



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

**State Narrative for  
Rhode Island**

**Application for 2013  
Annual Report for 2011**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section. IA - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

The following assurances and certifications are maintained on file in the Division of Community, Family Health and Equity at the Rhode Island Department of Health:

Non-construction program  
Debarment and suspension  
Drug free work place  
Lobbying  
Program fraud  
Tobacco smoke

Assurances and certifications can be obtained by contacting:

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### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

### **E. Public Input**

***/2013/ The mission of HEALTH's Title V MCH Program is to build integrated systems that support health, growth, and development for MCH populations, including CYSHCN. The Title V MCH needs assessment is a critical component and requirement of the Title V MCH Block Grant. Community participation in the needs assessment process is an important part to understanding the MCH needs in Rhode Island. In order to understand the needs of the community, a combination of quantitative and qualitative information is required.***

***The three components of community participation in Rhode Island's five-year Title V MCH needs assessment cycle are: an annual open meeting, an annual community input survey (available in survey monkey and paper format), and annual solicitation of public input from professionals and families who participate in the DCFHE standing program meetings and individuals who participate in other meetings in which DCFHE staff participate. These***

*annual activities are linked specifically to the Title V MCH application process to facilitate comment from any person during its development.*

*In addition, Rhode Island has regular mechanisms in place to obtain input and feedback on its MCH programs through advisory and other groups charged with addressing specific programs and issues. Some of these groups are administered by the DCFHE and others are administered by external partners. Input and feedback 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 CYSHCN. RI's Title V needs assessment activities and studies occur in an ongoing manner over the five years intervening the required needs assessment development.*

*Data obtained in calendar year 2010 and early calendar year 2011 was used to develop the Title V MCH FY2011 comprehensive needs assessment process (Year One of the current Five-Year Cycle), which allowed RI to use data to examine capacity, identify priority needs, establish state performance measures, set annual targets for national and state performance measures, identify activities to address priorities, allocate resources, and monitor progress. Results from the needs assessment process and community input provided a comprehensive picture of the MCH population needs in Rhode Island.*

*In May 2011, the DCFHE, in partnership with RI KIDS COUNT, hosted a meeting to discuss current evidence-based programs that support parents and families. In addition, the DCFHE hosted a community input meeting with over 110 participants representing a diverse mix of over 40 community organizations. Participants participated in breakout sessions based on the state's MCH priority population groups during which the participants identified the major themes impacting each population. Participants in each group engaged in robust discussions about the themes, which including the identification of systems needs for each priority population.*

*With respect to early childhood, the priority themes identified included family support and involvement, parent education, data sharing, oral health care, prenatal care, and employer supports (maternal depression, breastfeeding, etc.). The state priority established for early childhood for the current five year cycle is to expand capacity and access to evidence-based parent education and family support programs in the early years. The corresponding state performance measure developed for this priority is the percent of resident families with at risk newborns that receive a home visit during the newborn period.*

*For middle childhood, the priority themes identified included health and wellness, family support and involvement, partnerships/integration with schools, communities and providers, mental health/bullying, access to care, transportation, homeless youth, and oral health. The state priority established for this population is to reduce tobacco initiation among middle school students and the performance measure is the percent of middle school students who have initiated tobacco use.*

*For adolescence, the priority themes were family support and involvement, access to care (physical, mental health, and contraception), partnerships among youth serving state/community agencies, health and wellness, transportation, homelessness, LGBT, and teen dating violence/bullying). The state priority for this group is to increase the percentage of teens that have an adolescent well care visit each year and the state performance measure is the percent of teens who receive an annual preventive care visit.*

*For CYSHCN, the themes identify were mental health, access to care/medical home, family support and involvement, health and wellness, and partnerships among schools and communities specific to CYSHCN. The state priority for CYSHCN is to increase the social and emotional health of CYSHCN and the state performance measure is the percent of*

*high school students with special needs who report feeling sad or hopeless.*

*For women across the lifespan, the themes were access to preconception care, health and wellness/obesity prevention, and preventive care/screening for chronic conditions. The state priority is to increase the percentage of women who have a preventive care visit in the past year and the state performance measure is the percent of women who have a preventive care visit in the past year.*

*For pregnant women, the themes identified were access to prenatal care, supportive networks for women and children, and prenatal home visiting. The state priority is to initiate a prenatal home visiting program and the state performance measure is the percent of pregnant women delivering babies served by home visiting.*

*Overarching themes included health and wellness, partnerships, data systems, access to care/medical home, mental health, family involvement and support, and use of evidence-based practices. The state priorities are to promote use of evidence-based programs to support parents and families of all children and to adopt social determinants of health into public health practice. The state performance measures are the percent of adolescents who report food insecurity, and the percent of high school students who earn a high school diploma or diploma equivalent in the 6 core cities.*

*In FY2012, the DCFHE held an open meeting on June 18, 2012, distributed a community input survey (available in survey monkey and paper format), and annual solicited public input from professionals and families who participate in the DCFHE standing program meetings and individuals who participate in other meetings in which DCFHE staff participated throughout June 2012 as a part of the Title V MCH application process for FY2013. The themes that emerged from this year's community input process were similar to the themes that emerged in FY2011 and FY2012, which provided assurances and reinforcement that to the DCFHE that its state priorities and performance measures remain both current and relevant. Attached is a description of each of DCFHE's MCH priorities, a summary of the community input received for each priority, and a description of the strategies the DCFHE is using to address the community input received for each priority //2013//.*

*An attachment is included in this section. IE - Public Input*

## **II. Needs Assessment**

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

See document under section II - C Needs Assessment Summary.

***An attachment is included in this section. IIC - Needs Assessment Summary***

### **III. State Overview**

#### **A. Overview**

*/2013/ In order to develop and implement priorities for Rhode Island's (RI's) Title V MCH Program, it is first necessary to understand the health needs of the state's entire population and the general health care delivery environment. Equally important is an understanding of the geographical and cultural characteristics of the state, its localities (including their governmental structures), and the state's economic, housing, and educational characteristics since they also impact the health needs of the state's population.*

*It is also important to understand the key policy issues related to MCH currently being debated in RI's public arenas. Current agenda items include the economy, jobs, unemployment, taxes, health care, economic development, education, affordable housing, and welfare reform. However, the state's safety net infrastructure has been damaged by cuts made in response to the fact that RI is struggling to recover from a major economic recession.*

*RI demographic data shows that Rhode Islanders are older, more culturally diverse and that the state has fewer workers in their prime productive years. Rhode Islanders are less self-sufficient and more reliant on government assistance, requiring continued taxpayer investment in entitlement programs and fundamental public services. At the same time, the majority of the state's voters believe that taxes are too high in RI and the state is not doing enough to lower taxes and spend taxpayer money wisely.*

*On the positive side, the federal Health Care Reform Act provides RI with opportunities to improve health outcomes, delivery and payment systems, and measurement and assessment metrics. In addition, the state's health reform efforts will have far reaching impacts to its economy. The health care and social service sector represents nearly 20% of all private employment in RI and it is expected to grow substantially over the next decade. The expected reduction in the number of uninsured Rhode Islanders under health care reform will increase demand for health care services. At the same time, RI is implementing several innovative new solutions designed to address some of its more vexing health care, education, human services, and economic challenges.*

*Geographical & Cultural Characteristics: The state of RI is a small, coastal area (1,214 square miles) with just over one million residents (1,051,302). The entire state measures just 48 miles, from north to south, and 37 miles, from east to west. Historically, most Rhode Islanders have been White descendants of European immigrants, plus some long established African American families and members of the small Narragansett Native American Tribe.*

*With the establishment of the first water-powered cotton mill in the nation in Pawtucket in 1793, RI became the birthplace of the industrial revolution in the United States. Since then, waves of immigrants -- from the Italians, Irish, French/French Canadians, and Portuguese in the late 19th century to the Asians and Latinos in the late 20th century -- have come to RI in search of a better life. Currently, 12.5% of Rhode Islanders are foreign-born. Between 2000 and 2010, the number of foreign-born residents in the state increased by 12.6%.*

*The largest share of the foreign-born population in RI is from Latin America (36.8%), followed by Europe (32.9%), Asia (16.4%), Africa (10.1%), and Northern America (3.5%). Among people at least five years old living in RI in 2005, 20.4% spoke a language other than English at home. Of those speaking a language other than English at home, 48.7% spoke Spanish and 51.3% spoke some other language.*

**The three largest ancestral groups in RI are Italian, Irish, and French-Canadian. Rhode Island has a higher percentage of Italian Americans and persons of Portuguese ancestry, including Cape Verdeans, than any other state in the nation. Although there are still many more Catholics in Rhode Island than any other religion, the number of Catholics who belong to parishes is down by 14% in RI - enough of a loss to impact its longstanding distinction as the most heavily Catholic state in the nation. That position now belongs to Massachusetts. Currently, 44.3% of Rhode Islanders are connected in some way to the Catholic Church.**

**Although RI ranks high in percentage of forested land (60%), 75% of its population resides in a 40-mile long urban/suburban corridor along the shores of Narragansett Bay and in the valleys of the Blackstone and Pawtuxet Rivers. This corridor, which includes Providence, contains nearly all of the state's public infrastructure, major transportation routes, and institutional and cultural centers. Providence, the second largest city in New England after Boston, is a major metropolitan community in which an estimated 175,255 residents live.**

**Providence is one of RI's six (6) designated "core" communities, defined as being a city or town in which more than 15% of the children live in poverty. RI's other core communities include Pawtucket, Central Falls, Newport, Woonsocket, and West Warwick. Thirty-four (34.2%) percent of the state's population resides in these six core communities, where 37.3% of children under six (6) years and 33.9% of children under eighteen (18) years live below poverty.**

**According to the U.S. Census 2010, the racial/ethnic distribution of RI's population consisted of Whites (81.4%), Blacks (5.7%), Asians (2.9%), Native Americans (0.6%), Native Hawaiian or Pacific Islander (0.1%), some other one race (6%) and those who identified themselves as being two or more races (3.3%). Also, 12.4% of the population identified themselves of Hispanic or Latino origin.**

**RI's children are diverse in race, ethnic background, language, and country of origin. In 2006, there were 9,848 foreign-born children under age 18 living in RI, representing 4% of the state's child population. In RI, 78% of children ages 5-17 speak only English, 14% of children speak Spanish, 6% speak other Indo-European languages, and 2% speak Asian or other Pacific Island languages.**

**Of RI's immigrant children, 42% are from Mexico, Central, or South America; 29% are from the Caribbean; 11% are from Europe; 11% are from Africa; and 6% are from Asia. More than three-quarters (78%) of all minority children live in RI's six core communities. RI has the highest percentage of Hispanic children living in poverty (79%) and the fourth largest percentage of black children (71%) living in neighborhoods in which more than 18% of persons are in poverty in the nation.**

**State & Local Government Structure: RI has advantages for effective public health program implementation, given its small geographical size and unique governmental structure. With the exception of the state court system, there is no county level of government in RI. The state is made up of 39 cities and towns ranging from 1.3 to 64.8 square miles in size. In RI, local communities possess control of areas such as primary and secondary education, subdivision of land and zoning, and housing code enforcement. A combination of cultural, socio-economic, and transportation-related factors makes "the neighborhood" the most important level of community in many parts of RI, especially in low-income communities.**

**Unfortunately, local revenue sources have been declining in recent years. Between FY2008 and FY2012, direct state aid to cities and towns in RI was reduced by 72.6%. Moreover, as residential property values have seen steep declines in the recent recession, local tax bases have eroded. The resulting pressures on cities and towns to meet service level**

**demands given increasingly constrained resources, coupled with unaffordable expenditure structures that some communities have not modified, have pushed some local governments to the brink of insolvency.**

**The City of Central Falls became the first municipality to file for bankruptcy in the state's history. East Providence has a state-appointed receiver. Five other cities and towns in RI face financial difficulties: Providence, Woonsocket, Pawtucket, North Providence, and West Warwick. Precarious municipal budgets are not all those communities have in common. They top the statewide lists for highest poverty rates and lowest incomes. Poor people have less income to pay in taxes and live in less valuable housing, upon which taxes are based and that limits what municipalities can collect to pay for city services. Those factors have combined with others such as cuts in state aid.**

**In 2010, RI elected its first independent Governor, Lincoln D. Chafee. The state legislature, the General Assembly, is a part-time legislature that is in session for about six months each year (January to June). The state House of Representatives includes 75 members, 87% of whom the Democrats. The state Senate has 38 members, 76% of whom are Democrats.**

**In early May 2012, the State Budget Office reported that RI was anticipating a \$102.7 million surplus in the state budget year ending on June 30, 2102. One piece of the overall revenue gain came from about \$29 million in savings in the current year from Medicaid and cash assistance programs (including welfare), due to lower than anticipated demand for costly Medicaid services, including hospital treatments and services covered by RIte Care.**

**In late May 2012, the House unveiled an \$8.1 billion state budget that represented a \$398 million increase from the fiscal year ending on June 30, 2012. The budget used the one-time revenue that makes up much of the projected \$102.7 million surplus this year to plug holes in next year's spending plan. In June 2012, the House and Senate passed the \$8.1 million budget and the General Assembly adjourned for the year. On June 15, 2012, the Governor signed the \$8.1 million state budget into law.**

**Key health-related measures passed by the legislature this year (with health being defined broadly) includes an increase of \$33 million in school aid (plus \$20 million to upgrade infrastructure for wireless connectivity in schools); a hike in the cigarette tax to \$3.50 per pack, an increase in the minimum wage from \$7.40 per hour to \$7.75 per hour effective January 1, 2013; the restoration of oral health care services for Medicaid clients; a homeless bill of rights that protects the homeless against discrimination in employment, emergency medical services, use of public spaces and voting; and the amendment of state health insurance laws to reflect the federal health care reform law.**

**Failed health-related legislation included proposals that would have banned smoking in outdoor public areas and in cars when a young child is present, provided judges greater authority to require installation of ignition interlock systems for DUI drivers, capped interest on short-term payday lending loans to 36% (down from the current cap of 260%), expanded family planning services for low-income women, and repealed a provision in the state's 2008 welfare overhaul law preventing families from drawing on benefits for more than 24 consecutive months.**

**The RI Department of Health (HEALTH) is the sole public health authority making it legally responsible for the provision of core public health activities at both the state and local levels. HEALTH contracts for the provision of most non-regulatory services rather than deliver them directly. This strategy helps to create a seamless, uniform quality public health service system in RI. The absence of local health authorities means that health care providers in the state look to HEALTH for policy guidance and other forms of**

assistance.

*RI is an ideal site for innovation in health care. It's a state of "one" -- "one" hour to every geographic corner, "one" thousand square miles in size, "one" major metropolitan area (Providence), "one" department of health, and "one" medical school (Brown University School of Medicine). This makes it relatively easy to get everyone in one room to work on "one" health topic in RI. The state's Title V MCH Program is located in HEALTH within the Division of Community, Family Health & Equity (DCFHE).*

*Economic Needs of the State's Population and Select Innovative Solutions: Although the US recession ended in the summer of 2009, RI's recession stretched into early 2010. Since then, the recovery has been both slow and uneven. In May 2012, RI's unemployment rate was 11%, the second highest in the national after Nevada (11.6%). RI's unemployment rate was also the highest in New England. In contrast, the national unemployment rate was 8.2% in May 2012.*

*RI's recession began months before the national recession began in December 2007. The economy in RI hit rock bottom in September 2009. In 33 months, the state lost 39,700 jobs, or 8% of its jobs. According to economists at HS Global Insight in Massachusetts, if nothing changes, RI will not recover all the jobs it lost in the Great Recession until at least 2021 -- 9 years from now and 12 years after it hit rock bottom. It is predicted that after Michigan, RI will take the longest of the 50 states to regain all the jobs it lost during the recession. The unemployment rate, which hit double digits 3 years ago, is not expected to drop below 10% until next year. Some blue collar jobs, which sustained workers for years, will not come back at all.*

*Racial and ethnic minorities are disproportionately impacted by the high unemployment rates in RI. According to the Economic Policy institute, the Providence metropolitan area had one of the largest increases in Hispanic unemployment in the nation from 2009 to 2010 -- 4.6%. The unemployment rate for Hispanics is more than twice the unemployment rate for all of RI. By one estimate, the unemployment rate during the Great Depression peaked at 22.9% in 1932 (Carter, 2006). The Great Recession of 2007 has pushed the unemployment rate for Hispanics in RI into this range. The Hispanic unemployment rate in RI averaged 20% in 2009 and 21.6% in 2010.*

*According to the Center for Labor Markets and Policy at Drexel University in Philadelphia, RI's plummet was among the steepest and longest lasting in the country because the state's economy is built on the type of blue collar work that was hardest hit by the recession. Forty-five percent (45%) of all job losses hit the goods-producing sectors, including manufacturing, construction, and other labor-intensive industries. Further more, the recession arrived near the tail end of a steady, decades-long decline in manufacturing -- once the core of the state's economy. In the 1940s, manufacturing accounted for about two-thirds of all private sector jobs in the state. Today, it has fallen to about 10% of the state's jobs.*

*The sons and daughters of Rhode Island's workers may have to leave, rather than wait a decade or more for better jobs that may never show up. A survey conducted by the Association of Independent Colleges and Universities in RI found that only one in three college graduates stays in RI. The Rhode Islanders still trapped by the states' worst recession in 70 years may very well face a future that is not much different than their past. One factor in RI's high unemployment rate, frequently mentioned by economists, is the lack of a skilled workforce that matches what employers need. In the changing economy, it is difficult to find RI workers trained for jobs in such fields as health care and technology. Forty-eight percent (48%) of RI's jobs are in the "middle skill" category, but only 37% of the workforce has the skills to fill these jobs. another potential risk to the state's recovery includes, but is not limited to, sustained weaknesses in the housing*

market.

