In response to the Title X changes that were supposed to be in effect in May 2019, a number of lawsuits were filed, including one joined by the RI Office of the Attorney General. Injunctions were ordered to put the rule revisions on hold. Yet as recently as the end of June 2019, an appellate court lifted the injunctions and order the rules be put into effect. Several national organizations have filed motions for the injunctions to be reconsidered.

Hepatitis A

With outbreaks of hepatitis A occurring across the country, including Massachusetts and New Hampshire, the RIDOH Immunization Program is working with internal programs, state agencies, and community organizations to implement strategies aimed at preventing a hepatitis A outbreak. Part of the strategy has been to create awareness among clinical and social service providers and so that they can encourage their high-risk populations to get vaccinated. Additionally, over 800 people in the high-risk population have been vaccinated against hepatitis A. RIDOH has created a Hepatitis A Task Force to monitor the national outbreak, develop a plan should RI experience increased cases of hepatitis A, and continue to implement strategies aimed at preventing a hepatitis A outbreak in RI. The MCH Medical Director participates in the task force.

FY 2019 Application/FY 2017 Annual Report Update

Ongoing needs assessment activities

Data Collection and Analysis

Ongoing data collection and analysis is performed for MCH data to evaluate state MCH priority needs, monitor key national and state performance and outcome measures, and generate hypotheses for analytical studies. The MCH Program uses administrative and population-based data to describe the health of the MCH population for routine collection for analysis. The MCH team meets with data partners to ensure routine, quality data collection. For example, the MCH team meets with the RI Office of Vital Records on a quarterly basis to review and discuss data quality and governance for files regarding births, deaths, fetal deaths, and induced terminations. The MCH Program also participates in the YRBS and BRFSS Advisory and Planning Committees and the PRAMS Steering Committee to help select key questions that inform public health issues with the MCH population. The MCH Program continues to report timely data. Updated data for this report includes, but is not limited to, provisional 2017 RI Vital Records files (birth, death, fetal death, and induced terminations), 2017 YRBS, 2016 hospital discharge data, 2015 PRAMS, and 2016 NSCH. NSCH have changed their survey methodology in 2016, so it is not comparable to previous NSCH data. Please refer to the domain updates for measures and indicators reported.

The MCH Program builds data capacity through ongoing linkages within and outside of RIDOH. It currently has a linked birth and death file, and plans to link infant records with maternal data. The MCH Program also works with other state agencies to link data systems to report key health indicators. KIDSNET is the comprehensive child data system that collects information from various program such as home visiting, newborn screening, and immunizations. This data system routinely links to Department of Education data systems monthly, which comprises the state's Early Childhood Integrated Data System (ECIDS). This linkage would address the health status regarding the 3rd grade reading level population. RIDOH also links Vital Records data to Office of Medicaid through a data collaborative project called the Ecosystem. This linkage would help the MCH Program analyze and report data, addressing and informing MCH outcomes using administrative healthcare and billing data.

State Priority Needs

RI monitors Title V national and state measures and strategies to state priority needs to determine how determine how effective is the RIDOH response.

- 1) RI has made efforts to increase the number of Title X clients served, which increases preconception care and education among women of child-bearing age. Overall, teen pregnancy has also shown improvement with a continued decreasing trend, yet racial/ethnic disparities continue to exist.
- 2) RI has made improvements in breastfeeding outcomes due to breastfeeding support and education and the licensing of lactation consultants. National Performance Measures 4a and 4b show improvements in breastfeeding at any time and breastfeeding exclusively at 6 months, respectively. RI is also working to achieve that all hospitals are designated as Baby-Friendly.
- 3) Although various activities have focused on childhood obesity and physical activity, results show no significant improvement among children ages 2-4 and 6-11. The MCH Program will continue to monitor outcomes for childhood obesity and physical activity to determine if current trends improve, while evaluating current strategies.
- 4) The Increase in Title X client enrollment and the expansion of the Teen Outreach Program demonstrate improvement in building systems of care for adolescents. Decreases in teen pregnancy in Core Cities and non-Hispanic Black teen birth rates, and increases in adolescent immunization and physical activity are positive trends for the health of RI's adolescents.
- 5) The Family Visiting Program continues to reach targeted infant and maternal populations, with particular emphasis placed on identifying, engaging, and retaining individuals most at risk for negative outcomes.
- 6) Although the proportion of CSHCN receiving a medical home remains low compared to the target of 55%, RIDOH has now developed a medical home portal that families with CSHCN can navigate systems of care, which the MCH Program will assess by monitoring web use. The MCH Program is still pending evaluation for assessing adolescent transition among the CSHCN population.
- 7) RI demonstrates slight improvement among pregnant women with a preventive dental visit, whereas data is not yet

available to determine the trend among children with a preventive dental visit. RI, however, developed a state oral health strategic plan for CSHCN in 2017. RI also plans to increase training among providers for oral health.

- 8) RI has seen an increasing number of certified community healthcare workers (CHWs), which is a new SPM that measures improvement of systems coordination in communities and statewide that facilitate improved health outcomes. The MCH Program, along with the Rhode Island Certification Board, have developed a certification process that includes eligibility for recertification after two years.
- 9) RI currently has mixed results regarding the improvement of mental behavior across the life course. Youth suicide ideation and suicide rates have increased. However, postpartum depression had a slight decrease since 2012.
- 10) RIDOH identified the need to develop a statewide surveillance system to monitor the State's progress towards improving the social, economic, and environmental conditions that impact health. RIDOH reconvened an existing health assessment group called the Community Health Assessment Group (CHAG), which is currently working on a dashboard that measures social determinants of health within the state. Also, an epidemiologist/evaluator group at the health department have convened a workgroup and drafted guidelines for the uniform collection of data elements addressing vulnerable populations.

Addressing Health Disparities

RIDOH has adopted the 2010 Healthy People goal of eliminating health disparities as one of the three leading priorities in Rhode Island. The Health Equity Institute (HEI) reexamined their strategic plan that addresses the RIDOH leading priority of eliminating disparities and promoting health equity by incorporating a formal approach to measuring health disparities among RI sociodemographic populations. The identification of these health disparities is necessary to better describe vulnerable populations in RI and prioritize efforts for these populations through interventions. One of the most affected social groups that generate health disparities are those classified by race/ethnicity. Yet HEI will systematically identify other sociodemographic groups such as education, income, and disability status. Although HEI currently uses absolute and relative measures for rates and proportions to measure these health disparities using population-based and survey data, HEI plans to introduce more robust measures such as indices when dealing with a sufficient sample size. Using composite and proxy variables will be used to measure health disparities with small numbers. Current measures of disparities can be found in the domain updates.

Partnerships, Collaboration, and Coordination

RI MCH program is a consistent leader in maternal and child health policy and program in Rhode Island. RIDOH staff champion the interests of mothers and children on statewide committees and boards as exemplified in an attached document in the supporting documentation section of the report.

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 (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 RI MCH (Title V) Program is part of the Health Equity Institute (HEI). Health equity is an important priority of the Title V program. The HEI is strategically located in the Office of the Director, who provides leadership, vision, communication, and direction across all RIDOH divisions and programs.

It is the responsibility of the RI MCH 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. 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 leadership team meets on a bi-weekly basis to discuss program development, fiscal and administrative management, and to identify system level challenges and solutions. The MCH leadership team has drafted an MCH Measures Dashboard, which contains Title V and SSDI (State Systems Development Initiative) measures shared with the team as a tool for program planning and evaluation. 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. Last year, RIDOH hired an MCH Epidemiologist who oversees and monitors Title V measures, evaluates state priority needs, and provides epidemiological support to HEI.

Various RIDOH programs take the lead on different MCH strategies. The Chronic Care and Disease Management Team is responsible for reducing the incidence, burden, and associated risk factors related to asthma, arthritis, heart disease and stroke, diabetes, and cancer to improve health outcomes. The Health Promotion and Wellness Team is responsible for strategies that support and reinforce healthy living through the life course. The Perinatal and Early Childhood Health Team is responsible for supporting healthy birth outcomes, positive early childhood development, and school readiness by providing and assuring mothers and children have access to quality services. The Preventive Services and Community Practices Team is responsible for improving the quality of preventive and community services by increasing access and availability to vulnerable populations. The Special Needs Team is responsible for assuring the systems of care is accessible and equipped to handle CSHCN. The Healthy Homes and Environment Team is responsible for protecting the health and safety of children, workers, and the general public by identifying and decreasing environmental hazards. RIDOH is also home to the Center for Health Data and Analysis and Vital Records. CHDA leads, supports, and coordinates the collection, analysis, and dissemination of public health data that informs and drives program and policy development. All RIDOH's programs work together to ensure a statewide system of services that reflect the principles of comprehensive, coordinated, community-based, family-centered care which are essential for effectively fostering and facilitating MCH activities and goals.

Emerging Public Health Issues

Drug Overdose

Rhode Island is experiencing an epidemic of drug overdose. The rapid increase in drug overdose deaths (over 110% since 2009,) has been driven in part by an extraordinarily high prevalence of illicit substance use, combined with a high rate of opioid prescribing. In August 2015, the Governor of Rhode Island passed an executive order to convene a "Governor's Task Force on Overdose Prevention and Intervention". The Task Force meets on a monthly basis and includes appointed members from the state and local police, clinicians, researchers, Emergency Medical Services (EMS), the Rhode Island Department of Corrections (RIDOC), the Prescription Drug Monitoring Program (PDMP), recovery and treatment community centers, and individuals in active recovery. 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. Within those four key strategies, primary activities include: (1) expand access to medication assisted treatment (MAT), including methadone and buprenorphine; (2) increase distribution of naloxone to high-risk populations; (3) prevent high risk prescribing of opioids, including co-prescription of opioids with benzodiazepines; and (4) increase access to peer-based recovery services.

Neonatal Abstinence Syndrome (NAS)

RI has concurrently experienced a rapidly growing rate of infants born with opioid drug dependency, who experience NAS. The rate has more than doubled from 3.7 in 2006 to 9.1 per 1,000 live births in 2016. The NAS Task Force was formed as part of the Governor's Task Force on Drug Overdose. Members of the NAS Task Force include representatives from RIDOH, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, the Department of Children Youth and Families, local drug treatment providers, perinatal medical providers from the major birthing hospitals specializing in NAS, and others. The goal of the NAS Task Force is to improve a coordinated system for early identification and plans of safe care for impacted women, children and families, with an emphasis on comprehensive, family-focused, cross sector, care coordination to support the best health and social outcomes. RIDOH staff plays a key role in the leadership and administration of the NAS Task Force which meets on a quarterly basis and includes.

Maternal Mortality/Severe Morbidity

RI recognizes the increasing trend in maternal mortality in the U.S and its importance to address this issue. The maternal mortality rate in RI for the five years 2013-2017 is 11.2 per 100,000 live births. Given the state's small numbers, trends in mortality rates and analysis by race/ethnicity and other risk markers is challenging to interpret and even more challenging to utilize to inform public health actions. The severe maternal morbidity rate in RI for 2016 is 209.0 per 10,000 delivery hospitalizations RI severe maternal morbidity data revealed an increased trend from 2013 to 2016 and a large disparity morbidity among non-Hispanic Black women. RIDOH is working with AMCHP on a data communication project that will disseminate an effective data-driven communications product addressing issues concerning maternal mortality, severe

maternal morbidity, and preconception health. The goal is to educate legislative partners about the importance of maternal mortality/severe morbidity and preconception health, and develop policy that addresses these issues.

FY 2018 Application/FY 2016 Annual Report Update

Needs Assessment Process

The mission of RI's Title V MCH Program is to build integrated systems that support health, growth, and development for all MCH populations, including CSHCN, and their families. The Title V MCH community needs assessment is a critical component and requirement of the Title V MCH Block Grant and the data analyzed through the needs assessment process is used to determine the importance, magnitude, value, and priority of competing factors which impact health service delivery systems in the state.

Guiding Frameworks - The guiding frameworks that informed this process are drawn from: 1) the life course approach that emphasizes the role of early life events in shaping an individual's health trajectory; 2) the Health Impact Pyramid developed by Dr. Thomas Frieden at the CDC, which underscores the impact of interventions that address the socio-environmental determinants of health; and 3) RIDOH Health Equity Framework which aims to achieve health equity for all populations, through eliminating health disparities, assuring healthy child development, preventing and controlling disease and disability, and working to make the environment healthy.

Stakeholder Involvement – Stakeholders engaged in the needs assessment process included staff representing the RIDOH as well as other state agencies, service delivery organizations, MCH workforce, youth, and caregivers (including those of CYSHCN). Community input was sought through surveys, community meetings, and written feedback.

Methods and Data Sources - Critically important to the success of RI's MCH Program is the effective use of data to monitor, evaluate, and guide programmatic activities. Many different sources of data were used for analysis.

RIDOH data included: Family Planning, Newborn Screening, Family Visiting, WIC, Lead Screening, Vital Records, Birth Defects, Hospital Inpatient Data, Emergency Department Visit Data
RI Survey Data: PRAMS, BRFSS, YRBS
National Surveys: National Survey of Children with Special Health Care Needs (CSHCN), National Survey of Children's Health (NSCH), and National Immunization Survey

Three different surveys were developed for additional input for the needs assessment: 1) a community member survey; 2) a community organization survey; and 3) an internal RIDOH staff survey.

Prioritization process for action plan - The second phase of the needs assessment (March 2015 - May 2015) focused on an internal prioritization process with the needs assessment planning group members, program managers, and RIDOH leadership in a series of meetings to develop and select state priorities for each population domain.

Findings - A summary of the comprehensive 5 year needs assessment can be found in the "Supporting Documents" section of this grant.

Title V Program Capacity

Organizational structure

RIDOH is the lead RI agency responsible for addressing the maternal and child health needs throughout the state. RIDOH is located within the state's Executive Office of Health and Human Services (EOHHS), a cabinet agency that reports directly to the Governor. The RI MCH Program is a part of the Health Equity Institute (HEI). The 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 of the Title V program, especially for women 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.

It is the responsibility of the RI MCH 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. 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 leadership team meets on a bi-weekly basis to discuss program development, fiscal and administrative management, and to identify system level challenges and solutions. 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.

Agency Capacity

All RIDOH's programs work together to ensure a statewide system of services that reflect the principles of comprehensive, coordinated, community-based, family-centered care which are essential for effectively fostering and facilitating MCH activities and goals. 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. 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. This is most exemplified in the Health Equity Zone (HEZ) Initiative. RIDOH is currently funding 10 RI non-profit organizations and local governments to support innovative approaches to preventing chronic diseases, improve MCH outcomes, and address the social and environmental determinants of health. HEZs are designed to affect change at the lowest level of the population health pyramid by increasing strategic planning and the integration of non-traditional partners to promote health and well-being within smaller geographic areas and target populations.

MCH Workforce Development and Capacity

There are 128 FTEs employed by RIDOH who are working on MCH related programs and services. This includes staff that provide planning, implementation, evaluation, and data analysis. In addition, 2 CDC Prevention Public Health Consultants have been placed at RIDOH this year.

Senior MCH staff includes:

Dr. Nicole Alexander-Scott - Director of Health and Adult and Pediatric Infectious Disease Specialist

Ana Novias – Executive Director of Health, previous Title V Director

Deborah Garneau – Co-Director, Health Equity Institute and current Title V/CSHCN Director

Jaime Comella – Program Manager, Title V MCH Program

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

Blythe Berger – Chief, Center for Perinatal and Early Childhood

Kristine Campagna – Deputy Chief, Center for Perinatal and Early Childhood

Sam Viner-Brown – Chief, Center for Health Data and Analysis

Ellen Amore – KIDSNET Program Manager

RIDOH also directly supports the MCH workforce through many community contracts including family visitors, peer resource mental health specialists, parent consultants, community health workers, safety-net clinical providers, youth advisory groups, sexual health counselors, breastfeeding lactation consultants, and prevention educators.

Partnerships, Collaboration, and Coordination

RI MCH program is a consistent leader in maternal and child health policy and program in Rhode Island. RIDOH staff champion the interests of mothers and children on statewide committees and boards as exemplified in "Supporting Documents" section of the grant.

RI MCH participates in a network of MCH partnerships and collaborations between state agencies, within the state health

department itself, and with community organizations to promote the health of women, infants, and children. These partnerships allow for coordination of programs and strategic use of resources.

Affordable Care Act Partnerships - As an early adopter of the ACA, RI has placed significant emphasis on consumers' understanding of available health care options for themselves and their children. RIPIN contracts with the Office of the Health Insurance Commissioner for RI's Marketplace Consumer Assistance Program. RIPIN has contracted with HealthSource RI to provide consumer assistance with health insurance selection. During 2015, RIPIN worked with RIDOH to become a Disability Navigator site through the National Disability Navigator Resource Collaborative. CHWs in the HEZ and community setting assisted numerous families with insurance, education, and access to mental health services.

Colleges and Universities - RIDOH benefits from relationships with several well-respected colleges and universities, including Brown University School of Public Health, Providence College, University of Rhode Island, and Rhode Island College. In 2016, RI took a deliberate step to formalize these relationships by designating itself as an "Academic Health Department (AHD)" when the agency formed the RIDOH Academic Center (RIDOH-AC). Several MCH projects are being strengthened through these partnerships including CHW workforce development, a PRAMS data to action initiative, and the Hassenfeld Child Institute which is researching genetic, prenatal, and early life factors associated with health problems of children.

Family Consumer Partnership and Leadership Programs - A main tenant of RI MCH program is parent/professional partnership through supporting, empowering, training, hiring, and promoting decision making, policy development, service provision, and community development. Throughout RI, over 1000 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. Since 2014, RIDOH has invested in hiring and supporting Youth Resource Specialists due to their invaluable input into the transition process and generating self-determination resources.

Family Planning/Title X - The RIDOH Family Planning Program promotes the reproductive and sexual health of Rhode Island women, men, and adolescents through implementation of program activities, policy development, care systems coordination, and community outreach and engagement. It provides comprehensive, high quality, affordable, and accessible family planning services to support individual choice in pregnancy prevention or planning. Services provided include clinical family planning and related preventive health services, education and counseling related to family planning, and referral services. The Family Planning Program is a key partner of the MCH Program as preconception care and education is include as one of the priority areas in the MCH State Plan. The programs meet regularly to discuss strategies and progress toward national and state outcome measures.

Family Visiting - RIDOH's Home Visiting Leadership Council brings together agencies including EOHHS, BHDDH, and DCYF, with the purpose of aligning state policies for evidence-based home visiting programs, secure sustainable funding, support data collection and benchmark measurement, and identify unmet needs of families. First Connections home visitors perform screenings and serve as liaisons between DCYF and EI providers. MIECHV Programs are also working with DCYF to refer families to long term evidence-based programs. DCYF field staff was trained to use KIDSNET to identify preventive services needed by children in foster care.

Federally Qualified Health Centers (FQHCs) - RIDOH programs support FQHCs by funding targeted activities (Title X, Diabetes Prevention, HIV/STD screening and treatment, etc), providing technical assistance and training to staff, and ensuring wrap around services and social supports for patients at the health centers. RIDOH convenes FQHC leadership on a regular basis through the Primary Care Physician Advisory Committee. FQHCs also partner on primary care quality improvement strategies with RIDOH, Care Transformation Collaborative, RI's State Innovation Model, and Medicaid Managed Care Plans. HEI engages regularly with FQHC leadership on CHW strategies.

Health Plans - RIDOH participates in the *PCMH-Kids*, advocating for adoption of best practices for addressing the needs of mother, children, youth and CYSHCN including integrating behavioral health services into the medical home. MCH staff and participating primary care practices and area child psychiatrists in implementing RI's professional child psychiatry referral support system. RI MCH Special Needs staff participate in the Neighborhood Health Plan Medicaid Managed Care Special

Needs Consumer Advisory Committee.

Medicaid - RI MCH worked collaboratively with RI Medicaid to enhance the Early Periodic Screening Diagnosis and Treatment Schedule (EPSDT) benefit and availability of services to reflect updates to Bright Futures and include adolescent transition services. RIDOH staff participates in Medicaid's Consumer Advisory Committee which is convened monthly by EOHHS and charged with ensuring that families' needs are at the center of program decision-making. Through the HRSA Systems Integration Grant, RIDOH and Medicaid transformed the Cedar Certification Standards to reflect shared plan of care principles and best practice in care coordination. RIDOH works collaboratively on implementing evidence-based home visiting program, early intervention, refugee health, oral health, childhood immunizations, lead screening, and child care assistance. RIDOH and Medicaid operate under a collaborative cooperative agreement for comprehensive data sharing.

RI State Systems Development Initiative (SSDI) - The SSDI works to enhance and support data capacity and promote use in needs assessment, program planning, evaluation and quality improvement efforts for MCH. SSDI collaborates with Title V and associated MCH Programs, as well as CHDA, including Office of Vital Records. More recently, SSDI has supported RI's Infant Mortality CoIN through improved availability and reporting of data to inform efforts that drive quality improvement and collaborative learning.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Program - The mission of WIC is to improve birth outcomes of pregnant women and health and development of young children living in poverty. This is accomplished by a combination of assessments, education, referrals and foods prescribed to meet individual needs of those eligible for the program. Key internal collaborators include many RIDOH MCH programs: Family Visiting, Hearing Screening, Immunization, Lead Program, Healthy Housing, Physical Activity and Nutrition, CSHCN, Minority Health, Rural Health, Diabetes Control, Asthma Control, Diabetes Prevention Program, and Tobacco. The WIC works with these programs to help educate the public on WIC services and benefits and identify and enroll eligible families.

FY 2017 Application/FY 2015 Annual Report Update

Needs Assessment Update

129 individuals (Figure 1) responded to a survey, either in person or online. Respondents represented a cross-section of the state including community members, parents/guardians, adolescents, healthcare professions, service providers, and other state agencies. CHE held an open meeting and distributed two public input surveys to people seeking services from Vital Records, WIC, and providers, and solicited input from professionals and families participating in CHE program and other meetings throughout the year. Survey results show no significant shift in the identified needs of the community. There was an increase in participants identifying obesity and nutrition as a community need. Approximately 95.3% of respondents said that the state priorities developed reflected the needs seen in their communities. Behavioral health remains a top concern. Key findings of the surveys and selected data related to the areas of concern identified in the surveys are:

- The top five concerns for **perinatal/infant health** are breastfeeding education & support; parenting education, developmental screening, newborn care, and quality childcare.

Breastfeeding education & support

The percent of children ever breastfed rose 12.6 % from 70.8% in 2010 to 79.7% in 2014 (National Immunization Survey). 2013 PRAMS data reflect 87% were ever breastfed. Rates are highest among those of Hispanic ethnicity (95%) compared to Non-Hispanic (84.2%) women.

Infant Mortality

Although infant mortality rates have decreased, disparities persist. For example, in 2014 the Black infant mortality rate (7.9 per 1000 births) was 2.3 times higher than for Whites (3.4 per 1000).

Infants Born with Developmental Risk Factors

There has been no change in five years in the percent (63%) of infants screened positive at birth for developmental risk factors.

- The top five health concerns for **young children ages 1 to 4** are breastfeeding education & support; growth and development; developmental screening, quality childcare/early education, immunization, and nurturing environment and healthy families.

Quality childcare

The Bright Stars Program conducts early learning program quality assessments. Six hundred ninety programs were participating as of January 2016 (95% of Family Childcare Centers located in a core city compared to 64% in the rest of the state).

Family Visiting

Family Visiting provides information and support around growth and development, parenting, breastfeeding, immunization, and healthy home environments to at-risk families with young children. As of October 2015, 823 families were enrolled in evidence-based home visiting programs.

Immunization

In 2014, RI achieved a vaccination completion rate (for the 4:3:1:3:3:1:4 series) of 76% for children ages 19-35 months. This was higher than the national rate (72%), but did not reach the Healthy People 2020 target (80%).

Lead

The number of children under age six with blood lead levels at or above 15 µg/dl decreased by 76% over the past ten years. However, an increase between 2014 (n=70) and 2015 (n=84) indicates a need for constant vigilance. Of those children tested, those living in the core cities (12.5% elevated) are more than twice as likely to have blood lead levels at or above 5 µg/dl compared to the rest of the state (5.2%).

- The top five health concerns for **children ages 5 – 12** are behavioral and mental health; obesity/nutrition; family support and care coordination; after school care, wellness (healthy diet, physical activity, etc.), and positive youth development.

After School Care

Although licensed school-age child care capacity has grown, it does not meet the need. There are only 4,830 slots for 27,055 (17.9%) children ages 6-12 in the core cities and 6,993 slots for 59,202 (11.8%) children in the remainder of the state.

Asthma

Among children with asthma, 37% were chronically absent from school (missed 10% or more of school days) during at least one school year between 2009 and 2013. Asthma emergency department visits and hospitalization are highest among Black children ages 5-17 (18.6% compared to 7.2% overall).

Insurance Coverage

Insurance coverage rates have improved from 5.2% of children under 18 having no insurance in 2008 to 3.3% in 2014 (US Census, American Community Survey). Despite good coverage, care coordination remains a community concern.

- The top five health concerns for **youth and adolescents age 13-21** are behavioral and mental health; tobacco, alcohol, or other substance use; obesity/nutrition; sexual behaviors (preventing sexually transmitted infections,

pregnancy prevention/knowledge or contraception and effective use, etc.), and positive youth development.

Obesity

Youth Risk Behavior Survey data show no change in the 15% adolescent obesity prevalence from 2005 to 2015. Rates for Hispanic (19%), male (16%), and Black (15%) high-school students were higher than their White (10%) and female (8%) peers. Physical activity (at least 60 minutes five days per week) among all adolescents declined from 81.8% in 2009 to 71.3% in 2013. For high school students 43.7% were physically active in 2015.

Mental Health

The 2009/2010 National Survey of Children's Health estimated that 34% of Rhode Island children needing mental health care did not receive it. During 2015, 10.5% of high school students reported they had attempted suicide, down from 14% in 2013. 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 60.8% felt sad or hopeless compared to 26.4% overall, 34.7% considered attempting suicide in the past year, and 33.1% attempted suicide compared to 11% overall. The RI hospital discharge database has seen a steady increase over the past 10 years in mental health related hospitalizations for children under age 18, from 1797 in 2005 to 2744 in 2014.

Teen Pregnancy

Mirroring the national trend, teen pregnancy rates are declining in RI. The five-year average teen (ages 15-19) birth rate from 2000-2004 was 31.7 per 1000 compared to 18.6 per 1000 in 2010-2014. In 2014, the rate was a record low 15.8 births per 1000 teen girls. 2010-2014 rates are almost double in the core cities (32.7 per 1000) compared to the rest of the state (10.6 per 1000). During 2010-2015, there were an average of over 700 births per year to teens ages 15-19. Despite the downward trend, pregnancy prevention knowledge and contraception remain a concern.

- The top five health concerns for **children with special health care needs from birth to 21 years old** are access to services, family education and support, adequate health insurance coverage, care coordination, and behavioral and mental health.

Early Intervention and Special Education Services

As of June 30, 2015, 6% of children under age 3 were receiving Early Intervention services (7% in the core cities), 7% of preschoolers ages 3 – K were enrolled in Pre-school Special Education (6% in the core cities), and 15% of students K-12 were enrolled in Special Education (17% in the core cities).

Autism

RI Department of Education data show that the number of children in schools diagnosed with autism has risen steadily from 174 in 1997 to 2316 in 2015. Some of this increase is likely due to improved awareness, better screening and evaluation tools, and a broadened definition.

Mental Health

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 11% overall.

- The top five health concerns for **women of reproductive age and pregnant women** are behavioral and mental health, healthy relationships, early prenatal care, prenatal/postpartum care and education, and substance use.

Maternal Depression

According to 2013 PRAMS survey results, 10.5% of women reported experiencing depression during their pregnancy, and 11.9% reported post-partum depression.

Prenatal Care

The percent of infants born to women receiving prenatal care in the first trimester has remained stable at around 87% over the past five years. The method of data collection changed in 2015 when Rhode Island adopted the 2003 birth certificate. Using this method, which is not comparable to previous years and has resulted in a lower rate nationally, 82% of infant's mothers received prenatal care in the first trimester in 2015.

Neonatal Abstinence Syndrome

The rate of drug exposed infants diagnosed with neonatal abstinence syndrome increased from 10 per 1000 in 2008 to 14.1 in 2013. Provisional data for the first three quarters of 2015 show a decline to 9.5 per 1000 births.

Organizational Capacity & Structure

RIDOH, is the lead RI agency addressing MCH-related needs of children and their families. Section 23-13 of the RI General Laws gives RIDOH broad authority for administering Title V MCH services. RIDOH is located within the state's Executive Office of Health and Human Services (EOHHS), a cabinet agency directly reporting to the Governor. (See Supporting Document 1 for organizational charts).

RIDOH strategic priorities are to (1) address the social and environmental determinants of health, (2) eliminate the disparities of health and promote health equity, and (3) ensure access to quality health services for Rhode Islanders including vulnerable populations. Guided by these strategic priorities, RIDOH leadership and EOHHS partners developed 23 Statewide Integrated Population Health Goals to Improve the Health of Rhode Islanders (see Attachment). Each integrated population goal supports one of the following 5 strategies that are greatly influenced by MCH principles: Promote healthy living for all through all stages of life; Ensure access to safe food, water, and healthy environments in all communities; Promote a comprehensive health system that a person can navigate, access and afford; Prevent, investigate,

control, and eliminate health hazards and emergent threats; Analyze and communicate data to improve the public's health.

Further, RIDOH has aligned its organizational structure and investments by creating the Health Equity Institute, which is strategically positioned within the Director of Health's Office to apply a health equity lens to all RIDOH programs and policies, especially priority populations of MCH, people with disabilities and racial / ethnic minorities. RI's MCH Title V and CYSHCN programs reside within the Health Equity Institute. HEI systematically addresses health disparities for people with disabilities and racial / ethnic minorities in each of the population health goals. Specifically HEI provides guidance on data analysis, develop joint work plans, and enlist the MCHB-funded National Center technical assistance as appropriate. The Director's Office provide leadership, vision, communication, and direction across all RIDOH Divisions. It is the responsibility of the Title V MCH Program to assure that MCH initiatives collaborate to ensure a continuous system of care for mothers, children, CYSHCN, and families that is coordinated, comprehensive, and community-based; and to embed MCH priorities in statewide systems improvement initiatives such as SIM, HEZ, Care Transformation Collaborative, Patient Centered Medical Home - Kids Project, SBIRT, behavioral health system, Race to the Top, Children's Cabinet, Early Learning Standards, Prematurity Taskforce, Oral Health Commission, and OHIC Affordability Standards.

MCH Workforce Development

RI's "Peer Support Workforce Initiative", developed under the National MCH Workforce Development Center (WDC), provides Title V leaders training, collaborative learning, coaching and consultation in implementing health reform using a variety of learning platforms.

In 2016, HEI will continue to advance the *Community Health Worker (CHW)* profession by making certification available to CHWs, developing reimbursement pathways, offering training, and supporting infrastructure such as a CHW at the Samuels Sinclair Dental Center and peer CHWs at the RI Parent Information Network.

Culturally and Linguistically Appropriate Services in Health and Health Care

In April 2015, over 50 people were trained and given CLAS assessments to complete at their respective HEZ agencies. HEI and the Chronic Disease program provided an in-person CLAS and cultural competency training to over 30 RIDOH employees and chronic disease partners. HEI continues to provide training to Family Visitors and provides subject matter expertise and technical assistance for CLAS standards and cultural competency.

II. B. 2.c. Partnerships, Collaboration, and Coordination

A network of MCH partnerships and collaborations between state agencies, within the state health department itself, and with community organizations promotes the health of women, infants, and children. These partnerships allow for coordination of programs and strategic use of resources. Updates to RIDOH's partnerships detailed in last year's narrative follows:

RIDOH participates in the *Patient Centered Medical Home Initiative for Children*, advocating for adoption of best practices for addressing the needs of adolescents including integrating behavioral health services into the medical home. MCH staff and participating primary care practices and area child psychiatrists are designing a model of professional child psychiatry referral support modeled after the Massachusetts model MCPAP. A recent adolescent PCMH pilot program promoted use of the validated Rapid Assessment of Adolescent Preventive Services survey to screen for a variety of concerns.

RIDOH has demonstrated Family/ Consumer partnerships in many different ways. Through partnership with RIPIN, RI families and professionals had access to an array of workshops and learning opportunities. Of particular importance to many families was "The Beginner's Guide to Public Policy". It illustrates how parent, family, and individual testimony can speak to the public health needs of a community and/or family. This collaboration was vital to the passing of RI's Temporary Caregiver's Insurance law that allows RI citizens to request 4 weeks of PAID family leave to care for an ill family member or to bond with a new child.

Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

Needs Assessment Goal and Guiding Frameworks. The mission of the Rhode Island (RI) Title V MCH Program is to build integrated systems that support health, growth, and development for MCH populations, including CYSHCN. The primary goal of the RI statewide Title V MCH Needs Assessment is to improve MCH outcomes and strengthen state and community partnerships for addressing the needs of its MCH population. Planning and conduct of the needs assessment followed the Title V MCH Program Needs Assessment Planning, Implementation and Monitoring Process where engagement of stakeholders was the main priority from the outset. The guiding frameworks that informed this process are drawn from: 1) the life course approach that emphasizes the role of early life events in shaping an individual's health trajectory; 2) the Health Impact Pyramid developed by Dr. Thomas Frieden at the CDC, which underscores the impact of interventions that address the socio-environmental determinants of health; and 3) CFHE's Health Equity Framework which aims to achieve health equity for all populations, through eliminating health disparities, assuring healthy child development, preventing and controlling disease and disability, and working to make the environment healthy. These underlying principles inform RI's assessment of strengths, needs and capacities; focusing on how the state is faring in the larger context of addressing health disparities.

MCHB's revised guidance focuses on the health status of the MCH population in the context of 6 MCH population health domains as a way to exhibit contributions of Title V MCH programs in impacting health outcomes across the lifecourse. This framework complements RI's lifecourse approach to health planning and shaped the needs assessment process.

Stakeholder Involvement . Stakeholders engaged in the needs assessment process included staff representing the RI Department of Health (HEALTH) as well as other state agencies; professionals and MCH workforce; youths and families/parents, including those of CYSHCN, who participate in the Division Community, Family Health and Equity (CFHE) program meetings and individuals who participate in other CFHE attended meetings. Additional community input was sought through surveys, community meetings and written feedback.

In September 2014, the RI MCH Program convened an internal Needs Assessment Planning Group (PG) tasked with advising the process. The PG was comprised of staff from various divisions/teams across HEALTH.