**Economists say RI can make the transition from an older, post-industrial economy to a knowledge-based model in which skilled workers produce goods and services the world already needs. Already, there are pockets of entrepreneurs across the state that are developing innovative products, forming businesses and hiring workers at good pay rates. A recent study by the Federal Reserve Bank of Boston showed the number of Hispanic-owned firms in Providence grew from 731 in 1997 to 3,001 in 2007, far outpacing other small industrial cities in the region, illustrating the industriousness of the state's Hispanic community. However, more needs to be done. The state has to capitalize on its unique assets that include two ports on the Atlantic Ocean, an expanding regional airport, and preeminent academic and health care institutions where students and researchers can turn ideas into companies that create jobs. To change its economy, RI needs to focus on the types of companies it wants to create and then the skills that workers will need to fill those jobs.**

**State leaders have already embarked on a strategy to create more jobs based on RI's medical and higher-education institutions, where researchers and innovators work to create new products and services. The health care and social assistance sectors are one of the few growing industries in RI. When the state lost 11,100 manufacturing jobs from peak employment in December 2006 to its lowest job count in September 2009, the health care and social assistance sectors gained 1,900 jobs during the same period.**

**One particularly bright spot for RI was the announcement on June 14, 2012 stating that the state won a \$2.78 million grant from the US Department of Labor. Rhode Island is one of 26 grant recipients whose Workforce Innovation grant funds totaled nearly \$147 million. The state Department of Labor & Training expects to use the funds to develop strategies to help people return to work and then study which methods work best for various groups of people seeking to make career changes, find jobs in a current field, and improve their work skills.**

**Educational Needs of the State's Population and Select Innovative Solutions: RI is lagging its New England neighbors in terms of educational achievement. According to the US Census, 83.7% of Rhode Islanders age 25 years and older have a high school education. In contrast, the percentages are higher for the United States (85%), New Hampshire (90.9%), Vermont (90.6%), Maine (89.8%), Massachusetts (88.7%), and Connecticut (88.4%). Although the percentage of Rhode Islanders age 25 years and older who have a bachelors degree or more (30.3%) is higher than the percentages for the nation (27.9%) and Maine (26.5%), it is lower than the percentages for Massachusetts (38.3%), Connecticut (35.2%), Vermont (33.3%), and New Hampshire (32.9%).**

**RI's public education students are a diverse group. On October 1, 2011, 64% of RI's 142,854 public school students were non-Hispanic White, 22% were Hispanic, 8% were Black, 3% were Asian/Pacific Islander, 3% were Multi-Racial, and 1% were Native American. Forty-four percent (44%) were low-income. Eighteen percent (18%) were receiving special education services and 6% were receiving English as a Second Language (ESL) or bilingual education services. RI's ESL students spoke 77 different languages. The majority spoke Spanish (75%), followed by Asian languages (8%), Creole or Patois (8%), Portuguese (4%), African languages (1%), and other languages (5%).**

**In 2011, the four-year high school graduation rate in RI was 77%. The four-year high school graduation rate is the number of RI students who graduate in 4 years or fewer divided by the total number of students who started 9th grade in 2007-2008, adjusted for transfers in and out. During the 2010-2011 school year, 90% of RI's high school seniors reported planning to attend a 2-year or 4-year college. In 2011, 64% of RI's graduating seniors had taken the SATs. However, only 35% of those who took the SAT achieved a**

**score that indicated likely success in college and in the work force.**

**More than half (53%) of RI's 18-24 year olds were enrolled in college in 2009, a higher percentage than any other state. Two-thirds (66%) of RI students enrolled in 4-year colleges graduated within 6 years, higher than the national rate of 56%. Among RI students enrolled in 2-year colleges, 12% graduated within 3 years, lower than the national rate of 29%. This rate does not include the 20% of 2-year college students that transferred to 4-year colleges. Between 2008 and 2010, and estimated 4,407 (7%) youth ages 16 to 19 were not in school, not in the Armed Forces, and not working in RI. Forty-three percent (43%) of these youth were high school graduates and 57% had not graduated from high school. In 2011, RI raised its school attendance requirement from age 16 to 18.**

**RI has started to implement an ambitious public education agenda, and it is beginning to see results, such as the growing number of students achieving proficiency on the New England Common Assessment Program (NECAP) assessments. Additionally, for the first time since the National Assessment of Educational Progress (NEAP) was first administered, RI's 4th graders scored above the national average on mathematics assessment. At the same time, it is evident that much work remains. RI ranks 6th highest in the nation for per pupil education expenditures, but 29th in 8th grade NEAP mathematics and reading performance. Further, RI underperforms relative to other national and regional averages on the SAT and has higher percentages of adults without at least a high school diploma than the other New England states and the nation.**

**The state, working with local school districts, has moved forward on a number of key initiatives central to its strategic plan for public education, such as finalizing implementation of a Uniform Chart of Accounts, adopting Common Core Standards, and developing an educator evaluation system. These reforms have garnered national attention and were key parts of the state winning a \$75 million grant in the Race to the Top competition in August 2010. RI was one of only 12 states in the nation awarded Race to the Top funding, which it will utilize over four years to implement a statewide approach to addressing challenges faced by Rhode Island's public education system.**

**In the area of Human Capital Development, the state is expanding and improving pathways to the teaching profession and developing a new program to support novice teachers. By 2014, RI will be able to match excellent teachers with hard-to-staff areas, and its new, successful teachers will be given the mentoring and support they need to be successful. With respect to School Transformation and Innovation, RI is coordinating federal and state resources to help its persistently lowest-achieving schools improve. By 2014, struggling state schools will receive comprehensive support to dramatically improve student achievement.**

**RI's investments in early childhood education paid off significantly when Rhode Island was one of just 9 applicants to receive a federal Race to the Top Early Learning Challenge grant in December 2011. The state will receive \$50 million to strengthen and improve early childhood programs, training for teachers, and outreach to parents. In addition, the state's education-financing formula calls for \$10 million to be added to public pre-kindergarten over 10 years. Five participating state agencies share responsibility for implementing the reform strategies and achieving grant outcomes, including the Departments of Education (the lead agency); Human Services; Children, Youth, and Families; HEALTH (the DCFHE); and the Executive Office of Health & Human Services.**

**In May 2012, RI was one of eight states to win federal approval for a new system to measure and classify school performance and to improve the most troubled schools. The new system replaces 2 controversial federal education mandates -- the No Child Left Behind (NCLB) law and the School Improvement Grant's turnaround program. The RI Department of Education believes that the new system is fairer because it focuses on**

**students making progress over time rather than judging schools on a single year of test data, or forcing struggling schools to select from a narrow list of approved interventions.**

**Housing Needs of the State's Population and Select Innovative Solutions: During the Great Recession, RI's housing market collapsed because home prices here soared higher than in the rest of the nation. Prices were inflated as demand was driven up by the glut of sub-prime mortgages issued to less than creditworthy borrowers. Additionally, a large number of homeowners borrowed money against the value of their property. When the housing bubble burst, property values sank in RI. As people lost their jobs, they could not afford to pay their mortgages or sell their homes because they owed more than the houses were worth. That caused a spike in mortgage delinquencies and foreclosures. Banks stopped lending to recover from the avalanche of bad loans that buried their balance sheets.**

**Since 2009, 6,740 foreclosures have been recorded in RI, according to Housing Works RI. More than 2,000 residential foreclosures were filed in 2011, up 6%, compared with 2010, but down when compared with 2009, when 2,840 foreclosure deeds were recorded in the state. Nearly one-third of foreclosed properties were multifamily homes in the state's urban core, which has significantly affected renters in the state. For every multifamily property foreclosed, approximately two to three families find themselves without shelter. Housing works estimates over 6,300 apartments were lost due to the 2,178 multifamily foreclosures from 2009 through 2011. According to Housing Works RI, about 10,500 mortgages were either in the foreclosure process or more than 90 days delinquent during the 4th quarter of 2011, down from over 11,000 during the 4th quarter of 2010. But RI still ranks 10th in the nation in new foreclosures started during a quarter, on a percentage basis.**

**According to a report issued by Housing Works RI in February 2012, nearly 40% of Rhode Islanders rent their homes, more than any other New England state, and 27% of these renters are paying more than half their incomes for housing. Rental costs have spiked while the foreclosure crisis has driven more people into the rental market. For example, the average cost of a 3-bedroom apartment was \$1,531 in 2010 -- 75% higher than in 2001. During the same period, the average rent for a 2-bedroom apartment increased by 50%, while the cost for a 1-bedroom apartment jumped 47%.**

**Rhode Islanders renters earn far less than homeowners. Renters have a median household income of \$29,864, far below the median income of the state's home-owning households, \$75,553, and less than the statewide median household income of \$54,902. Many renters are families. Forty-six percent (46%) of RI renters are living in family households. Renters are almost evenly divided by educational attainment, with 21% having a bachelor's degree or above, 28% having some college or an associate's degree, 29 % having completed high school, and 23% having less than a high school diploma.**

**In 2011, there were 4,410 documented homeless people in RI (about 1,100 people on any one given night). The homeless population has grown from 3,926 in 2007 to 4,410 in 2011, a 12.3% increase. About 600 are chronically homeless and 455 are homeless for the first time. According to the RI Homeless Management Information System, the primary reasons for being homeless are: unable to pay rent/mortgage (16.9%), unemployment (16.8%), addiction (15.4%), jail/prison (9.8%), physical/mental disabilities (6.9%), and other (34.2%).**

**In 2011, 132 single youth ages 18-20 and 318 young adults ages 21 to 24 received emergency shelter services through the adult emergency shelter system in RI, an increase of 9.1% over the previous year. There were an additional 136 youth ages 13 to 17 who received emergency shelter services with their families in RI in 2011.**

**In addition, a \$25 million housing bond will go before the voters for approval on Election Day in November 2012. Rhode Island spends far less than neighboring states, including**

**Massachusetts and Connecticut, to provide affordable homes. A \$50 million "Building Homes Rhode Island" housing bond approved by voters in 2006 has all been allocated and was used to help develop 1,255 affordable homes in 30 communities.**

**Social Service Needs of the State's Population & Select Innovative Solutions: Struggling with a lingering recession and high unemployment, more Rhode Islanders fell below the poverty line last year, according to the US Census. The poverty rate in the state rose to 14% in 2010 from 11.5% in 2009 (under 100% of the federal poverty level). Seventeen percent (17%) of Rhode Islanders live in near poverty (100%-200% of the FPL).**

**The state's poverty rate, the highest in New England, is less than the nation's 15.3% rate. After RI, Maine had the highest poverty rate in New England at 12.9%. The poverty rate for Blacks in RI is 36.5%, nearly four times that of whites (9.4%). The poverty rate for Hispanics is 30.3%, more than three times the rate for whites. People with disabilities are more likely to be living below or near poverty (49%) than all Rhode Islanders (31%).**

**Nearly one in five children struggles with poverty. According to RI Kids Count, 19% of Rhode Island's children lived in poverty in 2010. The state's childhood poverty rate increased to 16.9% in 2009, from 15.5% in 2008. The nation's child poverty rate was 21.6% in 2010, up from 20% in 2009 and 18.2% in 2008. RI ranked 22nd in the country for child poverty. Fourteen percent of children in RI had at least one parent who was jobless in 2010.**

**According to a report issued by the non-profit Corporation for Enterprise development in Washington, DC, in January 2012, one in five Rhode Islanders lacks the money needed to weather a job loss, a major medical bill, or other financial crisis. They are "asset poor" workers with little or no savings or other assets to cover 3 months of expenses if they lose a job or face an emergency.**

**RI ranks 38th in the nation in the financial security of its households, far behind New England's other states. High housing costs helped lower RI's overall score, earning the state an "F" in housing and home ownership, among the worst in the nation. At United Way RI, the number of calls to the agency's 2-1-1 hotline is up sharply. During the first 9 months of 2011, the number of calls from Rhode Islanders seeking food jumped by 206% compared with the same period the year before. The number of foreclosure-related calls increased by 115%.**

**Since the start of the recession in 2007, the number of Rhode Islanders getting free food from pantries, soup kitchens, and other programs has increased by nearly 60%, according to the RI Community Food Banks "2011 Status Report on Hunger in RI". About 60,000 people a month receive food from the 117 food pantries, 27 meal programs, and 7 shelters served by the Food Bank, an 8% increase over 2010. About 60% of those who get groceries from food pantries also rely on SNAP benefits. Minorities and families with children have been especially hard hit by the economic downturn. About 16% of emergency food program users are Black; 35% are Hispanic or Latino.**

**Food stamp use is at a record level. In June 2011, the number of Rhode Islanders receiving SNAP benefits increased to a record 163,608 from 87,235 in June 2008, a nearly 88% increase, according to the RI Department of Human Services. That's about 1 in 6 Rhode Islanders. The number of SNAP users has grown for 36 consecutive months and topped 100,000 in spring 2009.**

**RI has dramatically scaled back its cash assistance program for poor and low-income wage earning families. Families who received cash assistance, known as the RI Works benefit, fell to 7,028 in 2011 (less than half of the 15,548 receiving the benefit in 2001). Advocates for the poor and low income families in RI lobbied the state legislature to repeal**

***a part of the state's welfare reform program in next year's budget (FY2013). Specifically, they wanted to eliminate the current "time limit" language preventing families from drawing on welfare for more than 24 consecutive months (the current lifetime cap of 4 years total on welfare would remain in effect). The bill failed to pass. Even with the change, RI's welfare program would still be among the most restrictive in the nation. Thirty-five states cap benefits at the federally mandated 5 years of eligibility.***

***Another anti-poverty proposal introduced this year in RI included legislation that would have capped at 36% the amount of interest that "payday lending" companies can charge individuals. In RI, payday lenders are allowed to provide small, short-term loans up to \$500 that are intended to be paid in full in 2 weeks and are typically secured with a post-dated check. State law allows these lenders to assess what amounts to an annual interest rate of up to 260% on the loans. This bill also failed to pass.***

***On the positive side, in June 2012, the Governor signed into law the first minimum wage hike in six years. The law raises the minimum wage by 35 cents, from \$7.40 to \$7.75 per hour effective January 1, 2013. RI's minimum wage was the 4th lowest of the six New England states where it is \$8.46 in Vermont, \$8.25 in Connecticut, \$8.00 in Massachusetts, \$7.50 in Maine, and \$7.25 in New Hampshire.***

***Health Care Needs of the State's Population & Select Innovative Solutions: Like elsewhere in the nation, assuring the health of RI's women and children presents challenges. Of the six New England states, RI has highest preterm birth rate (11.4%), the second highest rate of low birth weight births along with Connecticut (8%), the second highest rate of adult women who are overweight or obese (57% in 2010), the second highest rate of high blood pressure among adult women (28.6%), and the second highest Chlamydia rate (457.4 per 100,000 women in 2010). On the positive side, RI enjoys the highest rate of adult women who had a cholesterol check within the past five years (85.7% in 2009) of the six New England states.***

***With respect to children's health, of the six New England states, RI has the highest childhood obesity rate (30.1% in 2007); the second highest rate of children (2-17 years) with emotional, developmental, or behavioral problems (76% in 2007); and the highest rate of children (1-17 years) with oral health problems (26.4% in 2007).***

***On the positive side, RI finished the influenza season this year in May 2012 after having increased influenza vaccination by at least 10%, with 91.5% of children aged 6-35 months getting vaccinated. RI's vaccination rates remain among the best in the country. In addition, of the six New England states, RI has the highest rate of children (0-17 years) who had both a medical and dental preventive care visit the previous year (85.3% in 2007), and is tied with Connecticut as having the second lowest teen (15-19 years) death rate (39 per 100,000 teens in 2008).***

***According to a report issued by CDC in April 2011, RI's teen birth rate from 2007 to 2010 fell 24% - the third steepest decline in the nation. In 2010, the state had the 7th lowest teen birth rate in the country, though its rate remains the highest of the New England states. Yet, the teen birth rate in some communities has remained stubbornly high. The teen birth rates are highest in Providence, Pawtucket, Central Falls, and Woonsocket, which account for 70% of all teen births from 2006 to 2010.***

***Legislation was introduced this year that would provide family planning services to low-income, Medicaid-ineligible women of childbearing age up to 250% of the federal poverty level. With fewer births, the state would stand to cut its Medicaid spending by \$272,000 in the first year of the program and by more than \$4 million a year once the program has been running for several years. The proposal would also mirror language in 22 other states that provide such coverage. The bill failed to pass.***

**According to a recent report issued by the Trust for Health and the Robert Wood Johnson Foundation in May 2012, 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.**

**RI missed out on a higher score because it is among 35 states that do not mandate convicted drunk drivers to use car ignitions that remain locked if they are intoxicated. On June 6, 2013, the state house of Representatives voted 72 to 0 to pass a bill that would allow judges and magistrates to require the installation of ignition interlock systems in cars operated by drivers who have been convicted of driving under the influence, however, the bill failed to pass.**

**The annual drive to impose a state tax of one cent per ounce of any beverage containing high-calorie sweeteners like sugar or corn syrup drew support from local health care organizations who argued at a hearing in April 2011 that it would encourage better food choices and help fund obesity prevention programs. The bill failed to pass.**

**Between 2000 to 2010, the incidence of childhood lead poisoning in RI declined from 6.1% to 1% and the number of new cases declined from 1,740 to 252. However, nationwide, the budget that CDC allocates for healthy homes and lead poisoning prevention has dropped from \$29 million to \$2 million. Two years ago, the state received \$850,000 from CDC for lead poisoning prevention and control; this was reduced to \$594,000 in FY2012 and cut to \$0 for FY2013. At its peak, RI received over \$1 million from CDC for lead poisoning prevention and control.**

**The cut meant that the state will lose its capacity to monitor lead poisoned cases and respond to every child who has an elevated blood level with a home inspection and referrals for medical intervention and remediation of lead hazards. Additionally, the program's critical prevention efforts will likely disappear regarding proactive housing policies and community education and outreach. The cuts are coming soon after the CDC reduced in half the blood lead threshold that triggers medical intervention, lowering it to 5 micrograms per deciliter. The tougher standard means that 1,279 children in RI would have been newly diagnosed as lead poisoned in 2010, instead of the 252 who required intervention under the old standard -- a six-fold increase. In June 2012, the state legislature restored the funding for a year.**