Specific to the FY16 needs assessment, stakeholders were engaged in two phases:

i) The Community Input Phase (April 2014-February 2015) consisted of a large public community meeting, open comment session, and surveys of community members and partnering organizations as well as HEALTH staff. Input related to state MCH needs and priorities were collected from over 450 individuals including participating stakeholders. The first phase of stakeholder involvement culminated in the 2015 MCH Community Input Meeting held on February 26, 2015; hosted by CFHE, this event was attended by over 130 people including state officials, partnering organizations, community members, youth, parents and family members. Break-out sessions were organized by population domain; attendees participated in two sessions to discuss and provide feedback on the strengths, needs and capacities of RI's MCH populations and programs. Each session included discussions related to access and utilization of services, health disparities and social determinants of health. Summaries of the discussions and their overarching themes were generated to serve as the basis for the next phase.

ii) The Priority Selection Phase (March 2015–May 2015) was conducted after all qualitative and quantitative data collection activities were complete. A series of meetings with internal PG members and other HEALTH stakeholders were held to discuss and rank priority areas, and to select corresponding NPMs and SPMs for RI's MCH State Action Plan.

Methods and Data Sources. Critically important to the success of RI's MCH Program is the effective use of data to monitor, evaluate, and guide our programmatic activities. Utilizing data from Family Planning, Newborn Developmental Risk Screening, Family Visiting Program databases, among other sources, provide a current picture of the needs of pregnant women, infants, and their families. The Pregnancy Risk Assessment Monitoring System is an additional tool to assess the experiences, behaviors, development, and/or well-being of these populations. Vital Records data allow us to track MCH indicators such as entry into prenatal care, low birthweight, and infant mortality.

Program databases such as WIC, Lead Screening, and Birth Defects provide information on children. RI's KIDSNET system is crucial in tracking data related to children's preventive services and assessment of medical homes. Hospital inpatient and ED visit data and Youth Risk Behavior Survey (YRBS) are examples of tools to assess the well-being of RI's youth. The Behavioral Risk Factor Surveillance System (BRFSS) allows for detailed analyses of adults. These data sources allow HEALTH to analyze trends and health status at different stages of the life course. National surveys, such as the National Survey of Children with Special Health Care Needs (CSHCN), National Survey of Children's Health (NSCH), and National Immunization Survey, provide state-level data on children, including CSHCN. Detailed data briefs were developed from these data sources for each of 6 population domains.

Primary data collection, captured through surveys, assessed RI's top concerns across population domains. A Community Member Survey and Community Organization Survey were administered online and in person. These surveys were fielded between April 2014 and February 2015 with a total of 307 responses. An internal staff survey assessed top priorities for each of the six population domains from programs/divisions across HEALTH including CFHE, Violence Injury and Prevention, Asthma Control, Preventive Services, Immunization, WIC, Oral Health, Newborn Screening, Office of Special Needs, Family Planning, and Healthy Homes and Environment, amongst others. The survey was administered between December 2014 and January 2015 with responses from 24 various programs/divisions. Responses were reviewed and analyzed to assess top concerns for each population domain. Open ended responses were coded for common themes related to service needs, gains and areas for improvement. Similarly, discussions at the 2015 MCH Community Input Meeting were transcribed by note-takers. Detailed notes were reviewed with the RI MCH Program and summarized for general themes pertaining to strengths, needs and capacities. Summary packets included findings from all data collection activities and were utilized for the prioritization phase.

Prioritization process for action plan. The second phase of the needs assessment (March 2015 - May 2015) focused on an internal prioritization process with the PG members and related program managers and staff in a series of meetings to develop and select state priorities for each population domain. Summaries of the quantitative and qualitative data highlighting identified strengths, needs and capacities were reviewed by each team member. With these data and their own programmatic expertise, each team member completed a prioritization tool (See Appendix C), ranking issues related to the specific population on a scale of 1-5 (1=low level of attention needed and 5=high level of attention needed) by four criteria: magnitude, impact, disparity and effort. Ranking scores were tallied and presented during a series of 6 prioritization meetings addressing each population domain with life-course/cross cutting themes overarching all meetings. During the meetings, members discussed the summary of findings, selected potential priorities and measures, action strategies, and set five-year target objectives. At the final meeting, the team developed the Action Table/Plan including final 10 State Priorities, NPMs and potential SPMs.

II.B.2. Findings

II.B.2.a. MCH Population Needs

i. Maternal/Women's Health

Based upon key findings of the needs assessment for the Maternal/Women's Health domain, RI selected "NPM 1 well woman visit - % of women with a past year preventive medical visit." This NPM related to 4 of RI's developed MCH state priorities: improving routine provision of preconception care and education, development and supporting implementation of the Family Visiting Program, improving behavioral/mental health across the life course, and improving access to dental services.

Access to Care

For women, the ability to access preventive services is very important given their longer life expectancies, reproductive and gender specific conditions, and historically greater burden of chronic disease and disability. According to the RI BRFSS, during 2013, the percentage of women with a preventive health visit in the past year was 81.4%, representing a 4.3% decrease from 2009 (85.1%). (NPM_1) In 2012, 19.2% of women age 18 and older reported not having a pap smear within the past three years, compared to the national average of 22.4%; 19.0% of women age 40 and older report not having a mammogram within the last two years, compared to 25.7% nationally.

Early prenatal care is important to identify and treat health problems and influence health behaviors that can compromise fetal development, infant health and maternal health. In RI between 2009 and 2013, 13.3% of women who gave birth either

received no prenatal care or did not begin care until the second or third trimester. Pregnant adolescents in RI are the most likely to delay prenatal care. During 2009-2013, nearly one-quarter (24.4%) of teens aged less than 20 received delayed prenatal care, compared with 12.4% of women aged 20 and older. Racial/ethnic disparities also exist where Black (19.7%), Asian (16.9%), and Hispanic women (16.9%) were more likely to receive delayed prenatal care than White women (10.9%). Additionally, pregnant women living in the four core cities (Central Falls, Pawtucket, Providence and Woonsocket) were nearly twice (1.7 times) as likely to have delayed prenatal care (17.5%) compared to pregnant women in the rest of the state (10.4%).

Pregnancy and Behavioral Health

Behavioral health among women of reproductive age remains an ongoing priority in RI. Data from RI PRAMS indicate that during 2004-2012, the proportion of RI mothers who were diagnosed with depression during pregnancy ranged from 6.8% to 10.0%. The proportion of RI mothers who reported postpartum depressive symptoms (PDS) ranged from 10.3% to 11.9% during 2009-2011. Demographic characteristics that were significantly associated with being diagnosed with depression during pregnancy included education level, marital status, health insurance type, and participation in the WIC program. The community and HEALTH staff survey results of the 2015 needs assessment identified behavioral/mental health as the top issue of concern related to Women and Maternal Health.

Birth Outcomes

Neonatal Abstinence Syndrome (NAS) refers to the withdrawal and series of ill effects often experience by a child born to a mother dependent on illicit drugs or pharmaceutical drugs (most commonly opioids like prescription pain medications or heroin). RI has been tracking rates of NAS as an indicator of birth outcomes. In 2011, 94 babies were born with neonatal abstinence syndrome at a rate of 85.2/10,000 and in 2014 increased to 97 babies at a rate of 92.0.

An infant's birthweight is a key indicator of maternal health. Infants born weighing less than 5 pounds, 8 ounces (2500 grams) are at greater risk for physical and developmental problems than infants born at normal weights. Increased risk of low birth- weight is associated with maternal poverty, smoking and low levels of educational attainment. In 2013, the percent of low birth weight deliveries (<2,500 grams) was 7.0%, representing a 12.5% decrease from the 2009 rate of 8.0%. Among these low birthweight babies, 1.4% were very low birthweight (less than 1,500 grams), a 17.6% decrease from the 2009 rate (1.7%). There are racial and ethnic disparities in rates of low birthweight. In RI between 2009 and 2013, 11.4% of Black infants, 9.4% of Asian infants, and 7.7% of Hispanic infants were born at low birthweight, compared to 6.8% of White infants. In 2013, the percent of primary, low-risk cesarean deliveries in RI was 21.4%, compared to 26.9% nationally. (NPM_2) Because RI's rate is lower than the national average and has been declining in recent years it was not highlighted as a measure.

Summary of Findings

During the 2015 MCH Community Input Meeting, several issues were noted as important to Women/Maternal Health. They include: mental health and substance abuse (e.g. availability and access to education and services, integration of substance abuse and mental health, and the rising concern of NAS); medical home/family centered approach (e.g. expanding access of social service agencies, care coordination for pregnant women, and a family-centered approach for providers caring for families); access to care (e.g. advocacy needed around increased insurance reimbursement for coverage of MCH services); education (e.g. preconception and perinatal health and prevention); and, oral health (e.g. education on the importance of pre-, during, and post-pregnancy oral health to providers and families, and a stronger referral system between medical and dental visits).

Behavioral/mental health persists as a priority issue for pregnant women as well as women of reproductive age in general. Furthermore, stakeholders identified substance use as an integral aspect of behavioral health and noted NAS as a growing problem in RI. Several assets and opportunities were identified as strengths in the current system of care in RI. These include: a psychiatric hospital (Bradley) with recognized success for substance abuse treatment and recovery; expansion of home visiting services that include regular meetings with agencies to facilitate centralized/ family-centered referrals; and the new Health Equity Zones initiative.

ii. Perinatal/Infant Health

Key findings of the Perinatal/Infant Health domain lead to the selection of NPM 4; NPM 4A percentage of infants who are ever breastfed; and NPM 4B percentage of infants breastfed exclusively through 6 months. This links directly to state MCH

priorities of developing and supporting implementation of the Family Visiting Program and increasing awareness and social support for breastfeeding.

Birth Outcomes

The U.S. birth rate has been declining in recent years. In 2013, the US fertility rate was 62.5 per 1000 women aged 15-44 years. At 50.5 births per 1,000, the 2013 RI fertility rate was lower than the national rate. The total number of births among RI residents in 2008 was 12,031 and in 2013, this total decreased 10.3% to 10,788 births. The total births include RI residents who gave birth out of state.

Infant Mortality Rate (IMR) is one of the primary indicators of birth outcomes. During 2009-2013, 362 RI infants died before their first birthday, an average rate of 6.6 per 1,000 births. Among the infants who died during this time period, 263 (74.3%) were low birthweight, 89 (25.1%) were born at normal weights, and 2 (0.6%) had unknown birthweights. Communities greater challenges such as high poverty, unemployment and low literacy levels tend to have higher infant mortality rates than more advantaged communities. For example, the infant mortality rate was 8.3 in the four core cities compared to 5.3 in the rest of the state. In RI, between 2009 and 2013, many minority groups had IMRs greater than the rate for White infants (5.3/1,000 live births). The Black IMR was 11.2/1,000 live births and the Asian infant mortality rate was 6.3/1,000 live births. The Hispanic IMR was 5.8/1,000 live births, compared with 6.3/1,000 live births among non-Hispanics in RI. Provisional data indicate that the 2013 RI infant mortality rate was 6.5 /1,000 live births. (OM_9.1), which is higher than the HP2020 target of 6.0/ 1,000.

In July 2014, with the official expansion of the Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN), HEALTH joined the national initiative. RI has assembled a state team to address its infant mortality rate with a goal to develop and operationalize a state action plan to reduce infant mortality rates and disparities in birth outcomes for black infants. Within the CoIIN are Learning Networks focused on topics that contribute to infant mortality and have specific aims. RI is focusing its strategies on 3 areas: 1) Safe Sleep; 2) Pre/Interconception Health and; 3) Social Determinants of Health.

Safe Sleep

According to RI PRAMS (2009- 2011), 76.9% of mothers placed their infants to sleep on their backs (NPM_5). However, there are disparities in the prevalence of safe sleep practices. Mothers who were aged 30 or older, white, non-Hispanic, married, had more than 12 years of education, had private health insurance, and did not participate in the WIC program had a higher prevalence of placing infants to sleep on their backs compared with their counterparts. Mothers less than 20 years old had a prevalence of 63.2%; mothers ages 20-29 had a prevalence of 74.1%. Black mothers had a prevalence of 61.0%; Hispanic mothers had a prevalence of 66.2%; mothers with 12 years of education had a prevalence of 72.7%; mothers with less than 12 years of education had a prevalence of 67.3%; unmarried mothers had a prevalence of 69.8%; mothers with public health insurance had a prevalence of 70.2%; mothers participating in WIC had a prevalence of 70.3%. (NPM_5).

Risk Identification and Response

Universal newborn screening is the practice of testing every newborn for metabolic, genetic, hearing, and developmental risk factors, which, if left undetected, place a child at risk for serious health consequences or death. All infants born in RI are screened through HEALTH's Newborn Risk Assessment Program. In 2013, 6,558 infants (63% of all infants born) "screened positive," indicating the presence of one or more risk factors associated with poor developmental outcomes.

RI has services in place to address family needs that are identified as a result of newborn and early childhood screening. Home visiting is one type of service. HEALTH, in partnership with community agencies funds four home visiting programs. First Connections is a risk identification and response program. Families receive a visit from a nurse, social worker, or paraprofessional based on newborn developmental screening or a referral before the child is age 3 years. In 2013, 44.9 % of the families who were referred received a visit. HEALTH also funds three long-term evidence based home visiting programs- Healthy Families America, Nurse Family Partnership and Parents as Teachers. As of December of 2014 these programs were serving 621 families with young children. These programs have been shown to foster positive outcomes around child health and education, as well as family self-efficacy.

Surveys of HEALTH staff and external stakeholders stress the importance of these programs. Developmental screening, home visiting, support and education of parents in newborn care, and providing support for breastfeeding, especially as it pertains to perinatal/infant health remain a top priority for RI.

Breastfeeding

From 2009-2013, 64.5% of new mothers in RI indicated that they intended to exclusively breastfeed. One in four new mothers (25.0%) intended to exclusively formula feed and 10.5% intended to use a combination of both breast and formula feeding. Of new mothers surveyed three months after giving birth in 2012, more than 8 out of 10 (82.0%) new mothers in reported having ever breastfed. The highest breastfeeding rates were among mothers who were not WIC Program participants (91.1%); married (90.6%), with private health insurance (89.8%), with more than a high school education (89.3%), of Hispanic ethnicity (89.0%), and aged 30 and older (87.1%). (Source: RI PRAMS)

Toxic Stress

Early exposure to Toxic Stress can result in changes to brain architecture that compromises a child's ability to reach his or her full potential. In 2013, RI was funded to develop a system for identification of and responding to toxic stress/trauma. Based on data, RI has identified two significant groups of children who are at risk; those with three or more risk factors for poor outcomes as identified at birth (n=215) and children birth to three in the child welfare system (n=292). Despite these numbers RI does not have adequate programs and systems to meet the needs of these families, as raised by community members as an important need.

Summary of Findings

During the 2015 MCH Community Input Meeting, several issues were identified as important to Perinatal/Infant Health. Strategies offered included: focusing on maternal mental health and substance abuse through increased screening for behavioral/mental, need to build support and awareness for perinatal mental health, proactive use of toxic stress screening, and addressing the rising concern of NAS; systems coordination and engagement of providers (especially OB/GYN) to conduct preventive screenings – mental health, substance abuse, chronic conditions, etc., improved coordination of efforts and policies by DCYF, and transportation to increase engagement and retention; and providing breastfeeding support through focused education to normalize breastfeeding, and, improved breast feeding accommodations in the workplace, as well as in schools for teen mothers and teachers.

iii. Child Health

During RI's five year needs assessment, childhood obesity and nutrition remained a major concern for the Child Health domain. Due to this finding and additional feedback, RI chose to address childhood obesity and nutrition as one of its 2016-2020 MCH state priorities which also correlates with NPM 8 on physical activity; % of children ages 6-11 who are physically active at least 60 minutes per day.

Children's Health

RI does well supporting child health. The 2011/12 NSCH reported in RI that 86.8% of children were in excellent or very good health compared to 84.2% nationally. (OM_19) In RI, 31.5% of children ages 10 months to 5 years were screened for being at risk for developmental, behavioral and/or social delays using a parent-reported standardized development behavioral screening tool during a health care visit compared to 30.8% nationally. (NPM_6)

In 2014, RI's child death rate for children ages 1 to 14 was 12 per 100,000 children, a decrease from 16 per 100,000 children in 2009. This resulted in RI's national rank improving from sixteenth to third best in the nation. (OM_15) RI is ranked first in the nation for immunizations of toddlers. According to the 2013 National Immunization Survey, 82% of children in RI ages 19 to 35 months were fully immunized compared to the U.S. rate of 72%.

Obesity and Physical Activity

The epidemic of childhood obesity occurring across the nation is also evident among RI youth. It is a problem that affects children of every age and demographic. In 2013, of the 22,185 children ages one to four enrolled in WIC, 11% were obese (2,521). In addition, 55% of postpartum women, and 56% of pregnant and breastfeeding women participating in WIC were either overweight or obese. The 2013 RI YRBS reported 25% of middle school students described themselves as slightly or very overweight. Additionally, 2013 RI YRBS reported 49.8% of middle school respondents and 44.9% of high school respondents reported being physically active at least 60 minutes per day on five or more of the past seven days. (NPM_8) The physical activity rate among RI high school students was slightly lower than the national rate (47.3%).

Injury-Related Hospitalizations

The rate of injury-related hospital admissions per population ages 0-19 years was 1310.5/100,000 in 2013. (NPM_7) Causes of injuries include those related to falls, poisonings, motor vehicle traffic, self-inflicted, and assaults. According to a recent report issued by the Trust for Health and the Robert Wood Johnson Foundation, RI ranks 9th lowest for injury-related fatalities and was graded 8 on a scale of 10 for its efforts to prevent injuries. The state earned points for its laws requiring seat-belt use, child booster seats, and bike helmets for children. It also scored for its efforts to prevent domestic violence and teen dating violence, monitor prescription drug abuse, and protect youth from sports-related concussions.

Behavioral/Mental Health

Behavioral/mental health in childhood and adolescence is defined as the achievement of expected developmental, cognitive, social and emotional milestones and by secure attachments, satisfying social relationships and effective coping skills. Behavioral health problems affect children of all backgrounds. In RI, one in five (19.0%) children ages 6 to 17 has a diagnosable mental health problem; one in ten (9.8%) has significant functional impairment. The 2011/2012 NSCH reported that 34.0% of RI children aged 12-17 who needed mental health treatment or counseling in the past 12 months did receive services compared to 39.0%, nationally.

Summary of Findings

Behavioral/mental health was the focus of many breakout sessions discussions at the 2015 MCH Community Input Meeting. Participants expressed the need for more supports in positive mental health development and better coordination of services between state agencies and community partners. Stakeholders discussed the need for increased capacity to provide pediatric mental health services throughout the state. Navigation of the system, coordination focused around prevention and co-location with other health services were additional needs that were raised. Behavioral/mental health was one of top 5 health issues identified in stakeholder surveys.

Physical activity, obesity and nutrition were also among priority issues identified for children's health. Community input meeting attendees suggested the need to expand WIC services to include farmers' markets, and train practitioners to talk about diet and nutrition.

iv. Adolescent Health

Based on key findings under Adolescent Health, RI chose to address increasing the capacity and efficiency of the adolescent systems of care as one of its state MCH priorities. RI chose NPM 10 - adolescent well-visit due to its associated NOMs which align with our priority of capturing a more comprehensive picture of the health of RI adolescents.

Adolescent Health

The 2011/12 NSCH reported that 89.3% of RI children aged 12-17 received one or more preventive visits in the past 12 months compared to national estimates of 89.7%. (NPM_10) To ensure that all high school seniors are fully vaccinated before beginning college or work, the RI Immunization Program runs Vaccinate before You Graduate (VBYG) in high schools throughout the State. The program informs parents and students of the importance of immunization and holds vaccination clinics throughout the year at each participating school. The immunizations are funded by the State's Vaccines for Children program and are offered at no cost to students. During the 2012-2013 school year, 86 schools participated in VBYG. In total, 8,180 vaccine doses were administered to 6,147 students. The two most administered vaccines were influenza (5,375 doses) and HPV (768 doses).

Teen Pregnancy

Teen pregnancy affects long-term well-being of families and communities and can impact the development of teen parents and their children. During 2009-2013, the teen pregnancy rate (per 1,000 females aged 15-19) among RI teens decreased by 40% from 42.4 in 2009 to 25.5 in 2013. Disparities persist with higher rates among Black/African American teens (62.9) and Hispanic teens (63.5), more than 2.5 times the rate for White teens (24.8) in 2009-2013. Similarly, teens in the core cities (56.1) were 2.6 times more likely to become pregnant compared to teens in the rest of the state (21.5).

Obesity and Physical Activity

RI schools are mandated to provide daily recess opportunities for elementary school students as well as physical activity opportunities (i.e., stretch breaks, athletic programs, etc.) for middle and high schools in addition to physical education

requirements. In 2013, four out of five (76.7%) RI high school students reported attending physical education classes on one or more days in an average week.

Adolescents who are overweight have a 70% chance of becoming overweight or obese adults. In 2013, 25.2% of RI middle school students described themselves as slightly or very overweight. 54.7% of female middle-schoolers and 37% of male students said they were trying to lose weight. According to the 2013 RI YRBS, 10.7% of high school students were obese. Male students were more likely to be obese than female students (13.3% vs 7.8%) and Hispanic and black students were at higher risk for obesity than white students (16.6%, 15.8%, and 8.4% respectively). 60.2% of all female students were trying to lose weight compared to 32.0% of males.

Injury

The rate of injury-related hospital admissions per population ages 0 through 19 years was 1545.4 per 100,000 in 2011, 1449.2 in 2012, and 1310.5 in 2013. (NPM_7) During 2009-2013, there were 98 deaths among children aged 1-14, a rate of 11.5 per 100,000 children. Between 2009-2013, there were 113 deaths of teens ages 15 to 19 in RI, a rate of 28.2 per 100,000 teens. Between 2009-2013 in RI, 46% of the 82 teen deaths caused by injury were unintentional. One-third of all injury deaths involved motor vehicles.

Behavioral/Mental Health

One in five RI children ages 9 to 17 has a diagnosable mental health disorder, and one in ten has a mental health problem that is severe enough to substantially interfere with their functioning at home, in school, or in the community. Despite the high rates of mental health disorders among children, four out of five children do not receive needed treatment and those that do often receive treatment in a setting that does not best meet their needs or the needs of their families.

In 2013, there were 2,737 hospitalizations of children with a primary diagnosis of mental disorder at hospitals statewide. This represents a 53% increase from 2003 (1,794), possibly due to more children and youth being hospitalized for behavioral health problems. It has also been partly attributed to the systemic problem of “pediatric boarders” and “stuck kids.” Inpatient treatment at a psychiatric hospital is the most intensive type of behavioral health care. The most common diagnoses for young people treated in 2014 in an inpatient setting at Butler or Bradley Hospitals were depressive disorders (41%), bipolar disorders (38%), anxiety disorders (12%), and adjustment disorders (5%). The 2011/2012 NSCH reported that 34.0% of RI children age 12-17 years who needed mental health treatment or counseling in the past 12 months did not get mental health services, compared to 39.0% nationally.

The 2013 RI YRBS reports that 18.1% of High School students and 40.1% of middle school students report being bullied on school property (NPM_9). In 2013, 14.3% of high school students reported attempting suicide in the last 12 months. Acute depression was two and a half times more prevalent in the disabled population (42% vs. 17%), and the attempted suicide rate was over three times higher (17% vs. 5%). More than 1 in 4 (25.8%) high school students reported feeling sad or hopeless in the past 12 months. Compared to their peers, emotional disability was more prevalent among lesbian, gay and bisexual high schoolers (31% vs. 13%), and acute depression was 2½ times more common (55% vs. 22%). These students were also 4 times more likely to attempt suicide (29% vs. 7%).

Summary of Findings

Behavioral health, bullying, sexual behaviors, healthy relationships and tobacco, alcohol and substance use were among the top health concerns identified during the needs assessment. Teen suicide is also a rising concern with related root causes. The majority of RI schools provide training for student assistance counselors and peers to recognize the signs of self-injury/suicide as part of their prevention strategies.

Community Input Meeting discussions on Adolescent Health also identified coordination and provision of services a significant issue statewide. Disparities and barriers related to ethnic, cultural, sexual identity issues were noted as well. Care coordination for adolescents in school is challenging, including follow-up care after an initial assessment. Transitions and the need for support in life skills and financial literacy were also identified by stakeholders. Other issues noted include no state oversight and limited awareness of parents of school district health/wellness committees; no standardized prerequisites for health care at colleges or universities; and, lack of access due to coverage and/or geography.

v. Children with Special Health Care Needs

Key findings under the Children with Special Health Care Needs domain feature two national performance measures

(NPMs): medical home (children with and without special needs) (NPM_11) and receipt of services necessary to transition to adult health care (children with and without special needs) (NPM_12). For the CSHCN domain, many of the top concerns and feedback mirrored those of Adolescent Health and identified a need for systems changes. RI chose improving the system of care for CSHCN as a state MCH priority. This correlated with both CSHCN NPMs, NPM 11 - % of adolescents with and without special health care needs having a medical home and; NPM 12 - % of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care.

The 2011/2012 National Survey of CSHCN (reported 21% of RI children have at least one special health care need, compared to 20% nationally). Children with disabilities often receive a broad range of services that include home and community-based services; behavioral health services; and/or hospital-based acute care services. As their care needs are often very complex, many children with disabilities do not have community-based primary care providers, but rely on specialists for much of their primary care. Data from the 2011/12 NSCH show that 8.2 % RI children aged 2-17 currently take medication for ADHD, emotions, concentration, or behavior. However, CSHCN were fifteen times more likely to take these medications (30.3%) than children without special health care needs (1.8%).

Nearly one in five RI children (19.0%) ages 6- 17 have a diagnosable mental health problem; one in ten (9.8%) have significant functional impairment. More specifically, 5.3% of RI children have anxiety problems and 2.9% have depression. In RI, 10.2% of children ages 2-17 have ADD or ADHD as reported by the 2011/12 NSCH compared to 7.9% nationally. The 2011/2012 NSCH reported that 34.0% of RI children ages 12-17 in need of mental health treatment or counseling in the past 12 months did not get mental health services compared to 39.0% nationally. Sixty-nine percent of CSHCN received needed mental health or treatment compared to 50.4% of non-CSHCN in RI.

Medical Home

The needs of children with special needs are best met through a medical home, which can provide care that is comprehensive, coordinated, continuous, accessible and family centered. According to the 2011/12 NSCH, 50.4% of CSHCN and 62.4% of non-CSHCN in RI received care within a medical home compared to national estimates of 46.8% and 56.3%, respectively. (NPM_11) Although 90.0% of all RI children received a preventive health care visit in the past year, CSHCN were more likely to have had a preventive visit (95.7%) compared to 88.5% of children without special health care needs. In RI, 32.6% families of CSHCN reported they were without family-centered care; 22.1% had doctors who never or sometimes spent enough time with their child; 7.9% had doctors who never or sometimes listen carefully; 7.9% had doctors who never provided enough information; and 2.1% had doctors who never are sensitive to their family's values. The 2009/2010 National Survey of CSHCN reported in RI 20.7% of CSHCN ages 12-17 are served by systems of care that meet all age-relevant core outcomes compared to 17.6% nationally.

Pediatric Specialty Services works to provide medical home enhancement for children and youth with special healthcare needs including children and youth with Autism Spectrum Disorder. The Pediatric Practice Enhancement Project (PPEP) ensures a coordinated system of care for children and youth with special needs, and their families, by placing trained parent consultants in pediatric primary and specialty care practices to assist families in accessing community resources, accessing specialty services, and to identify barriers to coordinated care. In 2014, PPEP expanded to 28 pediatric primary and specialty practices throughout the state and served more than 2500 families.

Adolescent Transition

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." The 2009/2010 National Survey of CSHCN reported 43.7% of CSHCN ages 12-17 received the services necessary to make appropriate transitions to adult health care, work and independence compared to 40.0% nationally. (NPM_12). Adolescent transition, behavioral/mental health, and access to services were identified as top priorities.

Impact on Families

The 2009-2010 National Survey of CSHCN finds that many RI families with CSHCN have had financial problems (14.7%), cut work hours or stop working (25.6%), spend 11 or more hours per week providing and/or coordinating care (11.3%). The 2011/12 NSCH reported that 17.3% of CSHCN and 8.4% of non-CSHCN families had trouble paying or were unable to pay child's medical bills compared to national estimates of 19.5% and 8.9% respectively.

Summary of Findings

Stakeholders highlighted limited oral health services, especially those with reimbursements for the CSHCN population. Other challenges included a lack of a continuum of services and coverage for children requiring multiple specialist visits and home based therapy. The burden on families was not only financial. Community Input Meeting attendees, many parents of CSHCN, reported discrepancies how school districts provide special education and involve parents. Some school districts – West Warwick and Central Falls – have partnered with local health centers to provide comprehensive health care to children with special needs. Parents expressed the need for more information about services available for families and called for a focus on prevention rather than crisis intervention.

vi. Cross-cutting/Life Course

To select and develop its state MCH priorities and NPMs, RI solicited feedback on life course issues as well as noted common themes across the other MCH population domains. RI developed four cross-cutting/life course priorities: improve access to dental services; improve system coordination in communities and statewide to facilitate improved health outcomes; improve behavioral/mental health across the life course; and adopt social determinants of health in public health planning and practice to improve health equity. RI chose the following associated NPMs; NPM 1-Well-woman visit; NPM 8-Physical; NPM 10 Adolescent well-visit; NPM 11-Medical; NPM 12-Transitions; and NPM 13 Oral Health; and NPM 15 -adequate insurance coverage.

Oral Health

Oral health during pregnancy is particularly important as pregnancy causes hormonal changes increasing the risk of developing gum disease, which can affect the health of a developing baby. From 2009-2011, 52.4% of RI women visited a dentist or dental clinic during the most recent pregnancy. (NPM_13) Mothers aged 20 and under (39.5%); black (33.5%); Hispanic (47.8%); with less than 12 years of education (45.3%); with public health insurance (40.1%); and participating in WIC (42.6%) had a lower prevalence of a dental visit during pregnancy compared with their counterparts.

Dental caries is the most common disease among children ages 5-17. Children with untreated dental problems are more likely to have issues chewing and swallowing, speech problems, and poor school performance due to difficulty concentrating and absenteeism. According to the 2011/12 NSCH, 76.1% of RI children ages 1-17 had teeth in excellent /very good condition. Minority children have the highest rates of tooth decay and untreated dental problems. Non-Hispanic White children are more likely to have had a recent dental visit than non-Hispanic Black or Hispanic children.

2012 data reports that 89% of RI children had some form of dental coverage (public or private). RI's most vulnerable populations, including CSHCN, have higher disease rates and more limited access to high-quality oral health services. Dental care was the health service most often reported as needed but not received; nationally and in RI, more than 6% and 4% of CSHCN, respectively, needed preventive dental care but did not receive it.

Tobacco Use

The relationship between smoking and illness, particularly lung cancer, the leading cause of cancer mortality among women, is well documented. Smoking is more common among men than women, but takes an enormous toll on both sexes. High quantity and duration of smoking have been shown to have adverse effects on several health conditions, including cancer, heart disease, stroke, and respiratory illness. For women, there are strong negative effects on fertility and pregnancy. According to 2012 BRFSS, 16.2% of RI women age 18-64 are current smokers. According to RI birth certificate data, women reporting smoking during pregnancy decreased from 9.5% in 2009 to 7% in 2013. While this rate has been trending down, pregnant women remain a priority population for statewide tobacco control efforts although it was not chosen as a state priority.

Adequate Insurance

Insurance coverage is critical for determining child health outcomes. RI's ranks 10th best in the U.S., with 94.0% of children with health insurance. Two-thirds of RI children are covered by private health insurance, most of which is obtained through their parents' employers. Employer-sponsored health insurance has eroded in RI over the past decade. From 2010-2012, 61.8% of children were covered by ESI, a 15% decrease from 73.1% during 1999 -2001; and 6% of RI children under age 18 were uninsured, compared with 9.4% of children in the U.S.

(See MCH Population Data Briefs & Population Summaries in Appendix C)

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

HEALTH's CFHE plays the lead role in RI in addressing the MCH-related needs of children, including CSHCN and their families. This role is granted by Section 23-13 of the RI General Laws which provides HEALTH with broad authority for administering Title V MCH services, including services for CSHCN. HEALTH is located within the state's Executive Office of Health and Human Services (EOHHS), a cabinet agency that directly reports to the Governor. (See Appendix B for organizational chart). CFHE is organized into the Office of the Executive Director (OED) and 6 Teams: (1) Preventive Services and Community Practices, (2) Perinatal and Early Childhood Health, (3) Health Promotion and Wellness, (4) Chronic Care and Disease Management, (5) Healthy Homes and Environment, and (6) Health Disparities and Access to Care.

The OED is responsible for providing leadership, vision, communication, and direction to the administrative staff, team leads, and support staff across all six teams. OED includes an Executive Director, a Medical Director, an Interdepartmental Project Manager, Chief of Program Operations as well as MCH Program Manager. This position is responsible for coordinating all MCH activities, including the preparation of the Title V application. It is the responsibility of the OED and MCH Program to assure that MCH initiatives, within HEALTH 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.

II.B.2.b.ii. Agency Capacity

As the recipient of the State's Federal Title V MCH block grant funds, CFHE has the capacity to promote and protect the health of all mothers and children, including CSHCN, and families in the state. CFHE's goal is to achieve health equity for all Rhode Islanders through eliminating health disparities, assuring healthy child development, preventing and controlling disease, preventing disability, and working to make the environment healthy. CFHE uses a life course and health equity approach that addresses the social determinants of health as its framework for health planning. Like elsewhere in the nation, long established and emerging social, institutional, political, and economic conditions and policies continue to influence and shape MCH-related health outcomes in RI.

While CFHE has made significant progress in meeting its Title V PMs and HP 2020 goals, disparities still exist. CFHE offers quality programs, leverages limited resources, and works to assure that all Rhode Islanders achieve optimal health throughout the lifespan through a statewide system of services that are comprehensive, community-based, coordinated and family-centered. This approach is informed by the comprehensive MCH needs assessment, which serves as the foundation for RI's MCH infrastructure.

With HEALTH's focus on a life-course framework, each team under CFHE, as well as HEALTH's Center for Health Data and Analysis (CHDA), has programs that touch each of the 6 MCH domains:

The Health Disparities and Access to Care (HDAC) Team, which includes the Office of Special Needs (OSN) is responsible for assuring equitable systems, empowering communities, and building capacity to promote access to comprehensive high quality services that are responsive to the needs of RI's diverse populations so that they achieve their optimal state of health.

The Healthy Homes and Environment (HHE) Team is responsible for protecting the health and safety of children, workers, and the general public by identifying and decreasing environmental hazards.

The Chronic Care and Disease Management (CCDM) Team is responsible for reducing the incidence, burden, and associated risk factors related to asthma, arthritis, heart disease and stroke, diabetes, and cancer to improve health outcomes.

The Health Promotion and Wellness (HPW) Team is responsible for strategies that support and reinforce healthy living through the life course.

The Perinatal and Early Childhood Health (PECH) Team is responsible for supporting healthy birth outcomes, positive early childhood development, and school readiness in preparation for a healthy, productive adulthood by providing and assuring mothers and children access to quality MCH services.

The Preventive Services and Community Practices (PSCP) Team is responsible for improving the quality of preventive and community services by increasing access and availability to vulnerable populations.

HEALTH also houses CHDA and Vital Records. CHDA leads, supports and coordinates the acquisition, provision and use of clear, accurate and appropriate data and analyses. These activities should inform and drive public health program and policy decisions through internal and external partnerships.