**During the period 2009-2010, 61% of RI's non-elderly population (0-64 years) had employer-sponsored health insurance, 4% had individual health insurance, 19% had Medicaid, 2% had other public insurance, and 13% were uninsured. Although the rate of uninsured non-elderly residents in RI was lower than the nation (18%), it was tied with Connecticut as the highest in New England. In New England, RI tied with New Hampshire as having the highest percentage of women ages 19-64 years with no health insurance (13%) in 2010.**

**During this same period, 54% of RI's children (0-18 years) had employer-sponsored insurance, 36% had Medicaid, and 7% were uninsured for health care. The rate of uninsured children in RI is lower than the nation (10%). However, it is tied with Connecticut as the highest in New England and higher than Maine and New Hampshire (5%), Vermont (4%), and Massachusetts (3%). The percentage of RI children without a medical home in 2007 was 36.4%, the second highest in New England after Connecticut (37.6%).**

**Fourteen percent (14%) of RI children under age 18 are estimated to have special health**

**care needs. Currently, 23% of all households in RI have a child with at least one special health care need. A higher percentage of children in low-income families in RI have special health care needs compared to those in the United States, with 16% of RI children in families with incomes less than 200% of the federal poverty level reporting special health care needs, compared with 14% nationally.**

**There is some good news with respect to RI's commercially insured health insurance rates. In May 2012, the state Office of the Health Commissioner released its annual installment of the private health insurance market study, which examines trends in commercial health insurance programs. The report covers data from 2005 to 2011 for the 3 largest insurers in Rhode Island: Blue Cross & Blue Shield of Rhode Island, United Health Care of New England, and Tufts Health Plan.**

**According to the study, over half of Rhode Islanders (53%) are covered by private insurance and 4,256 more people were enrolled in private insurance in 2011 than in 2010 (the first increase in over 6 years). Although small, this increase may indicate that the privately insured market is returning to its pre-recession strength. After losing more than 31,886 covered lives in 2009 at the height of the economic crisis, the market cut its losses to 12,370 in 2010 before posting the small gain of 4,256 in 2011. Self-insured plans (employers who collect premiums and pay employee claims themselves) drove the growth in private insurance. Since 2005, the share of the population in these plans has grown from 34% to 42%. For the first time, there were more Rhode Islanders in self-insured plans than in large group plans.**

**With respect to dental health, it is important to understand that dental insurance is not available to many working families in Rhode Island. Fewer than half (48%) of Rhode Island employers offer dental insurance to their full-time employees, and 14% offer it to their part-time employees. Despite this, the percentage of Rhode Island women who had a dental visit in 2010 within the past year was 79%, which ranked Rhode Island higher than the nation (71.7%) and the third highest of the six New England states. State law requires schools to provide dental screenings for all newly enrolled students, annually for children in grades K through 5, and at least once between grades 7-10.**

**Still, there are significant numbers of Rhode Islanders who have inadequate access to dental care. In response to this concern the Inaugural Rhode Island Mission of Mercy (RIMOM) was launched at the Community College of RI in Lincoln in June 2012. Though this initiative, free dental services were provided to hundreds of patients with a high priority on those suffering from infections or pain. Patients lined up for services the day before the event and demand for services quickly exceeded capacity. HEALTH staff from the DCFHE's Oral Health Program and Center for Public Health Communications was instrumental in organizing the RIMOM and participated as event volunteers.**

**A CDC study released in October 2011 based on data collected by the National Survey on Drug Use and Health (NSDUH) found that among all states, RI has the highest percentage of adults who made plans to commit suicide and who attempted suicide. It also ranked higher than regional and national averages -- but not at the very top -- in the number of people who had serious thoughts about suicide. The findings came on the heels of a report issued two weeks before which found that RI had the highest rate of mental illness in the nation, 24.2%.**

**The study found that suicidal thoughts and attempts were higher among females, young adults, and adolescents. Among other findings: 6.2% of adults had serious suicidal thoughts in the previous year (nationally, the rate was 3.7%), 2.8% of adults in RI reported making suicidal plans (nationally, the rate was 1%), 1 in every 67 adults in RI attempted suicide in the previous year (nationally, the rate was 1 in every 200 adults). In 2010, 38.2% of RI adult women reported poor mental health in the previous 30 days. This rate was the**

*third highest in New England after Vermont (43%) and Maine (39.9%).*

*According to NSDUH data, RI is the worst state in the nation with respect to the percentage of people age 12 and over who have used illicit drugs in the past month -- 13.3%. Rhode Island also ranks in the highest fifth for the category for youth ages 12-17 years -- second of all states at 12.4%. For those Rhode Islanders who need treatment for substance abuse, but are not getting it, RI was in the highest group ranking second at 3.9%. With respect to those ages 12-17, the state remained in the top fifth, in 6th place at 4.9%.*

*RI has the 3rd highest rate of non-medical use of opioid drugs (6.13%) among people 12 and older. The national rate is 4.8%. At 17.2 per 100,000 population, RI also has the 7th highest rate of drug overdose deaths in the nation and the highest rate of drug overdose death rates in New England. In response to this epidemic, HEALTH is utilizing federal grant funds from the US Department of Justice to electronically enhance its current prescription monitoring program to further reduce "doctor shopping" and diversion, share data with other states, and provide pharmacists and physicians with prescription drug usage information on their patients.*

*HEALTH's Refugee Health Program serves about 148 newly arrived refugees each year. The greatest percentage of refugees arrive from Asia, mainly from Bhutan and Myanmar, and they are followed by Africans and Eastern European refugees. Thirty-nine languages are being spoken. The Program is working to increase the percentage of refugees to 100% for whom a health screening form is submitted by community health care providers to the program within 30 days of the refugee's arrivals a CQI initiative. The Refugee Health Program works with more than 75 community partners. With the support of Brown University, a Resource Network was established at the African Alliance in 2010. In 2011, mini-grants were awarded to 3 non-profit agencies to develop a CHW curriculum, a partnership to provide the uninsured African refugee population with free health care services, and an ecological approach to healing and adaptation within the refugee community. World Refugee Day is celebrated by both the International Institute and the Diocese of Providence. Both celebrations are exceptionally well attended.*

*Several other innovative health related strategies are also taking place in RI. Led by Lt. Governor Elizabeth Roberts under an Executive Order issued by the Governor last year, RI has moved ahead with plans for a health benefits exchange. RI is one of 13 states that received federal money to implement an exchange. New York and Minnesota have followed Rhode Island's lead, launching exchanges on the basis of Executive Orders alone. In addition, the state enacted legislation in June 2012 that will bring the state's health insurance laws into compliance with federal health insurance laws. Stakeholders are coming together in RI to improve the primary care health care system. About 25% of primary care in RI is now provided through patient-centered medical homes. This new model includes open access (sick today, seen today), robust electronic medical records, medication management, medical information for patients and behavioral and physical therapy programs integrated into the practice. On the horizon in the state are further developments that should benefit everyone: the medical neighborhood (coordinating primary care with specialists, behavioral health, and other sources of care), statewide patient-data systems and electronic health records that can talk to one another and enable integration with hospitals.*

*With respect to tobacco control efforts, the state enacted legislation in June 2012 increasing the excise tax on cigarettes from \$3.46 to \$3.50. Rhode Island's tobacco tax is the 2nd highest in the nation after New York (\$4.36). The City of Providence has done more than any other RI community to control the sale of tobacco and its use, especially by the young. In January 2012, the city enacted two ordinances banning the sale of all tobacco products at discounted prices and the sale of products other than cigarettes with*

*distinctive flavors and aromas such as spice or fruit. Providence is one of the first cities in the nation to legislate in those two areas.*

*Two RI programs -- one for premature babies and one for children with asthma -- are among 26 projects in the nation selected for the first batch of federal Health Care Innovation grant awards. In May 2012, the US Centers for Medicare and Medicaid services announced awards totaling \$122.6 million made possible by the Affordable Health Care Act. Financed for 3 years, the chosen projects are intended to save money, deliver high-quality care, and create jobs.*

*A program at Women & Infants Hospital of RI for about 2,400 mothers of preterm babies will receive \$3.2 million. The hospital's Neonatal Follow-Up Program now serves families of children born before 32 weeks gestation; the grant enables the program to expand to children born 32-37 weeks gestation. These children often seem healthy when they go home, but are more susceptible to infections and respiratory problems. They can also have learning difficulties that are not detected until they begin school. The new program will try to nip such problems in the bud by working with the families and their babies when the babies leave the hospital.*

*RI will also share \$4 million to help low-income children with asthma in four states. The program will send community health workers into the home to teach how to manage asthma medications and eliminate environmental triggers. The money will also provide equipment such as air purifiers and vacuum cleaners with HEPA filters. A similar program already serves 140 children ages 2-6 in Providence. The new grant will expand the program to an additional 283 children through age 17.*

*In late 2011, RI was awarded competitive federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program funds to provide voluntary, evidence-based home visiting services to pregnant women and children through three years of age in the state's core communities to improve maternal and child health; prevention of child injuries, child abuse, and child neglect; reduce emergency department visits; improve school readiness and achievement; reduce domestic violence, improve family economic self-sufficiency; and improve coordination and referrals to other community-based supports. Administered by the DCFHE, the MIECHV Program has opted to implement the following evidence-based home visiting models: Nurse Family Partnership, Healthy Families America, and Parents as Teachers.*

*State Title V Priorities: Public health services are best delivered locally, at the community level, but the majority of public health departments, including HEALTH, lack funding, information technology, and staff to adequately provide disease surveillance and protection to their residents. With decreasing annual budgets, their ability to perform traditional public health functions is stretched.*

*HEALTH and its lead maternal and child health division, the DCFHE, have been able to look beyond these challenges and implement several innovative strategies for addressing the public health needs of RI's population, including its maternal and child health populations. It is particularly proud of its work to eliminate disparities, coordinate care, promote primary prevention, optimize access to care for all Rhode Islanders, and build the community's capacity to stay healthy. In the upcoming year, the DCFHE will use Title V funds to support an integrated MCH/chronic disease RFP, the MCH hotline and distribution center, the BRFSS (RACE module and asthma), health equity activities, the Toddler Wellness Overview Survey (TWOS), PRAMS, parent consultants, Family Voices, YSHCN, PPEP, teen outreach, Ready to Learn Providence, asthma health resources, and the Title V needs assessment update.*

*State fiscal year 2012 was a decent year for public health in RI. After experiencing cuts to*

***its budget for the past five years, the HEALTH was level funded for state fiscal year 2013. In addition, HEALTH, including the DCFHE, has been successful in bringing in new federal grant dollars to address the public health needs of its residents and there is a dedicated commitment on the part of the DCFHE to invest in evidence-based initiatives.***

***As the lead MCH authority in the state, the DCFHE 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. The DCFHE's approach to public health is built on the following three pillars of health equity: the social and environmental determinants of health, the life course approach, and the integration of categorically funded services with other categorically funded services.***

***When allocating resources and making decisions on what interventions should be implemented, the DCFHE uses the "Equity Pyramid" (adapted from Thomas Frieden, MD, MPH, presentation at the Weight of the Nation Conference, in Washington D.C., July 27, 2009) as a tool to help prioritize its work. The "Equity Pyramid" establishes five levels of program impact/effectiveness from level one (less impact) at the top of the pyramid to level five (most impact) at the bottom of the pyramid. The DCFHE has also created grant review guidelines and protocols to ensure that all applications for funds and work plans reflect the three pillars of equity. Core competencies for staff have been identified and professional development opportunities offered to all staff to increase health literacy and understanding of the core domains of health equity.***

***During the 2011 Title V MCH needs assessment year, the DCFHE identified new MCH priorities informed by data collection and surveillance, family and community input, and interagency collaboration. These priorities have not changed. State Performance Measures 2-6 mirror the identified priorities reflected in the themes based on data and community input. State Performance Measures 1 and 7 are related priorities based on a life course perspective for prioritizing health care needs and services by looking at health and wellness across the lifespan.***

***The measures are for specific populations yet our intent and purpose is an overarching priority across all of the MCH population groups. State performance measures 8 and 9 are indicators of the social determinants of health. Most health disparities affect groups that are disadvantaged or marginalized because of their socioeconomic status, race/ethnicity, gender, sexual orientation, disability status, geographic location, or any combination of these. Access to healthy food and quality education are social determinants that contribute to good health.***

***DCFHE convened an internal MCH planning group. This group met monthly to discuss integrative opportunities around MCH priorities and related performance measures. Community input has been analyzed by the group and incorporated into division and program level work. DCFHE programs conduct on-going needs assessment as part of their usual activities around planning, implementation and evaluation of specific initiatives. DCFHE programs consider each opportunity for interaction with the community as a form of needs assessment.***

***The DCFHE has also developed tools and resources for staff to incorporate a lifecourse development approach that addresses the determinants of health as a framework for health planning across programs. DCFHE leadership has fostered sensitivity to local needs by intentionally demonstrating that it has heard and will strive to meet community needs as they relate to maternal and child health issues. For FY2013, the DCFHE's priorities and measures for action under Title V continue to be as follows:***

**Priority: Increase access to and capacity to support evidence based parent education and family support programs.**

**SPM1: Percent of RI resident families with at-risk newborns that receive a home visit during the newborn period (<=90 days).**

**SPM 7 Number of parents with children in early childhood that enroll in parenting education/support programs.**

**Priority: Reduce tobacco initiation among middle school students.**

**SPM2: Percent of middle school students who have initiated tobacco use.**

**Priority: Increase the percentage of insured adolescents who have a preventive "well care" visit each year.**

**SPM3: Percent of insured adolescents who have a preventive "well care" visit each year.**

**Priority: Increase the social and emotional health of children and youth with special health care needs.**

**SPM 4 Percent of high school students with disabilities who report feeling sad or hopeless.**

**Priority: Increase the percentage of women who have a preventive care visit in the last year.**

**SPM 5: Percent of women who have a preventive care visit in the last year**

**Priority: Initiate prenatal home visiting program.**

**SPM6: Percent of pregnant women delivering babies served by home visiting.**

**Priority: Adopt the social determinants of health into public health practice.**

**SPM 8: Percent of RI adolescents who report food insecurity.**

**SPM 9: Percent of RI high school students who earn a high school diploma or diploma equivalent in the six core cities.**

**Through ongoing partnerships with community advocates, providers, and the families the DCFHE serves, the DCFHE is committed to realizing these priorities and ensuring that all families in our state have the opportunity to raise safe and healthy children in safe and healthy communities. The DCFHE has utilized these processes to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery in the state, including the current and emerging issues and has chosen to use Title V funds to, among other things, support an RFP to provide integrated evidence-based maternal and child health/chronic disease evidence-based services with a focus on addressing health inequalities in targeted neighborhoods in RI //2013//.**

## **B. Agency Capacity**

### B. Agency Capacity

/ 2013/ Title V Agency's Capacity to Promote & Protect the Health of all Mothers and Children Including CSHCN //2013//: **Chapter 23-13 of the Rhode Island General Laws (1937, 1999) designates the RI Department of Health (HEALTH) as the state agency responsible for administering the provisions of Title V of the federal Social Security Act in Rhode Island relative to MCH services. Michael Fine, MD has served as Director of Health since 2011. In this role, Dr. Fine oversees the single state agency with over 400 employees and an operating budget of over \$110 million. Dr. Fine's career as both a family physician and manager in the field of health care has been devoted to health care reform and the care of underserved populations.**

**Before his confirmation as Director of Health, Dr. Fine was the Medical Program Director at the Rhode Island Department of Corrections; founder and Managing Director of Health Access RI (the nation's first statewide organization making prepaid, reduced fee primary care available to people without employee-sponsored health insurance); Physician Operating Officer of Hillside Avenue Family & Community Medicine (the largest family practice in the state); Physician-in-Chief of the Rhode Island and Miriam Hospitals' Department of Family and Community Medicine; founder of the non-profit Scituate Health Alliance (making this rural Rhode Island town the first community in the nation to provide primary medical and dental care to all its residents). Dr. Fine's priorities include the following areas: prescription drug abuse, prematurity, C-sections, HIV prevention, and colon cancer. His strategies for addressing these areas include continuous quality improvement, public health department accreditation, and primary care workforce development //2013//.**

As the recipient of the state's federal Title V MCH block grant funds, HEALTH's Division of Community, Family Health & Equity (DCFHE) plays the lead role in the state in addressing the MCH-related needs of children, including those with special health care needs (CSHCN) and their families in Rhode Island. The DCFHE has the capacity to promote and protect the health of all mothers and children, including CSHCN, in the state. The goal of the DCFHE is to achieve health equity for all Rhode Islanders, including mothers and children, through eliminating of health disparities, assuring healthy child development, preventing and controlling disease, preventing disability, and working to make the environment healthy. The DCFHE uses a life course development approach that addresses the 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 Rhode Island.

While the DCFHE has made significant progress in meeting its Title V national and state performance measures and Healthy People 2020 goals, disparities still exist. Therefore, proactive and applied public health strategies must continue to focus on all members of Rhode Island's state and local communities to eliminate health disparities in the state. It is through this collective work effort that DCFHE continues to offer quality programs, leverage 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 Rhode Island's MCH infrastructure.

Housed in the DCFHE, the Office of Special Health Care Needs (OSHCN) is the designated state Title V MCH Office of CSHCN. The OSHCN is responsible for: 1) working to provide medical home enhancement for children and youth with special health care needs, including children with Autism Spectrum Disorder, through the Pediatric Enhancement Project (PPEP), which ensures a coordinated system of care by providing trained parent consultants in pediatric primary and specialty care practices to assist families access community resources, assist physicians and families access specialty services, and identify barriers to coordinated care; 2) promoting health, wellness, and emergency preparedness for people with disabilities, including children, through surveillance professional development opportunities, and communities initiatives; a Special Needs Emergency Registry for people with special needs, chronic conditions, and disabilities in the event of an emergency; and a Traumatic Brain Injury (TBI) Registry and linkage program; and 3) assisting youth with chronic health conditions and disabilities transition to the adult system of primary and specialty care, education, employment, and insurance through its Adolescent Transition Program, which makes resources available for physicians, parents, and youth regarding the timeline and necessary components of transition that support self-determination. The DCFHE and its MCH and CSHCN programs, along with all of the other programs administered by the DCFHE, work together to ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care which are essential for effectively fostering and facilitating MCH activities. The DCFHE 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 MCH health becomes a 100% reality.