All CFHE's programs work together to ensure a statewide system of services that reflect the principles of comprehensive, coordinated, community-based, family-centered care which are essential for effectively fostering and facilitating MCH activities and goals. CFHE also 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.

This is most exemplified in the Health Equity Zone (HEZ) Initiative, which is a \$2.15M place-based initiative developed by HEALTH in 2015 with funding from the CDC and Title V. HEALTH funded 11 RI non-profit organizations and local governments to support innovative approaches to preventing chronic diseases, improve birth outcomes and improve the social and environmental conditions of local areas. HEZs are designed to address social determinants of health and promote health equity from the community level and thereby affecting change at the lowest level of the population health pyramid by increasing strategic planning, and integration of non-traditional partners to promote health and well-being of within geographic areas and target populations.

Examples of additional agency capacity include:

- CHDA and the RI Department of Education (RIDE) administer the YRBS every other year in RI high schools and middle schools and produces reports linking key health indicators and academic outcomes along with disparities in health including gender, sexual orientation and disabilities; they also have new initiatives focused on linking data and collecting Child Outreach screening data.
- RIDE collaborates with HEALTH on Thrive, RI's coordinated school health program through maintenance of a joint website.
- CFHE convenes the RI Collaborative for Health Equity, a group of state and local stakeholders learning together and sharing resources to support their communities. Communities are supported via the Healthy Places Learning Community and Healthy Places Resource Center, which provide trainings, networking, web-based resources, and TA, to help communities address health equity and disparities.
- CFHE convenes a Healthy Housing Collaborative designed to help move communities towards a more comprehensive approach to healthy housing. RI KidsCount, Annie E. Casey Foundation, and CFHE launched and continue to report the 'health and house' indicator in the KidsCount FactBook.
- Newborn Screening Program coordinates with community-based and hospital-based programs, addressing the needs of families with children who have specific disabilities and disorders.
- OSN and parent consultants worked with parents to develop "medical passports," which contain information about RI services for CSHCN and their families.
- PPEP, a medical home enhancement for children and youth with special needs, ensures a coordinated system of care by placing trained Peer Resource Specialists in pediatric primary and specialty care practices to assist families access resources and identify barriers to coordinated care. PPEP partners with PCMH-Kids to train Peer Resource Specialists as non-clinical case managers to enhance pediatric medical home services.
- HHE coordinates with RI Medicaid, to refer and provide non-medical case management services and family support, and education. CFHE supports a clinic offering lead screening free of charge for uninsured children.
- Successful Start Steering Committee, comprised of community members and state agencies, is responsible for helping to

implement RI's early childhood comprehensive systems plan. An Adolescent Transition Advisory Group also meets to develop systems to support youth and adolescents.

- CFHE and the RI Asthma Control Coalition work to reduce asthma hospitalization and ED visit rates. Asthma in Schools and Clinical Care Committees target youth by addressing the environmental health of schools, communication with school nurse teachers, and improvement in asthma care among PCPs
- WIC Program is co-located within local Community Health Centers and Hospitals providing direct referrals and increased access medical and social services.
- WIC works closely with HPW and local hospitals to promote breastfeeding in the workplace and baby friendly hospitals. Statewide Breastfeeding Coalition has impacted breastfeeding support both in the community and at the legislative level.
- HEALTH coordinates with providers, community based hospitals and health centers to offer recommended vaccines to uninsured children at no charge via a universal vaccine purchase and distribution system.

II.B.2.b.iii. MCH Workforce Development and Capacity

There are 128 FTEs who work in CFHE as state employees. This includes staff that provide planning, implementation, evaluation, and data analysis. In addition, CFHE's staffing configuration includes 8 consultants (which include 2 CDC Prevention Public Health Consultants) and 39 parent consultants (12 of whom work directly at HEALTH and 27 of whom work in community settings). WIC Program budget, including staffing, were transferred to DHS, but the 11 WIC FTE positions are currently located in CFHE. As of 2015, the PPEP has placed 45 resource specialists in pediatric practices serving high volumes of CYSHCN throughout the state in pediatric primary care, specialty care, federally qualified health centers, and hospital diagnostic facilities. All CFHE staff, with the exception of PPEP resource specialists, is centrally located at HEALTH in Providence, RI. See Appendix B for bios of senior level management staff.

MCH Workforce Development. RI's "Peer Support Workforce Initiative" has been developed under the National MCH Workforce Development Center (WDC). The purpose of the WDC is to provide Title V leaders training, collaborative learning, coaching and consultation in implementing health reform using a variety of learning platforms.

Major transformations in the health care and health financing sectors offer opportunities to improve the public health, healthcare delivery, and ultimately, key health outcomes for MCH populations. Title V programs are uniquely positioned to help lead and influence major health system reform as they affect women, children and families.

Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards). RI's Office of Minority Health (OMH) has continually led state efforts to implement the National Standards for CLAS. In April 2015, OMH launched its recently developed CLAS 101 required training for Health Equity Zone grantees and creating a CLAS Toolkit to support development and implementation of the CLAS Action Plan.

II.B.2.c. Partnerships, Collaboration, and Coordination

RI's MCH system of care is organized through a network of partnerships and collaborations between state agencies, within the state health department itself, and with community organizations to promote the healthy development of women, infants, and children including CYSHCN. These partnerships allow for coordination of programs and the strategic use of resources.

RI State Systems Development Initiative (SSDI). The SSDI works to enhance and support data capacity and promote use in needs assessment, program planning, evaluation and quality improvement efforts for MCH. SSDI collaborates with Title V and associated MCH Programs, as well as CHDA, including Office of Vital Records. More recently, SSDI has supported RI's Infant Mortality CoIIN through improved availability and reporting of data to inform efforts that drive quality improvement and collaborative learning.

State Implementation Grant. OSN applied for and was awarded the State Implementation Grant for Enhancing the System of Services for CYSHCN through Systems Integration. To develop a state plan for an integrated system, OSN engaged community stakeholders in examining needs assessment data on the barriers of an integrated system of care for CYSHCN. The system is planned to be a "one stop shop" for information, resources, and referrals to key CYSHCN partners. The plan includes engagement in national learning collaboratives to develop priorities in care coordination, systems integration and

shared resources.

ACA and Medicaid. As an early adopter of the ACA, RI has placed significant emphasis on consumers' understanding of available health care options for themselves and their children. RIPIN contracts with the Office of the Health Insurance Commissioner for RI's Marketplace Consumer Assistance Program. RIPIN has contracted with HealthSource RI to provide consumer assistance with health insurance selection. During 2015, RIPIN worked with OSN to become a Disability Navigator site through the National Disability Navigator Resource Collaborative.

CFHE worked collaboratively with RI Medicaid to enhance the EPSDT benefit and availability of services. PPEP assisted numerous families with CSHCN with insurance, education, and access to mental health services. HEALTH staff participates in Medicaid's Consumer Advisory Committee; convened monthly by EOHHS and charged with ensuring that families' needs are at the center of program decision-making.

CFHE supported the toll-free Family Health Information Line, a statewide resource which refers families to appropriate resources, including Medicaid, SSI, and Katie Beckett. It is staffed by bi-lingual information specialists. Culturally appropriate informational materials for families are distributed through HEALTH's centralized distribution center.

Early Childhood Comprehensive Systems (ECCS). Successful Start, RI's ECCS initiative is a partnership between CFHE, the DHS and RIDE. The initiative includes instituting developmental screening by PCPs at 9, 18 and 30 months.

Family Visiting. CHFE's Home Visiting Leadership Council brings together agencies including EOHHS, BHDDH, and DCYF, with the purpose of aligning state policies for evidence-based home visiting programs, secure sustainable funding, support data collection and benchmark measurement, and identify unmet needs of families. First Connections home visitors perform screenings and serve as liaisons between DCYF and EI providers. MIECHV Programs provides comprehensive evidence-based home visiting services to pregnant women and families with children up to ages two or three, depending on the model. MIECHV Programs are also working with DCYF to refer families to long term evidence-based programs. DCYF field staff was trained to use KIDSNET to identify preventive services needed by children in foster care.

Family Consumer Partnership and Leadership Programs. A main tenant of CFHE's OSN is parent/professional partnership through supporting, empowering, training, hiring, and promoting decision making, policy development, service provision, and community development. As an example of this partnership, HEALTH led a Family Leadership Development Institute to develop an RI network of family leaders to make a positive impact on schools, communities and in health care arenas. Parent education and workshop sessions are provided through RIPIN, Parent Support Network and Sherlock Center for Disabilities. Through this collaboration, 50 families participated in the Agents of Transformation Training that educated parent mentors in accessing the children's welfare and children's mental behavioral health system. Throughout RI, over 1000 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. Resource Specialists are culturally diverse family members with experience accessing MCH services and are assigned to CFHE programs based on the program's need for parent and consumer participation. They are full partners in policymaking, outreach, and program quality assurance and evaluation. Since 2014, the OSN has invested in hiring and supporting Youth Resource Specialists due to their invaluable input into the transition process and generating self-determination resources.

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,700,000	\$1,636,953	\$1,700,000	\$1,624,486
State Funds	\$1,910,912	\$1,594,822	\$2,079,960	\$1,815,653
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$2,423,241	\$1,812,718	\$0	\$0
Program Funds	\$22,718,744	\$26,516,547	\$28,726,379	\$29,444,033
SubTotal	\$28,752,897	\$31,561,040	\$32,506,339	\$32,884,172
Other Federal Funds	\$40,341,758	\$45,188,729	\$75,202,279	\$67,953,126
Total	\$69,094,655	\$76,749,769	\$107,708,618	\$100,837,298
	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,700,000	\$1,647,805	\$1,900,000	
State Funds	\$2,071,934	\$1,921,703	\$2,167,896	
Local Funds	\$0	\$0	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$30,958,381	\$30,515,416	\$34,000,771	
SubTotal	\$34,730,315	\$34,084,924	\$38,068,667	
Other Federal Funds	\$76,482,469	\$65,403,192	\$72,533,251	
Total	\$111,212,784	\$99,488,116	\$110,601,918	

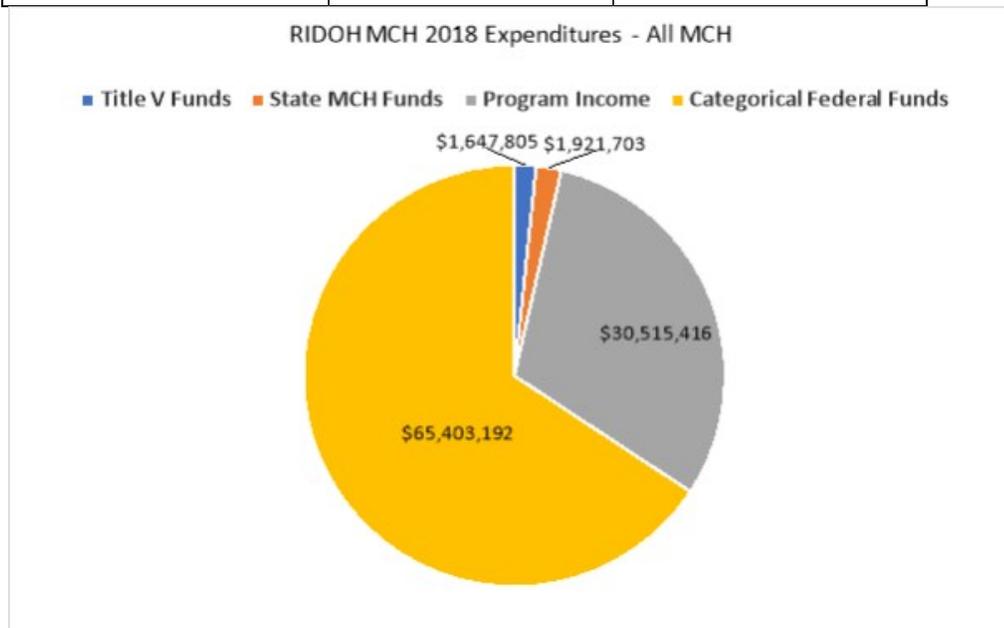
	2020	
	Budgeted	Expended
Federal Allocation	\$1,950,000	
State Funds	\$2,281,459	
Local Funds	\$0	
Other Funds	\$2,450,041	
Program Funds	\$38,024,089	
SubTotal	\$44,705,589	
Other Federal Funds	\$66,841,053	
Total	\$111,546,642	

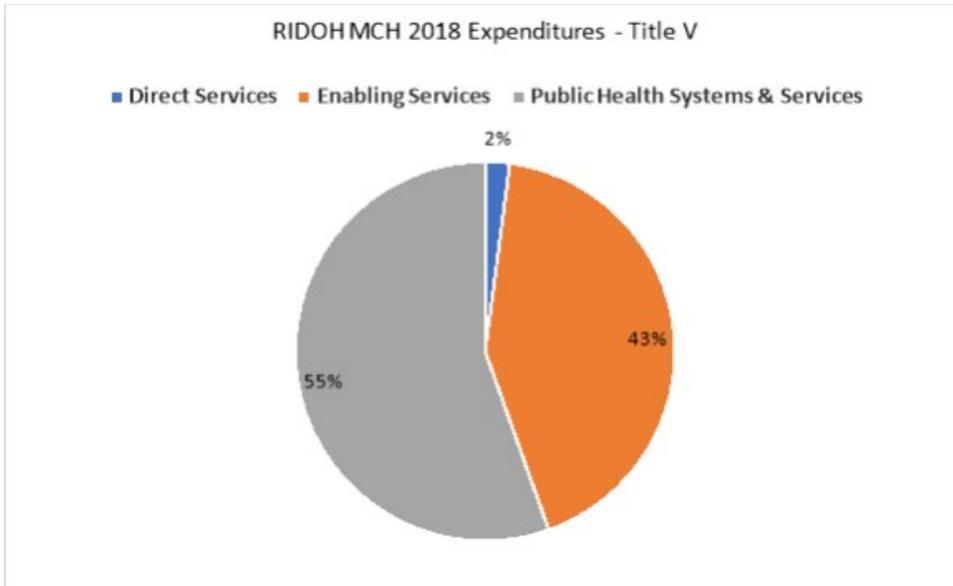
III.D.1. Expenditures

2018 Expenditures (forms 2, 3a, 3b)

For SFY18, the federal allocation funding of \$1,647,805 was fully expended. The amount of State Funds expended is \$150,231 less than budgeted due to a reduction of maternal and child health expenditures by \$12,297, associate director expenditures by \$15,529 and newborn screening expenditures by \$122,405 compared to the SFY18 Governor’s recommended budget request. There is also a decrease of \$442,965 for Program Funds which is related to the immunization revenue.

	2018	
	Budgeted	Expended
Federal Allocation	\$1,700,000	\$1,647,805
Unobligated Balance	\$0	\$0
State Funds	\$2,071,934	\$1,921,703
Local Funds	\$0	\$0
Other Funds	\$0	\$0
Program Funds	\$30,958,381	\$30,515,416
Subtotal	\$34,730,315	\$34,084,924
Other Federal Funds	\$76,482,469	\$65,403,192
Total	\$111,212,784	\$99,488,116





The FY17 budget partially supported 12 full time RIDOH employees and two seasonal interns for a total personnel cost of \$382,591. General office and program supplies accounted for 3.75% of the total budget (\$61,903) and consisted of costs for printing, copying, information technology, breastfeeding marketing materials, statistical analysis software, and incentives for our PRAMS program. Consultant costs made up 27% of the total expended and was primarily allocated towards our Rhode Island Parent Information Network (RIPIN) Resource Specialist program (\$162,050), John Snow Inc. (JSI) Child Death Review analysis (\$27,740), and the First Connections contracts (\$70,232). Our contractual budget totaled \$705,168 with supporting the Health Equity Zones (HEZ) at a total cost of \$368,086. Other major contracts include the RIPIN Family Voices program (\$204,123) and the Teen Outreach Program (TOP) contracts (\$34,267).

Rhode Island’s HEZ initiative is an innovative, community-led, place-based model that brings people in a defined geographic area together and invests in helping them build the infrastructure needed to achieve healthy, systemic changes at the local level. 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. In Rhode Island, there is at least one HEZ in each of the state’s five counties. 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 (\$538,557 at 32.68%) and at least 30% for Children with Special Health Care Needs (\$661,914 at 40.17%). The proportion of federal MCH funds expended for FY18 for Administrative Costs is 6.45% (\$106,225), which is under the allowable 10%.

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

Rhode Island previously had a low rate of grant spending for direct services. For FY18, there was \$34,267 expended for direct services for Community Health Education for Teen Pregnancy Prevention. \$699,884 (42.47%) of the FY18 budget was spent on enabling services. The largest portion, 55.45% of the FY18 budget, (\$913,654) was spent on public health systems and services.

2018- 2019 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, \$197,919 was approved through this process. The projects are outlined below.

Program	Amount Requested	Project Name	Project Description
Newborn Hearing/KIDSNET	\$ 25,000.00	Migrating RITRACK into KIDSNET	Migrate newborn hearing screening database (RITRACK) Data into KIDSNET
PAN	\$ 4,999.00	RI Health Schools Coalition Breakfast	Primary sponsor for the breakfast that brings together over 300 individuals from school districts across the state
Adolescent Transition	\$ 15,000.00	Youth Advisory Council	Support for logistics to run Youth Advisory Council
Family Visiting	\$ 1,170.00	Car Seat Safety Checks	Home visitors will be trained as passenger safety technicians
SEN Taskforce	\$ 25,000.00	SEN Strategic Planning	Strategic planning/visioning process that will incorporate short and long term plans
Safe Sleep	\$ 25,000.00	Safe Sleep Flip Book	Design and printing of safe sleep flip book that can be used by home visitors and other service providers
Oral Health	\$ 25,000.00	expansion SEAL RI!	Innovative strategies to improve Seal RI! Uptake including: new consent form process, hire dental hygienist to work with program, develop newsletter, purchase The Sealant Book, update the Seal RI! Brochure
Violence and Injury Prevention	\$ 20,000.00	Youth Sport Concussion Prevention Program	Outreach and coordination with schools to promote knowledge and utilization of neuropsychological online testing for student athletes.
Health Equity Zones	\$ 10,000.00	HEZ Training and Technical Assistance	Contribute to contract with Health Resources in Action Technical Assistance and capacity building for all HEZ.
West Warwick HEZ	\$ 25,000.00	Trauma-informed schools	Provide trauma informed training to school social workers, grandparents raising grandchildren, and community campaign
LAUNCH/Family Visiting	\$ 21,750.00	Family Involvement in RIDOH's Early Childhood Program	Create and sustain parent advisory committee, trained on how to run "Parent Cafés" in Woonsocket and West Warwick

III.D.2. 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 2020 Governor's Recommended budget for RIDOH is a total of \$188,616,584 which is \$32,240,040 (17.09%) in general revenue, \$106,001,980 (56.2%) in federal funds, \$49,974,564 (26.5%) 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 2018 budgets:

1. **Division of Central Management (\$14,720,679)** 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 (\$7,171,557)** 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 (\$13,145,439)** 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 (\$18,360,053)** 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 (\$108,422,912)** 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 (\$13,689,640)** 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 (\$13,106,304)** 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 FY2020, RIDOH proposes to spend \$1,950,000. 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 \$558,343 (28.6%) of the total budget. Similarly, travel costs are spread across all Title V population domains for a total \$28,458. General office and program supplies are classified as Administrative costs and are budgeted at \$44,100. 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 \$273,000 consultant budget consists of support for our Behavioral Risk Factor Surveillance System (\$10,500), Youth Risk Behavior Survey (\$25,000), 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 prenatal/postnatal systems development (\$45,000) 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, \$250,000 is reserved to support the approved Venture Capital Requests (VCR) during the 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 \$1,950,000 proposed, 46.53% (\$907,343) will support Enabling Services and 53.47% (\$1,042,657) will support Public Health Systems and Services.

Budget Details by Type of Individuals Served

The FY2020 MCH Title V budget allocates 15.61% (\$304,400) for pregnant women, 35.9% (\$700,069) for children with special care needs, 33.5% (\$653,309) for preventive and primary care services for children and 3.84% (\$74,942) for administrative costs.

Health Equity Zones

HEZ are partially funded through the Title V MCH block grant and funding is categorized across population domains. The HEZ initiative supports local communities that have documented health disparities, poor health outcomes, and poor social and environmental conditions. HEZ are funded to identify and prioritizing health issues, develop and implement plans of action, and monitor and assess success. A braided funding approach, using both state and

federal dollars, is utilized to support HEZ. RIDOH went through a new solicitation for HEZ in which ten (10) agencies were funded throughout the state, which consisted of seven (7) existing agencies (Cohort 1) and three (3) new agencies (Cohort 2). The Title V contribution from the FY20 budget is \$500,000. This funding will support multiple MCH projects including but not limited to:

- **Breastfeeding support groups** (Baby Cafés, community integration with WIC, breastfeeding resource materials in community baby packets)
- **Community Health Workers (CHWs)** - training and placement in local organizations to encourage utilization of MCH services, provide linkages and referrals to clinical, safety-net, and social services, and to provide education and training.
- **Nutrition/Healthy eating** - building community gardens, increasing access to farmers markets, increasing WIC utilization, cooking classes, and community meals
- **Oral Health** - encourage utilization of school based health services
- **Parent Engagement/Education** – Parents As Teacher, Incredible Years, Familias Unidas
- **Physical Activity** – physical activities at summer meal sites for children, after school dine and move programs, recess campaigns, scholarships for bike camps/sports camp, memberships to YMCA/Boys and Girls Club, promote RI Great Outdoor Pursuit
- **Youth engagement** – youth groups, advisory councils, snow removal program for elderly, teen outreach program (TOP), Dare to Dream, CYSHCN transition to adulthood
- **Reproductive/preconception health** – promotion of local Title X services, peer to peer outreach and marketing campaign, targeted outreach to primary care providers, partnerships between clinical services and school districts, increased hours for sexual education in health classes at High School
- **Mental Health** – suicide prevention, mental health referrals, improve systems of care for children in need of urgent mental health consultation
- **Infant Health** – Project LAUNCH, collaboration with Family Home Visiting Programs, safe sleep promotion (build a bed), welcome baby packets at birthing hospital
- **Policy** – educate lawmakers on need to recess law, build support among school administrators and municipals leaders for physical activity.
- **Social Determinants of Health**
 - built environment - improve bike paths, walking paths, green space
 - safety - walking school bus, improve relationships with police, non-violence training
 - housing - abandoned/dilapidated housing
 - toxic stress – workshops on restorative practices, alternative approaches to school discipline, toxic stress education for community leaders and partner organizations
 - food insecurity - implementation of a community-wide food insecurity screening

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.

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 six months, 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 is 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 RIDOH's 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.



Addressing 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 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 updates. 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, socioeconomic, 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.

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 women, 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. 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

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

Ana Novias – Executive Director of Health, previous Title V Director

Deborah Garneau – Co-Director, Health Equity Institute and current Title V/CSHCN Director

Jaime Comella – Program Manager, Title V MCH Program

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

Blythe Berger – Chief, Center for Perinatal and Early Childhood

Kristine Campagna – Deputy Chief, Center for Perinatal and Early Childhood

Sam Viner-Brown – Chief, Center for Health Data and Analysis

Ellen Amore – KIDSNET Program Manager

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 front line staff meetings are 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 by providing opportunities for CHWs to obtain their hours through teaching evidence-based programs. Additionally, 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 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 on in RI schools. RIDOH was a lead sponsor and exhibitor at the event.

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 2018. Roughly 50 students attended each session for a total of 200 nursing students from RI College receiving training on oral health.

OB/GYNs – 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 women. Aside from being provided with various *TeethFirst!* resources, including the newly updated flipbook that includes information about pregnant women, dental providers were able to strategize and discuss how best to identify and communicate with women of child bearing 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 HEX Learning Networks and to individual HEZs.

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

RIDOH has partnered with the RI Parent Information Network's (RIPIN) to support family partnerships.

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 (DCYF)
- 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 if 1 per month) in various communities upon request, and in our 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 that we cover 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)
- 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 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. An orientation/kick-off session is planned for July 2019 for interested parents. Once participants are selected and oriented, regular meetings will take place over the course of the next year. This work will be 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.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The State Systems Development Initiative (SSDI) supports MCH data collection and reporting in several ways including: the creation and update of a 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 revised HRSA minimum and core dataset guidance and update of SAS code to match the guidance; review of all RI measures to recommend modifications, eliminations, or additions to national and state performance, outcome and process measures to align with new Title V guidance; working with Vital Records staff to improve timeliness of access to birth and death data; successful completion of AMCHP's e-learning data communication technical assistance with a focus on RI maternal morbidity and mortality data; 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 exploring 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 2 of the 8 to 4 of 8 (Birth, Death, Newborn Hearing, and Hospital Discharge). Direct access to PRAMS has been proposed. 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 that are underway.

III.E.2.b.iv. 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.

^[1] U.S. News & World News Report. (n.d.). *Health Care Rankings*. Retrieved on July 11, 2019, from www.usnews.com/news/best-states/rankings/health-care

^[2] *2019 Rhode Island Kids Count Factbook*. (2019). Providence, RI: Rhode Island KIDS COUNT.

^[3] Economic Progress Institute of RI. (2018). *Rhode Island is tied for second lowest rate of uninsured in New England and fourth lowest in the country thanks to the Affordable Care Act*. [Press Release]. Retrieved from www.economicprogressri.org/wp-content/uploads/2018/09/PRESS-RELEASE-Census-Health-Care-Press-Release-FINAL.pdf

^[4] *Rhode Island Community health Centers Healthcare Heroes 2017-2018 Annual Report*. (2019). Providence, RI: Rhode Island Health Center Association.

^[5] *Key determinants of rural health in RI, 2016*. (2016). Providence, RI: RI Department of Health.

^[6] US Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2018). *1115 Medicaid demonstration approval letter*. Retrieved on July 11, 2019, from <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf>

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

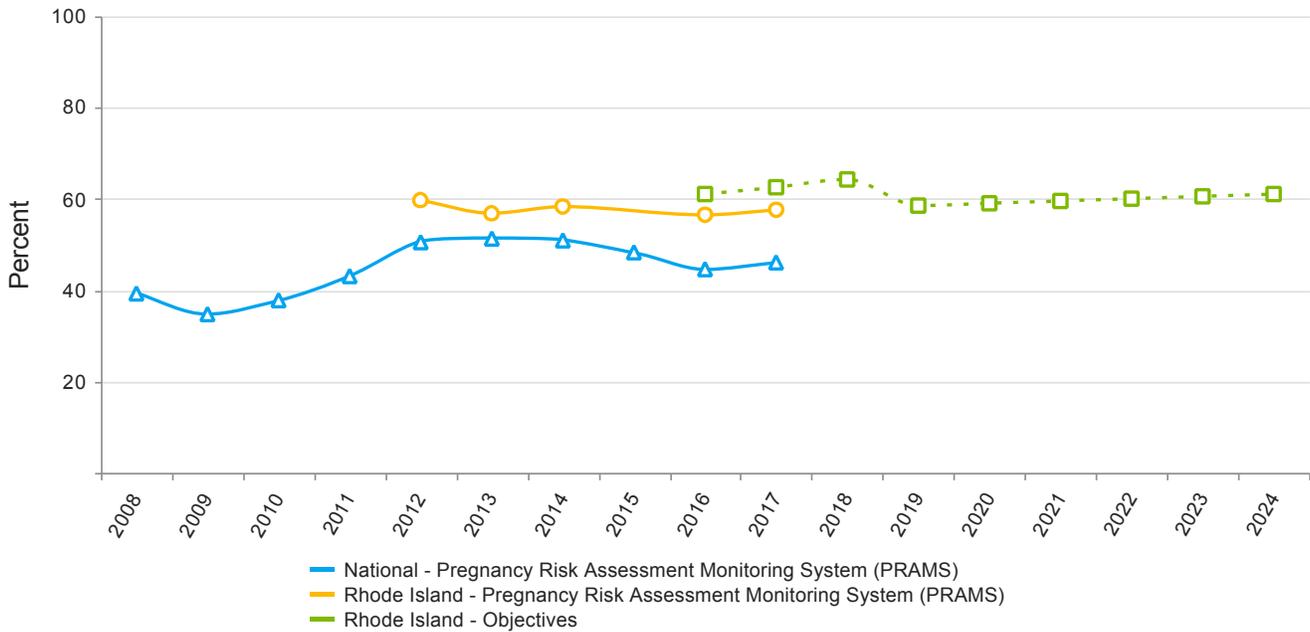
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	8.5 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.5 %	NPM 13.1

National Performance Measures

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
Annual Objective	61	62.5	64.2
Annual Indicator	58.4	58.4	57.7
Numerator	5,897	5,897	5,697
Denominator	10,093	10,093	9,869
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2014	2017

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	58.5	59.0	59.5	60.0	60.5	61.0

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Number of healthcare providers trained on Oral Health

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	250.0	250.0	250.0	250.0	250.0	250.0

State Performance Measures

SPM 5 - Effective Family Planning Methods among Title X Clients

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	64.5	66.0	67.0	68.0	69.0	70.0

State Outcome Measures

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	31.2	29.0	26.8	24.6	22.4	21.2

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	13.5	13.0	12.5	12.0	11.5	11.0

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

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	18.4	16.3	14.2	12.1	9.9	7.8

State Action Plan Table

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

Priority Need

Improve access to oral health services (Women/Maternal Health)

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

Increase the percent of women who had a preventive dental visit during pregnancy from 58.4% in 2014 to 67.6% in 2020.

Strategies

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 perinatal women and infants.

Pilot an electronic dental referral and data collection system between dental and medical providers.

Incorporate dental referral functionality into electronic health record systems used by perinatal medical providers and Federally Qualified Health Centers with OB/GYN services.

Continue to 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.

Continue to promote oral health resources and communication about early dental visits and oral health care for pregnant women through the TeethFirst! bilingual campaign for parents.

ESMs

Status

ESM 13.1.1 - Number of healthcare providers trained on Oral Health

Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

Improving routine provision of preconception care and education (Women/Maternal Health)

SPM

SPM 5 - Effective Family Planning Methods among Title X Clients

Objectives

Increase the percentage of Title X female clients who use a most to moderately effective family planning method from 61% in 2017 to 66% in 2020.

Strategies

Support family planning at Title X agencies.

Promote routine pregnancy intention screening with the OKQ.

Coordinate Preconception Health social marketing campaign.

Improve coordination of transition from OBGYN to primary care.

Integrate preconception care into undergrad/graduate/continuing education and training for clinical providers and allied health professionals.

Promote reimbursement of Long-Acting Reversible Contraceptives (LARC) during post-partum period.

Survey providers to assess current policies and practices related to preconception care.

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

Priority Need

Improving routine provision of preconception care and education (Women/Maternal Health)

SOM

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

Objectives

Decrease the five year average birth rate among Hispanic teens from 33.4/1,000 female teens in 2018 to 29.0/1,000 female teens (ages 15-19) in 2020.

Strategies

Support family planning at Title X agencies.

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

Priority Need

Improving routine provision of preconception care and education (Women/Maternal Health)

SOM

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

Objectives

Decrease the five year average birth rate among non-Hispanic Black teens (ages 15-19) from 14.0/1,000 in 2018 to 13.0/1,000 in 2020.

Strategies

Support family planning at Title X agencies.

State Action Plan Table (Rhode Island) - Women/Maternal Health - Entry 5

Priority Need

Improving routine provision of preconception care and education (Women/Maternal Health)

SOM

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

Objectives

Decrease the teen pregnancy rate (ages 15-19) in RI core cities from 22.6/1,000 female teens in 2016 to 16.3/1,000 in 2020.

Strategies

Support family planning at Title X agencies.

Women/Maternal Health - Annual Report

Women's Health refers to the health of women of child-bearing age, usually 15-44, although demographics show that this age range has been widening. Maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care. Preconception health is an area that focuses on women's health before she becomes pregnant. 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. Preconception care was chosen as a priority need based on the 2015 needs assessment. Last year, RI also chose to move its priority around oral health - improve access to oral health services - into the women's/maternal domain and selected NPM 13a (# of women who received a preventative dental visit during pregnancy).

Maternal Health Data

Preconception Health

PRAMS data indicate that 38.5% of women had an unintended pregnancy, a gradual decrease from 42.2% in 2012-2015. While trends have been improving for all populations, disparities exist with 33.1% of Non-Hispanic Whites, 45.6% of Hispanics 45.6%, and 61.9% Non-Hispanic Blacks reporting unintended pregnancies. 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. Cigarette smoking before pregnancy has decreased from 2015 (11.6%) to 2018 (8.6%), although this trend may not account for the prevalence in electronic cigarette use. According to PRAMS, the percentage of women who used multivitamins daily was 37.4% between 2014-2017.

Access to Care

According to BRFSS, 79.7% of women received a past year preventive medical visit in 2017, a slight increase from 77.3% in 2016. Cost also appears to be a factor in access to care. Among women with a household income of \$35,000-\$49,999, 14.2% reported that they were unable to see a doctor because of cost, compared to 6.9 % of women with a household income \$50,000 or greater.

In 2018, 82.7% of infants born to pregnant women received prenatal care beginning in the first trimester, a slight increase from 81.7% in 2017. Furthermore, 1.5% of infants were born to pregnant who received late or no prenatal care in 2018, a slight decrease from 1.6% in 2017. Adequate prenatal care is a calculation that measures the appropriate utilization of care during pregnancy using two dimensions: timing of prenatal care initiation and number of expected prenatal visits. In 2018, 63.3% infants were born to pregnant women who received adequate prenatal care, a statistically significant decrease from 75.2% in 2017. Hispanic (58.0%) and Non-Hispanic Black (57.5%) pregnant women had less adequate prenatal care than Non-Hispanic White pregnant women (67.0%) for 2018.

Health During Pregnancy

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. Birth 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, 8.1% had gestational hypertension/preeclampsia, and 5.4% smoked tobacco during pregnancy.

Delivery and Postpartum Health

In 2018, 27.2% of women had cesarean delivery with a low risk first birth. The percentage of non-medically indicated early elective deliveries for 2018 was 2%. This percentage represents a continued increasing trend from 2017 with 25.2%. Between 2014 - 2018 there were less than 10 maternal deaths in RI. The 2017 maternal morbidity rate was 239.6 per 10,000 delivery hospitalizations, which increased from 209.0 per 10,000 in 2016. Hospital discharge data from 2013-2017 show that non-Hispanic Black women (306.0 per 10,000 delivery hospitalizations) had a higher

maternal morbidity rate than non-Hispanic White women (179.4 per 10,000 delivery hospitalizations). Lastly, 2016 PRAMS data show that percentage of women reporting symptoms of postpartum depression was 12.6%, a slight increase from 11.2% in 2015.

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 2018, the RI Oral Health Program contracted with two physician consultants to conduct academic detailing visits to pediatrician, family practice, and OB/GYN offices. Dr. Lisa Littman, an OB/GYN, visited six OB/GYN offices to speak with staff on the importance of oral health during pregnancy and the need to make referrals to dental offices and then left additional materials for the providers. The materials included the National Consensus Statement on oral health during pregnancy (a combined brochure on oral health during pregnancy and the age one dental visit), an Rx pad to use as referral form and consent for the pregnant woman to receive dental care, and other relevant materials.