State Statutes Relevant to Title V

***/2013/ Section 23-13 of the Rhode Island General Laws (RIGL) provides the Department of Health with broad authority for administering Title V MCH services. Specifically, the statute "designates the state Department of Health as the state agency for administering in Rhode Island the provisions of Title V of the Social Security Act" relative to maternal and child health services and requires the Department of Health to "administer a program of ambulatory health services for mothers and children and supervise the administration of those services included in the program which are not directly administered by the department. The purposes of those programs are: to reduce maternal and infant mortality, reduce the incidence and prevalence of preventable diseases and disabling conditions among children, reduce the need for inpatient and long-term care services, increase the number of children (especially low income children) receiving immunization, health assessment, diagnostic, and treatment services, develop, extend, and improve ambulatory health services to locate, diagnose, care for, and rehabilitate children with disabling conditions, and otherwise preserve, protect, and promote the health of mothers and children. The director of health is authorized to promulgate rules and regulations that may be necessary to carry into effect the provisions of this section".***

***State Program Collaboration with Other State Agencies and Private Organizations, State Support for Communities, Coordination with Health Components of Community-Based Systems: The DCFHE works closely with other state agencies and private organizations to promote the healthy development of women, infants, and children, including CSHCN, in Rhode Island. It is important to point out that the state's human service departments are administered by the states' Executive Office of Health & Human Services (EOHHS). The EOHHS was created to facilitate cooperation and coordination among the five state departments that administer Rhode Island's health and social service programs -- HEALTH, the Rhode Island Department of Human Services (including the Divisions of Elderly and Veterans Affairs), the Rhode Island Department of Education (RIDE), the Department of Children, Youth , and Families (DCYF), and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). Together, these departments affect the lives of virtually all Rhode Islanders, providing direct services and benefits to over 300,000 citizens while working to protect the overall health, safety and independence of all Rhode Islanders. HEALTH collaborations with these agencies are as follows:***

**RIDHS: The DCFHE has a Medicaid interagency agreement with DHS for several program/services - Lead Inspections, Environmental Health Administration, MCH Administration, Communicable Diseases, Primary Care Administration, and Nurse Assistant Registry (Division of EHSR). HEALTH also has Memoranda of Agreement with DHS to share data related to KIDSNET //2013//.** Staff from HEALTH provide consultation and professional expertise to DHS in the areas of assessment, assurance, and policy development through formalized workgroups and program specific discussions to target outreach and program efforts.

The DCFHE also works collaboratively with DHS in the administration of the state's care coordination system for CYSHCN (CEDARR), the provision of services through the Early Intervention program, statewide access to screening and assessment for children with complex special health care needs, Viral Hepatitis B and C prevention efforts, and the administration of parent engagement to support clinical practices such as the Pediatric Practice Enhancement Project (PPEP). The DHS and the OSHCN collaborate on family engagement programs, parent leadership and stakeholder initiatives. The DCFHE and DHS also jointly manage and fund the Child Care Support Network. DHS is a full partner in the implementation of Successful Start, RI's Early Childhood Comprehensive Systems initiative.

DHS collaborates on DCFHE's Oral Health for Pregnant Women initiative to increase the number of pregnant women on Rite Care who visit a dentist during their pregnancy, encourage the integration of primary and oral health care to improve birth outcomes of Medicaid recipients. The DHS funds and certifies lead centers that provide non-medical case management to children with elevated blood lead levels. The DCFHE provides quality assurance, establishes protocols, conducts reviews, offers training and sets minimum standards based on CDC guidance and benchmarks. DHS shares de-identified asthma-related Medicaid data with HEALTH's Asthma Control Program. **//2013/ These data include Rite Care data. Medicaid staff participates as members of the Home Asthma Response Program, formerly known as the RI Asthma Emergency Department (ED) Diversion Pilot Project Advisory Committee //2013//**

RIDE: RIDE is a key partner in the implementation of RI's Early Childhood Comprehensive Systems Plan. HEALTH also has a seat on RI's Early Learning Council, which was appointed by the Governor and is charged with implementing specific goals around learning for children birth to five. **//2013/ In 2011, RIDE received an Early Childhood Race to the Top grant, in which HEALTH is a key partner in both the management and implementation of grant activities//2013//.** The OSHCN collaborates with RIDE on implementing and assuring access to special education through the Parent Information Network Resource Center, assisting families through the PPEP and providing workshops and technical assistance for families and school districts. RIDE and OSHCN partner on autism initiatives including the screening, diagnosis, and education of children and youth with autism spectrum disorders. The OSHCN is a member of the RIDE-led Transition Council established by state statute to coordinate the activities of state agencies and school districts for youth with disabilities transitioning from school to adult life; and RI's Special Education Advisory Council that oversees IDEA services in RI. RIDE continues to collaborate with DCFHE on thrive, RI's coordinated school health program through maintenance of a joint website. RIDE, DCFHE, and HEALTH's Center for Data and Evaluation administer the Youth Risk Behavior Survey every other year in RI high school and middle schools and produce reports linking key health indicators and academic achievement along with reports that illustrate the disparities in health including gender, sexual orientation and disabilities.

HEALTH participated with RIDE in the development of Surveyworks, a new survey for students, parents and teachers related to factors involved in teaching and learning including health issues. HEALTH has an ongoing collaboration with RIDE through the Vaccinate Before You Graduate Program (VBYG), a statewide school based influenza immunization program for students in grades K-12 and a dental screening program in select schools. DCFHE collaborated with RIDE to prioritize asbestos inspections in schools located in Environmental Justice Areas as defined by

EPA. DCFHE participated in monthly meetings with the RI School Building Maintenance Director's Association, strengthening partnerships and communication regarding the Asbestos Hazardous Emergency Response Act requirements and responsibilities. ***/2013/ The DCFHE provides technical assistance to RIDE in administering the Tools for Schools Program, which addresses indoor air quality and other environmental hazards. HEALTH also partners with RIDE in implementing sports concussion and injury prevention program. DCFHE partners with RIDE in the Child Opportunity Zone (COZ) initiative focused on parent and community support for student learning //2013//.***

RIDCYF: The DCFHE is collaborating around data sharing via KIDSNET to better coordinate preventive health care for children in foster care. The DCFHE's First Connections Home Visiting Program is working with DCYF in the implementation of new regulations regarding screening young children with substantiated cases of child abuse/neglect for Early Intervention eligibility. First Connections nurse home visitors perform screening and serve as a liaison between DCYF and Early Intervention providers. DCYF is a full partner in the implementation of RI's Early Childhood Comprehensive Systems Plan. The DCFHE's OSHCN partners with DCYF and DHS on the design and implementation of the children's behavioral health system in RI. The OSHCN convenes and sponsors opportunities for family involvement and stakeholder participation in the children's behavioral healthcare system. The DCFHE participates on the Children's Trust Fund, which administers the state's primary and secondary prevention of abuse and neglect. ***/2013/The Initiative for a Healthy Weight collaborates with DCYF, RIDE and DHS to improve nutrition and physical activity requirements for licensed childcare providers. //2013//*** The Immunization Program partners with DCYF in educating child care workers and families about immunizations. DCFHE is also collaborating with DCYF to better understand the needs of youth in foster care especially as it relates to teen pregnancy prevention.

***/2013/ BHDDH: The DCFHE collaborates with BHDDH's Division of Substance Abuse (DSA) around training for Maternal, Infant, & Early Childhood Home Visiting (MIECHV) Program home visitors on substance abuse topics. The DCFHE collaborates with the DSA and DCYF through the Task Force on Premature Births to develop strategies for identifying pregnant women who misuse substances with the goal of decreasing preterm births while maintaining intact families. The Tobacco Control Program collaborates with BHDDH around the enforcement of laws related to sales of tobacco products to minors. The Director of BHDDH has a seat on the DCFHE's Home Visiting Leadership Council (HVLC), the purpose of which is to create and align state policies for evidence-based home visiting programs, secure sustainable funding, support data collection and benchmark measurement, and identify unmet needs of families. A representative of the DSA has a seat on the Successful Start Steering Committee. The DCFHE's OSHCN coordinated transition services for youth with developmental disabilities and behavioral health diagnoses from pediatric to adult services in addition to participating on statewide advisory committees in behavioral health, developmental disabilities, and transition planning with BHDDH.***

***In addition to collaborating with the departments administered by the EOHHS, the DCFHE coordinates with the following other state departments: //2013//***

The RI Department of Environmental Management (RIDEM): The DCFHE collaborates with DEM's Division of Agriculture in the promotion, support and monitoring of the WIC Farmers Market Nutrition Program. HEALTH and the RI DEM collaborate on reducing hazards from exterior lead paint and from asbestos. DCFHE worked in partnership with DEM, the RI National Guard and the EPA Region 1 Criminal Investigation Unit on several investigations regarding asbestos related compliance.

The RI Department of Transportation (RIDOT) has a cooperative agreement with DCFHE's Initiative for a Healthy Weight for improvements in community built environments to encourage active transportation. ***/2013/ The Violence and Injury Prevention Program works with DOT, as***

**part of the RI Traffic Safety Coalition to prevent motor vehicle injuries through passenger safety, graduated drivers licensing and driving under the influence policy work. It also works closely with RIDOT's Bicycle Safety Program //2013//.**

The RI Department of Administration (RIDOA), Division of Statewide Planning (DSP): The DCFHE's Initiatives for a Healthy Weight Program, in partnership with the DSP, works with municipalities to incorporate elements of health in municipal comprehensive plans.

**/2013/ In addition to collaborating with state departments, the DCFHE collaborates with numerous private organizations including, but not limited to, the Rhode Island Chapter of the American Academy of Pediatrics (RI-AAP), the Rhode Island Chapter of the American College of Obstetricians and Gynecologists (RI-ACOG), The Warren Alpert Medical School at Brown University, Women & Infants Hospital of Rhode Island, the Safety Alliance Furthering Educational Resources, the RI Real Estate Investor Group, the RI Marine Trade Association, the RI Nursery and Landscape Association, the RI Manufacturers Association, four Lead Centers (St. Joseph Hospital Lead Center, Blackstone Valley CAP, West Bay CAP, East Bay CAP, the Pawtucket Red Sox, the RI Lung Association, Apeiron Institute, RI Builders Association, RI Community Action Programs, Association of School Building Maintenance Directors, Green & Healthy Housing Initiative, Rhode Island Keep Space, RI Hospitals for a Healthy Environment, DCYF-licensed child care providers in center-based and home programs, the RI Training School, Planned Parenthood of Rhode Island, the Primary Care Physician Advisory Committee (PCPAC), the Children's Neurodevelopment Center at Hasbro Children's Hospital (CNDC), the WIHRI RI Hearing Screening Assessment Program (RIHAP), the RIHAP Hearing Screening & Follow-Up Committee, RI Family Voices, school and child care providers, the RI Oral Health Commission, the RI Parent Information Network (RIPIN), the RI Task Force on Premature Births, the Brain Injury Association of RI, Olneyville Housing Corporation, Quality Partners, Inc., the RI Health Center Association, the American Lung Association, the RI Breastfeeding Coalition, the RI Chronic Care Collaborative, the RI Asthma Control Coalition, the Asthma Regional Council (ARC), and the Community Health Worker Association of RI (CHWARI) //2013//.**

State Support for Communities

DCFHE supports breastfeeding training of WIC nutritionists, WIC Peer Counselors and community educators, by offering training as Certified Lactation Consultants (CLC) and International Board Certified Lactation Consultants (IBCLC).

Ready to Learn Providence (R2LP) supports the Providence Plan's strategic planning initiative to increase utilization of MCH services among young families, including CYSHCN living in the city of Providence. The DCFHE continues to work with the Providence Plan to develop a statewide housing database to target unhealthy housing in the core cities **/2013/ and to link lead poisoning data to elementary school test scores //2013//.**

Child Care Support Network supports healthy child care environments through contracts to local community agencies. These agencies have staff that conduct technical assistance to childcare providers to promote children's mental health and healthy development.

The Successful Start Early Childhood Comprehensive Systems initiative supports a plan with specific goals and objectives around developing an overall early childhood system which includes five core components of the state's existing early childhood system including medical homes, social and emotional development, child care, parenting education, and family support for all children. Progress has been made on all of the goals within the plan and after four years of implementation, in **/2013/ 2011/2012 //2013//**, the plan was updated and is in the process of being approved. A transition advisory group to include adolescent systems development has produced a strategic plan for adolescent health, a needs assessment of adolescent access to preventive

care services and informed teen pregnancy prevention efforts.

The Title X Family Planning Program collaborates with several federally qualified community health centers, Planned Parenthood of Southeastern New England, Youth in Action, and the Women's Division of the Rhode Island Department of Corrections to provide affordable, confidential contraceptive and preventive health services to culturally diverse, primarily low-income men and women.

**KIDSNET: /2013/ The Asthma Control Program added an asthma component to KIDSNET to allow providers in the Blackstone Valley Community and St. Joseph Health Centers to refer families to the Breathe Easy at Home Project in the cities of Pawtucket and Providence//2013//.**

**Rhode Island Chronic Care Collaborative (RICCC): /2013/The DCFHE, Chronic Care and Disease Management Team continue to contract with 16 RICCC health centers to improve asthma and diabetes care to women and children using the Care Model and Model of Improvement //2013//.**

**RI Asthma Control Coalition: The RI Asthma Control Program continues to work closely with the Coalition to reduce asthma hospitalization and ED visit rates. The Asthma in Schools and Clinical Care Committees target youth through addressing the environmental health of schools, communication with school nurse teachers, and improvement in asthma care among primary care providers. /2013/ The Advocacy and Policy Committee convened for the first time on March 2nd to address disparities in pediatric asthma //2013//.**

**RI Asthma Emergency Department (ED) Diversion Pilot Project Advisory Committee: The RI Asthma Control Program convenes RI Asthma ED Diversion Pilot Project Advisory Committee guide efforts designed to reduce asthma ED visits by providing home visits to children who enter the ED or are admitted to Hasbro due to asthma. Home visits include an educational and environmental component. Hasbro Children's Hospital, St. Joseph Health Center, and RI Parent Information Network are partners in this effort.**

**/2013/ Home Asthma Response Program (HARP) Advisory Committee: The RI Asthma Control Program convenes the Home Asthma Response Program (HARP) Advisory Committee which guides efforts to reduce asthma ED visits by providing home visits to children who enter the ED or are admitted due to asthma. Home visits include an educational and environmental component. Hasbro Children's Hospital, St. Joseph Health Center, and RI Parent Information Network are partners in this effort. 29 patients completed the program in Phase 1. 70 additional patients are currently being recruited in Phase 2 which ends September 2012 //2013//.**

**The Diabetes Prevention and Control Program (DPCP) will fund a follow-up demonstration pilot project to ensure that women who have been diagnosed with gestational diabetes receive oral glucose testing and referrals to appropriate services for diabetes or pre-diabetes care. /2013/ Four of the RICCC sites and RI's largest birthing hospital are participating in this project. This project has increased the percentage of women screened for diabetes from 45% to 63% //2013//.**

**/2013/ The DCFHE supports the implementation of Teen Outreach Program, an evidence based youth development program in eight sites in Rhode Island including the four core cities //2013//.**

Coordination with Health Components of Community-Based Systems

HEALTH provides all recommended childhood vaccines to providers at no charge via a universal vaccine purchase and distribution system. The program coordinates with providers, community

based hospitals and health centers to offer free vaccines to uninsured children.

The WIC Program is co-located within local Community Health Centers and Hospitals providing direct referrals and increased access to services including medical care, dental care, social services, lead screening and immunizations.

The Perinatal and Early Childhood Team coordinates with a number of existing systems relevant to children's health care. Watch Me Grow RI, the First Connections Home Visiting Program, and the Child Care Support Network all coordinate with SCHIP, Early Intervention, the system of Community Mental Health Centers, and the Child Care Subsidy system. The Newborn Screening program coordinates with the birthing hospitals, the State Laboratory, and the RI Hospital. The ***/2013/ Healthy Housing and //2013//*** Lead Poisoning Prevention Program also coordinates with Medicaid, the states system of Lead Centers and the two lead clinics in the state that provide medical treatment for significantly lead poisoned children.

First Connections Home Visiting Program contracts with four community based agencies to conduct home visits to almost 25% of families with newborns who have specific risk profiles created from information collected at birthing hospitals providing general parenting information, conducting home assessments, and educating parents about infant care, and linking families to appropriate resources. The program will make home visits to children who are beyond the newborn period and link families with services. Home visitors also serve as the follow-up staff for the Newborn Screening, Lead Poisoning Prevention, and Immunization Programs. First Connections is an active contributor to the Child Find system for the Early Intervention program. The DCFHE is implementing an intensive home visiting model as well as prenatal home visiting through First Connections.

***/2013/ The MIECHV Program provides comprehensive evidence-based home visiting services to pregnant women and families with children up to age three. MIECHV programs include Nurse Family Partnership, Healthy Families America, and Parents as Teachers. MIECHV programs are required to participate on MIECHV Local Implementation Teams (LITs) which were established to coordinate MIECHV activities and to identify unmet needs on the local level. The LITs are composed of a wide array of local community agencies and advocates from a variety of disciplines including, but not limited to, medical care, housing, substance abuse, mental health, education, social services, etc. The MIECHV Program has also established a Home Visiting Leadership Council (HVLC) to create and align policies for MCH home visiting programs in the state and a Home Visiting Network (HVN) to coordinate all home visiting activities in the state (not just those that are MIECHV funded).***

***The Race to the Top Early Learning Challenge works with other state agencies, including RIDE (the lead state Race to the Top agency) to improve early learning and development opportunities for young children. The DCFHE is responsible for supporting 90 pediatric practices to implement standardized developmental screening and also for providing supports to primary care providers to address the needs of families in their practice that arise as a result of developmental screening //2013//.***

Watch Me Grow RI is a program that provides support to pediatric primary care providers and child care providers to implement developmental screening within community-based settings. ***/2013/WMGRI will be significantly expanded in 2012 through a partnership with RIDE and Race to the Top. //2013//*** WMGRI also provides technical assistance around understanding community services and how to refer/link to these services. As a result of the AAP recommendation around autism specific screening in addition to standardized developmental screening, WMGRI and the OSHCN provides technical assistance on standardized measures of development.