Dr. Jennifer Levy, a practicing family physician, performed academic detailing visits to pediatrician and family practice provider offices. Dr. Levy provided support incorporating oral health into well child visits and distributed 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 pursued 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. Interagency weekly meetings were put on hold in the summer due to a Department of Administration approval review process, the need to resolve United Way 211 directory coding and interface issues, and to allow time for the IT build. Because of this additional review process, monthly data collection about dental referrals is delayed. The RI Oral Health Program anticipated testing this new system in September 2019.

- ***Incorporate dental referral functionality into electronic health record systems used by perinatal medical providers and Federally Qualified Health Centers with OB/GYN services.***

The RI Oral Health Program continues to work with FQHCs to discuss this possibility. Unfortunately, no FQHC has decided to digitize the existing oral health referral RX pad resource into electronic health record systems. The OB/GYN Rx referral resource, which was adopted from Connecticut, helps decrease any potential concerns among dentists in treating pregnant women by providing them with a signed form from a patient's OB/GYN provider that states routine dental care may be given.

- ***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 2018 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 2nd annual Oral Health Night.

Efforts to Outcomes is the case management database utilized by RI's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs. Staff from the RI Oral Health Program and the RIDOH MIECHV program continue to regularly pull and analyze oral health assessment and referral data from two of the three RIDOH MIECHV programs. For all of 2018, there were 85 referrals were made for infants and pregnant women and 275 dental referrals total have been made since August 2016.

While there were no direct trainings of RIDOH Home/Family Visitor front line staff in 2018, an oral health presentation was given to the Successful Start Steering Committee, an interagency birth to 3 stakeholder group. The mission of this body is to ensure the development of policies and approaches that help populations of vulnerable children. As a result of this presentation, RIDOH Home/Family Visiting programs were able to order additional TeethFirst! supplies and DCYF committed to disseminating Age 1 resources. Additional outreach locations included: Pawtucket Red Sox games, pride fest, state lead poisoning centers, Narragansett Indian tribal events, and the Warwick Mall.

- ***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 Oral Health Program continues to maintain a partnership with RI KIDS COUNT and its TeethFirst! initiative, which is dedicated to educating families, providers, and community organizations about the age one dental visit. A mid-year contract modification allowed RI KIDS COUNT to produce additional copies of the TeethFirst! bilingual patient education flipbook, order more TeethFirst! branded toothbrushes and brochures, and conduct focus group research of dental hygienists about the age one dental visit and providing dental care to pregnant women. Through RI KIDS COUNT, the RI Oral Health Program purchased an additional 4,250 TeethFirst! Age 1 brochures, 4,250 TeethFirst! pregnant women and Age 1 combo brochures, 1,000 TeethFirst! toothbrushes, and 425 TeethFirst! flipbooks between April and July 2018. All toothbrushes were branded with the TeethFirst! Logo and will be distributed in a variety of locations where families may visit.

Priority: Improve Routine Provision of Preconception Care and

- ***Support family planning at Title X agencies.***

RIDOH's Family Planning Program supports twenty-eight family planning services sites, including twenty-three federally qualified community health center sites, three school-based health centers, a teen clinic operated by Planned Parenthood of Southeastern New England, 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 women, 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 CY2018, Title X agencies provided family planning services to over 29,000 women, men, and adolescents. Among unduplicated Title X clients served in CY2018: 26% were less than 20 years of age; 21% 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.

- ***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® 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. Six of eight Title X have implemented routine pregnancy intention screening with the OKQ model; the other two Title X agencies are working on systematically scaling up screening. RIDOH Home Visiting programs have 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. RIDOH Family Planning has presented on pregnancy

intention screening at 2018 Reproductive Health Summit, the 2018 Neonatal Abstinence Syndrome Conference, and the 2018 Conference on Youth Sexual Health Education.

- ***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. As of May 2019, the Right Time has been downloaded by 2,500 users.

- ***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 and Prematurity Task Force conducted a Contraceptive Access Survey to RI clinical providers to assess providers’ perceptions of barriers to contraceptive access. With over 100 responses, RIDOH presented survey findings to Medical Directors of RI insurance companies to facilitate discussion of postpartum LARC reimbursement for commercial insurance plans. RIDOH has worked with the insurance companies to assess existing practices for LARC reimbursement to identify any potential barriers to access. 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.

Other Programs/Projects Related to Women/Maternal Health

Adult Immunization Registry – During the 2019 legislative sessions, RIDOH proposed legislation to expand the

State's childhood immunization registry to include adults. With passage of the bill, the Immunization Program and KIDSNET will move ahead to finalize development of the Rhode Island Child and Adult Immunization Registry and begin testing and implementation. 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. 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, 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 - The maternal mortality rate in RI for the five years 2013-2017 is 11.2 per 100,000 live births. During this five year period, there were 6 cases of maternal deaths (death within 42 days of giving birth). 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. RI is plans to stand up a functioning MMRC by the end of 2019.

AMCHP Infant Mortality Collaborative Improvement and Innovation Network (ColIN) - is a multi-year national initiative supported by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Service Administration (HRSA). ColINs 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. ColIN 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 ColIN. Two policy initiatives are being pursued through this work: 1) increasing access to Doula's and 2) revising the current birth center regulations. Recently, AMCHP was successful in recruiting Dr. Joia Crear-Perry of the National Birth Equity Collaborative, to become RI's team coach. RI is thrilled to be working with Dr. Crear-Perry and looks forward to learning from her during the remaining year of the project.

Disparities in Infant Mortality (DIM) Advisory Board - When undertaking the IM ColIN 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 women 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 meets monthly to discuss data, consider the perspectives of women 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. During the first year of the group we found out that members of the nonprofit sector were putting forth a doula reimbursement bill with the state legislature. With the drafting of this bill, and the invitation to the DIM group of the policy analyst responsible for writing the bill- RIDOH saw an opportunity to inform regulatory revisions that could produce the intended results and increase the capacity of the state's doula workforce, through appropriate reimbursement for time spent with clients and the services provided. The Doula Bill (H5609), introduced by RI state representative Marcia Ranglin-Vassell, introduced this legislative session, and have would mandated reimbursement for doula services by both private and public insurers, but referred to House Finance for analysis. 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 - Seeking improved access to low-intervention models of care, the MCH Program saw an opportunity to help revise key facilities regulations through a process that mandated every state agency to re-open and revisit all of its regulatory processes. The Birth Centers Regulatory Advisory Committee (BCRAC) was 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 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. The regulations are expected to go through the formal review process again this summer/fall before they are codified.

Maternal Psychiatry Resource Network (MomsPRN) Program - The MomsPRN Program is a new statewide initiative at the RI Department of Health, funded by HRSA-18-101 Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program, that seeks to assist obstetrical, adult primary care, pediatric, and adult psychiatric providers in optimizing behavioral health care for pregnant and post-partum women. To achieve this end, a psychiatry consult line that is staffed by perinatal experts at the Center for Women's Behavioral Health at Women and Infants Hospital is available to help answer clinical and referral questions among calling providers caring for pregnant and postpartum women. Additional individualized quality improvement coaching will be provided to prenatal care practices seeking to implement maternal behavioral health screening, referral and treatment into their workflow. Ongoing continuing education and evaluation efforts will be used to enhance care, identify improvements,

share best practices, and measure outcomes.

Doula Workforce Study - RIDOH conducted a cross-sectional survey via Survey Monkey to collect information on doula demographic characteristics, doula training and practice, and doula client characteristics in RI. The survey was anonymous and voluntary. Thirty four 34 Doulas participated and twenty-six (26) completed the entire survey. The information will be used to inform the work of the MCH Program.

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. From 972 unique women, 1785 referrals were made through the CHN. Of the 1785 referrals made to the CHN, 208 unique women were referred to LSP and participated 511 times; 529 women were referred to gyms, Jazzercise, yoga, and smoking and participated 3910 times; 212 women were referred to HCP and participated 318 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 state-wide 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 20 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 Program Manager (PM) has worked with the WCSP for the past 21 years and all WCSP staff have worked together with the program for over 13 years. 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.

Plans for Next Year: Women/Maternal Health

In the next grant period, the Oral Health Program will engage in the following strategies related to the oral health of women:

- **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 women 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.

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.

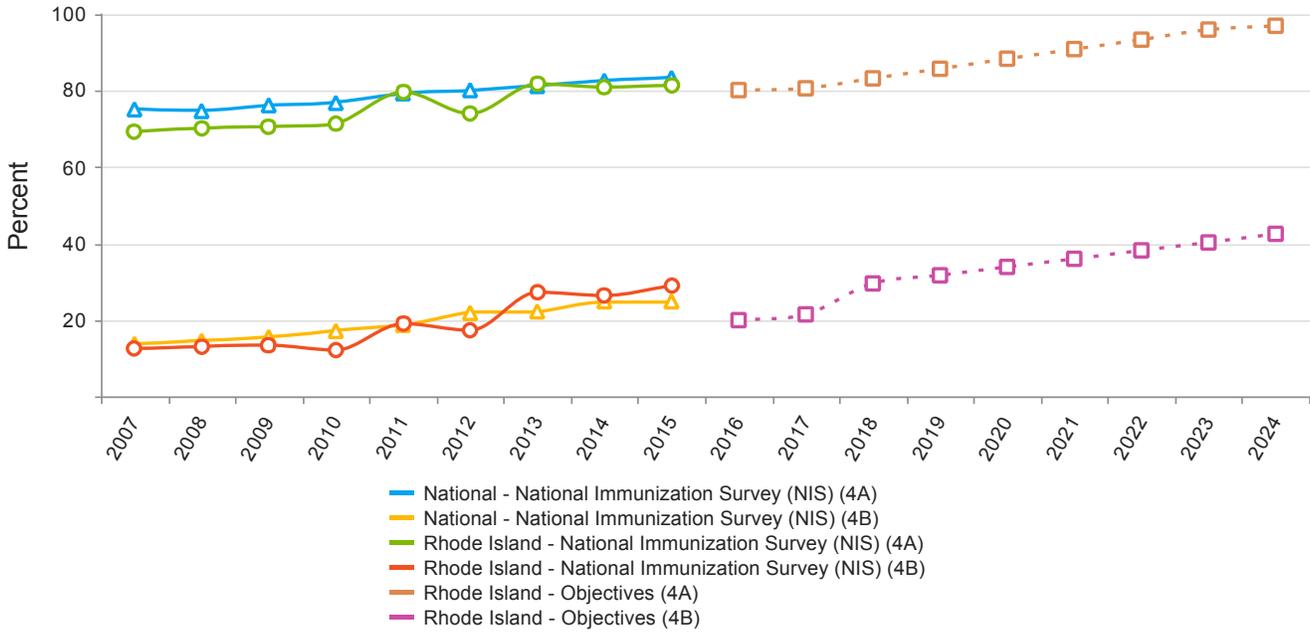
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	5.6	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.2	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 4

National Performance Measures

**NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives**



NPM 4A - Percent of infants who are ever breastfed

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	85.6	88.2	90.7	93.2	95.8	96.8

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	31.7	33.9	36.0	38.2	40.3	42.5

Evidence-Based or –Informed Strategy Measures

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	99.7	99.7	99.7	99.7	99.7	99.7

State Performance Measures

SPM 3 - Depression screening for primary care givers enrolled in family visiting

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		80	90.9	
Annual Indicator	76.2	89.6	89	
Numerator	474	524	412	
Denominator	622	585	463	
Data Source	Family Visiting Database	Family Visiting Database	Family Visiting Database	
Data Source Year	2016	2017	FFY 2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	92.3	93.6	95.0	96.3	97.6	98.9

State Outcome Measures

SOM 5 - Post-Partum Depression

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	12.8	12.0	11.3	10.5	9.7	9.0

SOM 6 - Black/White Infant Mortality Rate Ratio

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.5	2.0	1.7	1.5	1.2	1.2

SOM 7 - Percent of Children Living in Poverty

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		20	18.4	
Annual Indicator	20.4	19.4	16.6	
Numerator	43,282	40,675	33,818	
Denominator	212,038	209,667	203,723	
Data Source	ACS Population estimate (B17001)	ACS 2016 Population estimate (B17001)	ACS 2017 Population estimate (B17001)	
Data Source Year	2015	2016	2017	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	15.5	14.4	13.3	12.2	11.1	10.0

State Action Plan Table

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

Priority Need

Increase breastfeeding awareness and social support (Perinatal/Infant)

NPM

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

Objectives

Increase the percent of infant who are ever breastfed from 80% in 2017 to 83% by 2020.

Increase the percent of infants who are exclusively breastfed from 26% in 2017 to 29% by 2020.

Strategies

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

Support efforts to increase the number of racial and ethnic minority IBCLCs.

Support baby-friendly hospitals statewide.

Support workplace lactation accommodations in accordance with state law.

Create breastfeeding data workgroup.

ESMs

Status

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

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

Continue to support the implementation of the Family Home Visiting Program (Perinatal/Infant Health)

SPM

SPM 3 - Depression screening for primary care givers enrolled in family visiting

Objectives

Increase depression screening for primary care givers enrolled in family visiting from 89.6% in 2017 to 93% by 2020.

Strategies

Use evidence-based screening tools to identify family needs and make appropriate referrals

Identify, engage, and retain individuals at risk for poor outcomes

Continue to support and maintain a high-quality professional development system for family visiting staff.

Sustain and expand the Family Visiting Program.

State Action Plan Table (Rhode Island) - Perinatal/Infant Health - Entry 3

SOM

SOM 5 - Post-Partum Depression

Objectives

Reduce the percentage of women who experience postpartum depressive symptoms following a recent live birth from 12.6% in 2017 to 9.9% in 2020.

Strategies

Develop and maintain a model of mental health consultation within the family visiting program.

State Action Plan Table (Rhode Island) - Perinatal/Infant Health - Entry 4

Priority Need

Continue to support the implementation of the Family Home Visiting Program (Perinatal/Infant Health)

SOM

SOM 6 - Black/White Infant Mortality Rate Ratio

Objectives

Decrease the Black/White Infant Mortality Ratio from 3.8 in 2017 to 2.0 in 2020.

Strategies

Convene Disparities in Infant Mortality Advisory Board implement identified activities and strategies.

State Action Plan Table (Rhode Island) - Perinatal/Infant Health - Entry 5

Priority Need

Continue to support the implementation of the Family Home Visiting Program (Perinatal/Infant Health)

SOM

SOM 7 - Percent of Children Living in Poverty

Objectives

Decrease the percentage of people living in poverty from 19.4% in 2017 to 16.4% in 2020.

Strategies

Use evidence-based screening tools to identify family needs and make appropriate referrals

Perinatal/Infant Health - Annual Report

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. Indicators of infant health, including rates of preterm birth, low birth weight, and infant mortality are considered indicators of the health of a population and its children. 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 also working to reduce infant mortality by improving breastfeeding rates and safe sleep practices. Emphasis is placed on identifying pregnant and parenting families who are at high risk of negative outcomes and linking them to appropriate services.

Child Births

The total fertility rate of the U.S. in 2017 is 1,765.5 births per 1,000 women. In comparison, the Rhode Island fertility rate was lower at 1,508.5 per 1,000 women. In 2018, the total number of maternal resident RI births was 10,502, a decrease of 3.0% from the total number of maternal resident RI births in 2014 (10,831). This trend is not uniform across ethnic groups; from 2015 to 2018, there was a 55% decrease among Non-Hispanic White births and 26.2% increase in Hispanic births.

Low Birth Weight

In 2018, there were 798 infants were born with low birth weight, this represents 7.6% of all infant born. Of those, were 137 (1.3%) infants had very low birth weight (less than 1,500 grams) and 6.3% had moderately low birth weight (1,500 – 2,499 grams). Ninety-five percent 95.6% of all very low birth weight infant were born in a Rhode Island Level III NICU hospital. Racial disparities are also observed in low birth weight babies. The difference in low birth weight between non-Hispanic White (6.5%) and Non-Hispanic Black (11.1%) births is 4.6 per 100 births. Due to the high correlation between birth weight and gestational age, low birth weight tends to serve as a proxy measure for preterm birth.

Prematurity

The preterm birth rate in Rhode Island is 8.9% in 2018. This represents an increase from the preterm birth rate of 8.2% in 2017. Early preterm birth, defined as a birth at a gestational age less than 34 week, represented 2.6% all births. Late preterm birth, gestational age 34-36 weeks, represented is 6.3% of births. Preterm birth has been associated with other pregnancy risks in Rhode Island such as gestational hypertension and previous preterm birth. The difference in preterm births between Non-Hispanic White (8.0%) and Non-Hispanic Black (11.1%) births is 3.1 per 100 births.

Infant Mortality

Provisional data for 2018 indicate that the infant mortality rate in RI is 4.6 infant deaths per 1,000 live births. The perinatal infant mortality rate in is 4.8, the neonatal mortality rate is 4.0, and the post neonatal mortality rate is 1.0 per 1,000 live births. The preterm-related mortality rate in RI is 219.0 per 100,000 live births. In 2018, there were less than ten cases of Sudden Unexpected Infant Death (SUID). The Black/White infant mortality ratio for 2016-2018 is 3.8:1, with Non-Hispanic Blacks having infants having a mortality rate of 12.8 per 1,000 live births compared to that of Non-Hispanic White infants with 3.4 per 1,000 live births.

Newborn Risk Screening/Family Visiting

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. Of the 6,860 infants born in 2018 who were risk-positive for poor developmental outcomes and were not deceased, 2,432 (35.5%) received a home visit.

Breastfeeding

In 2017, 92.2% of RI resident births occurred in hospitals designated as Baby Friendly. According to 2017 NIS data, 80.5% of RI infants were ever breastfed and 21.5% of RI infants were breastfed exclusively through 6 months. Of the 7,769 women who initiated breastfeeding at maternity hospitals in 2017, women who had less than 12th grade education (49.0%), were single (51.1%) and had public health insurance at delivery (55.7%) had the lowest rates in Rhode Island.

Other Birth Outcomes

Hospital discharge data in 2017 shows that 112 newborns were discharged with neonatal abstinence syndrome, this represents a rate of 110.6 per 10,000 delivery hospitalizations. This is an increase from 2016 with a newborn rate of 95.1 per 10,000 live births. In 2016, PRAMS data shows that 77.2% of mothers reported that they most often place their infants to sleep on their backs. The 2017 birth defects prevalence rate in RI was 328 per 10,000 live births.

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 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 annual 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 ~ Olneyville 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 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 will be hosted on the RIDOH Breastfeeding website to be easily accessible. 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 will be distributed to WIC clinics and Family Visiting programs. Electronic versions of these materials will be 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 ~ Olneyville, 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 Peer 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 annual 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.

- ***Provide education on breastfeeding resources such a free breast-pumps and insurance coverage benefits.***

Edits to the RIDOH breastfeeding website are being completed 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, information on insurance benefits such as breast pumps, 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. This was an activity that was going to be supported by the CDC SPAN funding. 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 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. This was an activity that was going to be supported by the CDC SPAN funding.

Priority: Support the Implementation of the Family Visiting

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, for more than 20 years, RIDOH has supported First Connections, a RI grown, short term family visiting program. Prioritized populations, 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 home visiting programs without strong collaborations with key stakeholders and partners. Many of the community and state partners sit on the 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 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 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 visiting local implementation team meetings to discuss relevant topics including flu, T-Dap and varicella, school-based vaccination clinics. The family 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 care for pregnant women as well as the age 1 dental visit.
- *Project LAUNCH* - identifies families that may benefit from family visiting. Family visiting continues to conduct regular developmental screenings and offers families services available through Project LAUNCH, such as Incredible Years and mental health consultation in pediatric practices. Project LAUNCH and the Family Visiting Program will be facilitating a parent/caregiver advisory council that will begin in July 2019.

- ***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 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.

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

As of June 2019, MIECHV is at 90% contracted capacity. The Family Visiting program remains committed to working with RI's most vulnerable families and providing support at critical points during the life course. By working with community partners such as the birthing hospitals, healthcare providers, substance use providers, Department for Children, Youth and Families (DCYF), family 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 high-risk families on long, term, evidence-based home visiting. The family 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 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 Visiting program provide clear guidelines for consistent efforts to engage and retain families, as does ongoing sub monitoring of program implementation. Family visiting agencies are encouraged to use continuous quality improvement to test strategies to support both initial engagement and retention in family 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, working with refugee families, children with autism, infant feeding, breastfeeding, self-care, oral health, and supporting mothers with maternal depression. RI recently requested technical assistance from HRSA and is aligning the family visiting professional development plan with new national core competencies. RIDOH is also receiving technical assistance from HRSA on a standardized orientation processes for all new family visitors, supervisors, and program managers. 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 Visiting Program works closely with RI's Association for Infant Mental Health to support family visitors and provide training related to behavioral health. In addition, the Family Visiting program has begun offering Brazelton training to some family visitors and will expand this offering in 2019 and beyond.

- ***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, 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. 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 in next 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.

Perinatal/Infant Health & Health Equity Zones

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.

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 develop and build a comprehensive system of supports for women, newborns, and families by providing prevention and intervention opportunities to avoid or ameliorate the outcome of prenatal substance exposure along. This work is done across the continuum of care using the life course approach.

RIDOH staff play a key role in the leadership and administration of the SEN Task Force which meets bimonthly (every two months) and employs a dynamic workgroup structure as follows:

1. Education: This workgroup is tasked with developing and disseminating Neonatal Abstinence Syndrome education to a variety of groups including but not limited to healthcare providers, early childhood providers, peer recovery coaches, substance use providers; and patients, and patients
2. Hospital Policy: This workgroup is tasked with providing guidance and support for hospitals in their development of appropriate and consistent policies regarding identification and support for substance exposed newborns and their families
3. Prenatal Referral and Linkage to Care: This workgroup is tasked with developing reciprocal referrals between prenatal providers, substance use treatment providers, and family visiting with family choice and family-focused coordination
4. Peer Recovery Coaches: This workgroup is tasked with training and supporting a growing cohort of recovery coaches working specifically with with new and expectant parents in recovery

SEN 2018 Achievements:

- 79 people attended the 3rd Annual SEN Conference held October 19, 2018 at Rhode Island College, the purpose of which was to increase knowledge and decrease bias around families impacted by substance use.
- The SEN Interagency Coordinating Team was convened in August 2018 in response to recommendations that came out of Rhode Island's participation in the National Governor's Association Learning Lab on Addressing Maternal Opioid Use Disorder to Prevent and Reduce the Effects of NAS.
- Rhode Island participated in the ASTHO OMNI Learning Community in August 2018 from which an Action Plan was developed with a focus on increasing screening for substance use disorder and decreasing stigma.
- 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,

particularly the Pawtucket/Central Falls HEZ.

- Plan of Safe Care was launched July 1, 2018. Through March 31, 2019, 69.9% of the 253 identified substance exposed newborns born in RI and their caregivers received a Plan of Safe Care, with a total of 253 new referrals documented on those Plans of Safe Care.
- RI presented as part of an ASTHO OMNI webinar (March 2019). RI presented at the ACF's Regional Head Start Meeting on the Opioid Crisis in NH (April 2019). RI served on a panel at the NGA's Capacity Building Meeting in IN (June 2019).
- The SEN Task Force commenced a strategic planning effort that will run through 2020. A Key Stakeholder Group was convened, focus groups and a retreat are scheduled later this summer.
- The First Connections NAS Pilot launched May 2019 to bring First Connections into Women & Infants Hospital and follow families back out into their communities.
- 18 trainings on substance exposed newborns and Plan of Safe Care were held for pediatric residents, pediatricians, outpatient treatment providers, Birth Defects Advisory Council, Home Visiting, and the VA Medical Center Community Task Force.

Safe Sleep - A Safe Sleep Workplan was developed, the goal of which is to decrease infant sleep-related deaths throughout the state through training, education, resources, and community outreach. A Safe Sleep Program Coordinator was hired at 50% effort in January 2018. The Coordinator is responsible for a comprehensive safe sleep education program. The Coordinator also chairs the monthly Interagency Safe Sleep Workgroup comprised of representatives from the RIDOH (including Title V), Department of Children, Youth and Families (DCYF), the State's Family Visiting Program, Early Intervention, and WIC amongst others. In 2019, the Safe Sleep Interagency Workgroup expanded its membership to include the following community-based organizations: Federal Hill House, Youth Build Prep, Women's Resource Center in Newport, and One Neighborhood Builders. RI is participating in the Child Safety Network's Safe Sleep Learning Collaborative

A two-hour training was developed. The objectives of the training include: understand 2016 American Academy of Pediatrics safe sleep recommendations; safe and unsafe sleep products and environments; barriers to practicing safe sleep; and, strategies to having effective safe sleep conversations with families. The following groups were identified as being priorities for safe sleep training in 2018: Family Home Visiting, EMS, WIC, DCYF, Early Intervention, and Early Headstart. Through 2018-2019 Eight safe sleep trainings were held for early education providers, early head start, early intervention, home visiting, police cadets.

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 also provided over 10,000 copies of a DCYF-purchased book titled, "Sleep Baby Safe and Snug". These books are being disseminated to families as part of their discharge packets. Additionally, NIH Safe Sleep information sheets in English and Spanish have been provided to hospitals for further patient education, and these sheets are currently being translated into Portuguese and Creole to support safe sleep education for these groups.

RIDOH has also required First Connections agencies within the Family Home Visiting Program become Cribs 4 Kids distribution sites. A tracking form was established by the Safe Sleep Program to ensure follow-through and information regarding who was receiving these cribs. All First Connections agencies became Cribs For Kids distribution centers, distributing 17 cribettes to families in need to-date.

The Safe Sleep Program also provides safe sleep information to the community at large. In 2018, Safe Sleep information was distributed at Parenting Matters, Youth-BUILD, Narragansett Indian Tribe Women's Day, Immunization Provider Conference, and a HEZ Learning Community Event in Warwick. More events are planned. A Safe Sleep

PSA aired on the local ABC Channel 6 in February-March 2019.

Linking Actions for Unmet Needs in Children's Health (LAUNCH) - The goal of LAUNCH is 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 builds 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.

According to the 2010 census, the three identified communities have a combined population of about 142,439. Between 2008 and 2013, there were 10,378 children who were born to families in these communities; approximately 64% of them were born to mothers who had 2 or more risk factors. Needs assessments document that these communities do not have the service capacity to meet the needs of the children birth to eight years who are at high risk. The specific LAUNCH 2015 activities will provide direct services to approximately 1,000 families. LAUNCH 2015 has a goal of providing 40% of its services to identified subpopulations, which would provide some amelioration of disparities. During 2018 and the first quarter of 2019, LAUNCH supported a total of 7 evidence-based Incredible Years parenting groups in the South County and Newport areas for parents of toddlers, preschoolers, and school aged children. In addition, LAUNCH delivered mental health consultation in primary care practices in all 3 communities and provided program-focused mental health consultation in 4 early care and education centers.

Newborn Screening Program - provides universal newborn screening for 32 core blood disorders, Critical Congenital Heart Disease, Hearing and Developmental Risk Assessment. In October 2018, RI began screening for 3 new conditions, Pompe, Adrenoleukodystrophy, and Mucopolysaccharidoses. 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 five specialty clinics (endocrine, metabolic, hemoglobin, cystic fibrosis, and immunology) are responsible for reporting the diagnosis and treatment plan of all infants identified with a positive screen.

In 2018, 100% of infants received a newborn blood spot screening and 99.8% were screened for Critical Congenital Heart Disease (CCHD). 93.6% of infants with a positive newborn bloodspot screening received a confirmed diagnosis. The Newborn Screening Program and the Birth Defects Program continue to collaborate to track and identify cases of CCHD. Both programs trained the Cardiology Clinic to report confirmed cases of CCHD in the provider's Birth Defects Registry.

Quality Improvement (CQI) initiatives are in place to ensure high rates of screening and follow up care. Some other CQI initiatives include specimen collection occurring within 24-48 hours of life, specimens arriving at the New England Newborn Screening Laboratory within 24 hours after collection, completion of all fields on the filter specimen slips, timely reporting of confirmed diagnosis into the electronic health information system, KIDSNET, yearly site visits at the five birthing hospitals, quarterly hospital report cards, monitoring data and system level issues, and ongoing review of policies and procedures by the Newborn Screening Advisory Committee. This Committee 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. Members include health care providers, public health experts, and people involved in delivering services, follow-up, and treatment in the state. The RI Newborn Screening Advisory Committee meets on a bi-monthly basis.

The Use and Retention Policy for Residual Blood Specimens was approved by the Newborn Screening Advisory

Committee and the Director of Health. Specimens will be stored for 23 years. Research involving residual specimens collected on or after March 18, 2015 will require parental consent. Research involving residual specimens collected prior to March 18, 2015 will be reviewed and approved by the Newborn Screening Advisory Committee and the Department of Health's Institutional Review.

The Newborn Screening Program implemented Saturday courier service to help improve the timing of specimens arriving at the regional laboratory located in Massachusetts. 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. One new condition, Spinal Muscular Atrophy has been recommended to be added to the Recommended Uniform Screening Panel for newborns. The Newborn Screening Program will work to build the infrastructure to screen for this new condition.

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. The focus of RI's EHDI program is to implement a high-quality EHDI continuum of care, by ensuring newborns and infants throughout RI receive, and remain engaged in, appropriate and timely services, which include meeting the Joint Committee on Infant Hearing's (JCIH) 1:3:6 recommendations of screening by 1 month of age, confirmed diagnosis by 3 months of age, and Early Intervention by 6 months of age.

RI has successfully expanded the existing EHDI Advisory Committee and has implemented a wider multidisciplinary committee with representation from various organizations. The overall goal of this expansion is to increase the knowledge and engagement of all EHDI stakeholders and discuss how to effectively contribute and participate in the EHDI system, while also stressing the importance of improving the outcomes for children who are deaf and hard of hearing. RI EHDI has identified a number of EHDI partners, pediatric health providers, families and other stakeholders willing to engage in a shared learning sub-committee to facilitate adoption and implementation of innovations within the RI-EHDI system at the community level. Sub-committees will be designed to provide an opportunity for stakeholders to explore improvement areas for systems issues, and to report updates and recommendations identified to the RI-EHDI advisory committee in order to achieve the 1:3:6 goals set by the JCIH in each community for parents of children identified with a hearing loss.

The Newborn Hearing Program has sustained and improved its successful universal newborn hearing screening and follow up efforts in FY 2018. This was accomplished by ensuring that all infants born in the state of RI are provided with a continuum of care from screening to Early Intervention services. Using quality improvement methodology addressing follow-up, audiological reporting, home birth population and border babies, RI continues to improve NBHS lost to follow-up rates. Specifically, the RI EHDI program conducted a continuous quality improvement project focused on decreasing the referral rate for diagnostic audiological assessment. As a result of this project and changes in protocol, the referral rate for diagnostic testing decreased from 25.7% in 2017 to 14% in 2018. The reduction in diagnostic referral rate both lessened the burden on RI diagnostic centers and led to an improvement in diagnosis by 3 months (per JCIH 1:3:6 guidelines).

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 providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services. It serves roughly 22,000 women, infants and young children throughout Rhode Island, approximately 53% of the births in the state of RI, overall serves approximately 73% of the total WIC eligible population, based on the 2018 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 will build a rapport with the participant, provide ongoing education and will promote and support 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 birthing 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; Physical Activity and Nutrition Program; Oral Health; Health Equity Zones (farmer's markets, breastfeeding promotion and support); Center for Emergency Preparedness and Responses (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 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 (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-vaccine testing is completed and referral to the Pediatric Liver Clinic for follow-up care as needed.

Plans for Next Year: Perinatal/infant Health

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. 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.

Family Home Visiting - In the past seven years, three evidence-based family visiting programs have been implemented that meet the unique need of families. RI uses MIECHV federal funding to support the implementation of the following evidence-based models: Healthy Families America (HFA), Nurse-Family Partnership®(NFP) and Parents as Teachers (PAT). In addition, RIDOH has managed First Connections, a short term, post-partum home visiting program for decades.

There are four key priorities and goals that RIDOH Family Home Visiting Program will continue to focus on in 2019:

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.

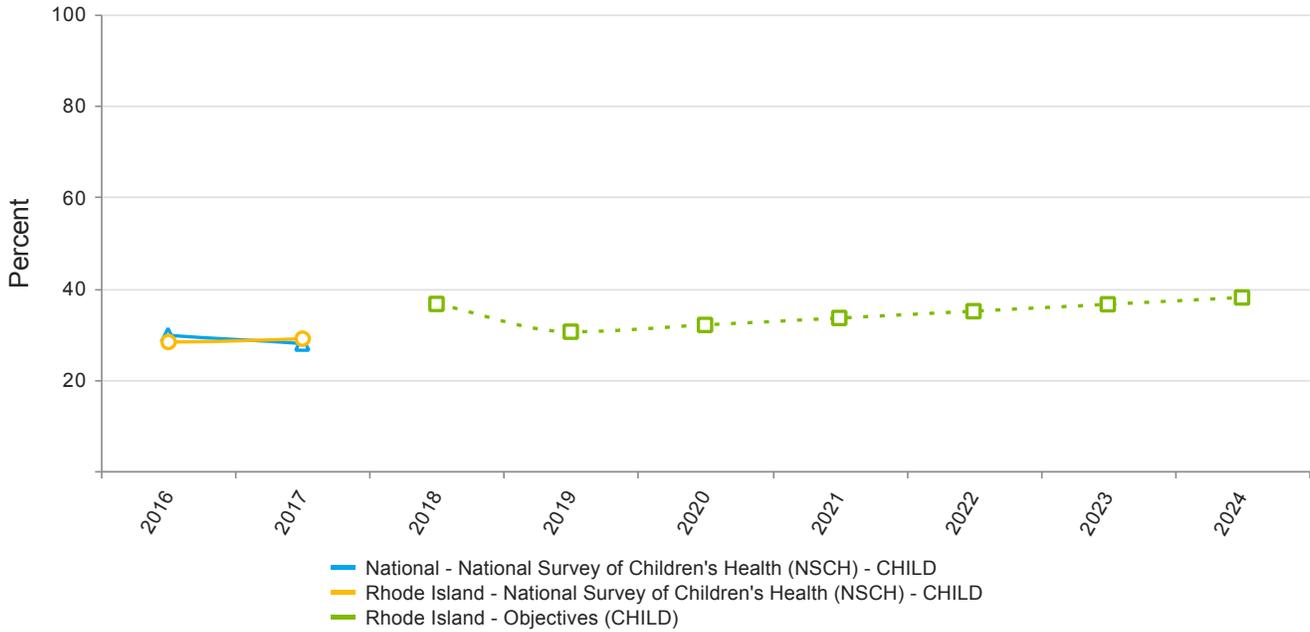
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.5 %	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-2016_2017	16.8 %	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-2014	16.3 %	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 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
Annual Objective			36.6
Annual Indicator		28.2	28.9
Numerator		21,354	19,772
Denominator		75,621	68,418
Data Source		NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017

i 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
Annual Objective			36.6
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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.5	32.0	33.5	35.0	36.5	38.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	52.0	97.0	142.0	187.0	232.0	232.0

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

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	65.0	69.0	73.0	77.0	81.0	85.0

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	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	17.0	20.0	22.0	25.0	28.0	30.0

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

Measure Status:					Active	
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	70.0	72.0	74.0	76.0	78.0	

State Outcome Measures

SOM 7 - Percent of Children Living in Poverty

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		20	18.4	
Annual Indicator	20.4	19.4	16.6	
Numerator	43,282	40,675	33,818	
Denominator	212,038	209,667	203,723	
Data Source	ACS Population estimate (B17001)	ACS 2016 Population estimate (B17001)	ACS 2017 Population estimate (B17001)	
Data Source Year	2015	2016	2017	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	15.5	14.4	13.3	12.2	11.1	10.0

State Action Plan Table

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

Priority Need

Address obesity/nutrition & physical activity for children (Child Health)

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

Increase the percent of children, ages 6 through 11, who are physically active at least 60 minutes per day from 28.2% in 2016 to 30% by 2020.

Strategies

- Increase physical activity and improve nutrition practices in childcare settings.

- Improve the built environment to encourage physical activity.

- Support the implementation of nutrition guidelines (healthy eating options) in locations that offer concessions where children congregate.

- Support the implementation of the walking school bus in communities.

ESMs	Status
ESM 8.1.1 - Physical Activity and Nutrition Technical Assistance to Child Care Centers	Active
ESM 8.1.2 - % children ages 5-19 impacted by improvements to the built environment	Active
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	Active
ESM 8.1.4 - % children (0-17) living in a HEZ community with initiatives related to physical activity and nutrition	Active

NOMs

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

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)

Child Health - Annual Report

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.

Children's Health Data

Rhode Island continues to do well supporting children's health. NSCH 2016/17 data also show that 74.8% of children were continuously and adequately insured in the past year. Furthermore, 51.3% of children without special healthcare needs meet the criteria of having a medical home. Child mortality rates are low RI. In 2018, less than 10 children ages 1-9 years died. NSCH 2016/17 data report that 14.9% of children live in a household where someone smokes tobacco.

According to the NSCH 2016/17, 90.5% of children were in excellent or very good health. A 2017 fiscal year report by the Center for Medicaid Services reveal that 48.7% of children ages 1 through 17 had a preventive dental visit in the past year. Of children ages 10 months to 5 years, 29.7% received a developmental screening using a parent-reported screening tool in 2016/17.

According to the 2015 National Immunization Survey, 77.2% of children in RI ages 19 to 35 months were fully immunized compared to 72.2% of the U.S. However, this RI measure represents a decrease from the 2013 with 82.1% of children being fully immunized. Nevertheless, RI is ranked high among other states in the nation for immunizations of toddlers.

WIC Participant and Program Characteristics 2018 data reports that 21.5% of children ages 2-4 were obese, which has increased from 19.9% in 2017. Hispanic children ages 2-4 (18.9%) were more likely to be obese compared to their non-Hispanic White counterpart (14.9%). Only 28.9% of children ages 6-11 years are physically active at least 60 minutes per day, which is slightly better than that the national average of 27.9%.

According to 2016 hospital discharge data, children ages 0-9 years had an injury-related hospitalization rate of 108.6 per 100,000 children. The asthma hospitalization rate among children <5 years was 9.7 per 10,000 children in 2017.

Priority: Address Obesity, Nutrition, and Physical Activity for

Last year, Title V MCH proposed to work with the RIDOH Physical Activity and Nutrition Program (PAN) Program on the following strategies to address obesity, nutrition, and physical activity for children in RI:

- Increase physical activity and improve nutrition practices in childcare settings
- Improve the built environment to encourage physical activity
- Support the implementation of nutrition guidelines (health eating options) in locations that offer concessions where children congregate
- Support the implementation of the walking school bus in community

It is important to first note that activities planned for 2018/2019 were established with the optimism that the PAN Program at RIDOH would secure funding for staff and programmatic work through the State Physical Activity and

Nutrition Program, CDC-RFA-DP18-1807. Rhode Island's application was approved but unfortunately not awarded, and it was among the top five for awards that were approved but not funded. That status is active for 24 months, so if CDC receives more money for the program in that time, additional grants could be funded. The CDC funded PAN for a total of \$1.3m per year for 5 years in the last round of funding. RIDOH no longer has that funding and as a result lost 5 FTEs, administrative support, and local investment funding to HEZs (food insecurity is among the top local issues faced by communities). This disinvestment has also caused RIDOH to lose momentum with other key partners who helped reduce overweight and obesity among children and adults through policy, systems and environmental strategies that were improving population health outcomes.

Despite these difficulties, RIDOH remains committed to improving the physical activity and nutrition of children throughout RI. The recently released report "The State of Obesity" by Trust for America's Health and Robert Wood Johnson shows over the past 15 years, evidence-based policies and programs have helped Americans eat healthier and be physically active in their homes, schools and communities is addressing the obesity epidemic, which remains imperative for ensuring the health of our state and the nation.

Nationally, RIDOH is advocating for RI, and for all states, to receive this critical CDC funding for physical activity, nutrition and obesity prevention. In fact, RIDOH senior leadership attended a recent CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) Ambassador Program training in Atlanta May 6-8. This training, for both funded and unfunded states, was in partnership with the Association of State Public Health Nutritionists (ASPHN) and the Society for Public Health Education (SOPHIE). The goal of the Ambassador Program is to keep states connected on physical activity, nutrition, and obesity work. It was also a venue to share new tools and information. The plenary sessions used a health equity lens and featured the racial and ethnic approaches in community health, which are in line with the overarching goals of the RIDOH.

RI Food Strategy

RIDOH is also collaborating with the Governor's officer and Sue AndreBois, Director of Food Strategy for the State of RI. The work includes attaining an equitable food system in our state for all people and is aligned with the work of several of the Health Equity Zones. In 2017, a RI Food Strategy was developed that includes the follow focus areas and activities:

1. Alleviate Food Insecurity & Hunger
2. Make Food Production More Accessible
3. Create, Sustain, & Grow Markets for RI Products
4. Create and Sustain the Climate for Food- Related Businesses

RI Health Schools Coalition Breakfast

Title V was the lead sponsor for the 2018 Rhode Island Healthy School Coalition (RIHSC) Breakfast for School Wellness Leaders. This is an annual event that convenes over 400 school and community leaders. Its goal is to highlight the proven link between health and learning outcomes and energize schools to prioritize and implement strong wellness policies and practices to create healthier school environments with the support of the larger community. It celebrates local successes in school wellness and provides attendees with ideas, resources, tools, information on national and state best practices, and connections to community partners within the framework of the Whole School, Whole Community, Whole Child (WSCC) model.

The 2018 agenda included a keynote presentation from Ellen Flannery-Schroeder, PhD on how to address student anxiety in the school setting, a panel discussion on Adolescent Sexual Health, including RIDOH Medical Consultant Philip Chan, MD and curriculum and health services support from CATCH Global on the risks and facts about vaping

and e-cigarettes. RIHSC staff provided an update on the Governor/Education Commissioner's "Eat, Learn, Succeed" campaign and were introduced to research on the benefits of school breakfast and resources to help implement alternative delivery models in any school. In addition, the new 2018 law prohibiting the marketing/advertising on foods and beverages that don't meet federal and state nutrition standards was reviewed with realistic and helpful examples of what is and isn't allowable.

Thirty-six community partners, including RIDOH, were part of the Ideas Exhibition where attendees had the opportunity to connect with experts on a wide array of health and wellness issues (social/emotional climate, health education, nutrition environment and services, PE and physical activity, family engagement, and school safety) critical to schools. 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.

Most RI districts consider the event a marker for a new year of district wellness engagement and committee work. Key leaders and team members leave equipped with up-to-date data, regulations, research and ideas for addressing needs in local school communities.

After the Breakfast, RIHSC staff provides personalized technical assistance, in collaboration with RIDE, throughout the school year to support all district committees with regard to policy, practices, monitoring, assessing and reporting as per the federal Healthy, Hunger Free Kids Act.

Body Mass Index (BMI) Data Partnership Plan - Concern over increasing rates of overweight and obese children generated a call for more data related to childhood obesity. Despite the collection in electronic health records, there is no statewide population-based registry with height, weight and body mass index (BMI) data for children. There are several related surveys and datasets, but each has limitations. For example, the National Survey of Children's Health and Youth Risk Behavior surveys provide state-wide data but cannot be broken down by smaller geographic areas and the Youth Risk Behavior Survey (YRBS) is for middle and high school only. Data are available for WIC participants but not for other preschool age children. The SSDI Director participated in a state-wide effort to explore new sources of BMI data. Data from multiple sources including WIC, CurrentCare (the state health information exchange), and managed care organizations were matched to children with records in KIDSNET that included demographic data such as race, ethnicity and city/town of residence. Clinical (height, weight, and BMI), diagnostic, and claims data related to obesity (example "Face-to-Face Behavioral Counseling for Obesity") were all included. The data were then analyzed by partners at the Hassenfeld Child Health Institute at Brown University to see if the data reflected Rhode Island's child population as a whole. Indeed, the combined dataset revealed a sample that reflected the population demographics of children in RI according to the American Community Survey of the national census. Overweight and obesity rates were similar to the national NHANES nutrition survey and self-reported rates on the YRBS. Although the methodology is novel and has limitations, the consistency of the results with national survey data gave the data team enough confidence in the representativeness of the sample to present the findings in several settings, including in the RI Kids Count Fact Book and Kids Count Policy Brief. This analysis may be repeated in the future as a way to monitor overweight and obesity trends in Rhode Island.

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 bike ability. 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:

Bristol HEZ:

- Partnering with Grow Smart RI to secure passage of a proposed Complete Streets ordinance
- Utilizing findings of a walking and biking infrastructure audit to develop a town-wide walk and bike plan

Newport HEZ:

- Promoting enactment of a proposed Complete Streets ordinance
- Creating walking paths with interpretive signage on the north side of the City
- Providing representation on Newport Bicycle Pedestrian Advisory Council
- Supporting Newport Waves vulnerable road user safety campaign that encourages increased awareness to reduce pedestrian and cyclist injuries and fatalities

Olneyville HEZ:

- Engaging local organizations and residents in promoting a Green and Complete Streets ordinance that incorporates green infrastructure to address storm water runoff as well as walk/bike features
- Facilitating public input on local road infrastructure projects around walkability/bikeability, including the 6/10 connector
- Supporting a walking school bus programs at William D'Abate Elementary school

Pawtucket/Central Falls HEZ:

- Participating in planning for transit-oriented development related to the planned Pawtucket-Central Falls Commuter Rail Station
- Promoting implementation of the Central Falls Green and Complete Streets ordinance, the first in Rhode Island
- Creating a rent-a-bike program and installing bike racks in both communities
- Establishing and supporting walking paths that incorporate art and history, and integrate active walking programs
- Coordinating walking school bus programs at Agnes Little and Henry J. Winters elementary schools

Providence HEZ: Southside, Elmwood, West End

- Participating in the City of Providence CityWalk Community Advisory Group which promotes walkability and better pedestrian connectivity between neighborhoods
- Partnering with RI Latino Arts to establish resident-led walking tours

West Warwick HEZ:

- Collaborating with municipal officials to integrate walkability/bike ability 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

Woonsocket HEZ:

- Collaborating with municipality to develop plan to extend the Blackstone River Bikeway through downtown Woonsocket and nearby neighborhoods

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.

Building community while getting to school on time

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. For example, as part of a recent Walking School Bus program organized by the Olneyville Health Equity Zone in Providence, 30 elementary students living too close to school to be eligible for the school bus participated in one of two Walking School Bus routes every day. Each child walked an average of 1.5 miles a day – approximately 300 miles per student per year! During the 2017-2018 school year, the local elementary school, William D'Abate Elementary School, had the highest average attendance rate in the district (94.8 percent) and the second-lowest chronic absenteeism rate. In nearby Pawtucket, RI, the Pawtucket-Central Falls Health Equity Zone reported a 63 percent decrease in absences and an 80 percent decrease in tardiness at Agnes E. Little Elementary School after the Walking School Bus was established. The Health Equity Zone also reported improved academic performance, better behavior, increased physical activity, and increased school breakfast participation.

Pawtucket's Harvest Kitchen Café: Optimizing community collaboration

The Harvest Kitchen Cafe in Pawtucket has blossomed with the support of the Pawtucket-Central Falls Health Equity Zone. The program demonstrates how the Health Equity Zone model can support stronger, more productive collaboration and synergy in the service of concrete, shared neighborhood goals. An initial partnership with Pawtucket Central Falls Development, a nonprofit community development organization, led Harvest Kitchen founders to identify the perfect location for their local foods Cafe and culinary job training program for youth. Both organizations are now members of the Pawtucket-Central Falls Health Equity Zone (HEZ), and HEZ partnerships have provided resources for continued success. A HEZ partner at Southside Community Land Trust is a source of fresh produce through new, local community gardens. Catering opportunities and collaborative learning opportunities for culinary trainees are provided by supportive community partners like Agnes Little Elementary School, which allows the Cafe to tap into programs like the Pawtucket Homework Diner, an evening program that brings together students, parents, and teachers to work together on students' homework. These collaborations allow Harvest Kitchen to operate successfully and create healthy food options in an area where there had been little choice. This important community hub would not have become this successful without the HEZ bringing together many partners to get it done.

Improving healthy food access in West Warwick

With only two grocery stores in West Warwick and 20% of city residents not owning cars, access to healthy foods has been one of the West Warwick Health Equity Zone's (HEZ) most robust programs. Since "day one" of the initiative, the HEZ has organized farmers markets and pop-up farmers markets, providing access to healthy food for populations with limited access, including the elderly. One example of the success of this program has been the food

program carried out in partnership with Be the Change, a local organization that receives food donations from large supermarkets, including Trader Joe's and BJ's, where residents are able to fill an entire grocery bag for only \$3 to \$6. Another service organized by the HEZ is a food delivery service for homebound residents that are unable to leave their home. This program was successful thanks to a partnership with West Bay Community Action Program, a local organization that also has a farm and a grocery store providing fresh produce to people who are unable to go get the food themselves. This program is particularly beneficial for people who may have used their SNAP benefits and still need access to affordable, healthy foods. A program with proven results is the library food program, which provides local children with free lunches during the summer. The goal of this program, which also provides some free educational programming for attending children, is to relieve some of the burden experienced by parents who cannot afford to feed their children over the course of the summer. In year two, organizers saw a 17% increase in the number of people participating in the program. The HEZ collaborative recently began a food access survey in order to gauge the impact made by their food access programs.

Other Program/Projects Related to Child Health

Developmental screening

In December 2016, Rhode Island's Race to the Top Early Learning Challenge funding, ended. As part of this grant, RIDOH had 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. Many of the practices that participated in this project, known as Screening to Succeed, conducted screening using an electronic system called CHADIS.

Since 2014, when the work with the practices began, providers screened 17,700 children. Many of these children have completed more than one screen. In addition, many other children have been screened either using another tool within CHADIS, another electronic system, and/or on paper. Currently, according to information available to the RIDOH, about 17 practices are currently screening using CHADIS.

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 years 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.

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.

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), RI Emergency Management/Municipalities & 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. Student who miss the clinic may get vaccinated by their regular primary care doctor.

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. 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.

Assessment, Feedback, Incentive, eXchange (AFIX) - Primary care practices enrolled in the state supplied vaccine program that see children and adolescents receive AFIX 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, incentives to increase coverage rates, and resources to help achieve that goal. AFIX is an evidence-based quality improvement tool employed by the Centers for Disease Control and Prevention to improve vaccination coverage rates. One recent incentive that was developed is a KIDSNET tool allowing practices the access to run their own coverage rate reports on demand. In 2017 AFIX staff received additional training in data sharing in order to provide enhanced AFIX visit presentations, which had a special focus on HPV vaccination.

KIDSNET (Includes the state Immunization Registry) - School Nurse Immunization Reports have been developed in KIDSNET that should make it even 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 Rhode Island. 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, it links the following projects: 1) Breathe Easy at Home (BEAH), a KIDSNET-based referral system 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 self-management education (SME), environmental trigger reduction and referrals to other CIACS programs (e.g., Breathe Easy at Home to address code violation) and to other community-based services not directly related to the child's asthma; 3) Draw a Breath (DAB), an evidence-based asthma education program at Hasbro Children's Hospital which provides group asthma education classes at the hospital and at schools; and 4) Controlling Asthma in Schools Effectively (CASE), a school-based intervention combining asthma education and trigger reduction in 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.

RIDOH completed an extensive cost analysis and evaluation of HARP utilizing Medicaid data which showed that HARP participants had a 75.5% reduction (\$600) in hospital/ED costs, and high utilizers had an 80% reduction (\$2,700) in costs. The success of this program has led to additional funding from the Volkswagen (VW) Clean Air Act Civil Settlement, and United Health Care that allows the program to extend the reach and intensity of the services.

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 the policy platform around repairing school facilities in support of 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, a tremendous investment that will improve indoor air quality in schools across the state.

Outdoor Air Quality Policies: RIACP has been participating in a number of different initiatives with a range of policy implications. 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 providing the City of Providence and its community partners asthma data and maps and 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 Rlte 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 women 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 benefits. 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.

Plans for Next Year: Child Health

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. During the next year RIDOH plans to:

- Continue to monitor and enhance data related to BMI to better assess rates of childhood overweight and obesity.
- Sponsor the Health Schools Collaboration 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.

RI is also considering joining the AMCP Emergency Preparedness and Response Action Learning Collaborative which could be a collaborative effort between Title V and the Center for Emergency Preparedness and Response. Possible activities could 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 women 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 women
 - 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.

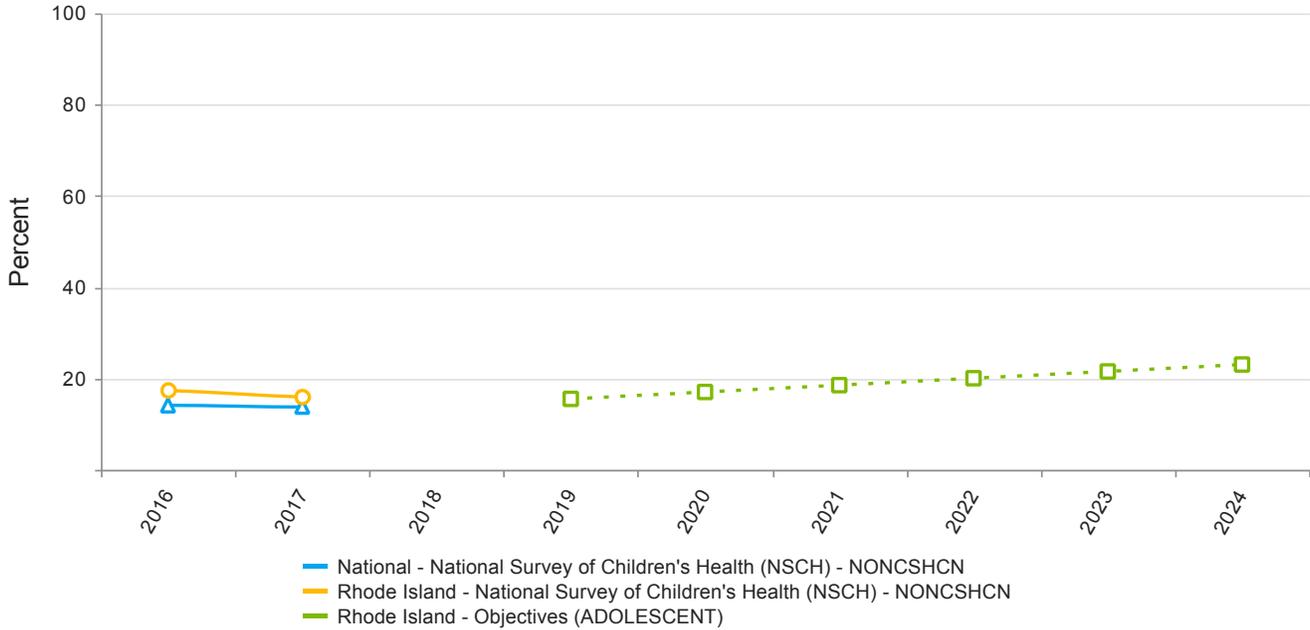
Adolescent Health

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-2016_2017	16.9 %	NPM 12

National Performance Measures

**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**



NPM 12 - Adolescent Health - NONCSHCN

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

State Provided Data		
	2017	2018
Annual Objective		
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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	15.6	17.1	18.6	20.1	21.6	23.1

Evidence-Based or –Informed Strategy Measures

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	18.0	20.0	20.0	20.0	20.0	20.0

ESM 12.2 - % of practices with a transition policy

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			2	3.2
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	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.4	3.2	4.0	4.8	5.5	6.3

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	
Annual Objective		1,000	1,800	
Annual Indicator	1,125	1,731	1,406	
Numerator				
Denominator				
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,750.0	2,000.0	2,250.0	2,500.0	2,750.0	3,000.0

ESM 12.4 - # of participants in Teen Outreach Program

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	240.0	245.0	250.0	255.0	260.0	265.0

State Outcome Measures

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	31.2	29.0	26.8	24.6	22.4	21.2

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	13.5	13.0	12.5	12.0	11.5	11.0

SOM 3 - Percent LGB high school students attempting suicide

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.5	19.9	17.2	14.6	11.9	11.9

SOM 7 - Percent of Children Living in Poverty

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		20	18.4	
Annual Indicator	20.4	19.4	16.6	
Numerator	43,282	40,675	33,818	
Denominator	212,038	209,667	203,723	
Data Source	ACS Population estimate (B17001)	ACS 2016 Population estimate (B17001)	ACS 2017 Population estimate (B17001)	
Data Source Year	2015	2016	2017	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	15.5	14.4	13.3	12.2	11.1	10.0

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

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	18.4	16.3	14.2	12.1	9.9	7.8

State Action Plan Table

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

Priority Need

Increase the capacity and efficiency of the adolescent systems of care (Adolescent Health)

NPM

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

Objectives

Increase the percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care from 13.4% in 2016 to 18% by 2020.

Increase the percent of adolescents without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care from 17.5% in 2016 to 20.5% by 2020.

Strategies

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).

Build self-determination skills among youth.

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

Promote use of and reimbursement for transition planning.

ESMs

Status

ESM 12.1 - % of medical homes with trained staff on transition Active

ESM 12.2 - % of practices with a transition policy Active

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

ESM 12.4 - # of participants in Teen Outreach Program 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

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

Priority Need

Increase the capacity and efficiency of the adolescent systems of care (Adolescent Health)

SOM

SOM 3 - Percent LGB high school students attempting suicide

Objectives

Decrease the percentage of LGB high school students attempting suicide from 27.8% in 2017 to 19.9% in 2020.

Strategies

Implement youth suicide prevention programs.

Adolescent Health - Annual Report

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.

Adolescent Health Data

Adolescent Mortality

Adolescent mortality has decreased in RI among adolescents ages 10-19 from 20.3 deaths per 100,000 adolescents in 2017 to 17.7 deaths per 100,000 adolescents in 2018. From 2016-2018, the adolescent motor vehicle mortality rate was 6.5 deaths per 100,000 adolescents 15-19. This is an increase from 5.9 deaths per 100,000 adolescents in 2015-2017, however, due to small numbers, these rates may be statistically unstable. The unintentional injury mortality for adolescents ages 15-19 was 4.5 deaths per 100,000 adolescents in 2017, but this rate should also be interpreted with caution. In 2016-2018, child death review data indicate that there were 5.5 deaths per 100,000 in adolescents ages 15-19 due to suicide. When expanding the population to include youth ages 10-24, the suicide rate was 7.8 deaths per 100,000 adolescents in 2018.

Healthcare and Immunization

According to the NSCH 2016/17, 86.7% of adolescents ages 12 to 17 received a past year preventive medical visit. In 2017, NIS reports that 88.5% of females and 88.7% of males, ages 13 through 17, have received at least one dose of the HPV vaccine. This represents a 76.6% increase in females and a 69.3% increase in males from 2013. RI has the highest rates of HPV vaccination in the US. Additionally, 74.2% of adolescents were vaccinated against seasonal influenza in 2017. Other adolescent immunizations were also high in 2017 with 94.1% receiving at least one dose of the meningococcal conjugate vaccine and 94.6% receiving at least one dose of the Tdap vaccine. Seasonal influenza, meningococcal, and Tdap vaccination in RI exceeds U.S. rates among adolescents.

Obesity/Physical Activity

Trends for obesity have increased among high school teens. YRBS shows that 15.2% of high school students were obese in 2017 compared to 9.1% in 2001. Hispanic high school students were more obese (21.2%) compared to Non-Hispanic Whites (13.3%) in 2017. Moreover, more Hispanic teens (66.6%) reported trying to lose weight than Non-Hispanic White teens (49.2%) and Non-Hispanic Black teens (39.3%). We have seen a drop of high school teens who did not participate in at least 60 minutes of daily physical activity from 46.7% in 2011 to 16.5% in 2017.

Behavioral/Mental Health

Although there was a decrease from middle school students who were ever bullied on school property from 40.1% in 2013 to 33.4% in 2017, there was little no change among high school students from 18.1% in 2013 to 17.3% in 2017. Suicide ideation is an important issue which the MCH Program monitors. YRBS 2017 data report a slight increase among high school teens who seriously considered committing suicide from 12.1% in 2007 to 15.9% in 2017. Disparities exist between 17.8% of Hispanic teens who seriously considered committing suicide compared to 9.3% of Non-Hispanic Black teens in 2017. The percentage of binge drinking (11.2%) among high school teens in

2017 shows a disparity between Non-Hispanic White teens (12.7%) and Non-Hispanic Black teens (6.1%).

Priority: Support the Capacity & Efficiency Adolescent Systems

- ***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).***

PCMH-Kids – RIDOH has partnered with the Care Transformation Collaborative (CTC) to support the 19 participating pediatric primary care practices in the implementation of the PCMH-Kids model through the provision of trainings and technical assistance. RIDOH will continue in the role of collaboration with the CTC to support PCMH-Kids practices in education around the National TA center on Transition (Got Transition) resources (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, 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.

Employment First - In 2014, the State of RI 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 through the development and implementation of youth initiatives such as the Youth Advisory Committee, Youth Internship Program, and Dare to Dream Conference to provide youth with information, resources, and experiences that promote successful transition to employment and independence.

Youth Advisory Council – Over the past six years, RIDOH has implemented the Youth Advisory Council (YAC) to provide youth and young adults, ages 14-24, interested in developing their leadership skills and learning about health topics with a forum for connection to other youth and an opportunity for the development of leadership skills. 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). This past year, the YAC was comprised 18 members, and included for 4 new members. The YAC met 15 times from September through June and worked on the following 3 focus areas: professional development and training, soft skills building, and project/event planning and facilitation. YAC accomplishments for this year include: the development of a youth transportation training; participation in an overdose prevention focus group, and participation in a HEZ Learning Community round table session with the Drug Prevention Task Force. Members of the YAC were active in the annual Dare to Dream 2.0 Youth Conference, providing the opening remarks and serving as event volunteer assistants. During 2018, the Youth Advisory Council was recognized as an emerging practice from AMCHP's Innovation Station.

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 program is designed to assist RI high school students in career exploration in areas of public health. Over the past year, RIDOH continued to expand the Youth Internship Program for youth with special needs to provide 9 students with opportunities to practice job skills in a real work setting. The participating RI school districts included: RI Nurses Institute Middle College Providence RI (3 students); Cranston Transition Program Cranston RI (1 student); Lincoln High School Lincoln RI Transition Program (2 students); West Bay Collaborative Transition Academy (2 students); and William Tolman High School Pawtucket RI (1 student). The RIDOH programs that participated in providing internship placements 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; Distribution Center; and Health Equity Institute. During the summer of 2018, two students were able to received compensation for their internship, with compensation provided through the City of Providence Office of Economic Opportunities. In 2019, the RIDOH was able to provide another student with a paid internship position to provide data entry support for the Traumatic Brain Injury Program. In 2018, the RIDOH Internship Program was awarded the AMCHP Innovation Station designation of "Promising Practice".

Teen Outreach Program (TOP) - TOP has served approximately 700 youth since 2013. It is estimated that the program will serve 225 youth in 2018-2019, and 240 youth in 2019-2020. 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 for us. This year, Progreso Latino obtained permission and support from the new administration to implement the Teen Outreach Program in Central Falls Middle School. Facilitator trainings and professional development opportunities through Response to Intervention (RTI) are addressed with the network on a regular basis. Additionally, two TOP Clubs (Sojourner House and Youth in Action) teamed up for “Intimate Partner Violence Training” and became “IPV” Peer Educators in their respective schools. Their story was featured in the US Department of Human Services, Family Youth Services Bureau quarterly newsletter (<https://www.acf.hhs.gov/fysb/success-story/innovative-partnership>).

Princes 2 Kings (P2K) – P2K is a youth mentorship program that combines academics and tutoring in **Science, Technology, English, Art, and Math (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).

The P2K Program currently has 64 participants (boys) and it is presently preparing for the 2019 summer enrichment program. 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. This year, the first cohort of 7 seniors will be graduating high school; the program is proud to report that each young man will be moving on to higher learning institutions.

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 will provide year-round mentoring, academic support, and leadership development program to a cohort of 62 young women of color who attend two middle schools in Providence, RI. The academic-year component of the program will emphasize academic performance and developing social and non-violent skills. The six-week summer component of the program will focus 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.medicalhomeportal.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 RIDOH to provide comprehensive diagnostic, education, specialty care, social service, and resource information and support to improve the system of care and health outcomes for CYSHCN. Sections of the MHP address specific areas including: Diagnosis and Conditions; Physicians and Professionals; Parents and Families; and a Services Directory. The MHP was developed through a partnership with the University of Utah in 2016, and has been an on-going contractual collaboration since, to build the RI Resource component of the portal directory. RIDOH worked with other state agencies and community stakeholders to import state specific provider and service information. As of June 2019, the number of listings in the RI Service directory was 720. The Family to Family Help Information Center (F2FHIC) and the Autism Project assist RIDOH in keeping the resources up to date. RIDOH convenes the MHP

Advisory Committee, comprised of families, partner state agencies, community stakeholders, health professionals, and advocates to provide guidance and oversight. In addition to the local advisory committee, RIDOH also participates as a member of the Medical Home Portal 's state partners' advisory board to ensure content integrity, improved avenues for resource navigation, and a mechanism for user feedback, utilization tracking and usability testing. A quality assurance project was initiated in January of 2019 to review and update pediatric specialists. Data is also collected monthly from a google analytics report for number of users, type of device used for MHP access, top twenty (20) viewed pages, and state location. This year's numbers increased dramatically due to the new national landing site and mechanism to select RI as your home state. The Medical Home Portal has been visited 4,894 times during the past year.

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".

Adolescent Health & Health Equity Zones

Growing a safer and more connected community: Central Fall's Youth Shoveling Program

As part of its Growing Communities Initiative, the Pawtucket-Central Falls Health Equity Zone started a Youth Shoveling Program in Central Falls. Through this program, youth in the community receive a stipend for shoveling and clearing the walkways and driveways of elderly residents during the winter. This program helps keep seniors in the community safe during the winter, and helps prevent social isolation by fostering relationships between youth and seniors in the community. Seed funding for a two-year pilot program helped this initiative get off the ground. During this time, the program became so popular that seniors knocked on doors and reached out to anyone they believed could help to make sure the program was continued. Their action was so impactful that the Mayor of Central Falls included the program as a line item in the City budget, continuing the program for a third year.

Engaging Youth in Community Planning

The Youth Advisory Council (YAC) collaborated with the Pawtucket/Central Falls HEZ evaluation team from Pawtucket/Central Falls HEZ in finding participants for a young adult focus group "Community Conversations: Help solve the substance use in Central Falls and Pawtucket". The HEZ was having difficulty recruiting participants. RIPIN staff person Geraldine McPhee connected the project Lead, Jennifer Constanza to the RIDOH YAC. The YAC encouraged members of the community to participate as a leadership opportunity. The Council also gave feedback on locations and times to ensure that the event was convenient. After the event, the YAC received a thank you from the HEZ team which included the following: "The event really well last night! Thank you for all your help organizing and recruiting the kids to come. I also think many of them were genuinely interested in the project and in coming to the big meeting where we prioritize needs and start developing the prevention plan as a community ". The event was such a success, that the YAC has been invited to additional focus groups and HEZ events.

Building social capital for a healthier Central Falls

To address senior isolation and improve access to better nutrition in the community, the Pawtucket-Central Falls

Health Equity Zone launched a pilot event to gauge the success of an intergenerational cooking program. This program paired local high school students with seniors to take part in cooking demonstrations at Forand Manor, a public housing facility for seniors. The program also incorporated a cultural education component thanks to a partnership with Rhode Island Black Storytellers, and a physical activity component where, thanks to a partnership with Health Equity Zone Collaborative member Progreso Latino, participants had the opportunity to take part in Zumba lessons and learn from a local dance troupe. One resident of the senior housing facility, a woman of Cape Verdean descent, felt much more socially isolated than other seniors in the program, because she felt most comfortable speaking in her native Cape Verdean Creole, a Portuguese-based Creole. Through the Health Equity Zone Collaborative, the program partnered with the Cape Verdean Club at the local high school, bringing students into the program who could communicate more effectively with her. Thanks to this partnership, she was able to communicate and build relationships with these students that continue to this day, and flourish.

Other Programs/Projects Related to Adolescent Health

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.

Adolescent Sexual Health Strategic Plan and Workgroup – In 2016, RIDOH collaborated with the Rhode Island Department of Education (RIDE) to develop a Profile on Adolescent Sexual Health. RIDOH continues to meet monthly to discuss activities and interventions related to adolescent sexual health. Since its publication, the Adolescent Sexual Health Profile has been presented to key stakeholders in many different settings. Using this profile as a basis for adolescent sexual health in Rhode Island, the workgroup is in the process of prioritizing next steps and determining the best ways to improve sexual health for adolescents in Rhode Island. The priorities for this plan include increasing access to health services and improving sexual health education. This is done through a variety of methods, including conferences such as the Conference on Youth Sexual Health Education, as well as working with the Rhode Island Healthy Schools Coalition to convene a series of focus groups with teens on adolescent sexual health education and services. Building upon the success of a pilot program in the Spring of 2018 semester aimed at reducing rising sexually transmitted disease rates among 15-24 year olds in Rhode Island, RIDOH offered student assemblies featuring an overview of sexual health topics for public/charter high schools in Providence, Central Falls, and Woonsocket. RIDOH’s Center for HIV, Viral Hepatitis, STD and TB Epidemiology (CHHSTE) has contracted with Planned Parenthood of Southern New England to offer the series of 20 English and Spanish language assemblies. The disease intervention program received high marks in evaluations from teachers, administrators and students.