The DCFHE convenes a Healthy Housing Collaborative, a statewide collaborative of agencies and individuals, designed to help move communities towards a more comprehensive approach to

healthy housing practices and encourage landlords to use the web based HomeLocatorRI.net to promote their rental units with healthy housing characteristics for families in need. RI KidsCount, the Annie E. Casey Foundation, and DCFHE launched the first 'health and house' indicator in the 2009 edition of the KidsCount Factbook. The DCFHE partners with the Green and Healthy Homes Initiative to implement a cost-effective and integrated approach to housing interventions by combining federal and philanthropic investments in weatherization, energy efficiency, health and safety.

#### Coordination of Health Services with Other Services at the Community Level

During a WIC Certification appointment clients are assessed for any needs on an individual basis. Appropriate referrals are made (i.e. smoking cessation, housing, fuel assistance, food pantries, etc).

First Connections Home Visiting Program coordinates with the system of pediatric primary care to accept referrals, coordinate information exchange and make referrals to many diverse community programs. ***/2013/ The Teen Outreach Program, an evidence based youth development curriculum is included in the services offered //2013//.***

The Newborn Screening Program coordinates with community based and hospital based programs, which address the needs of families with children who have specific disabilities and disorders. The Newborn Screening Program provides universal newborn screening and follow-up for 29 metabolic, endocrine, and blood disorders along with hearing screening and developmental risk assessments for newborns. Implementation of a newborn developmental risk module is integrated with a new electronic birth certificate system.

OSHCN and parent consultants worked with parents to develop "medical passports" which contain information about services for CYSHCN and their families in RI. The DCFHE works with the New England Regional Genetics Group (NERGG) for technical assistance in implementing HEALTH's statewide genetics plan focusing on access to genetics services.

The Pediatric Practice Enhancement Project (PPEP) is a medical home enhancement for children and youth with special healthcare needs. PPEP ensures a coordinated system of care for children and youth with special needs and their families by placing trained peer resource specialists in 24 pediatric primary and specialty care practices to assist families in accessing community resources and to identify barriers to coordinated care.

The Birth Defects Program continues to work to assure that children with birth defects are identified and that they and their families receive appropriate services on a timely basis. The Program's activities focus on case ascertainment, service assurance, prevention, and information dissemination. The RI Birth Defects Advisory Council provides guidance in all of these areas. DCFHE staff participate on the Birth Defects Advisory Council including representatives from the Offices of Special Health Needs, Newborn Screening Programs, and Office of Minority Health, The Birth Defects Program's parent consultant works with the Advisory Council to develop and implement strategies to obtain and disseminate information to families. The parent consultant also works closely with the Advisory Council in the planning of the pediatric grand rounds that are held annually in January and are focused on topics related to birth defects.

***/2013/ The Healthy Housing and Lead Poisoning Program refers children who are significantly lead poisoned to a network of lead centers that deliver direct services in the form of non-medical case management and services and family support, educational information, and referrals //2013//.*** The DCFHE supports a clinic offering lead screening testing free of charge for children who are uninsured in one of the major pediatric hospitals in Providence.

The Tobacco Control Program offers the Quit Works Program to health care providers to provide

their clients with a proven quit smoking resource and Nicotine Replacement Therapy.

***/2013/The Initiative for a Healthy Weight and KIDSNET continue to pilot a program to collect BMIs from pediatric practices, and to train providers in how to use information and counsel families to reduce childhood obesity //2013//.***

The Asthma Control Program contracts with RICCC health centers to improve quality of asthma care. In addition, the RIACP is building capacity to support environmental interventions for children with asthma that frequent the hospital and ED due to asthma. The Asthma Control Program has integrated the Asthma ED Diversion and Breathe Easy at Home Pilot Project into two RICCC health centers to provide resources to providers and patients to reduce triggers and improve outcomes related to asthma. ***/2013/Women with gestational diabetes who are diagnosed with pre-diabetes or at risk for diabetes are referred to an evidenced-based diabetes prevention program provided by the YMCA.//2013//.***

The Statewide Breastfeeding Coalition has had an impact on breastfeeding support both in the community and at the legislative level. WIC collaborates with Women & Infants Hospital to support breastfeeding in the Neonatal Intensive Care Unit and throughout the hospital for WIC eligible clients. The WIC Breastfeeding Coordinator works closely with the staff of the Initiative for a Healthy Weight to promote Breastfeeding in the workplace and to promote baby friendly hospitals in RI.

The Successful Start Steering Committee is comprised of approximately 20 community members and state agency representatives. This committee is responsible for helping to implement RI's early childhood comprehensive systems plan. A Successful Start Adolescent Transition Advisory Group was established in 2010 to continue to develop systems to support school aged children and adolescents.

The Women's Health Advisory Committee advises the HEALTH & the DCFHE's Office of Women's Health on statewide priorities and policies to enable women to live to their optimal level by promoting a gender-informed, coordinated, comprehensive, primary prevention approach to women's health across the lifespan. Work is targeted to eliminate health disparities across all dimensions of age, ability, geography, race, ethnicity, sexual orientation, economics, and education.

A Commission on Health Advocacy and Equity was established in June 2011 to coordinate the expertise and experience of the state's health and human services systems, housing, transportation, education, environment, community development and labor systems in developing a sustainable and comprehensive health equity plan. This commission, established within HEALTH, subsumes the existing Minority Health Advisory Committee and expands the scope and responsibility of its members. The commission will review and evaluate progress in reducing health disparities and implementing policies and programs to improve health outcomes of minorities across all settings.

Rhode Island is a 1914 A state (i.e. all children participating in the Supplemental Security Income program receive Medicaid benefits which includes rehabilitative services). The DCFHE participates in the Rhodes to Independence Medicaid Infrastructure Steering Committee, the Global Medicaid Waiver State Implementation Team, and the Family Voices Leadership Team to ensure a safety net for children eligible for SSI and their families. The Teams include the Departments of Health, Education, Human Services, Children, Youth and Families along with the RI Parent Information Network, RI Family Voices, and Hasbro Children's Hospital.

The DCFHE and its OCSHCN facilitates the development of community-based systems of services for CSHCN and their families, which focuses mainly on infrastructure building activities including: leadership for the special needs service delivery system, especially as it relates to access and quality of pediatric specialty services, educating children with special needs, family

engagement and secondary transition. DCFHE invests in the special needs infrastructure through parent support and empowerment opportunities and the provision of quality assurance through a special needs leadership council.

***An attachment is included in this section. IIIB - Agency Capacity***

## **C. Organizational Structure**

### **Organizational Structure**

***/2013/ As previously noted, the Rhode Island Department of Health's (HEALTH's) DCFHE plays the lead role in the state in addressing the MCH-related needs of children, including those with special health care needs (CSHCN) and their families in Rhode Island. HEALTH is located within the state Executive Office of Health and Human Services (EOHHS), a cabinet agency that directly reports to the Governor. The state's Title V Program, including the CSHCN program, are housed within the DCFHE. Section 23-13 of the Rhode Island General Laws provides HEALTH with broad authority for administering Title V MCH services, including services for CSHCN, in the state. In accordance with the Title V grant guidance, an organization chart has been included as a part of the FY2013 application as an attachment to this section.***

***The goal of the DCFHE 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. The DCFHE uses a life course development approach that addresses the determinants of health as its framework for health planning, including MCH planning. The DCFHE is organized into the Office of the Executive Director and six (6) Teams as follows:***

***The Office of the Executive Director (OED) is responsible for providing leadership, vision, communication, and direction to the administrative staff, team leads, and support staff across all six (6) teams. Proactive and applied public health strategies focus on all members of the community to eliminate health disparities throughout Rhode Island. As a division team, integration between public health programs, including social, political, and economic policies that determine health outcomes, plays a key role in improving the lives of all Rhode Islanders, including mothers, and children. It is through this collective work that the DCFHE offers quality programs and continues to assure that all Rhode Islanders, including mothers and children, will receive optimal health throughout the lifespan. On the leadership level, the OED includes an Executive Director, a Medical Director, a Chief Program Administrator, and a Chief of Program Operations. It is the responsibility of the OED to assure that maternal and child health initiatives taking place internally within the DCFHE and those taking place externally to the DCFHE work together to ensure a system of care for mothers and children, including CSHCN, that is coordinated, comprehensive, and community-based.***

***The Health Disparities and Access to Care Team 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 Rhode Island's diverse populations so that they achieve their optimal state of health. The Team includes five (5) offices: Special Health Care Needs, Minority Health, Primary Care and Rural Health, Community Partnerships, and Women's Health. The Team is responsible for managing the following initiatives:***

- Refugee Health Program: works to ensure that refugees and asylees enter into a comprehensive system of care;***
- Minority Health Promotion Program: works to eliminate racial and ethnic disparities to assure equal access to high quality health services;***

- **Healthy Rhode Island and CLAS Initiatives:** works to ensure the implementation of federal CLAS standards in all health care programs that receive federal funding;
- **Family & Peer Resource Specialist Program:** works to bring the perspectives of parents, youth, and consumers into policy development and medical home implementation;
- **Pediatric Specialty Services:** works to provide medical home enhancement for CSHCN;
- **Disability & Health Program:** works to promote health, wellness, and emergency preparedness for people with disabilities, including CSHCN;
- **Adolescent Transition:** works to assist youth with SHCN transition to the adult systems of primary and specialty care, education, employment, and insurance;
- **Healthy Communities:** works to reduce health disparities and improve access to care by providing communities with information, skills, and resources they need to improve preventive health systems;
- **Women's Health:** works to eliminate health status disparities for Rhode Island women;
- **Primary Care and Rural Health:** works to increase access to high quality, comprehensive, coordinated, culturally appropriate care for underserved Rhode Islanders through needs assessment, promotion of the health care safety net, workforce development, collaboration with health system stakeholders, and community capacity building; and
- **Hospital Charity Care:** works to educate health care providers and patients about state regulations that require non-profit hospitals to provide free and discounted care to the uninsured poor.

**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. The Team has six (6) programs:**

- **Indoor Air Quality: Asbestos Control Program:** works to protect the public from exposures to carcinogenic airborne asbestos through hazard assessment and abatement;
- **Childhood Lead Poisoning Prevention Program:** works to support statewide screening efforts;
- **Healthy Housing Pilot:** works to build strategic alliances for healthy housing, including "lead safe" and "smoke free" housing;
- **Environmental Professional Oversight:** works to meet all US Environmental Protection Agency (EPA) requirements for training, licensure, and certification of environmental professionals;
- **OSHA Consultation Program:** works to provide safety and health consultation services to small and medium size private businesses; and
- **Indoor Air Quality: Radon Control Program:** works to protect the public from lung cancer due to radon exposure.

**The Chronic Care and Disease Management Team is responsible for reducing the incidence, burden, and associated risk factors related to asthma, heart disease and stroke, diabetes, and cancer to improve health outcomes. The Team has five (5) programs:**

- **The Asthma Control Program:** works to increase access to quality health care, education, community resources and services for Rhode Islanders with asthma;
- **Heart Disease and Stroke Prevention Program:** works to eliminate disease by addressing systems changes including behavior change and enhancing access to care;
- **Diabetes Prevention & Control Program:** works to coordinate the statewide diabetes health system composed of over 700 agencies and individuals;
- **Comprehensive Cancer Control Program:** works to develop, implement, and maintain a statewide coalition representing a broad base of state and community cancer interests; and
- **Women's Cancer Screening Program:** works to reduce the burden of breast and cervical cancer among low-income women.

**The Health Promotion and Wellness Team is responsible for supporting healthy living through the life course. The Team has three programs:**

- **Tobacco Control Program: works to make it hard for people to start using and to continue to use tobacco (current focus includes 1) preventing initiation of tobacco use among young people through community mobilization; counter-marketing; school-based prevention; policy and regulatory action, including tobacco free policies; restricting sales to minors; and increasing the cigarette excise tax, 2) eliminating nonsmokers' exposure to secondhand smoke, 3) promoting quitting among adults and young people, and 4) eliminating tobacco-related disparities);**
- **Initiative for a Healthy Weight: works to prevent and control obesity; and**
- **Safe RI -- Violence and Injury Prevention Program: works to provide the community with the data and TA they need to provide effective injury prevention programs.**

**The Perinatal and Early Childhood Health 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 Team has seven (7) programs:**

- **WIC: works to provide healthy foods, nutrition assessment, and nutrition education for optimal nutrition during critical stages of growth and development and breastfeeding support and promotion;**
- **Newborn Screening and Follow-Up: works to screen all newborns for metabolic, endocrine, hemoglobin, hearing, and developmental risk factors;**
- **Early Childhood Development Screening and Follow-Up: works to increase the number of children birth to 8 receiving developmental and behavioral screenings consistent with current AAP recommendations in primary care, child care, and other settings and to provide comprehensive home visiting services -- including first Connections home visiting services for at risk children birth to 3 and evidence-based MCHB MIECHV services for pregnant women and at risk children birth to 3;**
- **Successful Start: works to maintain an early childhood system building initiative that focuses on five system components -- Medical Homes, Social & Emotional Health, Early Care and Education, Parent Education, and Family Support);**
- **RI-Launch: works to place mental health clinicians in pediatric primary care practices and child care centers to address the needs of children birth to 8 years old;**
- **Adolescent Health: works to promote healthy adolescent development through statewide systems, policies, and initiatives as well as targeted interventions to address health risks in high need communities; and, more recently**
- **Race to the Top Early Learning Challenge: works with other state agencies to improve early learning and development opportunities for young children (the Team will support 90 pediatric practices to implement standardized developmental screening and will also provide supports to primary care providers to address the needs of families in their practice that arise as a result of developmental screening)**

**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 Team has four (4) programs:**

- **Immunization: works to prevent and control vaccine preventable disease by maximizing the number of adults and children who are immunized;**
- **HIV/AIDS and Viral Hepatitis: works to reduce the number of new cases of HIV/AIDS and Hepatitis by providing HIV prevention and Ryan White HIV care services and Hepatitis prevention and harm reduction services;**
- **Oral Health Program: works to prevent oral health disease by increasing access to and utilization of preventive interventions including dental sealants for children and appropriate water fluoridation for all Rhode Islanders; and**
- **Family Planning Program: works to provide affordable Title X family planning**

*services, including comprehensive preconception care services, to low income men and women.*

*The WIC Program was transferred to the Rhode Island Department of Human Services (RIDHS) in 2011. It is still housed in the DCFHE at HEALTH. The Ryan White HIV Care Program was transferred to the Executive Office of Health & Human Services (EOHHS) effective July 1, 2012. There are plans for the program to move to the EOHHS sometime in the relative near future //2013//.*

*An attachment is included in this section. IIC - Organizational Structure*

## **D. Other MCH Capacity**

### **D. Other MCH Capacity**

*//2013/ There are 88 Full-Time Equivalent (FTEs) who work in the DCFHE as state employees. This number includes staff that provides planning, implementation, evaluation, and data analysis. In addition, the Division's staffing configuration includes 10 consultants (which include 2 CDC Prevention Public Health Consultants), 12 ADIL consultants, and 18 parent consultants (9 of who work directly in the Department and 9 of whom work in community settings). From the 11.6 time-limited FTEs hired as part of its CDC ARRA CPPW physical activity, nutrition, and tobacco prevention programs and its CDC-ARRA Chronic Disease Living well program, 4 time-limited positions remain filled. These grants are all ending in December 2012 and staff positions will be terminated. There are also 4 FTEs and 1 ADIL position for the Ryan White HIV Care Program located in the DCFHE, but the program was transferred to the state's Executive Office of Health & Human Services (EOHHS) effective July 1, 2012 and eventually staff will relocate. The USDA WIC Program budget, including staffing, were transferred to the state Department of Human Services, but the 8 filled WIC FTE positions and the 2 ADIL positions are currently located in the DCFHE //2013//.*

Parent consultants are culturally diverse *//2013/ parents with experience accessing MCH services //2013//* and are assigned to DCFHE programs based on the program's need for parent participation and the parent consultant's experience with the program. Parent consultants are assigned to the WIC Program, the Immunization Program, the Birth Defects Program (based in the Center for Health Data and Analysis), and the OSHCN. Many of the parent consultants are parents of CYSHCN and all are consumers of DCFHE programs or have been in the last three years. Parent consultants are full partners in policymaking, outreach, and program quality assurance and evaluation.

In addition to these parent consultants, the DCFHE also manages the Pediatric Practice Enhancement Project (PPEP), which has placed 24 resource specialists in pediatric practices serving high volumes of CYSHCN throughout the state. There are 12 pediatric primary sites, 10

specialty care sites and 2 sites outside the medical community. The pediatric primary care sites include hospital-based primary care clinics, health centers, private physician offices, and private physician group practices in geographic locations throughout the state serving ethnically, culturally, linguistically, and geographically diverse populations. Specialty care sites include multi-disciplinary evaluation, intensive clinical, disability specific, special intervention, and dental. The additional two non-medical sites include a correction department and a social service agency.

All DCFHE staff, with the exception of PPEP resource specialists, are centrally located at the RI Department of Health in Providence, RI. Brief biographies of senior level management staff are included below.