Social Media Marketing and RightTime App – In the fall of 2018, the Center for HIV, Viral Hepatitis, STD and TB Epidemiology (CHHSTE) collaborated with RIDOH’s Family Planning Program to develop an app for smartphones and other mobile devices named RightTime. The mission of this app is to help teenagers and people of all ages and genders to navigate an increasingly complicated landscape of information surrounding sexual health. It offers

information on birth control, family planning, and HIV/STD prevention, testing and treatment. It also offers a partner notification tool. This app was promoted in conjunction with other messages related to condom distribution and testing campaigns, on commercial TV, YouTube, Instagram, Facebook, SnapChat, and gay dating apps. In 2018, CHHSTE launched a robust multimedia campaign, “ProtectYourselfRI,” which encouraged adolescents to get tested for HIV/STDs and promoted RIDOH’s condom distribution program. In addition, prevention materials are regularly distributed to school nurse teachers.

Adolescent Clinical STD Services –CHHSTE has partnered with Providence Community Health Centers (PCHC) to enhance chlamydia screening among young women seen at their clinics. PCHC is a large health care provider to many individuals who are uninsured or underinsured and provides services to over 40,000 individuals annually in various settings including traditional, walk-in, school-based, homeless shelter, and dental clinics. The purpose of this collaboration is to improve the health of women and their children by screening, diagnosing, and treating sexually transmitted infections, primarily chlamydia. The project also includes screening data related to gonorrhea, HIV, Hepatitis C, and TB. RIDOH and PCHC staff have met regularly since the start of the partnership to discuss provider trainings, patient education, and electronic medical record system improvement. Through the collaboration, RIDOH has found that provider education and EMR reminders are useful tools to improve STD/HIV/Hep C screenings in the populations of interest and continues to partner with PCHC.

Additionally, due to the rising rates of chlamydia across the state, RIDOH has met with Rhode Island’s largest health insurance companies to discuss a collaboration to improve screening and treatment. Because chlamydia screening is a national HEDIS measure, the health insurers (especially United Healthcare) have been interested in exploring this opportunity. Future plans may include: analyzing HEDIS data stratified by geography and/or provider location; distributing CDC chlamydia Toolkits; developing a chlamydia awareness campaign; developing messaging for insurance company newsletters, and providing training and technical assistance to clinical providers.

Finally, the program continues to work to shape policy around explanation of benefits (EOBs) with the goal of ensuring all individuals have access to sexual health resources and adequate privacy in their healthcare and documentation of healthcare services.

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 2016-17, a total of 107 schools participated in VBYG program. A total of 2,433 students received one or more vaccines through the program and 5,060 vaccine doses were administered.

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) - collaborated 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.

The VIPP collaborates with the RI Department of Transportation, Office of Highway Safety on their 10-year highway safety plan including work on distracted driving, teen driver safety, impaired driving, as well as the rollout of the www.rippleeffectri.com impaired driving website and media campaign. The campaign kickoff event was hosted by RIDOH and online video and radio PSA’s include the Director of RIDOH as well as the RIDOH Office of the State Medical Examiner. The VIPP also participated in an Impaired Driving Summit, Older Adult Driving Summit, Distracted Driving Summit with public safety partners as well a federal agencies such as Federal Highway Motor Carrier, National Highway Traffic Safety Administration, and Federal Rail partners.

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. During October 1st, 2018 through May 31st, 2019. 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. 1626 students aged 11-18 completed baseline ImPACT testing. The Program was able to educate 596 parents who received concussion awareness information throughout the year. The Program also collaborated with the RIDOH’s School Nurse Consultant on steps to support schools in developing a return to learn protocol. Next steps for the Program are to work with the REAP Program, a national return to learn organization, to train the Youth Sport Concussion Prevention Coordinator in the REAP “Train the Trainer” program.

RIDOH Healthy Summer Toolkit for Youth Program Leaders - Multiple RIDOH programs plan to contribute health

information and links to health resources as part of a new bi-weekly sent between May-August. So far, three issues have gone out: insect and animal bite disease prevention, youth mental health resources, and emergency preparedness for youth. Future issues will include smoking/vaping/substance use prevention, healthy relationships, sun/extreme heat safety, and youth worker safety.

Plans for Next Year: Adolescent Health

Got Transition - During the next grant year, RIDOH, using best practice and guidance from the 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 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 Internships for adolescent transition - 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.

Children with Special Health Care Needs

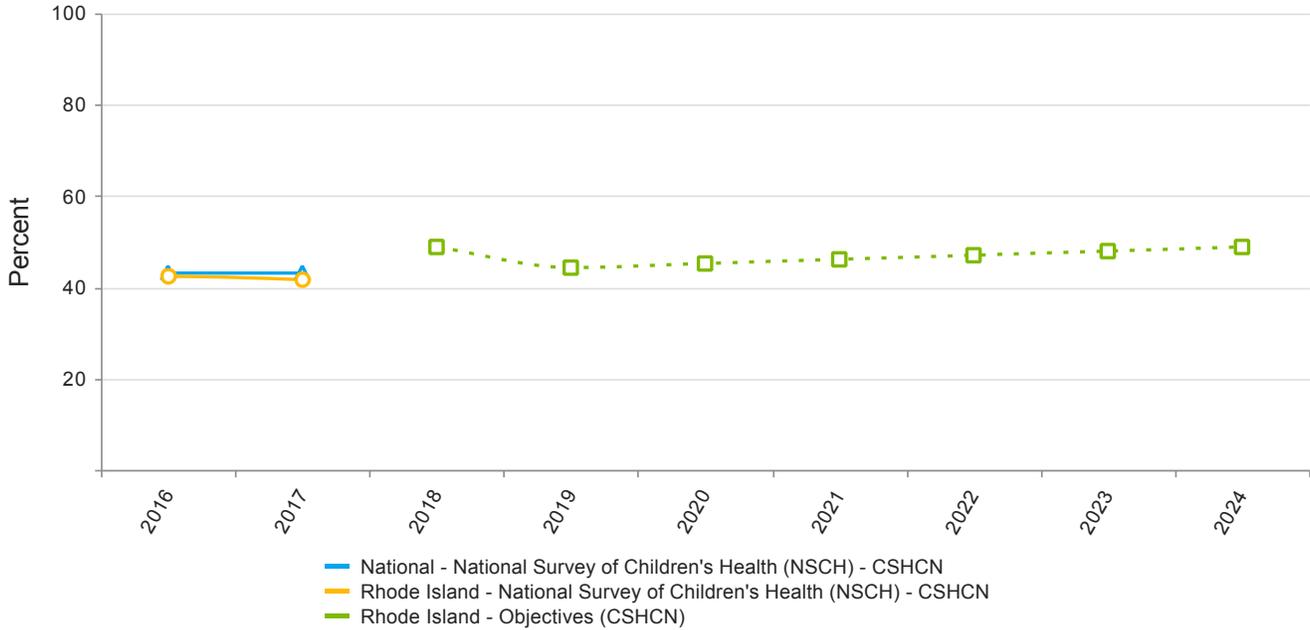
Linked National Outcome Measures

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-2016_2017	16.9 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	55.2 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.5 %	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-2016_2017	2.0 %	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
Annual Objective			48.8
Annual Indicator		42.5	41.6
Numerator		19,360	18,320
Denominator		45,543	44,071
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

i 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
Annual Objective			48.8
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	44.3	45.2	46.1	47.0	47.9	48.8

Evidence-Based or –Informed Strategy Measures

ESM 11.2 - % of Practices using Shared Plans of Care

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		8	15	
Annual Indicator	7.9	15.1	15.1	
Numerator	10	19	19	
Denominator	126	126	126	
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	19.0	19.0	19.0	19.0	20.0	20.0

ESM 11.3 - % of medical homes with trained staff

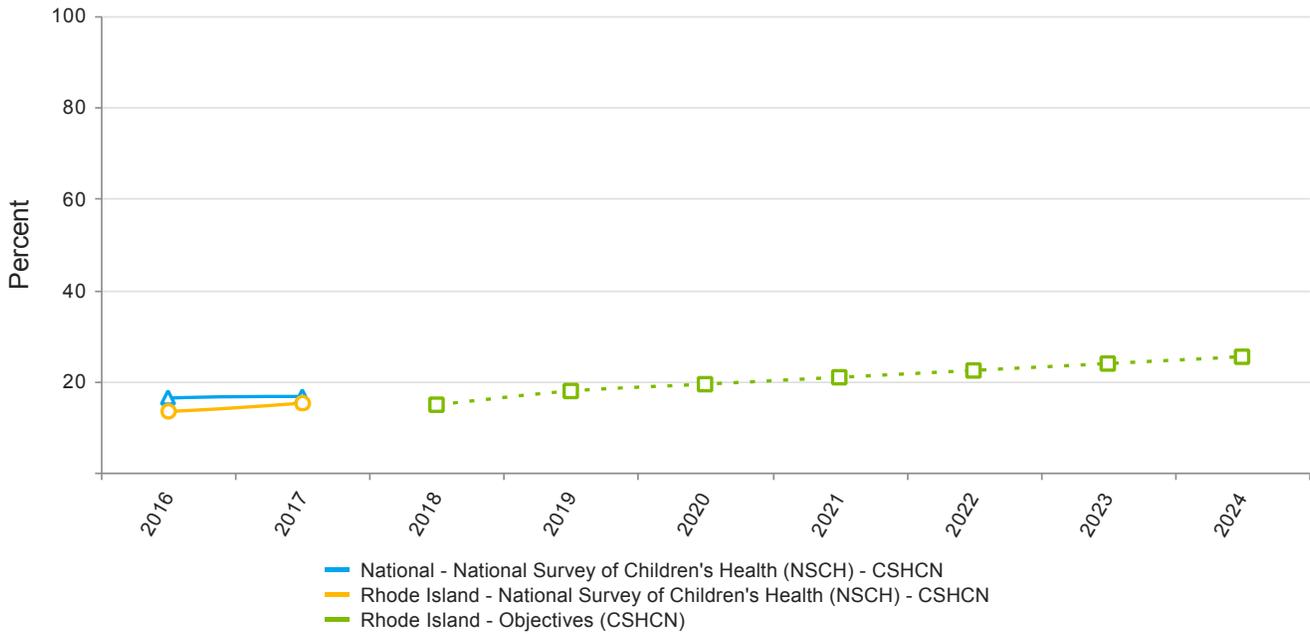
Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		14	16	
Annual Indicator	10.3	15.1	15.1	
Numerator	13	19	19	
Denominator	126	126	126	
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	
Data Source Year	2016	2017	2018	
Provisional or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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	19.0	19.0	20.0	20.0	20.0	20.0

ESM 11.4 - # web hits on medical home portal

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	5,000.0	5,500.0	6,000.0	6,500.0	7,000.0	7,500.0

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



NPM 12 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	2017	2018
Annual Objective			14.9
Annual Indicator		13.4	15.1
Numerator		2,540	3,136
Denominator		18,916	20,735
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

i 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
Annual Objective			14.9
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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	17.9	19.4	20.9	22.4	23.9	25.4

Evidence-Based or –Informed Strategy Measures

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	18.0	20.0	20.0	20.0	20.0	20.0

ESM 12.2 - % of practices with a transition policy

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			2	3.2
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	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.4	3.2	4.0	4.8	5.5	6.3

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	
Annual Objective		1,000	1,800	
Annual Indicator	1,125	1,731	1,406	
Numerator				
Denominator				
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,750.0	2,000.0	2,250.0	2,500.0	2,750.0	3,000.0

ESM 12.4 - # of participants in Teen Outreach Program

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	240.0	245.0	250.0	255.0	260.0	265.0

State Outcome Measures

SOM 4 - Percent High School Students with Special Health Care Needs attempting suicide

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		23	22.5	
Annual Indicator	23.1	24.4	24.4	
Numerator	1,671	1,845	1,845	
Denominator	7,249	7,567	7,567	
Data Source	YRBS	YRBS	YRBS	
Data Source Year	2015	2017	2017	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	21.5	21.0	20.5	20.0	19.5

State Action Plan Table

State Action Plan Table (Rhode Island) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve the system of care of children and youth with special health care needs (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 special health care needs, ages 0 through 17, who have a medical home from 42.5% in 2016 to 45% by 2020.

Strategies

Support the enhancement of care coordination with the PCHM-KIDS practices, with emphasis on CYSHCNs.

Support a comprehensive system of family leadership.

Support and enhance the medical home portal.

Participate in NASHP learning collaborative to strengthen managed care for children with complex medical conditions.

ESMs

Status

ESM 11.1 - Develop a Medical Home Portal	Inactive
ESM 11.2 - % of Practices using Shared Plans of Care	Active
ESM 11.3 - % of medical homes with trained staff	Active
ESM 11.4 - # web hits on medical home portal	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

Improve the system of care of children and youth with special health care needs (CSHCN)

NPM

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

Objectives

Increase the percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care from 13.4% in 2016 to 18% by 2020.

Strategies

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).

Build self-determination skills among youth.

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

Promote use of and reimbursement for transition planning.

ESMs

Status

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

Active

ESM 12.2 - % of practices with a transition policy

Active

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

Active

ESM 12.4 - # of participants in Teen Outreach Program

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

State Action Plan Table (Rhode Island) - Children with Special Health Care Needs - Entry 3

Priority Need

Improve the system of care of children and youth with special health care needs (CSHCN)

SOM

SOM 4 - Percent High School Students with Special Health Care Needs attempting suicide

Objectives

Decrease the percent of high school students with special health care needs attempting suicide from 24.4% in 2017 to 21.5% in 2020.

Strategies

Implement youth suicide prevention programs.

Children with Special Health Care Needs - Annual Report

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.

In RI, according to the NSCH, 21.1% of RI children ages 0-17 years have at least one special health care need, compared to 18.8% in the nation. Among children 3-17 years old, the prevalence of ADD/ADHD is 10.3%. It is also estimated that the current prevalence of autism, Asperger's Disorder, or other ASD in RI is 2.7%.

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 2016/17 data report that 41.6% of children with special healthcare needs (CSHCN) had a medical home, compared to 51.3% of children without special health care needs. This RI CSHCN measure does not meet the Healthy People 2020 target objective of 54.8%. Although 82.6% of all RI children received a preventive medical visit in the past year, 94.8% of CSCHN were more likely to have had a preventive medical visit compared to 83.4% of children without special health care needs population. In 2016/17, 69.4% of CSHCN are continuously and adequately insured in RI. Also, 16.9% of CSHCN received care in a well-functioning system in RI.

Adolescent Transition

Healthcare transition is a critical component of a comprehensive medical home for CSHCN, especially when youth have complex, poly-morbid physical, developmental, and social needs. RI NSCH 2016/17 data shows that only 15.1% of CSHCN received services necessary to make transitions to adult care compared to 15.9% of RI children without special health care needs; this is also slightly less than the national average of 16.7% for CSHCN.

Impact on Families

RI continues to study and monitor the financial impact that many families with CSCHN experience. The NSCH 2016/17 reports that 10.1% of families with CSHCN have had problems paying for any of the child's medical or health care bills in RI, compared to 17.3% 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 2.2% families of children without special health care needs in 2016/17.

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 are 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 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 2018- 2019, RIDOH partnered with the CTC to support continued implementation of the first and second cohorts of the PCMH-Kids and facilitation of the expanded initiative to include 17 additional practices for cohort 3. With this expansion, PCMH-Kids represents more than 50% of the children in RI and more than 80% of the state's pediatric Medicaid population. RIDOH collaborations supported technical assistance for practice learning sessions, care coordination, practice reporting, and stakeholder meetings.

Cedar Redesign - 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 significant changes to the existing state's care coordination system for CYSHCN resulting in a redesign of the Cedar Program by the state Medicaid agency 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 model. This past year, Cedar partnered with CTC to address how the Cedar and PCMH-Kids practices would collaboratively address enhanced care coordination for CYSHCN – specifically, practice referral criteria for the Cedar Program. The result was a screening tool was developed to provide criteria for patient referrals to the Cedar Program for care coordination. RIDOH also conducted a fact-finding study to assess the service capacity and quality standards of the Cedar Program after the move to an in-plan managed care service.

- ***Support a comprehensive system of family leadership.***

Rhode Island Parent Information Network - The RIDOH contracts with the Rhode Island Parent Information Network (RIPIN) for services to improve system navigation and resources for CYSHCN and their families. Specific areas of support include the administration of a comprehensive resource, information, and referral system; training, education, peer support, and system navigation for CYSHCN and their families; and promotion of the values of cultural diversity, family-centered systems, and family and professional partnerships. RIPIN 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 RIDOH contracts with RIPIN to ensure the incorporation of family leadership through the Family Voices (FV) program. Family Voices is a national grassroots network of families representing children and youth with special health care needs, with a chapter in each state. The Family Voices program fulfills the Title V Children with Special Needs mandate to provide opportunities for parent engagement, leadership development and policy to

address the uninsured and underinsured CYSHCN. Family representation and/or input is incorporated into the following: task forces, advisories, or councils for CSHCNs; communications development and distribution; parent and caregiver support groups; the facilitation of community outreach; and legislative policy development and 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
- Butler Hospital- (Behavioral health)
- The Center for Autism and Related Disorders
- The Governor’s Commission on Disabilities
- Care New England Neurodevelopment Center
- Neighborhood Health Plan of RI
- Parent Support Network of RI
- Paul V. Sherlock Center on Disabilities
- RI Consortium on Autism Research and Treatment
- RI Department of Health
- RI Parent Information Network

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 strategic planning process. A survey for CSHCN was developed and administered via community partners and social media. Survey results will be utilized by the FV Leadership Team to create a fact sheet that will inform legislative advocacy efforts to improve the quality of life for CYSHCN, to inform the Caregivers Summit agenda planned (fall of 2019) and included in the Title V MCH Needs Assessment.

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 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 places. 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, 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 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 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. During the last year, FV facilitated ten (10) monthly support group meetings that engaged eight (8) new family members of CYSHCN.

- ***Support and enhance the medical home portal.***

The Medical Home Portal (MHP) - www.medicalhomeportal.org is an online resource established by RIDOH to provide comprehensive diagnostic, education, specialty care, social service, and resource information and support to improve the system of care and health outcomes for CYSHCN. Sections of the MHP address specific areas including: Diagnosis and Conditions; Physicians and Professionals; Parents and Families; and a Services Directory. The MHP was developed through a partnership with the University of Utah in 2016, and has been an on-going contractual collaboration since, to build the RI Resource component of the portal directory. RIDOH worked with other state agencies and community stakeholders to import state specific provider and service information. As of June 2019, the number of listings in the RI Service directory is 720. The Family to Family Help Information Center (F2FHIC) and the Autism Project assist RIDOH in keeping the resources up to date. RIDOH convenes the MHP Advisory Committee, comprised of families, partner state agencies, community stakeholders, health professionals, and advocates to provide guidance and oversight. In addition to the local advisory committee, RIDOH also participates as a member of the Medical Home Portal 's state partners' advisory board to ensure content integrity, improved avenues for resource navigation, and a mechanism for user feedback, utilization tracking and usability testing. A quality assurance project was initiated in January of 2019 to review and update pediatric specialists. Data is also collected monthly from a google analytics report for number of users, type of device used for MHP access, top twenty (20) viewed pages, and state location. This year's numbers increased dramatically due to the new national landing site and mechanism to select Rhode Island as your home state. The Rhode Island Medical Home Portal has been visited 4,894 times during the past year.

Other Programs/Project Related to CSHCN

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. RIDOH and other state agencies participated in forums held every year in July. Forums conducted in the past few years led to the following important policy and systems changes in the disability system:

- 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 in-state 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 assisted 25 families with children or youth diagnosed with rare genetic conditions to identify physicians in RI and provided them with resources and information. In May 2019, RIPIN staff members were accompanied by 2 family members at the annual NERGN Conference held in Portsmouth, NH to ensure family representation among state and national experts in the genetics field.

RIDOH Youth Internship Program - The Rhode Island Department of Health Internship Program for youth with special needs/disabilities provided internships to nine students in various Department Programs during the 2018/2019. The RIDOH Internship Program received a Promising Practice recognition by AMCHP at the annual meeting in early 2019. 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 eventual transition to work and independence. Since there are many factors that impact successful employment for youth with special needs/disabilities, the RIDOH program provides students with a venue to become familiar with office norms, social behaviors, and daily work routine expectations. This past year, an internship placement in the Traumatic Brain Injury Program for data entry into the registry database led to an extended paid summer position.

Children With Special Health Care Needs & Health Equity Zones

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.

Plans for Next Year: Children with Special Health Care Need

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.

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.

Cross-Cutting/Systems Building

State Performance Measures

SPM 2 - Rhode Island youth suicide rate ages 10-24

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		4.2	7.8	
Annual Indicator	5.2	8.5	2.9	
Numerator	11	18	6	
Denominator	212,216	210,752	206,863	
Data Source	RI Vital Records, 2016 ACS Population Estimates	RI Vital Records, 2017 ACS Population Estimates	RI Vital Records, 2017 ACS Population Estimates	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	5.0	5.0	5.0	5.0	5.0	5.0

SPM 6 - Number of Certified Community Health Workers

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	258.0	268.0	278.0	288.0	298.0	300.0

SPM 7 - MCH Priority Areas with at least 50% of HEZ engaged in related MCH funded activities

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	8.0	8.0	9.0	9.0	10.0	10.0

State Action Plan Table

State Action Plan Table (Rhode Island) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Improve system coordination in communities and statewide to facilitate improved health outcomes (Cross-cutting/Life Course)

SPM

SPM 6 - Number of Certified Community Health Workers

Objectives

Increase the number of certified community health workers from 218 in 2017 to 238 in 2020.

Strategies

Continue implement and support of Health Equity Zone (HEZ) Initiative.

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

Facilitate Interdepartmental, interagency, and statewide discussion to improve the health care delivery system.

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

State Action Plan Table (Rhode Island) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Improve mental/behavioral health across the life course (Cross-cutting/Life Course)

SPM

SPM 2 - Rhode Island youth suicide rate ages 10-24

Objectives

Reduce the Rhode Island youth suicide rate from 4.3 per 100,000 in 2017 to 3.9 per 100,000 by FY2020.

Strategies

Increase the number of evidence-based programs implemented in Rhode Island that support healthy social/emotional development and address behavioral health issues.

Develop and implement model of mental health consultation to the Family Home Visiting Program.

Implement suicide prevention programs.

Offer training to support providers who may be caring for families who may be experiencing toxic stress.

Priority Need

Adopt social determinants of health in public health planning and practice to improve health equity (Cross-cutting/Life Course)

SPM

SPM 7 - MCH Priority Areas with at least 50% of HEZ engaged in related MCH funded activities

Objectives

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

Strategies

Continue to implement & support the Health Equity Zone (HEZ) Initiative.

Develop certification process & core competencies for the MCH workforce statewide through a Community Health Worker workforce development initiative.

Continue to support a comprehensive system of engagement & leadership development for vulnerable populations including CYSHCN, minorities, LGBTQ and children in the child welfare system.

Develop "data-to-action" initiatives to build internal and interagency support and action.

Cross-Cutting/Systems Building - Annual Report

RI understands that reducing poor outcomes and promoting health promotion is not limited to focusing on one segment of the MCH population. Good public health practice in the MCH population requires cross-cutting strategies that encourage systems-building. RI developed the following cross-cutting priorities: improve system coordination in communities and statewide to facilitate improved health outcomes; improve behavioral/mental health across the life course; and adopt social determinants of health in public health planning and practice to improve health equity.

Behavioral Mental Health

In Rhode Island, 2017 PRAMS data show that 18.1% of mothers with infants reported that they were diagnosed with depression during and/or after pregnancy. The NSCH 2016/17 reports that only 59.0% of children ages 3 through 17 diagnosed with a mental/behavioral health condition received treatment or counseling. Suicide ideation is also an important issue that the MCH Program monitors for teen behavioral health. YRBS 2017 data report that trends for high school teens who seriously considered committing suicide increased from 12.1% in 2007 to 15.9% in 2017. YRBS 2013-2017 data show that bisexual teens were more likely to experience depression, frequent mental stress, and inadequate support. YRBS data in 2017 also shows that gender-expansive youth are 3 times more likely to miss school because they felt unsafe, 2.5 times more likely to attempt suicide, and 2 times more likely to be bullied compared to cisgender youth. Behavioral/mental health issues are also evident among the CSHCN population. NSCH 2016/17 data show that 84.0% of CSHCN were bullied, picked on, or excluded by other children compared to 58.7% of non-CSHCN. In addition, NSCH 2016/17 also reports that 60.2% of CSHCN do not live in supportive neighborhoods compared to 45.9% of non-CSHCN.

Adequate Insurance

Insurance coverage is critical or determining child health outcomes. Adequacy of insurance is defined by NSCH as “1) having continuous insurance in the past 12 months, and/or 2) having current insurance which is adequate for the child’s healthcare needs”. NSCH 2016/17 data show that 74.8% of RI children have adequate insurance, significantly higher compared to 68.4% nationwide. RI children with the lowest adequate insurance prevalence are found among the 100-199% Federal Poverty Level group.

Social Determinants of Health

Through collaboration among participating state agencies, RI has adopted 15 Health Equity Indicators as statewide measures to address 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.

Focusing healthcare access as a determinant of health, BRFSS 2016 data show that 24.1% of Hispanics report not seeking medical care due to costs compared to 7.2% 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 2016 HousingWorks RI data show that the communities with the highest total burden are Narragansett (58.6%), Central Falls (57.3%), and Providence (46.3%). The social determinant of health measuring education from 2016 Rhode Island Department of Education data shows that 75.5% of RI Hispanic students have graduated in 4 years compared to 86.4% of non-Hispanic White students. This

disparity is more evident in some RI cities such as North Kingstown, where only 60.0% of Hispanic students graduate in 4 years compared to 88.4% of non-Hispanic White students. Incarceration is defined as the number of non-violent offenders under RI probation and parole per 1,000 residents ages 18 and over. This indicator reports that in 2017, the incarcerations rates were highest among Central Falls (12.5 per 1,000), Providence (11.6 per 1,000), and Woonsocket (10.9 per 1,000) compare to the lowest incarceration rates of Barrington (1.2 per 1,000) Jamestown (2.3 per 1,000).

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 announced that it is expanding 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. These new communities will share approximately \$1.4 million in funding with seven existing Health Equity Zones receiving support to continue their work in local communities.

- ***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.

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:

1. ADHD screening, diagnosis and treatment plans
2. Maternal post-partum depression screening: baseline of 22% to 87% with implementation of referral protocols for intervention
3. Screening, Brief Intervention, Referral, and Treatment (SBIRT) in the adolescents with 75 providers with a

total pediatric population of ~34,000

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 is currently working 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.

RI State Innovation Model Grant - RI was fortunate to receive a five-year grant from CMS from 2014 until 2019. The RIDOH MCH Program Medical Director participated on the RI SIM interagency team that identified state priorities to promote health care system improvement. RI SIM is a public/private partnership whose steering committee includes state agency leaders as well as health care sector professionals, community organization leaders, and patient advocates. The steering committee identified strategies, programs, and activities to be funded and provides high level oversight of implementation. The SIM Grant activities focused on MCH populations were aligned with the state's Title V block grant priorities. Key MCH activities supported through RI SIM efforts include:

- Funding for the PCMH-Kids statewide medical home initiative explained above.
- Funding for the establishment of a pediatric psychiatric teleconsultation program called Pedi-PRN (Psychiatry Resource Network) and staff support for the application for HRSA funding to expand the Pedi-PRN program.

- Completion of a data project bringing together multiple stakeholders and utilizing several data sources to better define child and adolescent obesity rates in RI.
 - Interagency braided funding model to create enhanced community health teams specializing in support for pregnant and postpartum women, and children and youth, and families affected by substance use disorder. These new community health teams will be an extension of the prenatal care or primary care medical home and will begin serving clients in the summer and fall of 2019.
 - Funding for work by the state's Office of the Health Insurance Commissioner to analyze barriers to implementing integrated behavioral health in primary care.
 - Established a forum for annual meetings on the states clinical quality "Aligned Measure Set" where stakeholders provide input on clinical quality measures that are mandated through insurer contracts with health care providers, hospitals, and Accountable Care Organizations.
- ***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. There are currently 20 members from the community who represent the diversity of RI as individuals of or representing racial / ethnic minorities (Latino, Native American, and Black), persons with disabilities, LGBTTTQQ, and people with limited English proficiency. The 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. CHAE often invites and welcomes representatives from RI's state agency.

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 plan for the upcoming report due December 2019 is to roll out RI's Statewide Health Equity Indicators and report on the disparities identified in RI's 23 Population Health Goals.

To date, CHAE has issued three letters of support for legislation, co-sponsored legislation on minimum wage, joined state-level policy workgroups, conducted a press briefing on Health In All Policies, hosted a health equity/minority health celebration event, sponsored a "Hill Day" for Health Equity Zone collaborative members to engage with legislators, issued their Disparity Report, aligned priorities with RI's SIM initiative, joined the RI PolicyLink Delegation, trained 2 commission members on conducting Health Impact Assessments, and co-sponsored the RI Health Equity Summit. Plans for 2019-2020, include increased collaboration with RIDOH health equity initiatives including minority youth mentoring programs addressing high school graduation, the community health worker association, and actively raising the awareness and resources required to achieve equity in RI.

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 2018-2019, youth resource specialists led a monthly Youth Advisory Council where an average of 30 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 480 students; and presented at the Turn Up Rhode Island Conference featuring career exploration for 300 students of color.

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 MomsPRN Program is a new statewide initiative at the RI Department of Health, funded by HRSA-18-101 Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program, that seeks to assist obstetrical, adult primary care, pediatric, and adult psychiatric providers in optimizing behavioral health care for pregnant and post-partum women. To achieve this end, a psychiatry consult line that is staffed by perinatal experts at the Center for Women's Behavioral Health at Women and Infants Hospital is available to help answer clinical and referral questions among calling providers caring for pregnant and postpartum women. Additional individualized quality improvement coaching will be provided to prenatal care practices seeking to implement maternal behavioral health screening, referral and treatment into their workflow. Ongoing continuing education and evaluation efforts will be used to enhance care, identify improvements, share best practices, and measure outcomes.

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. Activities include prompt telephonic consultations, including recommendations for medical prescribing; face to face psychiatric evaluations, as needed, with return to the treating primary care practitioner for medication management; phone availability for ongoing collaboration; referral to other mental health services and programs, and short-term therapy to bridge children awaiting the appropriate behavioral health services. In addition, PediPRN offers educational activities focusing on creating a culture of empowerment for pediatric primary care providers. Through CME opportunities, educational e-blasts and the PediPRN Intensive Program (PIP), the project offers training and educational support.

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 (VIPPP) 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 VIPPP 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: Three communities were supported to implement this strategy in one early care and education setting per community. Expected outcomes include, higher classroom functioning, better capacity of teachers to support children, early identification and referral for mental/behavioral health issues, reduced child behavioral problems and reduced rates of expulsion of children for behavioral problems.

Mental Health Consultation primary care settings: Three communities were supported to implement this strategy in 5 primary care practices. Expected outcome include increasing the capacity of primary care providers to address behavioral health issues, early identification and referral for mental/behavioral health issues, increase enrollment of children in services that support positive behavioral health.

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 currently conducting 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 comprehensive 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 Visiting Program will continue to support its' 12 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. One level is mental health consultation to family visitors. The Family Visiting Program provided each family visiting agency with dedicated funding in the agency's contract last year that may be used for mental health consultation and supportive services. The Family Visiting Program will continue to do so in future contracts.

In addition to providing funding to each family visiting agency, the Family Visiting Program has partnered with the RI Association for Infant Mental Health (RIAIMH) to provide additional support to the family visiting workforce. The

Family Visiting Program will continue to work with RIAIMH on training and support related to infant mental health. The Family 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 visiting staff have the competencies and skills to support the parent-child relationship and promote positive parenting practices that address the needs of infants.

- ***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 has implemented the SPI Youth Suicide Prevention work to some degree in every town in Washington County. The VIPP has also implemented the Emotional Regulation program in on SCHEZ middle school (Westerly). The VIPP has also participated in the HRSA funded Collaborative Office Rounds grant the HEZ has received and is targeted to local pediatricians. The Program also held a training with local pediatricians and the Bradley Hospital Pedi PRN. PediPRN is a State Innovation Model grant funded initiative providing tele-psychiatry access to pediatricians for medication management and other consultative services. 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 policies 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

- ***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.

This 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. This year, 54 families, including 68 children, received a total of 335 visits, and 9 group sessions were offered. Boys Town also offered one Common Sense Parenting program at a local elementary school to help parents communicate effectively with their

children.

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.

Finally, the Courageous Kids: Stand up to Stand Out program, a weeklong character-building summer program, was offered to help children learn to make healthy choices and strengthen their self-esteem, while also highlighting people in the community, like police, firefighters, and teachers, who can support the children. This program includes daily speakers, free dinners donated by local restaurants, free backpacks with school supplies to all children, and a community family movie night at the end of the week. Next year, the program will be expanded to be offered to up to 125 youth in Bristol.

Newport

The Newport Health Equity Zone currently hosts a breastfeeding support group for women of color to offer a safe space for women of color to gather for support, to share their challenges and victories, and to obtain education and resources related to breastfeeding. This year, a representative from the Newport HEZ attended the Black Mamas Matter Maternal Health Conference and Training Institute in Atlanta, Georgia. This conference assembled Black women, clinicians, professionals, advocates, and other stakeholders working to improve maternal health, and fostered learning and rich discussion, using the birth justice, reproductive justice, and human rights frameworks.

The Newport HEZ also hosted its second annual Community Baby Shower, in collaboration with Newport Hospital, Planned Parenthood, and community volunteers. This event offered free items and resources for expecting parents and families with children under five in the Newport community. Over 1,500 diapers were donated, along with clothing, furniture, and other essentials for babies and new parents.

A Community Health Worker Fellow in the Newport HEZ was certified through a Maternal Child Health Specialist training and certification program. This program is offered to health navigators, community health workers, outreach personnel, care coordinators, home visitors, doulas, childbirth educators, lactation educators, nurses, midwives, and physicians, and it provides ways to navigate through systems that provide perinatal health care for women at risk for poor obstetric outcomes.

The Newport HEZ also sent a Community Health Worker and a Community Health Worker Fellow to the Rhode Island Breastfeeding Coalition's Pearls of Wisdom Breastfeeding Conference. This conference provided information and education on breastfeeding, best practices in other countries, and highlights of baby-friendly hospitals. Lastly, the Rhode Island Department of Health hosted a 5-day training to become a Certified Lactation Counselor. The Newport HEZ was able to certify a Community Health Worker through this training, who now works as a Certified Lactation Consultant with the HEZ's breastfeeding group for women of color.

Pawtucket/Central Falls

In the Pawtucket Central Falls HEZ, the Blackstone Valley Community Action Program (BVCAP) worked to promote breastfeeding education and resources through their network. BVCAP's breastfeeding counselor works closely with expectant and new mothers to provide lactation consultants, support groups, and educational resources on breastfeeding. The Community Health Worker at BVCAP connects new and expectant mothers to available resources and BVCAP's breastfeeding counselor provided lactation consultations to 40 women, and resources and peer support to another 30 women.