#### Executive Director's Office

***/2013/ Ana Novais, MA, is the Executive Director of the DCFHE and, in this capacity; she provides leadership for the Division and its programming. She has been employed HEALTH since 1998 and has served as Associate Director of Health, Lead for the Center for Health Equity and Wellness, and Chief of the Office of Minority Health. Previously, she worked as the Director of Community Services for a multi-service organization serving culturally diverse families and children. She received her Masters Degree in Psychology from the Universite Catholique de Louvain in Belgium.***

***Peter Simon, MD, MPH, is the Medical Director of the DCFHE. Dr. Simon is a graduate of Cornell University and the State University of New York, Upstate Medical School in Syracuse. He received his MPH from Johns Hopkins University in 1976. He is certified by the American Board of Preventive Medicine and the American Board of Pediatrics. After working as a private pediatrician in Pawtucket, RI, he joined HEALTH as a Medical Epidemiologist in 1984 after having served for seven years as a Consultant Medical Epidemiologist for the state's Immunization and Childhood Lead Poisoning Prevention Programs. Dr. Simon continues to see pediatric patients at the Providence Community Health Centers and volunteers at the Hospital Albert Schweitzer in rural Haiti.***

***Carol Hall-Walker, has served as the DCFHE's Chief Program Administrator since 2006. She is responsible for strategic planning related to MCH, management oversight of the six teams to enhance and expand integration that include the programs directly receiving Title V support, communications and public engagement in partnership with DCFHE programs. Ms. Hall-Walker joined the staff of the Rhode Island Department of Health (RIDH) in 1993, as Communications Coordinator of the Tobacco Control Program. In 1999, she was named the Communications Manager of HEALTH's Division of Disease Prevention and Control, and in 2005, she was the Communications Manager for HEALTH's Center for Public Health Communications. Previously, she worked in direct services and advocacy related to public health issues.***

#### ***Perinatal & Early Childhood Health Team***

***Blythe Berger is currently the Team Lead of the DCFHE's Perinatal and Early Childhood Health Team. She is responsible for all activities relevant to Perinatal and Early Childhood Health for the State Health department, including WIC, Newborn Screening, Home Visiting, Early Childhood Screening and Follow-up, Adolescent Health, and Child Care Quality projects.***

#### ***Chronic Care & Disease Management Team***

***Dona Goldman, RN, MPH, has served as the Team Lead for the Chronic Care and Disease Management Team in the DCFHE since 2006. In this capacity, Ms. Goldman provides oversight of Women's Cancer Screening, comprehensive Cancer, Diabetes, Colorectal Cancer, Asthma, Heart Disease & Stroke Prevention, and the Chronic Disease Self-***

## **Management Program.**

### **Health Disparities & Access to Care Team**

**Carrie Bridges, MPH, is the Team Lead for the Health Disparities & Access to Care Team in the DCFHE. Ms. Bridges came to Rhode Island in 2004 while serving as a fellow with the Public Health Prevention Service at the Centers for Disease Control and Prevention. She has a Master of Public Health degree with a concentration in International Health from Boston University and a Bachelor of Science in Biology from Duke University.**

**Deborah Garneau is the Chief of the Office of Special Health Care Needs (OSHCN) at the RI Department of Health. In this position she is responsible for the supervision, management, and leadership of the OSHCN's three program areas including Pediatric Specialty Services, Disability and Health, and Family Support and Empowerment. Ms. Garneau served as a mental health clinician and administrator with at-risk children and their families prior to state service.**

### **Health Promotion & Wellness Team**

**Jan Shedd, EdM, is the Team Lead of the Health Promotion & Wellness Team. Jan Shedd has been employed by HEALTH since 1980 and in this capacity, she has worked in community health promotion and WIC, and has served as Manager of Rhode Island's Title X Family Planning Program and the RI State Adolescent Health Coordinator. Ms. Shedd has an Education Masters in Community Health Education from Oregon State University.**

### **Preventive Services and Community Practices Team**

**Patricia Raymond, RN, MPH, has served as the Team Lead of the DCFHE's Preventive Services and Community Practices Team since 2007. She has been employed by HEALTH since 1997, where she served as a Public Health Nurse with HEALTH's Children's Preventive Services Program. Ms. Raymond has a Masters of Public Health from the University of Massachusetts Amherst, School of Public Health and Health Sciences and a Bachelor of Science in Nursing from Rhode Island College.**

### **Healthy Homes and Environment Team**

**Robert R. Vanderslice, PhD, has served as the Team Lead of the Healthy Homes and Environment Team since 2007. Dr. Vanderslice has been employed with HEALTH since 1992. Prior to assuming his current position, he served as Chief and Toxicologist of HEALTH's Office of Environmental Health Risk Assessment; Environmental Scientist for the US Department of Housing & Urban Development, Office of Healthy Housing and Lead Hazard Control; and Toxicologist, US Environmental Protection Agency. Dr. Vanderslice received both his Masters Degree and PhD in Toxicology from North Carolina State University.**

### **Center for Health Data and Analysis**

**Sam Viner-Brown, SM, has served as Chief of HEALTH's Center for Health Data and Analysis since 2008. In this capacity, Ms. Viner-Brown is responsible for, among other things, all Title V MCH data, KIDSNET, and PRAMS. She served as the DCFHE's Chief of Data & Evaluation from 1991-2008. Ms Viner-Brown graduated from the Harvard University School of Public Health, where she concentrated in Health Policy and Management.**

**Ellen Amore, MS, has served as the Program Manager of HEALTH's KIDSNET since 2007. Ms. Amore received her Masters Degree from the Harvard School of Public Health, where**

*her field of study was Maternal and Child Health. She has been employed by HEALTH since 1995 and in this capacity she served as the Program Manager for the Home Visiting Program and the Program Manager for the Newborn Screening Program prior to becoming the Program Manager for KIDSNET.*

*Other available information about the non-governmental health care workforce, which includes the non-governmental MCH workforce, shed some light on the state's MCH workforce capacity. In 2008, the number of physicians per 10,000 population in Rhode Island was 34.5, which ranked the state higher than the nation (25.7% per 10,000 population) and the second highest of the six New England states after Massachusetts (39.7 per 10,000 population). In contrast, the number of physicians per 10,000 population in Connecticut was 33.5, in Vermont it was 33.3, in Maine it was 28.2, and in New Hampshire it was 26.4.*

*In 2010, the number of physician assistants per 10,000 population in Rhode Island was 27, which ranked the state equal to the national rate but the lowest in New England. In contrast, the number of physician assistants per 10,000 population in Maine was 49, in Vermont and Connecticut it was 47, in New Hampshire it was 43, and in Massachusetts it was 34.*

*In 2011, the number of nurse practitioners per 100,000 population in Rhode Island was 66, which ranked the state higher than the nation (58 per 100,000 population) but the lowest of the six New England states. In contrast, the rate in New Hampshire was 116, in Massachusetts it was 103, in Connecticut it was 96, in Maine it was 82, and in Vermont it was 80.*

*In 2011, the number of registered nurses per 100,000 population in Rhode Island was 1,174, which ranked the state higher than the nation (874 per 100,000 population) and the second highest of the six New England states after Massachusetts (1,321 per 100,000 population), In contrast, the number of registered nurses per 100,000 population in Maine was 1,115, in New Hampshire it was 1,051, in Vermont it was 1,017, and in Connecticut it was 1,014.*

*In 2007, the number of dentists per 10,000 population in Rhode Island was 5.4, which ranked the state lower than the nation (6.0 per 10,000 population) and the second lowest of the six New England states after Maine (5.0 per 10,000 population). In contrast, the number of dentists per 10,000 population in Massachusetts was 8.2, in Connecticut it was 7.7, in New Hampshire it was 6.3, and in Vermont it was 5.8 //2013//.*

## **E. State Agency Coordination**

### Section E: State Agency Coordination

Affecting positive change in maternal, child, and family health requires a common vision and collective effort. The DCFHE enjoys strong working relationships with other state departments and community-based agencies and organizations that enhance its efforts to promote and protect the health of MCH populations. ***//2013/ The DCFHE ensures that resources are coordinated and maximized through a guiding framework anchored in four requirements- integration across programs; equity-based planning, investments, and delivery of programs; application of a life course approach; and, building social and emotional competencies within communities.//2013//***

State Agency Partnerships

***//2013/ The DCFHE's partnerships with other state agencies were described in detail in***

**Section B (Agency Capacity) of this application.**

**Legislative Initiatives**

**/2013/ DCFHE participates on several legislative commissions concerning CYSHCN, including the Joint Commission for the Study of Children with an ASD or other DD in RI and the RI Vision Commission. The DCFHE also participates on the Permanent Legislative Commission of Child Care //2013//.**

**Coordination with Other HEALTH Programs**

DCFHE strives to fully integrate Department-wide operations, equity agenda and policy efforts across a number of high priority areas. **/2013/ The Maternal and Child Health Block Grant process creates integration and synergy within HEALTH for maternal and child health efforts. The Health Promotion & Wellness Team Initiative for a Healthy Weight works closely with the Perinatal and Early Childhood Health Team to ensure that nutritious foods are served in childcare settings //2013//.** The Health Disparities and Access to Care Team collaborates with the Chronic Care and Disease Management Team around training and support to the Community Health Worker Association of Rhode Island (CHWARI), connecting vulnerable populations to the full array of services provided by DCFHE and other state and local agencies. The Lead Poisoning Program collaborates with the Asthma Control Program assessing the feasibility of training Lead Center staff to incorporate asthma education and other healthy homes initiatives during home visits of children with elevated blood lead levels. The Immunization Program collaborates with the Viral Hepatitis Program to provide necessary vaccinations for at-risk adolescents and adults. **/2013/ The Office of Minority Health organizes periodic training for DCFHE staff on Federal Standards for the provision of Culturally and Linguistically Appropriate Services. The Asthma Program, Healthy Homes Team, Health Disparities & Access to Care Team, OSHCN, and Home Visiting Program are all working collaboratively with the Green & Healthy Homes Initiative, Community Health Workers Association of RI, and Health Leads Program to deliver introductory and intermediate healthy housing training for a cross section of external associations and programs that have staff that enter residents' homes. The intent is to cross train all persons that do home visits (e.g. home visitors, community health workers, housing agency staff, homelessness prevention programs, etc.) to understand the elements of healthy housing, assess residences they visit, and make appropriate referrals to help families improve the safety of their housing. /2013/ Last year's Healthy Homes training reached 120 professionals who enter the home of pediatric patients. The May 2012 Introductory training reached an additional 40 professionals.**

**The Healthy Communities Program collaborates with the Initiative for a Healthy Weight to support local partners to conduct a comprehensive community assessment, strategic planning and implementation process in the Olneyville neighborhood of Providence. The project is designed to address social and environmental determinants of health that impact chronic disease with a focus on improving physical activity, nutrition, and chronic disease management as well as lowering rates of tobacco use. Currently the project is implementing the first phase of the Olneyville Community Action Plan.//2013//**

The DCFHE participates as a member of the Department's Center for Public Health Communication, which sets policy and procedures for strategic and effective communication. **/2013/The DCFHE's Initiative for a Healthy Weight works closely with KIDSNET staff on a childhood BMI electronic data collection project with surveillance and coordination of care applications. The Tobacco Control Program works with the Asthma Control Program and the Healthy Homes and Environment Team to protect residents in multi-unit housing complexes from second-hand tobacco smoke //2013//.**

KIDSNET made immunization information available to the Division of Infectious Disease and

Epidemiology for disease outbreak investigations. The DCFHE also has ongoing partnerships with HEALTH's Division of Environmental and Health Service Regulation, which provide comprehensive site reviews of licensed health care facilities. The DCFHE works closely with the Office of Vital Records to coordinate data collection at maternity hospitals and to integrate birth certificate data with KIDSNET and newborn screening systems. ***/2013/ KIDSNET works with the Refugee Health and Lead programs to monitor immunization rates, lead screening and lead safe housing placements for refugee children which is reported on annually. KIDSNET also works with the Adolescent Health and Immunization Programs on access to care and coordination of health services.//2013//*** The Asthma Control Program will add an asthma component to KIDSNET to allow providers in the Blackstone Valley Community and St. Joseph Health Centers to refer families to the Breathe Easy at Home Project in the cities of Pawtucket and Providence.

The DCFHE participates on the state's Child Death Review Team, coordinated by HEALTH's Medical Examiner's Office. HEALTH's Division of Laboratories works with the Lead Program to analyze lead screening specimens and collect data. KIDSNET holds quarterly stakeholder meetings to coordinate with all HEALTH programs participating in KIDSNET. DCFHE coordinates with vital records to oversee RI's Newborn Screening Program using vital records for quality assurance and to identify home births which need follow-up to ensure that the infants received appropriate screening.

Collaboration with Private Organizations & Associations

***/2013/ The Division's partnerships with private, community-based organizations and associations are extensive. Community development is a DCFHE priority. There are no local health departments in Rhode Island. Community driven efforts are necessary to build and sustain local public health infrastructure //2013//***

Private Provider Community: The Medical Director is active in professional provider organizations. DCFHE staff has worked closely with the RI Chapter of the American Academy of Pediatrics (AAP), the RI Chapter of Family Practitioners, and the RI Chapter of the American Academy of Obstetricians and Gynecologists on a number of DCFHE initiatives, including the Women's Health Screening & Referral Program (WHSRP), KIDSNET, RI LAUNCH, Watch Me Grow, and Adolescent Medical Home. DCFHE works closely with the Physicians' Committee for Breastfeeding in RI. All primary care providers use KIDSNET. DCFHE staff members provide technical assistance to Rhode Island CATCH projects funded by the AAP including an adolescent medical home project in Woonsocket and Pawtucket, and an effort to increase prenatal care in the first trimester in Washington County. RI maintains a universal vaccine policy and provides vaccines to all providers at no cost. DCFHE coordinates the Primary Care Physician Advisory Committee (PCPAC) which advises HEALTH on programmatic and policy issues impacting primary care in Rhode Island. ***/2013/ Recent advisory topics include pediatric and adult immunization policy, transitions between emergency departments and primary care providers, community hospital charges, and primary care quality improvement measures.***

***DCFHE's programs actively collaborate with the Community Health Worker Association of RI on organization development issues like strategic planning, CHW training opportunities like healthy housing and health reform, and on the development of a statewide core training curriculum for CHWs that is to be piloted during the summer of 2012. The DCFHE also added funding to the 2012 MCH Home Visiting request for proposals to fund community organizations to hire CHWs to assist the home visiting network with patient referrals, assessments, and acquisition of community-based social supports to facilitate optimal child development //2013//***

A significant proportion of DCFHE investments support activities in Community Health Centers including, WIC, Family Planning, PPEP Parent Consultants, WHSRP, Tobacco Cessation, chronic disease management, Watch Me Grow, and three school based health centers. The

DCFHE works directly with individual Community Health Centers and the RI Health Center Association on larger policy issues impacting community health services delivery, such as the RI Chronic Care Collaborative and the transition toward Patient Centered Medical Home (PCMH). The DCFHE, Chronic Care and Disease Management Teams continues to contract with 18 RICCC health centers to improve care among chronic disease patients using the Care Model and Model of Improvement. This includes 10 sites that serve pediatric asthma patients.

The DCFHE has strong partnerships with several hospitals in RI. DCFHE provides funding to the Children's Neurodevelopment Center (CNDC) at Hasbro Children's Hospital. Memorial Hospital is a Title X family planning site. The Newborn Screening Program works closely with Women & Infants' Hospital and other birthing hospitals in RI around training and quality assurance. The Newborn Screening Program also works closely with metabolic, cystic fibrosis, and hemoglobinopathy clinics at Rhode Island Hospital for diagnosis, treatment, and follow-up. Newport Hospital is collaborating with the DCFHE and other partners on the Newport County Healthy Communities initiative. The DCFHE supports lead and immunization clinics for uninsured children at St. Joseph Hospital. The Birth Defects Program has been working closely with Women & Infants', Kent County, and Hasbro Children's Hospital to improve case ascertainment. Representatives from these hospitals provide information, consultation, and guidance; several are members of the Birth Defects Advisory Council. The Immunization Program provides all birthing hospitals in the state with a supply of Hepatitis B vaccine so that newborns receive the birth dose prior to discharge and the vaccination is reported to KIDSNET. PPEP Parent Consultants are placed at Hasbro Children's Hospital, Butler Hospital, Memorial Hospital, St. Joseph's Hospital Asthma Program and Women & Infants' Hospital. The DCFHE works with Bradley Hospital (the state's psychiatric hospital for children and adolescents) on a mental health resource guide and on developing mid-level mental health services for children graduating from intensive programs.

DCFHE, with the largest Medicaid insurer in the state, evaluated the PPEP Parent Consultant Program. The utilization analysis demonstrated that CSHCN who received PPEP services had lower health care costs as they had higher utilization of community based services, and lower institutional level of care services. The DCFHE continues to work with the two Managed Care Medicaid organizations in RI to share data and increase support for public health efforts for the vulnerable Medicaid population.

The DCFHE has strong partnerships with several VNAs through First Connections. Home visitors provide home assessments, connection to community services, and help with child development and parenting for almost 25% of all families with newborns each year. First Connections collects housing related information during the initial home visit and the DCFHE will use this data to promote access and availability to healthy housing. Another VNA provides newborn developmental risk assessment statewide, newborn blood spot screening follow-up and hepatitis B follow-up through contracts with the DCFHE. VNAs participate on the Birth Defects Advisory Council. The VNAs provide case management services for pregnant women/new mothers who are infected with chronic hepatitis B and C and the infant to assure completion of vaccination and medical referral. ***//2013/ The DCFHE has developed partnerships with social service agencies in the community to provide evidence-based home visiting to children in 6 communities at risk of poor outcomes. These evidence-based models are Healthy Families America, Nurse Family Partnership, and Parents as Teachers //2013//.***

The Child Care Support Network (CCSN) works closely with the child care provider community and families. CCSN is made up of a team of professionals who work with licensed center-based and home-based child care providers to improve the quality of care for all children in the following areas: health and safety, nutrition, physical activity curriculum development, early literacy, CSHCN, child development, family involvement, and mental/behavioral health.