The Childhood Lead Action Project (CLAP) continued to provide lead poisoning prevention and education to the Pawtucket and Central Falls communities. In the Pawtucket Central Falls HEZ, CLAP conducted community outreach at six locations, including housing authorities, health fairs, and a summer food program. CLAP also facilitated six lead poisoning prevention workshops and provided education to 115 families, landlords, and tenants throughout the HEZ. There have been 150+ Notice of Violations issued, and 170 homes have been made lead-safe due to the work of CLAP. These efforts have resulted in a 44% decrease in childhood lead poisoning in Pawtucket.

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. This year, 13 new cities joined the county-wide efforts that engage schools, preschool/child care organizations, public libraries, parks and recreation departments, food pantries, community health centers, healthcare providers, local businesses, and two local hospitals. Almost 40 policy, systems, and environmental changes have been implemented, including elimination sugary foods and drinks from menu offerings, making water and fruit more available, and improving the appearance of healthier foods in cafeterias.

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. This year, a total of 76 families were engaged in the Incredible Years Parenting program with almost half (n=34) participating in all 22 weeks.

West Warwick

This year, the West Warwick Health Equity Zone hosted a multitude of physical activity and nutrition classes (Zumba, Yoga, Fitness, EFNEP) for women, children and families at their HEZ Hub community space. Classes were free and inclusive of LGBTQ+ families, and sponsored 4 classes specifically for those who are transgender/gender non-conforming and their families or guests. The HUB increased their offerings from 9 classes up to 14 classes, and more than doubled participation. The University of Rhode Island' Expanded Food and Nutrition Education Program (EFNEP) offered 2 summer classes with a piloted childcare component, which resulted in a 50-200% increase in sign-up and maintained attendance over each 9-week course. The West Warwick HEZ is also collaborating with the Town of West Warwick to install the youth portion of a multi-generational fitness space in River Point Park.

To address food insecurity for West Warwick families and Children, the West Warwick HEZ continues to promote Farm Fresh RI's 'double your SNAP value' at farmer's markets. The weekly Summer Farmers Market and three WIC focused pop-up farmer's markets experienced a 38.7% increase in SNAP sales, and a 117% increase in customers. The West Warwick Library's and Sodexo's Summer Meals program for young people under 18 saw a 9% increase this year, after a 17% increase the previous year.

West Warwick Public Schools Implemented a 3-tier trauma-informed high school initiative and trained 80% of their high school staff on the first tier and a group of 15 for the second tier. The West Warwick HEZ provided a training for 15 foster and kinship caretakers called "How Trauma Shows Up for Kids" by Family Service of Rhode Island's

Trauma and Loss experts, and the event was livestreamed and is now available on the WWHEZ Facebook page. 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.

Thundermist has continued to implement healthy vending machines and expanded worksite wellness activities, and has initiated Size-Inclusive Best Practices, to provide the highest quality of care for everybody, with a focus on non-biased, equitable treatment. This practice recognizes that weight stigma is a social determinant of health that impacts the health of patients, leads to avoidance of healthcare appointments and screenings, and is a driver to the development of eating disorders, depression, anxiety, body dissatisfaction, malnutrition, and other health conditions independent of a person's size.

Woonsocket

In the Woonsocket HEZ, Thundermist expanded physical activities specifically for those who are transgender/gender non-conforming and their families and guests. The library held Zumba classes, and the YMCA facilitated healthy kids' days and healthier communities' initiatives, including access to healthy foods and physical activity. The Connecting Children and Families program continued to provide school-age programs including cooking and karate.

The Woonsocket HEZ continued to promote Farm Fresh RI's 'double your SNAP value' at farmers markets. Due to lack of attendance, the weekly winter farmer's market was discontinued and replaced with monthly winter farmer's markets near the Woonsocket WIC office inside the Thundermist clinic, which averaged 40-50 customers.

The Teen Health Chairs engaged Youth in Action to guide the workgroup in engaging youth to amplify the voice of teens with lived experience. Riverside youth is developing a peer-to-peer outreach campaign for teens. Thundermist continued to ask the One Key Question and worked to increase yearly primary care visits for adolescent patients. Woonsocket has seen over a 30% decrease in unplanned births to teens over the past 4 years.

The Teen Health Group embedded a Family Planner and Sexuality Educator in Woonsocket High School and implemented an inclusive, medically accurate, comprehensive, and evidence-based health curriculum for all 9th grade students. The school-based health center reported an increase of first-year students who have received services.

Thundermist Wellness Committee implemented healthy vending machines and expanded worksite wellness activities and continued to offer incentives for staff to engage in physical activities or spend at farmers markets. Thundermist has initiated Size-inclusive Health Best Practices, to provide the highest quality of care for every body, with a focus on non-biased and equitable treatment. This practice recognizes that weight-stigma, especially for women and girls, is a social determinant of health, and leads to avoidance of health care appointments and screenings and is linked to the development of eating disorders, depression, anxiety, body dissatisfaction, malnutrition, and other physical and psychological health conditions independent of a person's size.

Providence

The Providence Health Equity Zone continued to bicycle education throughout the city, and plans to expand the Recycle-a-Bike's Pedal Power programs at recreation centers. Promotion of farmer's market incentives for SNAP/EBT recipients contributed to a 34% increase this past year. The HEZ facilitated youth-led training on equity in outdoor spaces and recreation to Providence Public Schools teachers, with the goal of expanding these trainings on youth access to parks and natural spaces in the future. The Providence HEZ also engaged youth in a community gardening program, and led workshops on topics such as healthy relationships, healthy eating, and nutrition. The

HEZ also continued the Summer Food Service Program and free dinners in all Providence recreation centers.

Olneyville

The Olneyville Health Equity Zone continued its efforts to improve housing throughout the HEZ. ONE Neighborhood Builders, the HEZ's backbone agency, has provided safe, healthy, affordable housing to low-income Olneyville residents, leading to an improvement in overall neighborhood safety. The Olneyville HEZ also hosted their annual "Fall Festival" and continued summer youth programming from the YMCA and Woonasquatucket River Watershed Council. The walking school bus program to and from William D'Abate Elementary school continued to flourish, providing regular activity for the children who participate, and paid employment/volunteer hours for Olneyville residents. The HEZ also supports a mindfulness program at William D'Abate Elementary school taught by instructors from the Center for Resilience.

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 Navigante 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 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: 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 Training - RIDOH recently received a grant from the Kresge Foundation's Emerging Leaders in Public Health (ELPH) initiative to support agency transformation that helps us better integrate social justice approaches into our work. As part of this work, RIDOH is partnering with The Praxis Project and Berkeley Media Studies Group (BMSG) to host a one-day intensive training to help us communicate more effectively about issues and topics related to social justice and health equity. This professional development opportunity has value for every Division, Center, and Program at RIDOH, as we apply a health equity lens to work conducted across the Department.

The objectives of the training are to build capacity across RIDOH Divisions for:

- Social impact communications – using communications science to influence perceptions, behaviors, and

- policy outcomes to advance social justice and health equity
- Public health policy advocacy and message framing
- Strategic storytelling
- Social media and digital communications advocacy and outreach

The Praxis Project is a national non-profit working toward health justice for all. <https://www.thepraxisproject.org/> [thepraxisproject.org] BMSG is a nonprofit organization dedicated to expanding advocates' ability to improve the systems and structures that determine health. <http://bmsg.org/> [bmsg.org]

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. There are currently 20 members from the community who represent the diversity of RI as individuals of or representing racial / ethnic minorities (Latino, Native American, and Black), persons with disabilities, LGBTTTQQ, and people with limited English proficiency. The 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. CHAE often invites and welcomes representatives from RI's state agency.

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 plan for the upcoming report due December 2019 is to roll out RI's Statewide Health Equity Indicators and report on the disparities identified in RI's 23 Population Health Goals.

To date, CHAE has issued three letters of support for legislation, co-sponsored legislation on minimum wage, joined state-level policy workgroups, conducted a press briefing on Health In All Policies, hosted a health equity/minority health celebration event, sponsored a "Hill Day" for Health Equity Zone collaborative members to engage with legislators, issued their Disparity Report, aligned priorities with RI's SIM initiative, joined the RI PolicyLink Delegation, trained 2 commission members on conducting Health Impact Assessments, and co-sponsored the RI Health Equity Summit. Plans for 2019-2020, include increased collaboration with RIDOH health equity initiatives including minority youth mentoring programs addressing high school graduation, the community health worker association, and actively raising the awareness and resources required to achieve equity in RI.

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 largely came 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. Approximately 41% of arrivals are under the age of 18 and 59% are 18 years or older.

All newly arrived 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 LGBTTTQQ (Lesbian, Gay, Bisexual, Trans, Two-Spirit, Queer and Questioning) public health policies, systems, and environmental change. LGBTTTQQ 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. LGBTTTQQ 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 LGBTTTQQ health inquiries, and build relationships with other organizations to improve LGBTTTQQ 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.
- **LGBTTTQQ+ Health Resources** - RIDOH has developed a list of resources that RI LGBTTTQQ+ 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 LGBTTTQQ+ 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 LGBTTTQQ+ 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 4300 calls per month on behalf of the Department's programs and the Director's office. 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 in to 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.

Family to Family Health Information Center - Family-to-Family Health Information Centers (F2FHICs) are non-profit, family staffed organizations that help families of children and youth with special health care needs (CYSHCN) and the professionals who serve them. Family-to-Family Health Information Centers aid in a variety of ways, including support and referral, training workshops, advocacy, and sharing information via websites, newsletters, and other publications.

The Health Resources and Services Administration (HRSA) provides the primary funding and supports F2FHICs in all states and the District of Columbia. In RI, the F2FHIC is housed within Family Voices (FV) at the RI Parent Information Network (RIPIN). Family Voices, through the National Center for Family and Professional Partnerships, provides technical assistance, training, and connections to other F2FHICs. Data is collected in order to demonstrate the need for providing assistance to help the F2FHICs meet their accountability requirements. During the last grant period, the RI Department of Health (RIDOH) partnered with FV to support utilization of the F2FHIC in facilitate improved system coordination in communities and statewide for CYSHCN and their families.

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. Data collection of Head Start and Cedar Family Centers enrollment data has begun and will be rolled out to all agencies as soon as possible. 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 are working 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.

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. Once completed, 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 screening. The project will be complete, or near complete, by September 30, 2019.

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.

PRAMS data & maternal depression – RI KIDS COUNT used PRAMS data to produce an Issue Brief on maternal depression in RI and release it at a Policy Roundtable on January 22, 2018. Cross-departmental recommendations were developed through this process including recommendations to improve 1) health insurance coverage and policies for maternal depression screening and treatment, including payment for dyadic therapy; 2) public health activities to help prenatal and pediatric health care providers deliver universal, routine maternal depression screening and to ensure all pregnant and parenting mothers who screen positive are connected to resources for further evaluation, diagnosis and treatment, 3) integrating maternal depression screening/treatment into large early childhood systems that serve mothers with newborns and young children, including Early Intervention (Part C of IDEA) and Family Home Visiting; 4) professional development on maternal depression for health care providers and early childhood professionals, 5) public awareness through a statewide campaign, and 6) strategies to reduce risk factors that contribute to maternal depression (poverty, unintended pregnancy, domestic violence, untreated mental health problems, etc.)

Since the release of the Issue Brief, new collaborative activities are underway to improve the identification and treatment of maternal depression including: the development of a Rhode Island Think Babies policy campaign, drafting maternal depression legislation, and a federal grant was secured to address maternal depression.

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.

In 2019, 166 questions were asked on the survey. Of these, 86 are part of the national survey and 80 were recommended by the Rhode Island Department of Health. 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. Several examples of how this data were used in the past year include:

- BRFSS data were used to inform or support legislative proposals and policy decisions. The Oral Health Program developed a proposal for the Medicaid Adult dental benefit to be expanded in the Medicaid budget initiatives; BRFSS data were highlighted and shared with the Governor's Office. The Tobacco Control Program included in BRFSS data in written testimony when supporting RI TCP legislative priorities including increasing the tobacco sale age to 21, smoke free policies for state and college campuses, and increasing tax on tobacco products including electronic cigarettes. Fact sheets were also developed from the written testimony to include key data points to be provided to state legislators.
- The Health Equity Institute used BRFSS data to assess progress toward meeting state health objectives or performance measures. Health disparities were identified in key metrics of the Population Health goals (obesity, physical activity, smoking, cancer screening). Data are expected to be included in a disparities report by the Health Equity Institute with anticipated completion at the end of 2019.
- The WISEWOMAN program shared BRFSS data with the CDC regarding the prevalence of hypertension and related risk factors along with diet and physical activity as one activity to evaluate disease prevention programs.
- Maternal and Child Health Program/Title V created a MCH Dashboard of National and state performance/outcome measures using BRFSS data for program planning purposes. The Center for HIV,

Hepatitis, STDs and TB Epidemiology (CHHSTE) also used BRFSS data for program decision-making. The information collected from the BRFSS has been influential in allowing CHHSTE to estimate the number of people who may be at risk for HIV and have never been tested for HIV. It was included in the jurisdictional plan that was created in conjunction with EOHHS. It allows programs to estimate the size of the populations that may be most at risk, as well as to determine if those who are at highest risk receive adequate testing.

- The Office of Immunization monitors BRFSS adult influenza vaccination coverage rates, and the survey results are used to support policy decision making for RI's adult vaccine program. BRFSS data are disseminated to vaccine policy makers through varied presentations.

The Youth Risk Behavior Survey (YRBS) - 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. The YRBS was administered from January-May 2019, but the most recent data available are from 2017. 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. 2017 YRBS programmatic data applications include:

- 2017 YRBS data were presented in a recent school official report. To communicate YRBS data in a way that is meaningful to school officials, the report was aligned with Social and Emotional Learning (SEL) competencies. Topics addressed on the YRBS align with three of the five SEL core competencies: self-management, relationship skills, and responsible decision making. Skills that support these three competencies include recognizing and managing emotions, making responsible decisions, establishing positive relationships, and handling challenging situations effectively. School administrators can use YRBS data to promote social and emotional learning and promote students' well-being. Developing social and emotional skills is directly related to academic achievement and healthy behavior. Students with high social and emotional competencies are more likely to be active and successful learners and are less likely to engage in substance use, sexual activity, and have mental health problems.
- The MCH Program supports 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 Oral Health Program and Youth Suicide Prevention Program analyzed 2017 YRBS data to examine the association between oral and mental health status. The goal was to determine if oral health could potentially be an indicator for mental health concerns, as youth that are feeling self-conscious or embarrassed by one's teeth or mouth may be associated with poor mental health. 2017 data suggest an association and the two programs are collaborating on possible interventions such as integrating mental health screening into the medical risk assessment performed by dental providers to identify young people who would benefit from resources and services pertaining to mental health.
- The YRBS program and the Tobacco Control Program (RITCP) partnered with RI KIDSCount to update 3 Issue Briefs related trends in Youth Tobacco Use: E-Cigarettes and Vaping, Factors Influencing Youth Use, and State and School Tobacco Policies.
- STD and HIV Prevention Programs: YRBS data on sexual activity and condom usage are used to track trends of high-risk sexual behavior among adolescents over time. This information is then used to inform policy and to implement relevant interventions to improve adolescent sexual health. Furthermore, by asking

about gender identity and gender expression, RIDOH programs can measure health disparities among gender minority populations.

- Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH): Programs at BHDDH partner with RIYRBS to include questions about misuse of prescription drugs and over the counter drug use to inform the Governor's Overdose Task Force and obtain Rhode Island specific data to apply for grant opportunities to address teen substance use.

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 building upon internal and external partnerships and synergy to establish the RIDOH Culture of Learning at the department. The RIDOH Academic Center supports two areas of engagement to achieve these goals: the Public Health Education and Research Academy (PHERA), and the Workforce and Career Development Network (WCDN).

Public Health Education and Research Academy - Through the work of the RIDOH Academic Center, 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, Rhode Island College, Roger Williams University, 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.

The RIDOH Academic Center's PHERA also facilitates forums for collaborative state-academic partnerships 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.

Between June 2017 – June 2018, RIDOH staff helped author the following MCH related journal articles:

1. :
 1. [State Unintentional Drug Overdose Reporting Surveillance: Opioid Overdose Deaths and Characteristics in Rhode Island](#). Jiang Y, McDonald JV, Goldschmidt A, Koziol J, McCormick M, Viner-Brown S, Alexander-Scott N. R I Med J (2013). 2018 Sep 4;101(7):25-30.
 2. [MEASURING REFLECTIVE SUPERVISION WITHIN HOME VISITING: CHANGES IN SUPERVISORS' SELF-PERCEPTION OVER TIME](#). Low CM, Newland R, Silver RB, Parade S, Remington S, Aguiar S, Campagna K. Infant Ment Health J. 2018 Sep;39(5):608-617.
 3. [Oral Health Concerns and Connections to Mental Health among Rhode Island High School Students, 2017](#). Pellegrino A, Vendetti T, Jackson T, Zwetchkenbaum S. R I Med J (2013). 2018 Oct 1;101(8):56-59.
 4. [Disparities in Health Risk Behaviors and Health Conditions Among Rhode Island Sexual Minority and Unsure High School Students](#). Jiang Y, Reilly-Chammat R, Cooper T, Viner-Brown S. J Sch Health. 2018 Nov;88(11):803-812.

5. [The Cost and Cost-utility of Three Public Health HIV Case-finding Strategies: Evidence from Rhode Island, 2012-2014.](#) Li XC, Kusi L, Marak T, Bertrand T, Chan PA, Galárraga O. AIDS Behav. 2018 Nov;22(11):3726-3733.
6. [Assessing Educational, Developmental, and Parent Support Services Received by Families of Children with Craniofacial Birth Defects.](#) St John K, Houle DL, Viner-Brown S. R I Med J (2013). 2018 Nov 1;101(9):41-43.
7. [Action-focused, plain language communication for overdose prevention: A qualitative analysis of Rhode Island's overdose surveillance and information dashboard.](#) Waye KM, Yedinak JL, Koziol J, Marshall BDL. Int J Drug Policy. 2018 Dec; 62:86-93.
8. [Increasing Syphilis in Rhode Island: Return of an Old Foe.](#) Junco-Fernández A, Montgomery MC, Crowley C, Bertrand T, Marak TP, Maynard MA, Gummo C, Flanigan TP, Chan PA. R I Med J (2013). 2019 Feb 1;102(1):50-54.
9. [Childhood Cancer in Rhode Island.](#) Muhlbauer N, Oh J, Renaud T, Welch J. R I Med J (2013). 2019 Feb 1;102(1):46-49.
10. [Can Statewide Emergency Department, Hospital Discharge, and Violent Death Reporting System Data Be Used to Monitor Burden of Firearm-Related Injury and Death in Rhode Island?](#) Jiang Y, Ranney ML, Sullivan B, Hilliard D, Viner-Brown S, Alexander-Scott N. J Public Health Manag Pract. 2019 Mar/Apr;25(2):137-146.
11. [Increased overdose mortality during the first week of the month: Revisiting the "check effect" through a spatial lens.](#) Goedel WC, Green TC, Viner-Brown S, Rich JD, Marshall BDL. Drug Alcohol Depend. 2019 Apr 1;197:49-55.
12. [Community-Led Initiatives: The Key to Healthy and Resilient Communities.](#) Amobi A, Plescia M, Alexander-Scott N. J Public Health Manag Pract. 2019 May/Jun;25(3):291-293.
13. [Tobacco Product Availability Following Point-of-Sale Policy Implementation in Rhode Island.](#) Arnold J, Pearlman DN, Orr M, Guardino G. R I Med J (2013). 2019 Jun 4;102(5):53-56.

AMCHP Data Communications E-Learning Collaborative - From April to November 2018, RIDOH staff including the MCH Data Manager, MCH Epi, MCH Program Manager and an RIDOH Communications Specialist, participated in the AMCHP Data Communications E-Learning Collaborative. The goal of the collaborative was to develop a communications product highlighting the importance of an MCH issue. AMCHP provided technical assistance to translate analytic data into communications products, such as infographics, stories, or briefs for non-scientific audiences including program staff, policymakers, and community partners. Rhode Island chose to develop a maternal mortality and morbidity data brief. The document has been reviewed by the RIDOH MCH Policy Team and the Disparities in Infant Mortality Advisory Board. Feedback and recommendations will be incorporated before the data brief is finalized.

Plans for Next Year: Cross-Cutting Strategies

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 initiatives 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 comprehensive 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.

III.F. 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)*

Title V Public Comment Period

RIDOH plans to get feedback from the community on the 2018/2019 Title V application and annual report. Following the submission of the application to HRSA on July 15, 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, 2019 and will be incorporated into the final document that will be submitted to HRSA at the end of September.

Strategic Planning

Family Visiting Program

During 2018-2019, RI's Family Visiting Program went through a strategic planning process. Community and family participation has been a cornerstone of the planning and launch of the strategic planning process. RIDOH staff worked with the 12 Local Implementing Agencies to identify staff and families to participate. They provide input all strategic planning workshops and participate in between meetings via surveys and other feedback opportunities. The Family Visiting Program also conducted a series of focus groups across the State to inform priorities of the strategic planning process. Families that participate in family visiting and those that have never engaged were invited to provide feedback on what drives a family to participate, barriers to participation, what they like about family visiting, what could be improved upon, what their goals are for their families and what a coordinated early childhood system looks like to them. Families also provided feedback on mission and vision statements for family visiting. 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.

Program Evaluation

Perinatal and Early Childhood Health Programs

In the Winter of 2019 several of RIDOH's early childhood programs conducted focus groups and interviews with community partners and families about engaging families in services, including Family Home Visiting, Mental Health services (LAUNCH), Parent Education and support services. The following groups were surveyed:

1. Families who participated in WIC
2. Families who participated in Family Home Visiting
3. Family Home Visiting Providers
4. Pediatric Primary Care providers

Focus groups were mainly conducted in the core cities (Providence, Central Falls and Woonsocket). These focus groups and key informant interviews took place at different times and the results were summarized for the programs. Families reported that barriers to participating in services such as transportation, time commitment, perceived stigma and needing child care for other children. Family home visitors noted that sometimes it was difficult to schedule times with families, that the work was highly stressful and they would have appreciated additional support, also that they were very committed to the work and found it engaging. Providers suggested that it can be difficult for a family to stay for an additional (Mental Health) appointment and it could be hard for a families to come back for another appointment. They acknowledged the importance of incorporating mental health into the medical home.

Oral Health Program

During the Pawtucket Red Sox season, the RI Oral Health Program participated in their annual FanFest, which is a large festival for the neighborhood. During the event, the RI Oral Health Program asked attendees to complete a survey to gauge their knowledge of the age one dental visit and other oral health topics. Participants received an electronic toothbrush for participating. Fifty surveys were completed during the day. The RI Oral Health Program also uses community events to engage the public in general. The Program often learns about access issues or providers who are not providing care to pregnant women based on these interactions. It is also a great time to provide materials to families and talk about the importance of oral health during pregnancy in a relaxed atmosphere.

Women & Infants Hospital Kaizen

From June 25-27th, 2019, members of the RIDOH Perinatal and Early Childhood Health team participated in a Kaizen event, which is a short duration continuous quality improvement project, with Women & Infants Hospital (WIH) staff from their Obstetrics and Gynecology Care Center, Mother-Baby Unit, and Lactation and Social Work teams. The focus of the event was on this problem statement: Many pregnant and parenting families are offered multiple community-based resources and support services prenatally, immediately after birth, and at time of discharge from Women & Infants Hospital. Neither the messaging nor the service delivery is coordinated, which leaves both families and service providers confused, unsatisfied, and either under-engaged or over-engaged in services they don't understand. The goal of the event was to ensure that processes and systems are in place so that, 1) those offering the services to families provide clear and consistent messaging to all families; 2) all families, regardless of race, gender, religion, national origin, disability, and/or sexual orientation, are offered coordinated, family-centered, culturally competent services, as early as possible to ensure the best outcomes. Over the three-day event, the team identified steps in the process that are non-value added to the patient, developed action steps to address these, and mapped out an ideal state. Over the next few months the team will meet regularly and using the Plan-Do-Study-Act cycle will implement action plans, develop role-based standard work, and roll out a communication plan.

Birth Centers Regulatory Advisory Committee

Seeking improved access to low-intervention models of care, the MCH Program saw an opportunity to help revise key facilities regulations through a process that mandated every state agency to re-open and revisit all of its regulatory processes. The Birth Centers Regulatory Advisory Committee (BCRAC) was 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 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. The regulations are expected to go through the formal review process again this summer/fall before they are codified.

Needs Assessment Planning

The RI Title V Program is currently undertaking a comprehensive 5 year needs assessment process. The work is being coordinated with several other needs assessments: MIECHV Home Visiting (RIDOH), Preschool Development Grant Family Needs Assessment (DHS), Hospital Needs Assessments, and Health Equity Zones Needs Assessments. As much as possible, this work will be coordinated and aligned. Community, professional, and family input will be incorporated at various stages through the process including the development of Title V priority areas, strategies, and performance measures.

III.G. Technical Assistance

The following information represents a preliminary plan for technical assistance requests by RI's Title V Program.

TA #1: Maternal Mortality Review Committee – Consultant TBD

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. RI plans to seek technical assistance in the planning and development of a RI MMRC which will include recruitment, governance, data collection, clinical chart abstractions, and the structure of reports for public health awareness and policy development. RIDOH has received multiple inquiries from individuals who want to be a part of the committee, and it will be important to have a structured process for the formation of this committee.

TA: #2 Title V Needs Assessment – Community & Family Engagement – Abt Associates

As required by HRSA, RI's Title V Program is currently engaged in a comprehensive 5 year needs assessment process. RI plans to request technical assistance for the development and execution of community outreach strategy. Building off of the work that is currently underway in the Preschool Development Grant (DHS), the RI MCH Program aims to utilize a multipronged approach that will engage the community all critical points during the needs assessment process, including the identification of priorities areas and the development of strategies within each priority area. Community input will include both quantitative data (survey) and qualitative data (focus groups) and aim to collect data from a broad cross section of MCH stakeholders (medical community, community-based organizations, Health Equity Zones, and families).

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 2019, the MCH Program will seek consultation (maybe Kay Johnson) to understand, operationalize and measures SDOH that affect maternal and child health outcomes.

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 in 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 hospital's 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.

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 - [RIDOH Strategic Priorities.pdf](#)

Supporting Document #02 - [2019 RIDOH MCH Partnerships and Collaborations.pdf](#)

Supporting Document #03 - [HealthEquityZonesAugust2018.pdf](#)

Supporting Document #04 - [HealthEquityIndicators2019.pdf](#)

Supporting Document #05 - [FamilyVisitingStrategicPlan2019.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [OrgCharts_RI_2019.pdf](#)

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Rhode Island

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,950,000	
A. Preventive and Primary Care for Children	\$ 653,309	(33.5%)
B. Children with Special Health Care Needs	\$ 700,069	(35.9%)
C. Title V Administrative Costs	\$ 74,942	(3.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,428,320	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 2,281,459	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 2,450,041	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 38,024,089	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 42,755,589	
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)	\$ 44,705,589	
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)	\$ 66,841,053	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 111,546,642	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	\$ 550,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement	\$ 115,456
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 193,637
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)	\$ 697,192
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	\$ 284,340
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)	\$ 589,086
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose: Prevention for States Program	\$ 2,672,122
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 767,374
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 185,951
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 292,362
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	\$ 769,997
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	\$ 198,062
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	\$ 195,786
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 110,820
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 251,836
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 153,289

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,211,482
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 574,078
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Youth Suicide Prevention	\$ 863,995
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 23,666,138
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Asbestos	\$ 172,049
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Lead	\$ 204,585
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Radon	\$ 141,177
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Toxic Substance	\$ 57,875
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCCP)	\$ 825,481
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	\$ 1,668,940
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	\$ 515,565
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	\$ 166,560
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 1,536,168
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	\$ 15,095,832
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Care Access Program	\$ 313,443
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	\$ 8,506,174

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 386,201
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PPHF Tobacco Quitline	\$ 6,510
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Family Outreach	\$ 502,811
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhancing Cancer Registry	\$ 161,686
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > IMproving Arthritis	\$ 384,837
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Climate Change	\$ 199,259
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > OMH Stat Partnership	\$ 209,072
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Home Visiting CoOp	\$ 164,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid	\$ 779,987
Department of Health and Human Services (DHHS) > Other > OSHA	\$ 499,838

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,700,000		\$ 1,647,805	
A. Preventive and Primary Care for Children	\$ 525,647	(30.9%)	\$ 538,542	(32.6%)
B. Children with Special Health Care Needs	\$ 675,243	(39.7%)	\$ 661,914	(40.1%)
C. Title V Administrative Costs	\$ 88,294	(5.2%)	\$ 106,225	(6.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,289,184		\$ 1,306,681	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 2,071,934		\$ 1,921,703	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 30,958,381		\$ 30,515,416	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 33,030,315		\$ 32,437,119	
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)	\$ 34,730,315		\$ 34,084,924	
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)	\$ 76,482,469		\$ 65,403,192	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 111,212,784		\$ 99,488,116	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 275,994	\$ 257,183
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)	\$ 546,906	\$ 618,978
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 144,878	\$ 139,058
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	\$ 283,256	\$ 246,533
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)	\$ 449,726	\$ 584,718
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose: Prevention for States Program	\$ 1,802,818	\$ 2,479,012
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 743,030	\$ 676,024
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 141,678	\$ 151,065
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 235,223	\$ 219,767
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Public Health Actions-1422 Chronic Disease	\$ 3,926,215	\$ 4,177,556
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	\$ 2,230,847	\$ 2,320,025
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	\$ 15,810,689	\$ 12,409,050

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	\$ 187,749	\$ 185,970
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	\$ 175,000	\$ 201,482
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	\$ 147,331	\$ 183,643
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 83,376	\$ 101,667
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,400	\$ 245,561
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,059,204	\$ 1,137,180
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning Outreach	\$ 31,500	\$ 0
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 793,878	\$ 791,437
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Youth Suicide Prevention	\$ 799,378	\$ 751,939
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 25,247,431	\$ 21,957,892
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Asbestos	\$ 188,329	\$ 150,163
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Lead	\$ 123,916	\$ 164,907
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Radon	\$ 136,424	\$ 95,574
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Toxic Substance	\$ 51,949	\$ 121,028

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	\$ 772,750	\$ 842,742
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)	\$ 431,591	\$ 456,846
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 376,627	\$ 398,060
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	\$ 1,483,881	\$ 362,433
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	\$ 831,032	\$ 718,063
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 10,911,252	\$ 7,243,037
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 737,647	\$ 936,093
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	\$ 145,232	\$ 167,348
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 1,554,506	\$ 1,470,083
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement	\$ 70,485	\$ 66,948
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Child Care Support	\$ 170,000	\$ 7
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PPHF Tobacco Quitline	\$ 49,966	\$ 44,555

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Family Outreach	\$ 500,000	\$ 511,485
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhancing Cancer Registry	\$ 125,489	\$ 142,945
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Improving Arthritis	\$ 222,220	\$ 197,155
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Climate Change	\$ 276,282	\$ 187,166
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > OMH State Partnership	\$ 199,571	\$ 272,103
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Home Visiting CoOp	\$ 164,000	\$ 40,250
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Special NEEDS System Integration	\$ 280,182	\$ 1
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid	\$ 732,333	\$ 416,595
Department of Health and Human Services (DHHS) > Other > OSHA	\$ 505,198	\$ 513,622
US Department of Housing and Urban Development (HUD) > Community Planning and Development > Hurricane Sandy	\$ 75,100	\$ 48,243

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2020
	Column Name:	Application Budgeted
	Field Note:	
		MCH State \$4,502 CHE Associate Director \$103,571 Newborn Screening RR \$2,173,386
2.	Field Name:	5. OTHER FUNDS
	Fiscal Year:	2020
	Column Name:	Application Budgeted
	Field Note:	
		Minority Health \$446,665 Primary Care State Medicaid \$102,555 Occupational Health Lead \$221,800 Lead Inspection Medicaid \$33,750 Medicaid Admin State \$196,392 Health Risk Assessment \$635,383 Occupational and Radiological Health \$107,236 OSHA State \$131,334 Cancer Registry \$146,971 Tobacco Control State \$368,830 Smoking Cessation State \$26,125 Lead Prevention RR \$33,000
3.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2020
	Column Name:	Application Budgeted
	Field Note:	
		State Loan Repayment \$1,650,000 Childhood Immunization \$18,231,513 Adult Immunization \$17,756,177 Women's Cancer RR \$15,000 FH State Med \$371,399
4.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2018
	Column Name:	Annual Report Expended

Field Note:

MCH State \$1
Associate Director \$78,834
Newborn Screening RR \$1,842,868

5. **Field Name:** **6. PROGRAM INCOME**

Fiscal Year: **2018**

Column Name: **Annual Report Expended**

Field Note:

FH State Med \$345,690
Loan Repay RR \$594,488
Childhood Immunization \$15,253,202
Adult Immunization \$14,316,447
Women's Cancer Screening \$5,589

Data Alerts:

- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

**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 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 304,400	\$ 200,804
2. Infants < 1 year	\$ 325,642	\$ 237,806
3. Children 1 through 21 Years	\$ 327,667	\$ 300,751
4. CSHCN	\$ 700,069	\$ 661,914
5. All Others	\$ 217,280	\$ 140,305
Federal Total of Individuals Served	\$ 1,875,058	\$ 1,541,580

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 434,157	\$ 364,834
2. Infants < 1 year	\$ 822,110	\$ 696,551
3. Children 1 through 21 Years	\$ 15,571,066	\$ 13,034,360
4. CSHCN	\$ 1,934,571	\$ 1,629,027
5. All Others	\$ 19,243,615	\$ 14,767,771
Non-Federal Total of Individuals Served	\$ 38,005,519	\$ 30,492,543
Federal State MCH Block Grant Partnership Total	\$ 39,880,577	\$ 32,034,123

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:	2020
	Column Name:	Application Budgeted
	Field Note:	Children 1-21 years does not equal Preventive and Primary Care for Children and Preventive and Primary Care for Children includes Infants < 1 year

2.	Field Name:	IA. Federal MCH Block Grant, 3. Children 1 through 21 years
	Fiscal Year:	2018
	Column Name:	Annual Report Expended
	Field Note:	Children 1-21 years does not equal Preventive and Primary Care for Children and Preventive and Primary Care for Children includes Infants < 1 year

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 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 0	\$ 34,267
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	\$ 27,756
C. Services for CSHCN	\$ 0	\$ 6,511
2. Enabling Services	\$ 907,343	\$ 699,884
3. Public Health Services and Systems	\$ 1,042,657	\$ 913,654
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		
Community Health Education (Teen Pregnancy Prev)		\$ 34,267
Direct Services Line 4 Expended Total		\$ 34,267
Federal Total	\$ 1,950,000	\$ 1,647,805

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 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	\$ 1,443,110	\$ 994,147
3. Public Health Services and Systems	\$ 41,345,479	\$ 31,997,221
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	\$ 42,788,589	\$ 32,991,368

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: 11,063

Data Source Year: 2018

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	11,022 (99.6%)	56	26	26 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric 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	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)	Primary Congenital Hypothyroidism
Propionic Acidemia	S, β Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies
β -Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	

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
Hearing Loss	10,975 (99.2%)	214	44	44 (100.0%)
Critical Congenital Heart Defect	10,988 (99.3%)	13	8	8 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Rhode Island Newborn Screening Program does short-term follow-up only.

Form Notes for Form 4:

Refusals and deceased infants are included as not screened.
Only conditions screened on the blood spot for the full year are included in "Newborn". Pompe Disease, Adrenoleukodystrophy, and Mucopolysaccharidosis were added to the RI screening panel as of 10/1/2018 so approximately one quarter of the births were also screened for those conditions. Hearing and CCHD are reported separately under "Other newborn".

Field Level Notes for Form 4:

1.	Field Name:	Critical Congenital Heart Defect - Positive Screen
	Fiscal Year:	2018
	Column Name:	Other Newborn
	Field Note:	Includes infants that failed pulse oximetry screening or were diagnosed prenatally or were symptomatic and had an echocardiogram.
2.	Field Name:	Critical Congenital Heart Defect - Confirmed Cases
	Fiscal Year:	2018
	Column Name:	Other Newborn
	Field Note:	There were an additional two confirmed cases that passed the pulse oximetry screen (false negatives).

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 2018

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2	78.2	0.0	18.2	0.0	3.6
2. Infants < 1 Year of Age	278	69.0	0.0	29.1	0.5	1.4
3. Children 1 through 21 Years of Age	6,261	59.2	0.0	27.1	13.6	0.1
3a. Children with Special Health Care Needs	1,558	63.3	0.0	24.0	11.4	1.3
4. Others	1,760	23.7	0.0	71.7	4.6	0.0
Total	8,301					

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	10,638	No	11,266	100	11,266	2
2. Infants < 1 Year of Age	11,198	No	11,199	100	11,199	278
3. Children 1 through 21 Years of Age	265,122	No	231,945	100	231,945	6,261
3a. Children with Special Health Care Needs	58,512	No	45,399	100	45,399	1,558
4. Others	783,594	No	774,747	47	364,131	1,760

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2018
	Field Note:	55 women received First Connections prenatal home visits, 4.5% of the contract budgets (2 women) were paid by Title V.
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2018
	Field Note:	# of unduplicated children under age 1 who had at least one First Connections home visit in 2018, plus # Level 1 risk positive infants born in 2018 where reason not seen = y (meaning they got some kind of outreach), plus Newport HEZ breastfeeding
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2018
	Field Note:	# served in the following programs (multiplied by the % of budget from Title V funding): First Connections, SealRI, Dare to Dream, RIPIN RIREACH, HARP, Familias Unidas, Youth Sports Concussion Program, and Teen Outreach Program.
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2018
	Field Note:	Number served in #3 times 20.5% (the percent of children with special healthcare needs from Children's Health Survey). 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:	2018
	Field Note:	# mothers of Level 1 risk positive infants born in 2018 where reason not seen = y (meaning they got some kind of outreach), plus parents of children seen in Familias Unidas, plus teachers attending Dare to Dream, plus adults over 21 living in HEZ communities that received Title V funding.

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2018
	Field Note:	Includes occurrence births (unduplicated multiples) plus fetal deaths. Does not include pregnancy terminations (spontaneous or induced). All deliveries occur in hospitals that Title V works with for Baby-friendly hospitals, safe sleep policy and substance exposed newborns/plans of safe care. Insurance coverage for prenatal and post-partum care, educational material. Some pregnant women also receive WIC, family-visiting, KIDSNET, referrals to family visiting may be offered to pregnant women whose pregnancy resulted in fetal death.
2.	Field Name:	InfantsLess Than One Year
	Fiscal Year:	2018
	Field Note:	All infants born in RI, including home births, receive newborn screening (bloodspot, CCHD, hearing) or outreach to document parent refusal. Those born in hospitals (>99%) receive a newborn 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:	2018
	Field Note:	2018 ACS Census estimates (PEPSYASEX table). All RI 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), Head Start. KIDSNET is used to ensure they have preventive healthcare such as immunizations, lead screening or receive services for which they are eligible such as 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:	2018
	Field Note:	2018 ACS estimates (PEPSYASEX table) times 20.5% Children with Special Healthcare Needs from Children's Health Survey.
5.	Field Name:	Others
	Fiscal Year:	2018
	Field Note:	The Rhode Island Health Equity Zones represent communities that are home to approximately 50% of the population. To deduplicate we have calculated the number of individuals in those communities over age 21 and subtracted the number of women over age 21 from those communities who gave birth. The Family Planning and home visiting programs reach many of these individuals and some programs include work with the prison populations. To prevent duplication these have not been include in the estimate as they are small and most would be already counted in the HEZ community populations.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Rhode Island

Annual Report Year 2018

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	11,063	6,159	725	2,777	33	523	4	309	533
Title V Served	11,063	6,159	725	2,777	33	523	4	309	533
Eligible for Title XIX	5,305	1,864	518	2,225	26	166	3	208	295
2. Total Infants in State	10,502	5,681	715	2,748	33	482	5	307	531
Title V Served	10,117	5,407	696	2,725	33	469	4	295	488
Eligible for Title XIX	5,162	1,780	508	2,198	26	162	3	200	285

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	2. Total Infants in State
	Fiscal Year:	2018
	Column Name:	Total
	Field Note:	includes out of state deliveries to RI residents

2.	Field Name:	2. Title V Served
	Fiscal Year:	2018
	Column Name:	Total
	Field Note:	includes only resident, occurrence births

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Rhode Island

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(401) 222-5960	(401) 222-5960
2. State MCH Toll-Free "Hotline" Name	RIDOH Health Information Line	RIDOH 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"		85,576

B. Other Appropriate Methods	2020 Application Year	2018 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	http://www.health.ri.gov/grants/titlevmaternalandchildhealth/	http://www.health.ri.gov/grants/titlevmaternalandchildhealth/
4. Number of Hits to the State Title V Program Website		364
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		8,494

Form Notes for Form 7:

None

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	Director, Health Equity Institute
Address 1	3 Capitol Hill
Address 2	Room 304
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	Director, Health Equity Institute
Address 1	3 Capitol
Address 2	Room 304
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	Kathleen Kupier
Title	Family Resource Specialist
Address 1	3 Capitol Hill
Address 2	Room 304
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
List of MCH Priority Needs

State: Rhode Island

Application Year 2020

No.	Priority Need
1.	Improving routine provision of preconception care and education (Women/Maternal Health)
2.	Increase breastfeeding awareness and social support (Perinatal/Infant)
3.	Address obesity/nutrition & physical activity for children (Child Health)
4.	Increase the capacity and efficiency of the adolescent systems of care (Adolescent Health)
5.	Continue to support the implementation of the Family Home Visiting Program (Perinatal/Infant Health)
6.	Improve the system of care of children and youth with special health care needs (CSHCN)
7.	Improve access to oral health services (Women/Maternal Health)
8.	Improve system coordination in communities and statewide to facilitate improved health outcomes (Cross-cutting/Life Course)
9.	Improve mental/behavioral health across the life course (Cross-cutting/Life Course)
10.	Adopt social determinants of health in public health planning and practice to improve health equity (Cross-cutting/Life Course)

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Improving routine provision of preconception care and education.	Continued	
2.	Increase breastfeeding awareness and social support (Perinatal/Infant)	Continued	
3.	Address obesity/nutrition & physical activity for children (Child Health)	New	
4.	Increase the capacity and efficiency of the adolescent systems of care (Adolescent Health)	Continued	
5.	Develop and support implementation of the Family Visiting Program (Women/Maternal/Perinatal/Infant)	Replaced	
6.	Improve the system of care of children and youth with special health care needs (CSHCN)	Continued	
7.	Improve access to dental services (Cross-cutting/Life Course)	New	
8.	Improve system coordination in communities and statewide to facilitate improved health outcomes (Cross-cutting/Life Course)	New	
9.	Improve mental/behavioral health across the life course (Cross-cutting/Life Course)	New	
10.	Adopt social determinants of health in public health planning and practice to improve health equity (Cross-cutting/Life Course)	Continued	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 1

Field Note:

Preconception care and education optimizes health across the life course, before and between pregnancies, to improve health outcomes. The goal is to integrate across health, education and social service and sectors to ensure comprehensive, effective, sustainable promotion.

Field Name:

Priority Need 2

Field Note:

Based on the top issues identified for perinatal/infant health around breastfeeding and women/maternal health around preconception care and education, important to highlight as a priority due to the need for awareness, especially within minority communities.

Field Name:

Priority Need 3

Field Note:

Identified as one of the top issues in and highlights the importance of the social determinants of health and their effect on the life course. Reframes RI's 2011-2015 SPM regarding the reporting of food insecurity.

Field Name:

Priority Need 4

Field Note:

Priority reframed to address adolescent health from a broader, systems of care approach

Field Name:

Priority Need 5

Field Note:

Related to 2011-2015 priorities #1 & 6; With the home visiting program initiated within the previous cycle, the emphasis is now on implementation and expansion

Field Name:

Priority Need 6

Field Note:

Related to 2011-2015 priorities #3 & 4;
Priority reframed to address CYSHCN from a broader, systems of care approach

Field Name:

Priority Need 7

Field Note:

Access to dental care was a common theme across the population, especially in women/maternal and child health; primary issue was identified as a system issue

Field Name:

Priority Need 8

Field Note:

Coordination among the various systems of care was a common theme across all domains and issues outlined in the needs assessment.

Field Name:

Priority Need 9

Field Note:

Mental/behavioral health was a top issue across all population domains, and in different capacities; primary issue was identified as a system issue

Field Name:

Priority Need 10

Field Note:

Social determinants of health and health equity continue to be an overarching policy of all MCH work, and aligns with the priorities of the Director of the Department of Health.

Form 10
National Outcome Measures (NOMs)

State: Rhode Island

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

NOM 3, 9.5, 15 - 2018 numerator is < 10 so is non-reportable

NOM 16.2, 16.3 - numerator is < 20 and should be interpreted with caution

NOM 16.3 - data source changed from Vital Records to Child Death Review, which is more accurate

NOM 22.1-22.5 and NPM 4A and 4B will be entered in September after 2018 National Immunization Survey data become available.

SPM 2 - 2018 numerator is < 10 so is non-reportable

SPM 5 - baseline 2017 is 60.9%, 2018 59.2%

SPM 6 - baseline 248 certified Community Health Workers in 2018 - objectives met early and adjusted upward

SPM 7 - baseline 7 in 2018 - objectives met and adjusted upward

SOM 3 & 4 - most recent survey year is 2017

SOM 7 - objectives met and adjusted upward

ESM 8.1.4 - baseline 68.7% in 2018

ESM 11.4 - baseline 4737 in 2018 - objectives exceeded and adjusted upward

ESM 12.4 - baseline 237 in 2017/18 - objectives exceeded and adjusted upward

ESM 13.1.1 - baseline 509 in 2018 - funding and 2 positions responsible for training were eliminated - training will continue at a reduced level - objectives modified accordingly

All 2018 mortality data are considered provisional and will be updated in September

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
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	
	2018
Annual Indicator	82.7
Numerator	8,363
Denominator	10,115
Data Source	Vital Records
Data Source Year	2018

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
2015	158.1	13.9	132	8,350
2014	159.0	12.2	174	10,943
2013	134.2	11.1	147	10,952
2012	181.9	12.9	202	11,108
2011	144.2	11.4	161	11,169
2010	149.2	11.6	168	11,262
2009	132.2	10.8	153	11,575
2008	84.7	8.4	103	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	
	2018
Annual Indicator	239.6
Numerator	248
Denominator	10,352
Data Source	Hospital Discharge Data
Data Source Year	2017

NOM 2 - Notes:

None

Data Alerts: None

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2018
Annual Indicator	11.2
Numerator	6
Denominator	53,660
Data Source	Vital Records
Data Source Year	2014-2018

NOM 3 - Notes:

Maternal mortality rate uses the WHO definition for maternal deaths (deaths related to or aggravated by pregnancy, but not due to accidental or incidental causes, and occurring within 42 days of the end of a pregnancy). The count is < 10 and is non-reportable.

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
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	
	2018
Annual Indicator	7.6
Numerator	798
Denominator	10,502
Data Source	Vital Records
Data Source Year	2018

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
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	
	2018
Annual Indicator	8.9
Numerator	937
Denominator	10,502
Data Source	Vital Records
Data Source Year	2018

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
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	
	2018
Annual Indicator	24.5
Numerator	2,575
Denominator	10,502
Data Source	Vital Records
Data Source Year	2018

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
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:
 Indicator results were based on a shorter time period than required for reporting

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
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	
	2018
Annual Indicator	4.8
Numerator	53
Denominator	11,001
Data Source	Vital Records
Data Source Year	2018

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
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	
	2018
Annual Indicator	4.6
Numerator	48
Denominator	10,502
Data Source	Vital Records
Data Source Year	2018

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
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	
	2018
Annual Indicator	3.5
Numerator	37
Denominator	10,502
Data Source	Vital Records
Data Source Year	2018

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
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	
	2018
Annual Indicator	1.0
Numerator	11
Denominator	10,502
Data Source	Vital Records
Data Source Year	2018

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
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	
	2018
Annual Indicator	219.0
Numerator	23
Denominator	10,502
Data Source	Vital Records
Data Source Year	2018

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
2016	NR 	NR 	NR 	NR 
2015	NR 	NR 	NR 	NR 
2014	NR 	NR 	NR 	NR 
2013	NR 	NR 	NR 	NR 
2012	91.5 	29.0 	10 	10,926 
2011	127.7 	34.2 	14 	10,960 
2010	89.5 	28.3 	10 	11,177 
2009	87.4 	27.7 	10 	11,442 

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

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	
	2018
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 in RI PRAMS phase 8 (2016-2017).

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
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	
	2018
Annual Indicator	11.1
Numerator	112
Denominator	10,126
Data Source	Hospital Discharge Data
Data Source Year	2017

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
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

State Provided Data	
	2018
Annual Indicator	9.4
Numerator	17,969
Denominator	191,541
Data Source	National Survey of Childrens Health
Data Source Year	2017

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
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:

None

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
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	
	2018
Annual Indicator	17.7
Numerator	23
Denominator	130,247
Data Source	Vital Records/ACS
Data Source Year	2018

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
2015_2017	5.9 ⚡	1.6 ⚡	13 ⚡	219,235 ⚡
2014_2016	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2013_2015	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2012_2014	6.2 ⚡	1.7 ⚡	14 ⚡	225,834 ⚡
2011_2013	7.0 ⚡	1.7 ⚡	16 ⚡	229,317 ⚡
2010_2012	6.8 ⚡	1.7 ⚡	16 ⚡	234,659 ⚡
2009_2011	7.5 ⚡	1.8 ⚡	18 ⚡	240,035 ⚡
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
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	6.5
Numerator	14
Denominator	216,453
Data Source	Vital Records/ACS
Data Source Year	2016-2018

NOM 16.2 - Notes:

None

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
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

State Provided Data	
	2018
Annual Indicator	5.5
Numerator	12
Denominator	216,453
Data Source	Child Death Review/ACS
Data Source Year	2016-2018

NOM 16.3 - Notes:

NOM 16.3 Child Death Review data source is more accurate than Vital Records. 2016- 2018 data are considered final.

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
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

State Provided Data	
	2018
Annual Indicator	20.5
Numerator	42,599
Denominator	207,779
Data Source	National Survey of Childrens Health
Data Source Year	2017

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
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

State Provided Data	
	2018
Annual Indicator	15.1
Numerator	6,441
Denominator	42,599
Data Source	National Survey of Childrens Health
Data Source Year	2017

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
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

State Provided Data	
	2018
Annual Indicator	1.6
Numerator	2,661
Denominator	170,597
Data Source	National Survey of Childrens Health
Data Source Year	2017

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
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

State Provided Data	
	2018
Annual Indicator	8.5
Numerator	14,026
Denominator	165,275
Data Source	National Survey of Childrens Health
Data Source Year	2017

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
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

State Provided Data	
	2018
Annual Indicator	50.4
Numerator	11,252
Denominator	22,327
Data Source	National Survey of Childrens Health
Data Source Year	2017

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
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

State Provided Data	
	2018
Annual Indicator	91.4
Numerator	188,599
Denominator	206,450
Data Source	National Survey of Childrens Health
Data Source Year	2017

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
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 or a relative standard error ≥30% and is not reportable
- Indicator has a confidence interval width >20% 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
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	
	2018
Annual Indicator	14.7
Numerator	14,612
Denominator	99,494
Data Source	National Survey of Childrens Health
Data Source Year	2017

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
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	
	2018
Annual Indicator	3.2
Numerator	6,611
Denominator	207,577
Data Source	National Survey of Childrens Health
Data Source Year	2017

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
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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 95% confidence interval half-width/estimate > 0.6
- ⚡ 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
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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	
	2018
Annual Indicator	11.5
Numerator	411
Denominator	35,887
Data Source	Vital Records/American Community Survey
Data Source Year	2018

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
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
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

State Provided Data	
	2018
Annual Indicator	2.8
Numerator	5,724
Denominator	206,883
Data Source	National Survey of Childrens Health
Data Source Year	2017

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)
State: Rhode Island

NPM 4A - Percent of infants who are ever breastfed

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	85.6	88.2	90.7	93.2	95.8	96.8

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.

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	31.7	33.9	36.0	38.2	40.3	42.5

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.

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
Annual Objective			36.6
Annual Indicator		28.2	28.9
Numerator		21,354	19,772
Denominator		75,621	68,418
Data Source		NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017

i 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
Annual Objective			36.6
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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.5	32.0	33.5	35.0	36.5	38.0

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
Annual Objective			48.8
Annual Indicator		42.5	41.6
Numerator		19,360	18,320
Denominator		45,543	44,071
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

i 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
Annual Objective			48.8
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	44.3	45.2	46.1	47.0	47.9	48.8

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 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	2017	2018
Annual Objective			14.9
Annual Indicator		13.4	15.1
Numerator		2,540	3,136
Denominator		18,916	20,735
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

i 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
Annual Objective			14.9
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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	17.9	19.4	20.9	22.4	23.9	25.4

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
Annual Objective		
Annual Indicator	17.5	15.9
Numerator	8,345	8,049
Denominator	47,720	50,750
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2016	2016_2017

State Provided Data		
	2017	2018
Annual Objective		
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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	15.6	17.1	18.6	20.1	21.6	23.1

Field Level Notes for Form 10 NPMs:

None

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
Annual Objective	61	62.5	64.2
Annual Indicator	58.4	58.4	57.7
Numerator	5,897	5,897	5,697
Denominator	10,093	10,093	9,869
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2014	2017

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	58.5	59.0	59.5	60.0	60.5	61.0

Field Level Notes for Form 10 NPMs:

None

**Form 10
State Performance Measures (SPMs)**

State: Rhode Island

SPM 2 - Rhode Island youth suicide rate ages 10-24

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		4.2	7.8	
Annual Indicator	5.2	8.5	2.9	
Numerator	11	18	6	
Denominator	212,216	210,752	206,863	
Data Source	RI Vital Records, 2016 ACS Population Estimates	RI Vital Records, 2017 ACS Population Estimates	RI Vital Records, 2017 ACS Population Estimates	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	5.0	5.0	5.0	5.0	5.0	5.0

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

SPM 3 - Depression screening for primary care givers enrolled in family visiting

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		80	90.9	
Annual Indicator	76.2	89.6	89	
Numerator	474	524	412	
Denominator	622	585	463	
Data Source	Family Visiting Database	Family Visiting Database	Family Visiting Database	
Data Source Year	2016	2017	FFY 2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	92.3	93.6	95.0	96.3	97.6	98.9

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 family 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 5 - Effective Family Planning Methods among Title X Clients

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	64.5	66.0	67.0	68.0	69.0	70.0

Field Level Notes for Form 10 SPMs:

None

SPM 6 - Number of Certified Community Health Workers

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	258.0	268.0	278.0	288.0	298.0	300.0

Field Level Notes for Form 10 SPMs:

None

SPM 7 - MCH Priority Areas with at least 50% of HEZ engaged in related MCH funded activities

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	8.0	8.0	9.0	9.0	10.0	10.0

Field Level Notes for Form 10 SPMs:

None

**Form 10
State Outcome Measures (SOMs)**

State: Rhode Island

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	31.2	29.0	26.8	24.6	22.4	21.2

Field Level Notes for Form 10 SOMs:

None

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	13.5	13.0	12.5	12.0	11.5	11.0

Field Level Notes for Form 10 SOMs:

None

SOM 3 - Percent LGB high school students attempting suicide

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.5	19.9	17.2	14.6	11.9	11.9

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.

SOM 4 - Percent High School Students with Special Health Care Needs attempting suicide

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			23	22.5
Annual Indicator	23.1	24.4	24.4	
Numerator	1,671	1,845	1,845	
Denominator	7,249	7,567	7,567	
Data Source	YRBS	YRBS	YRBS	
Data Source Year	2015	2017	2017	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	21.5	21.0	20.5	20.0	19.5

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.

SOM 5 - Post-Partum Depression

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	12.8	12.0	11.3	10.5	9.7	9.0

Field Level Notes for Form 10 SOMs:

None

SOM 6 - Black/White Infant Mortality Rate Ratio

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.5	2.0	1.7	1.5	1.2	1.2

Field Level Notes for Form 10 SOMs:

- 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
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
 SOM 6: Ratio reflects a 3 year average

SOM 7 - Percent of Children Living in Poverty

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		20	18.4	
Annual Indicator	20.4	19.4	16.6	
Numerator	43,282	40,675	33,818	
Denominator	212,038	209,667	203,723	
Data Source	ACS Population estimate (B17001)	ACS 2016 Population estimate (B17001)	ACS 2017 Population estimate (B17001)	
Data Source Year	2015	2016	2017	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	15.5	14.4	13.3	12.2	11.1	10.0

Field Level Notes for Form 10 SOMs:

None

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

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	18.4	16.3	14.2	12.1	9.9	7.8

Field Level Notes for Form 10 SOMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)
State: Rhode Island

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	99.7	99.7	99.7	99.7	99.7	99.7

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.

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

Measure Status:				Active		
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	52.0	97.0	142.0	187.0	232.0	232.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	65.0	69.0	73.0	77.0	81.0	85.0

Field Level Notes for Form 10 ESMs:

None

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	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	17.0	20.0	22.0	25.0	28.0	30.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	70.0	72.0	74.0	76.0	78.0	

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - % of Practices using Shared Plans of Care

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		8	15	
Annual Indicator	7.9	15.1	15.1	
Numerator	10	19	19	
Denominator	126	126	126	
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	19.0	19.0	19.0	19.0	20.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.3 - % of medical homes with trained staff

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	19.0	19.0	20.0	20.0	20.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.4 - # web hits on medical home portal

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	5,000.0	5,500.0	6,000.0	6,500.0	7,000.0	7,500.0

Field Level Notes for Form 10 ESMs:

None

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	18.0	20.0	20.0	20.0	20.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.2 - % of practices with a transition policy

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			2	3.2
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	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.4	3.2	4.0	4.8	5.5	6.3

Field Level Notes for Form 10 ESMs:

None

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	
Annual Objective		1,000	1,800	
Annual Indicator	1,125	1,731	1,406	
Numerator				
Denominator				
Data Source	Health Equity Institute	Health Equity Institute	Health Equity Institute	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1,750.0	2,000.0	2,250.0	2,500.0	2,750.0	3,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.4 - # of participants in Teen Outreach Program

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	240.0	245.0	250.0	255.0	260.0	265.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.1.1 - Number of healthcare providers trained on Oral Health

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	250.0	250.0	250.0	250.0	250.0	250.0

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Rhode Island

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:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Number of youth suicides in RI ages 10-24</td> </tr> <tr> <td>Denominator:</td> <td>RI population ages 10-24</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>100,000</td> </tr> </table>		Numerator:	Number of youth suicides in RI ages 10-24	Denominator:	RI population ages 10-24	Unit Type:	Rate	Unit Number:	100,000
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:	<p>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.</p>									

SPM 3 - Depression screening for primary care givers enrolled in family visiting
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally)								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>For those not enrolled prenatally, number of primary caregivers enrolled in home visiting who are screened for depression within 3 mo. of enrollment; for those enrolled prenatally, the number of primary caregivers screened within 3 mo. of delivery</td> </tr> <tr> <td>Denominator:</td> <td>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 three months post delivery</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	For those not enrolled prenatally, number of primary caregivers enrolled in home visiting who are screened for depression within 3 mo. of enrollment; for those enrolled prenatally, the number of primary caregivers screened within 3 mo. 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 three months post delivery	Unit Type:	Percentage	Unit Number:	100
Numerator:	For those not enrolled prenatally, number of primary caregivers enrolled in home visiting who are screened for depression within 3 mo. of enrollment; for those enrolled prenatally, the number of primary caregivers screened within 3 mo. 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 three months post delivery								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Family Visiting Program Database, ETO								
Significance:	Family Visiting Local Implementing agencies to improve maternal depression screening and access to evidence based mental health services. Family Visiting will continue to collect benchmark data on maternal depression and use continuous quality improvement strategies to improve screening and referral rates. Family Visiting will continue to work with the Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) during Phase III, which is tentatively scheduled to start in September 2016, to continue to improve maternal depression screening and access to evidence-based mental health services.								

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:	<table border="1"> <tr> <td>Numerator:</td> <td>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.</td> </tr> <tr> <td>Denominator:</td> <td>Females served at Title X clinics, excluding those who are pregnant or seeking pregnancy</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	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
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:	<p>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.</p> <p>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.</p> <p>[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. <i>Contraception</i>, 93(5), 406-11.</p>								

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:	<table border="1"> <tr> <td>Numerator:</td> <td># of RI Certified Community Health Workers</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>300</td> </tr> </table>	Numerator:	# of RI Certified Community Health Workers	Denominator:	N/A	Unit Type:	Count	Unit Number:	300
Numerator:	# of RI Certified Community Health Workers								
Denominator:	N/A								
Unit Type:	Count								
Unit Number:	300								
Healthy People 2020 Objective:	PHI-6.1 Increase 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.								

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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of MCH Priority Areas with at least 50% of HEZ engaged in related MCH funded activities</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10</td> </tr> </table>	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
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 - 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:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Number of births to Hispanic teens ages 15-19 for past five years</td> </tr> <tr> <td>Denominator:</td> <td>ACS population estimates for RI Hispanic teens ages 15-19 for past five years</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> </table>	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
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:	<p>FP-8.1 Reduce 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</p> <p>FP-8.2 Reduce 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</p>								
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.								

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:	<table border="1"> <tr> <td>Numerator:</td> <td># births to Black teens ages 15-19 for past five years</td> </tr> <tr> <td>Denominator:</td> <td>ACS population estimates for RI Black teens ages 15-19 for past five years</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> </table>	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
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:	<p>FP-8.1 Reduce 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</p> <p>FP-8.2 Reduce 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</p>								
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.								

SOM 3 - Percent LGB high school students attempting suicide
Population Domain(s) – Adolescent Health

Measure Status:	Active								
Goal:	Reduce suicides among LGB students								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># LGB high-school students attempting suicide</td> </tr> <tr> <td>Denominator:</td> <td># LGB high-school students</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# LGB high-school students attempting suicide	Denominator:	# LGB high-school students	Unit Type:	Percentage	Unit Number:	100
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.								

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:	<table border="1"> <tr> <td>Numerator:</td> <td># High School Students with Special Health Care Needs attempting suicide</td> </tr> <tr> <td>Denominator:</td> <td># High School Students with Special Health Care Needs</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	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
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.								

SOM 5 - Post-Partum Depression
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	Reduce post-partum depression								
Definition:	<table border="1"> <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>	Numerator:	# post-partum women reporting symptoms of depression	Denominator:	# post-partum women	Unit Type:	Percentage	Unit Number:	100
Numerator:	# post-partum women reporting symptoms of depression								
Denominator:	# post-partum women								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	MICH-34 (Developmental) Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms								
Data Sources and Data Issues:	PRAMS								
Significance:	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.								

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:	<table border="1"> <tr> <td>Numerator:</td> <td>Infant Mortality Rate among Black Infants</td> </tr> <tr> <td>Denominator:</td> <td>Infant Mortality Rate among White Infants</td> </tr> <tr> <td>Unit Type:</td> <td>Ratio</td> </tr> <tr> <td>Unit Number:</td> <td>1</td> </tr> </table>	Numerator:	Infant Mortality Rate among Black Infants	Denominator:	Infant Mortality Rate among White Infants	Unit Type:	Ratio	Unit Number:	1
Numerator:	Infant Mortality Rate among Black Infants								
Denominator:	Infant Mortality Rate among White Infants								
Unit Type:	Ratio								
Unit Number:	1								
Healthy People 2020 Objective:	<p>MICH-1.3 Reduce the rate of all infant deaths (within 1 year)</p> <p>Baseline: 6.7 infant deaths per 1,000 live births occurred within the first year of life in 2006</p> <p>Target: 6.0 infant deaths per 1,000 live births</p> <p>Target-Setting Method: 10 percent improvement</p>								
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).								

SOM 7 - Percent of Children Living in Poverty
Population Domain(s) – Perinatal/Infant Health, Child Health, Adolescent Health

Measure Status:	Active								
Goal:	Reduce the percent of children living in poverty to no more than 18%								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># of children living below the federal poverty threshold</td> </tr> <tr> <td>Denominator:</td> <td># of children</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# of children living below the federal poverty threshold	Denominator:	# of children	Unit Type:	Percentage	Unit Number:	100
Numerator:	# of children living below the federal poverty threshold								
Denominator:	# of children								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	<p>SDOH-3.2 Proportion of children aged 0-17 years living in poverty</p> <p>Baseline: 20.7 percent of children ages 0 to 17 were living below the poverty threshold in 2010</p> <p>Target: Not applicable</p> <p>Target-Setting Method: This measure is being tracked for informational purposes. If warranted, a target will be set during the decade.</p>								
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 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:	<table border="1"> <tr> <td>Numerator:</td> <td># of teen (ages 15-19) pregnancies in RI core cities</td> </tr> <tr> <td>Denominator:</td> <td># of teen (ages 15-19) residing in RI core cities</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> </table>	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
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:	<p>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.</p>								

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Rhode Island

ESM 4.1 - % of RI Resident Births occurring in Hospitals Designated as Baby Friendly
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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of RI Resident Births Occurring in Hospitals Designated as Baby Friendly</td> </tr> <tr> <td>Denominator:</td> <td>Number of RI Resident Occurrence Births</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	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	
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:	<p>“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.”</p> <p>-World Health Organization’s Global Strategy on Infant and Young Child Feeding</p> <p>Breastfeeding saves lives; Breastfeeding saves money; Breastfeeding contributes to a more productive workforce; and Breastfeeding is better for the environment</p>									

ESM 8.1.1 - Physical Activity and Nutrition Technical Assistance to Child Care Centers
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:	<table border="1"> <tr> <td>Numerator:</td> <td># of childcare centers who received technical assistance or training to improve physical activity and nutrition practices from RIDOH or it's partners</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>250</td> </tr> </table>	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
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.								

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

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 border="1"> <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>	Numerator:	# children ages 5-19 living in municipalities where improvements to the built environment occurred	Denominator:	# children ages 5-19 living in Rhode Island	Unit Type:	Percentage	Unit Number:	100
Numerator:	# children ages 5-19 living in municipalities where improvements to the built environment occurred								
Denominator:	# children ages 5-19 living in Rhode Island								
Unit Type:	Percentage								
Unit Number:	100								
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								

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

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:	<table border="1"> <tr> <td>Numerator:</td> <td># training and technical assistance opportunities provided to municipalities about master plan and land use interventions by RIDOH or it's partners</td> </tr> <tr> <td>Denominator:</td> <td>N/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>30</td> </tr> </table>	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
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.								

ESM 8.1.4 - % children (0-17) living in a HEZ community with initiatives related to physical activity and nutrition
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 border="1"> <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>	Numerator:	# children (0-17) living in a HEZ community with initiatives related to physical activity and nutrition	Denominator:	# children (0-17) living in a HEZ community	Unit Type:	Percentage	Unit Number:	100	
Numerator:	# children (0-17) living in a HEZ community with initiatives related to physical activity and nutrition									
Denominator:	# children (0-17) living in a HEZ community									
Unit Type:	Percentage									
Unit Number:	100									
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.									

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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of Practices using Shared Plans of Care</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>	Numerator:	Number of Practices using Shared Plans of Care	Denominator:	Total Number of Practices	Unit Type:	Percentage	Unit Number:	100
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:	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> •Families •Physicians and Medical Home teams •Other Professionals and Caregivers <p>(medicalhomeportal.com)</p>								

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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of medical homes with trained staff</td> </tr> <tr> <td>Denominator:</td> <td>Total number of medical homes</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of medical homes with trained staff	Denominator:	Total number of medical homes	Unit Type:	Percentage	Unit Number:	100
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:	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> •Families •Physicians and Medical Home teams •Other Professionals and Caregivers <p>(medicalhomeportal.com)</p>								

ESM 11.4 - # web hits on 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								
Goal:	Increase the number of web hits on medical home portal from 1781 to 2300 by 2023								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># web hits on RIDOH medical home portal https://ri.medicalhomeportal.org/</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	# web hits on RIDOH medical home portal https://ri.medicalhomeportal.org/	Denominator:	N/A	Unit Type:	Count	Unit Number:	10,000
Numerator:	# web hits on RIDOH medical home portal https://ri.medicalhomeportal.org/								
Denominator:	N/A								
Unit Type:	Count								
Unit Number:	10,000								
Data Sources and Data Issues:	RIDOH CSHCN Program								
Significance:	<p>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 Medical Home Team, Care Coordinators and community partners.</p> <p>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</p>								

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

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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of medical homes with trained staff on transition</td> </tr> <tr> <td>Denominator:</td> <td>Total Number of medical homes</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of medical homes with trained staff on transition	Denominator:	Total Number of medical homes	Unit Type:	Percentage	Unit Number:	100
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:	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> •Families •Physicians and Medical Home teams •Other Professionals and Caregivers <p>(medicalhomeportal.com)</p>								

ESM 12.2 - % of practices with a transition policy

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 practices with a transition policy								
Definition:	<table border="1"> <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>	Numerator:	Number of practices with a transition policy	Denominator:	Total number of practices	Unit Type:	Percentage	Unit Number:	100
	Numerator:	Number of practices with a transition policy							
	Denominator:	Total number of practices							
	Unit Type:	Percentage							
Unit Number:	100								
Data Sources and Data Issues:	Health Equity Institute; Office of Special Needs								
Significance:	<p>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.</p> <p>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.”</p>								

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

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."	

ESM 12.4 - # of participants in Teen Outreach Program

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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number youth ages 11-18 served by Teen Outreach Program</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>300</td> </tr> </table>	Numerator:	Number youth ages 11-18 served by Teen Outreach Program	Denominator:	N/A	Unit Type:	Count	Unit Number:	300
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.								

ESM 13.1.1 - Number of healthcare providers trained on Oral Health
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.	

Form 11
Other State Data
State: Rhode Island

The Form 11 data are available for review via the link below.

[Form 11 Data](#)