Healthy Mothers/Healthy Babies Coalition, a partnership of individuals, professionals, and government organizations devoted to improving birth outcomes. DCFHE participates on it. Rhode Island Kids Count is a children's policy organization that provides information on child

wellbeing and stimulates state dialogue on children's issues. Each year, the agency publishes a factbook, which provides detailed community-by-community visuals of the condition of children in RI. The DCFHE provides a significant proportion of data utilized in the factbook. The DCFHE works closely with Covering Kids on community systems development initiatives to increase children's access to Medicaid. Childhood Lead Action Project is the only advocacy agency in RI dedicated to addressing the problem of childhood lead poisoning and is a member of the Healthy Housing Collaborative.

***/2013/DCFHE staff members provide technical assistance to community partners in the Olneyville neighborhood of Providence to develop and implement a comprehensive community assessment and strategic planning process designed to address social and environmental determinants of health that impact chronic disease. Local partners are currently rolling out the first phase of the Olneyville Community Action Plan which incorporates strategies to improve physical activity, nutrition, and chronic disease management as well as reduce tobacco use.***

***DCFHE's State Office of Rural Health supports systems building efforts in non-metro regions of the state. Current projects focus on improving children's mental health, increasing use of preventive care by teens and young women, and expanding care coordination efforts //2013//.***

Rhode Island Public Health Association (RIPHA) is the state affiliate of the American Public Health Association; DCFHE staff members participate on the board and other efforts. Rhode Island Public Health Institute (RIPHI) was formed to organize and activate private sector professionals interested in the advancement of public health in RI. DCFHE personnel participate on the board and collaborates on community assessments and workforce development efforts and other public health initiatives. Kids First is a non-profit organization that convenes the RI Healthy Schools Coalition and guides communities and their schools to improve the nutritional and physical well-being of children. DCFHE contracts with Kids First to work with School District Health and Wellness Subcommittees. DCFHE staff members participate on the steering committee and related workgroups.

Rhode Island Alliance is a statewide organization dedicated to reducing teen pregnancy and empowering pregnant and parenting teens. The Alliance works in collaboration with individuals and agencies throughout Rhode Island to provide resources and advocacy for youth and young families. DCFHE's teen pregnancy prevention efforts are aligned with the Alliance's statewide plan. Rhode Island Breastfeeding Coalition (RIBC) includes community organizations and groups dedicated to supporting and promoting breastfeeding in RI. Members include lactation consultants from local birthing hospitals, physicians, and other health care professionals. Rhode Island Food Dealers Association acts as the liaison between the WIC Program and 25 WIC vendors throughout the state. Childhood Immunization Action Coalition consists of DCFHE staff, community-based agencies, civic organizations, medical care providers, schools, Head Starts, childcare center-based nurse consultants, hospitals, and health insurance plans. The purpose of the Coalition is to share strategies and develop plans for improving utilization rates. Rhode Island Certified School Nurse Teachers' Association works closely with DCFHE on implementing health service requirements in schools and provides input and feedback for the school nurse teachers' conference.

The DCFHE actively collaborates with a number of family leadership and parent support agencies and programs. The DCFHE works closely with leadership from the RI Family Voices and participates in the Family Voices Leadership team. The DCFHE also contracts with the RI Parent Information Network (RIPIN) to provide training and technical assistance to the Parent Consultant Program and the Parent Support Network.

HEALTH and the DCFHE have active relationships with many of the state's colleges and universities. HEALTH has formal agreements with area institutions of higher education to facilitate staff training and collaborative research and grant writing. In partnership with three Rhode Island Colleges, the Lead Program offers training to nursing students about environmental threats in the

home. The DCFHE is also working with the RI Area Health Education Center (housed at Brown University) to develop and offer multidisciplinary training on early childhood mental health. Through the Joint Legislative Commission on the Educating Children with Autism Spectrum Disorders, the DCFHE is designing a teacher competency certification in ASD and incorporating these competencies into undergraduate special education curriculum. The DCFHE partners with Brown University faculty on a variety of special needs, especially Autism and other developmental disabilities.

Ocean State Adult Immunization Coalition has a formal contract with HEALTH to provide education and outreach to improve adult immunization. RI Association of School Principals is collaborating with HEALTH on a toolkit supporting mental health promotion among school age children. ***/2013/DCFHE is on the founding board of the RI Full Service Community School Alliance including the COZ and full service community school efforts in the state. The alliance seeks to build on local efforts and support other communities in the development of full service community schools //2013//.*** RI Asthma Control Coalition works closely with the RI Asthma Control Program 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 primary care providers.

RI Asthma Emergency Department (ED) Diversion Pilot Project Advisory Committee was convened by the RI Asthma Control Program and the Office of CYSHCN to provide guidance on the development, implementation, and evaluation of the pilot project in partnership with Hasbro Children's Hospital, St. Joseph Health Center, and RI Parent Information Network to reduce asthma ED visits by providing home visits to children who enter the ED or are admitted to Hasbro due to asthma.

The Diabetes Prevention and Control Program funds a follow-up demonstration pilot project to ensure that women who have been diagnosed with gestational diabetes receive oral glucose testing and referrals to appropriate services for diabetes or pre-diabetes care. Women with gestational diabetes who go on to be diagnosed with pre-diabetes will be referred to an evidence-based program provided by the YMCA.

#### Coordination with Other Federal Grant Programs

DCFHE programs receive funding from several federal grant programs. These programs include: Minority Health (Office of the Secretary DHHS), Family Planning (Title X), WIC (USDA), Newborn Hearing Screening (CDC), RI LAUNCH (SAMSHA), ***/2013/ Maternal, Infant, and Early Childhood home Visiting (HRSA) //2013//***, PRAMS (CDC), Immunization (CDC), ***/2013/ Healthy Housing and Lead Program (CDC), ABLES (CDC) //2013//***, Tobacco Control Program (CDC), Initiative for Healthy Weight (CDC), SafeRI, Violence and Injury Prevention Program (CDC and SAMHSA), and Teen Pregnancy Prevention and Child Care Support Network (ACF). ***/2013/ DCFHE programming is also supported through several HRSA grants including: Universal Newborn Hearing Screening, President's New Freedom Initiative Integrated Community Systems for CSHCN, State Early Childhood Comprehensive Systems, State Implementation Grant for ASD and other Developmental Disabilities, Healthy Tomorrows Partnership for Children, Primary Care Services, and the Rural Health Program and Healthy Tomorrows Partnership for Children. The DCFHE also receives federal funding from EPA for the environmental lead, radon, and asbestos programs //2013//.***

#### Advisory Committees

The DCFHE has established advisory committees and workgroups for many of its programs that include professional and consumer representation. Current DCFHE advisory and workgroups include the Childhood Immunization Action Coalition, Vaccine Advisory Committee, Influenza Task Force, School Immunization Improvement Advisory Committee, Successful Start Steering

Committee and a newly formed adolescent transition team, WIC Vendor Advisory Council, Oral Health Advisory Council, Healthy Housing Collaborative, and newborn screening advisory committees, Adolescent Health Advisory Committee, Primary Care Physicians' Advisory Committee, Women's Health Advisory Committee and the Refugee Health Advisory Committee. Other committees supported by DCFHE include: RI Prematurity Task Force, Healthy Homes Collaborative, Autism Spectrum Disorder Advisory Board, Injury Community Planning Group, Sexual Violence Prevention Planning Committee, the Tobacco Control Coalition. ***/2013/ The DCFHE's Initiative for a Healthy Weight works closely with KIDSNET staff on a childhood BMI electronic data collection project with surveillance and coordination of care applications. The Tobacco Control Program works with the Asthma Control Program and the Healthy Homes and Environment Team to protect residents in multi-unit housing complexes from second hand-tobacco smoke //2013//.***

## **F. Health Systems Capacity Indicators**

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

***/2013/ 2010 RI age-specific asthma hospitalization rate for ages 0 to 4: 49.2 per 10,000 children ages 0 to 4 years.***

***2011 RI age-specific asthma hospitalization rate for ages 0 to 4 (provisional): 29.6 per 10,000 children ages 0-4 years //2013//***

Narrative:

***/2013/ The rate of children under the age of five years old hospitalized for asthma appears to have decreased between 2010 and 2011. The rate of asthma hospitalization decreased by 40% for children under age five between 2010 and 2011. In 2011, more than half (58%) of the children who were hospitalized for asthma live in the state's culturally diverse, older, urban, "core" communities. The rate of asthma hospitalizations was 49.2 per 10,000 population in 2010 and 29.6 in 2011. From 2008 through 2010, the asthma hospitalities rate has remained steady. The reason for the one-third and two-thirds decrease in rates of hospitalization between 2010 and 2011 is not clear at this time, but changes in the health care laws, insurance policies, asthma education and interventions, and state population demographics may have had an impact on the rate changes.***

***Nine health centers continue their commitment to improving the quality of pediatric asthma care through the RI Chronic Care Collaborative. Phase 1 of the Home Asthma response Program (formerly the RI Asthma Emergency Department (ED) division Project) included 29 participants. Preliminary evaluation results look promising. An additional 70 participants will complete the program in Phase 2 through September 2012. The first referrals for the Breathe Easy at Home Project took place in April 2012 //2013//.***

First Connections Program home/environmental assessments were modified to be more comprehensive, encompassing healthy homes, asthma, and lead. The DCFHE is also collecting 'Healthy Housing Checklist' data submitted by certified lead centers, environmental lead inspectors and other home visitors. ***/2013/ First Connections integrates information about reducing asthma and promoting healthy housing in all home visits.***

***The Asthma Control Program partnered with the DCFHE's Office of Special Health Care Needs, the Newborn and Early Childhood Screening & Follow Up Programs, the Healthy Homes Program and the US Environmental Protection agency to offer the National Center of Healthy Housing's Healthy Housing Training in May 2012. Over 40 professionals and community health workers who provide a variety of services in the homes of pediatric patients participated in the training //2013//.***

The Tobacco Control Program has funded efforts for the Providence Housing Authority to begin the implementation of smoke-free policy in the housing units in five high-rise buildings. This will impact 5,700 residents. All of the Providence Housing Authority housing complexes will be smoke-free by 2012.

Health Systems Capacity Indicators 02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Narrative:

***/2013/ In Rhode Island, a majority of Medicaid enrollees receive one initial periodic screen before the age of one year old as follows: 88.9% in 2008, 90.1% in 2009 and 91.5% in 2010. This indicator has been steadily increasing //2013//.***

KIDSNET partners with the Rite care health plans to provide immunization data so that the plans can focus outreach efforts on children and practices on under immunized children. KIDSNET is working with Successful Start to develop collection and appropriate sharing of developmental screening data. ***/2013/ A pilot project for conducting and recording developmental screening in KIDSNET has begun at 4 primary care and 2 child care sites //2013//.***

KIDSNET is working with Medicaid on implementing a data-sharing plan. ***/2013/ KIDSNET is working the Rite Care health plans to establish a regular update of insurance information in KIDSNET. This will allow more accurate and current evaluations of preventive health care recorded in KIDSNET by insurance status //2013//.***

HEALTH has various mechanisms to follow-up on children with missed screening opportunities, including home visiting, KIDSNET data tracking and screening support systems. ***/2013/ A new report for primary care providers is in development, which will provide primary care providers with a list of their patients needing follow-up from newborn hearing screening //2013//.***

Health Systems Capacity Indicators 03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

Narrative:

Rhode Island does not distinguish between Rite Care, Rhode Island Medicaid Managed Care, and SCHIP. SCHIP is included in Rite Care. Ninety two percent 92% of Medicaid, including SCHIP, enrollees whose age is less than one year received at least one periodic screen.

Medicaid-eligible infants in Rhode Island are enrolled in one of three Medicaid managed care health plans. The RI Department of Human Services (DHS) monitors health plan performance and has developed mechanisms to reward the plans based on performance. Well-child visits within the first 15 months of life, is one of the indicators used by DHS to evaluate health plan performance.

KIDSNET collects data on newborn developmental, bloodspot, and hearing screening. KIDSNET has been working with Successful Start to develop collection and appropriate sharing of developmental screening data. KIDSNET is working with Medicaid on implementing a data-sharing plan.

Health Systems Capacity Indicators 04: The percent of women (ages 15 through 44) with a live birth during the reporting year whose observed expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Narrative:

***/2013/ In Rhode Island, the percentage of women giving birth who had observed expected***

***prenatal visits greater than or equal to 80% on the Kotelchuck Index has remained steady with 77.8% in 2008, 77.4% in 2009, and 77.3% in 2010. //2013//***

Rhode Island continues to lead the country in women's access to prenatal care. Pregnant women with incomes up to 250% of the Federal Poverty Level are eligible for Rlte Care, which provides a comprehensive pregnancy benefit package. The DCFHE works to increase access to prenatal care through the Title X Family Planning Program and the First Connections ***//2013/ and MIECHV Home Visiting Programs //2013//***. Women receiving pregnancy tests at Title X Family Planning Clinics receive counseling and education and referral to appropriate medical services. Agencies help connect women to the services they need early in pregnancy, or before a pregnancy, to improve the health of the mother and her baby.

***//2013/ The DCFHE, in partnership with Women & Infants Hospital, is currently working with the RI Task Force on Premature Births to develop risk assessment and screening templates by identifying priority areas based on state data to better address the needs of women. The DCFHE is also working with community partners to identify resources and services in order to develop a referral resource for providers to support the reproductive needs of their patients, including home visiting. //2013//***

Health Systems Capacity Indicators 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Narrative:

***//2013/ Approximately 83% of children eligible for Medicaid/SCHIP in Rhode Island accessed the program in 2010. This percentage has remained consistent over the last four years //2013//.***

The DCFHE manages several programs designed to facilitate access to Rlte Care by eligible children and families including WIC, Childcare Support Network, and the First Connections ***//2013/ and MIECHV Programs //2013//*** by referring families who are uninsured or underinsured directly to Medicaid. KIDSNET partners with managed care health plans to exchange lead screening and immunization data to enhance their capacity to provide targeted outreach to members needing those services. ***//2013/ KIDSNET and WIC developed and implemented an interface that will improve the capacity to monitor lead screening and immunization of WIC clients. The health plan that provides Medicaid managed care (Rlte Care) coverage agreed to provide enrollment data to KIDSNET on a regular basis. Technical procedures for the data transfer are being developed //2013//.***

Health Systems Capacity Indicators 07B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Narrative:

In Rhode Island, this percentage is increasing from 62% in 2006, to 88.1% in 2010. As the RI Department of Human Services (DHS) continues to work to improve the existing state infrastructure for providing dental services for Medicaid-eligible children through Rlte Smiles, RI's managed care dental program, it is expected that this percentage will continue to increase over time. ***//2013/Two major goals of Rlte Smiles are to increase the percentage of children on Medicaid who receive dental services, and to shift, over time, the types of dental services these children receive to more preventive care.***

***First Connections and MIECHV //2013//*** Home Visiting/WIC programs provide culturally appropriate information about early childhood caries/prevention. The Child Care Support Network, Child Care Health Consultants offers health consultation to child care centers conducting child health record reviews, providing staff training and technical assistance, distributing educational materials, and working directly with families to provide referrals to community services and resources.

***//2013/ School-based dental/sealant programs are located in many Rhode Island communities. The Association of State and Territorial Dental Directors (ASTDD), recommends that schools with 50% or more students eligible for free or reduced school meals (FRL) programs are targeted for school-based services. During the 2011-2012 school year, 65 RI elementary schools meet eligibility criteria, and of these, 60 schools (93%) are associated with a school-based/linked dental sealant program. //2013//***

Health Systems Capacity Indicators 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Narrative:

Rhode Island is a 1914A state and all children on SSI are enrolled in Medicaid. Medicaid benefits are extensive and include rehabilitative services. The CSHCN Program does not provide direct services. It is the goal of CSHCN Program to build resources in the community and sustain the provision of services for children with complex medical needs to other systems of care.

This health systems capacity indicator does not apply to Rhode Island

Health Systems Capacity Indicators 05A: Percent of low birth weight (< 2,500 grams)  
INDICATOR #05

Comparison of health systems capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State

Narrative:

Using birth certificate data, the percent of low birth weight infants (< 2,500 grams) for Medicaid, non-Medicaid, and all MCH populations in the State in 2009 was higher for the Medicaid population (8.6%) than it was for the non-Medicaid population (7.1%). Disparities remain between recipients of Medicaid and those insured by other means. The overall percentage for all MCH populations statewide is 8%.

Title X Family Planning clinics provide pregnancy testing services for at-risk populations. Women who receive positive pregnancy tests through the clinics are referred to appropriate medical and community services. Women who receive negative pregnancy tests are provided preconception counseling and also referred to services, as needed. The WIC Program provides nutrition assessments, coordination of care, education, and nutritious foods to low-income pregnant women (the majority of whom are enrolled in Rite Care) to promote healthy pregnancies and healthy births. Finally, the DCFHE, in partnership with Woman and Infants Hospital of Rhode Island, supports the RI Task Force on Premature Births and recommends policies, and programs to reduce low birth weight. The Tobacco Control Program provides funds to train providers to refer pregnant women to cessation services.

***//2013/ Rhode Island supports a continuum of home visiting initiatives, including First Connections and three evidence-based MIECHV models: Nurse Family Partnership, Healthy Families America, and Parents as Teachers //2013//.***

Health Systems Capacity Indicators 05B: Infant deaths per 1,000 live births  
INDICATOR #05

Comparison of health systems capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State

Narrative:

***//2013/ Provisional data for 2011 indicate that the perinatal mortality rate continues to increase from 6.5 in 2010 to 7.1 per 1,000 in 2011. In 2009, it was 5.1. Please note that in Form 18, the "All" category includes those with an "unknown" or "unreported" health***

**uninsurance status //2013//.** The Pregnancy Risk Assessment Monitoring System (PRAMS) collects information to improve the health of mothers and infants by reducing poor pregnancy outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS is an ongoing survey of recent mothers to learn about their behaviors and experiences before, during and after pregnancy.

**/2013/ The Title X Family Planning Program has partnered with the Center for Health Data & Analysis to provide multivitamins with folic acid to uninsured women who receive a pregnancy test at the Title X clinics. Folic acid supplementation reduces the likelihood of neural tube birth defects //2013//.**

Health Systems Capacity Indicators 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

INDICATOR #05

Comparison of health systems capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State

**/2013/ Using birth certificate data, the percent of infants born to pregnant women receiving care in the first trimester in 2010 was lower for Medicaid populations (81.2%) as compared to non-Medicaid populations (91.8%) with a total of 86.5% across all MCH populations. There is improvement in the Medicaid indicator from last year (78.6%), however, and the percentage has decreased from a high of 84% of pregnant women on Medicaid receiving prenatal care in 2004. Please note that in Form 18, the "All" category includes those with an "unknown" or "unreported" health uninsurance status.**

**The DCFHE supports numerous activities targeted to ensuring women access to prenatal care early in their pregnancy, including WIC, family planning and home visiting. The WIC Program provides nutrition assessments, coordination of care, education, and nutritious foods to low-income pregnant women to promote healthy pregnancies and healthy births. The Title X Family Planning Clinics provide pregnancy testing services to at-risk populations. Women who receive positive pregnancy tests through the clinics are referred to appropriate medical and community services. Women who receive negative pregnancy tests are provided preconception counseling and also referred to services, as needed.**

**The DCFHE, in partnership with the RI Task Force on Premature Births, worked to develop risk assessment and screening templates by identifying priority areas based on state data to better address the needs of women. The DCFHE is also working with community partners to identify resources and services in order to develop a referral resource for providers to support the reproductive needs of their patients, including home visiting //2013//.**

Health Systems Capacity Indicators 05D: Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

INDICATOR #05

Comparison of health systems capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State

Narrative:

Using birth certificate data, the percent of infants born to pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% of the Kotelchuck Index) in **/2013/ 2010 was lower for Medicaid populations (77.9%) as compared to Non-Medicaid populations (89.0%). The performance on this indicator increased for the Medicaid population compared to the previous year (68.7%). This indicator is 83.6% for all MCH populations statewide. Please note that in Form 18, the "All" category includes those with an "unknown" or "unreported" health uninsurance status.**

***The DCFHE supports numerous activities targeted to ensuring women access to prenatal care early in their pregnancy, including WIC, family planning, and home visiting. The WIC Program provides nutrition assessments, coordination of care, education, and nutritious foods to low-income pregnant women. The Title X Family Planning clinics provide pregnancy testing services to at-risk populations. Women who receive positive pregnancy tests through the clinics are referred to appropriate medical and community services. Women who receive negative pregnancy tests are provided preconception counseling and also referred to services, as needed.***

***The DCFHE, in partnership with the RI Task Force on Premature Births, worked to develop risk assessment and screening templates by identifying priority areas based on state data to better address the needs of women. The DCFHE is also working with community partners to identify resources and services in order to develop a referral resource for providers to support the reproductive needs of their patients, including home visiting. //2013//.***

Health Systems Capacity Indicators 06A : The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)

INDICATOR #06

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.  
Infants (0 to 1)

Narrative:

Infants (0-1) qualify for Medicaid if <250% of the federal poverty level (FPL). SCHIP does not include infants.

Eligibility for Medicaid and SCHIP have not changed. Rhode Island continues to enjoy one of the lowest rates of uninsured among children in the country. The DCFHE supports access to Medicaid through WIC, Childcare Support Network, the First Connections /2103/ and MIECHV programs //2013//, ***and the adolescent health program by referring families who are uninsured or underinsured directly to Medicaid. All WIC applicants are screened for health insurance, and referred as needed to Medicaid.***

***/2013/ The Title X Family Planning clinics provide services to at-risk populations. The program identifies health risks among women and connects women to medical and community services, including Rlte Care //2013//.***

Health Systems Capacity Indicators 06B: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children

INDICATOR #06

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.

Narrative:

Children (1-18) qualify for Medicaid if <250% of the FPL. Children (8-18) qualify for SCHIP if <250% of the FPL.

Eligibility for Medicaid and SCHIP have not changed. Rhode Island continues to enjoy one of the lowest rates of uninsured among children in the country. In 2009, a total of 89,746 children under the age of 19 were enrolled in Medicaid.

The DCFHE supports access to Medicaid through WIC, Childcare Support Network, the First Connections /2013/ ***and MIECHV Programs //2013//*** and adolescent health program to refer families who are uninsured or underinsured directly to Medicaid. All WIC applicants are screened for health insurance, and referred as needed to Medicaid.

***/2013/ The Title X Family Planning clinics provide services to at-risk populations. The program identifies health risks among women and connects women to medical and community services, including Rlte Care //2013//.***

Health Systems Capacity Indicators 06C : The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women  
INDICATOR #06

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.

INDICATOR #06

The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.

Narrative:

Pregnant/postpartum women qualify for Medicaid if their income is <185% of FPL.

Pregnant/postpartum women qualify for SCHIP if their income is between 185-250% of FPL.

Parents of Medicaid or SCHIP-eligible children with incomes between 100% and 185% of FPL are eligible for SCHIP. Families with incomes >150% of FPL are subject to a family partial premium. The premium threshold increases to 185% for families consisting of only pregnant women and infant(s). ***/2013/ In Rhode Island, there is also state funded program for pregnant women with income between 251% and 350% of FPL. Under this program, which requires a premium, the state funds the cost of labor and delivery //2013//.***

The DCFHE supports pregnant women's access to Medicaid through WIC, Childcare Support Network, the First Connections ***/2013/ and MIECHV Programs //2013//***, and the adolescent health program, refer families who are uninsured or underinsured directly to Medicaid. All WIC applicants are screened for health insurance, and referred as needed to Medicaid.

***/2013/ The Title X Family Planning clinics provide services to at-risk populations. The program identifies health risks among women and connects women to medical and community services, including Rlte Care //2013//.***

Health Systems Capacity Indicators 09A: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

Narrative:

The DCFHE links birth and infant death data from vital records on an annual basis. Birth data are also linked to WIC and newborn screening files. KIDSNET allows the DCFHE to also link birth data with newborn developmental risk screening, newborn hearing, immunization, lead screening, environmental inspections for children with elevated blood lead levels, early intervention, birth defects, foster care, and home visiting data.

The DCFHE has the ability to obtain data for program planning and policy purposes in a timely manner from the following registries/surveys: hospital discharge data for at least 90% of in-state discharges, PRAMS, and Birth Defects Surveillance. KIDSNET and the Department of Human Services have a signed data sharing agreement and are working to implement a plan to exchange data relevant to policy and planning. The Department of Human Services has developed a data warehouse which will greatly expand the capacity of DCFHE to access policy and program relevant data from DHS and in the future can create the ability to obtain annual data linking birth certificates and Medicaid eligibility or paid claims files, electronically. Training on the data warehouse ***/2013/ took //2013//*** place in 2011. ***/2013/ The SSDI Project Director and Data Manager were trained on the Department of Human Services data warehouse web application and the SSDI Project Director participated in an interagency work group for connecting data with the warehouse. /2013/ Although the DCFHE does not necessarily***

***needed a direct link to Medicaid data (it has KIDSNET), it is exciting that the state is working on a data hub that will link OHHS data with education data. Piloting is currently taking place and it is anticipated that the data hub project will be completed in 2015//.***

***WIC staff can now access KIDSNET immunization and lead screening data directly from the WIC Information System and print out lists of WIC clients needing these services. A pilot test of on-line referrals from primary care to city housing inspectors using KIDSNET was initiated. Participation and inspection data are available to the Asthma Program. CHDA/KIDSNET is part of an interagency effort working to develop an early childhood data system that links education, health, and other data under a National Governor's Association and Race to the Top initiative. Programming is underway to accept early childhood developmental screening scores in KIDSNET from Project Launch, primary care providers, home visitors, and other community partners that screen children. Development of on-line diagnostic reporting for newborn screening in KIDSNET has also begun. KIDSNET is working with health insurance companies to improve data on current insurance status of children //2013//.***

Health Systems Capacity Indicators 09B: The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.

Narrative:

HEALTH participates in the Youth Risk Behavior Survey (YRBS) and the DCFHE has direct access to the YRBS database for analysis. DCFHE participated in the development of RIDE's Surveyworks, replacing the SALT survey and providing school level data on a host of issues related to teaching and learning, including health concerns. A few questions from the YRBS are included in Surveyworks to allow for local comparison of state level data. The DCFHE produces user-friendly data tools that combine and compare multiple data sources to identify determinants of youth risk behaviors such as tobacco use.

***//2013/ CDC provided funding for HEALTH's Center for Health Data Analysis to implement YRBS with a Providence high school sample. This was the first time such a city-level YRBS was implemented and data from the survey have proven to be invaluable for local initiatives in Providence. Linking individual child-level data from RIDE, DOH, DCYF, Providence Public Schools, and community organizations (and eventually Family Court and BHDDH) is now in a robust demonstration phase, and this integrated and coordinated youth-focused data system is beginning to help RIDE build the capacity of community and state agencies to plan and deliver appropriate services in a timely manner. The DataHub database and web portal are developed, housed, and maintained by The Providence Plan //2013//.***

## IV. Priorities, Performance and Program Activities

### A. Background and Overview

#### Background and Overview

Results from the statewide needs assessment results, state and national performance measures, capacity indicators, and community stakeholders' input provide a comprehensive view of the MCH needs in Rhode Island. DCFHE identified state priorities and associated State Performance Measures from quantitative and qualitative information. The state priorities represent the four levels of the MCH pyramid and all MCH population groups. The capacity to address significant public health challenges at various service levels in an integrated way is a special mandate of Title V. DCFHE is proud of its coordinated, leveraged, and evaluated investments in community care for children and their families across the state.

For FY2011, the DCFHE developed new state priorities and State Performance Measures based on its comprehensive needs assessment and the community input received in FY2010. ***/2013/ In 2012, there was a small revision in SPM 6 and 7 that provided clarity to the measure. The focus and intent of the measures remain the same. The DCFHE's //2013//*** state priorities and State Performance Measures for FY2013 are as follows:

Priority: Increase access and capacity to evidence-based parent education and family support programs.

SPM1: Increase the number of RI resident families with at-risk newborns that receive a home visit during the newborn period ( $\leq 90$  days).

SPM 7 Increase the number of parents with children in early childhood that enroll in evidence based parenting education/support programs.

Priority: Reduce tobacco initiation among middle school students.

SPM2: Reduce tobacco initiation among middle school students.

Priority: Increase the percentage of adolescents who have a preventive "well care" visit each year.

SPM3: Increase the percentage of insured adolescents who have a preventive "well care" visit each year.

Priority: Increase the social and emotional health of children and youth with special health care needs.

SPM 4 Decrease the percentage of high school students with disabilities who report feeling sad or hopeless.

Priority: Increase the percentage of women who have a preventive care visit in the last year.

SPM 5: Increase the percentage of women who have a preventive care visit in the last year

Priority: Initiate prenatal home visiting program.

SPM6: Percent of pregnant women determined to be at risk for poor outcomes residing in selected communities who receive a home visit during the prenatal period.

Priority: Adopt the social determinants of health into public health practice.

SPM 8: Decrease the number of Rhode Island adolescents who report food insecurity.

SPM 9: Increase the number of Rhode Island high school students who earn a high school diploma or diploma equivalent in the six core cites.

All of the State Performance Measures ***/2013/ were //2013//*** new with the exception of SPM 1. This measure is a modified version of former SPM 3. The modification reflects the current efforts in Rhode Island's home visiting initiatives. State Performance Measures 2-6 mirror the identified

priorities reflected in the themes based on statewide data and community input. State Performance Measures 1 and 7 are related priorities based on a life course approach for prioritizing health care needs and services by looking at health and wellness across the lifespan. The measures are for specific populations. Our intent and purpose is to have an overarching priority across all MCH population groups. State Performance Measures 8 and 9 are indicators of the social determinants of health. Most health disparities affect groups that are disadvantaged or marginalized due to socioeconomic status, race/ethnicity, gender, sexual orientation, disability status, geographic location, or any combination of these. Access to healthy food and quality education are social determinants that contribute to good health.

These state priorities and corresponding performance measures, along with the 18 National Performance Measures are collectively designed to positively impact the six National outcome measures including: (1) perinatal mortality, (2) infant mortality, (3) neonatal mortality, (4) postneonatal mortality, (5) child mortality, and (6) infant death disparity. The new State Performance Measures are short-term precursors for the National outcome measures. All six National outcome measures focus on mortality among our most vulnerable populations yet, within the context of State and National Performance Measures, the necessity and breadth of a life course approach is evident to reach these goals. Also, DCFHE's commitment and emphasis to include efforts across both the MCH and health equity pyramids, demonstrates our commitment to reduce disparities and achieve health equity for all Rhode Islanders.

This section will illustrate how the DCFHE will be accountable for maternal and child health efforts supported by the Maternal and Child Health Block Grant. Measuring progress toward successful achievement for each individual performance measure includes: budgeting and expending funds over the four levels of the MCH and health equity pyramids, positively impacting the six National outcome measures.

## **B. State Priorities**

### State Priorities

This section describes the relationship of the State priorities, National and State performance measures along with the capacity and resource capability of HEALTH's DCFHE, as the State Title V administrator. This discussion pertains to the new State priorities and performance measures developed in */2013/ 2011 //2013//*.

DCFHE uses a life course development approach that addresses the determinants of health as its framework for health planning. Social, political, and economic policies and conditions evolve and determine health outcomes. While HEALTH has made significant progress in meeting Title V measures and Healthy People 2010 goals, disparities still exist. Therefore, proactive and applied public health strategies focus on all members of the community to eliminate health disparities in Rhode Island. It is through this collective work effort that DCFHE offers quality programs and continues to assure that all Rhode Islanders will achieve optimal health throughout the lifespan via a statewide system of services that are comprehensive, community-based, coordinated and family-centered. This approach links with the MCH needs assessment and program narrative to form the basis of our work in this application.

State priorities were developed in */2013/ 2011//2013//* as part of the five-year needs assessment. */2013/ A few of the priorities (3, 6, 7) were refined in 2012 //2013//*. All nine state priorities address significant needs identified through data analysis and community input. The DCFHE has assessed internal capacities as well as external resources to meet these needs. State Performance Measures were developed for each of the new priorities, along with a statement of significance for each measure. Where appropriate, selected example activities under each priority will address each level of both the MCH and Health Equity pyramids as discussed in detail in the Needs Assessment. Attention to each level of the pyramid ensures that individual;

family/community; and systems needs are addressed to create healthful environments to support maternal and child health. In addition, many of the state priorities directly relate to the National Performance Measures.

Priority: Increase access and capacity to evidence-based parent education and family support programs.

SPM1: Percent of RI resident families with at-risk newborns that receive a home visit during the newborn period ( $\leq 90$  days). Related National Performance Measures include: 1, 12, 15, 17, 18.

This measure is the former State Performance Measure 3 revised to reflect the expanded home visiting efforts in Rhode Island. There are gaps in services for families with young children to provide parent education and family support. These are needed to improve outcomes.

This priority is in both infrastructure building and social determinants of health level of the MCH and Equity pyramids. Parent education and support programs can assist families in connecting to and accessing enabling and population based services. Empowered parents can assess their child's development and advocate for needed services, as well as work to change the context of health choices as the default option within individual home and in community-based settings that serve children and their families.

Priority: Reduce tobacco initiation among middle school students.

SPM2: Percent of middle school students who have initiated tobacco use. Related National Performance Measures include: 5, 13, 15.

The tobacco industry is losing its customer base as adults quit smoking and/or die of smoking related illnesses. To ensure a steady stream of tobacco users, tobacco companies target young people with very seductive marketing campaigns. Prevention of youth initiation will ensure fewer youth will become addicted to tobacco in adulthood.

The priority is in both the infrastructure building and social determinants of health portion of the pyramid. Strategic policy development can eliminate access to tobacco for minors. Additionally, population based services like health education can inform youth about tobacco and create environments where healthy choices are the default choice. Direct health care services and education and counseling could include the development of evidence-based approaches to support youth who have initiated tobacco use already.

Priority: Increase the percentage of insured adolescents who have a preventive "well care" visit each year.

SPM3: Percent of insured adolescents who have a preventive "well care" visit each year. Related National Performance Measures include: 2,3,4,5, 6,8,10,13,16.

Rhode Island has a low rate of uninsured children including adolescents. This measure includes only adolescents enrolled in health plans however, children who are not insured most likely do not receive preventive care. Health plans in Rhode Island report HEDIS measures including adolescent well care visits for their enrolled populations. Even though, only 7% of Rhode Island's children under age 18 were uninsured between the time period of 2006-2008, approximately 40% of adolescents did not receive a well care visit in the previous year as per the HEDIS measure. There was no difference between private and public health insurance plans in terms of adolescent well care visit. The HEDIS national benchmark measure for adolescent well care visits is under 60%, which may explain why the health care utilization for adolescent well care is not better.

This measure effects all levels of both pyramids as health insurance can provide access to care yet it does not guarantee that adolescents will utilize the care. Direct health care such as provider practices (e.g. adolescent friendly, wellness promotion/risk reduction versus traditional visit), enabling services such as health plan incentives (e.g. use of services by enrolled members),

population based services such as youth and parent engagement strategies (support for visit, and how it aligns with adolescent developmental needs) as well as infrastructure building policies (such as required physical for high school and a more rigorous HEDIS measure) to increase the number of adolescents receiving well child visits needs to be considered to develop supportive systems of care for adolescents thereby addressing social determinants of health.

***/2013/ The DCFHE developed a report on Access to Care for Adolescents that includes a literature review on the state of adolescent health care access, quantitative data, a qualitative analysis of RI adolescent health access and system development recommendations. An adolescent health summit this fall will engage stakeholders' commitment to implement the recommendations //2013//.***

Priority: Increase the social and emotional health of children and youth with special health care needs.

SPM 4 Percent of high school students with disabilities who report feeling sad or hopeless.

Related National Performance Measures include: 2, 3, 4, 5, 6.

The behavior risk status of RI's youth with special needs is of great importance to state and local policy leaders from health, education, human services, and juvenile justice. Data from the YRBS indicate that students with disabilities are more likely to start earlier and currently smoke cigarettes, drink alcohol, and use marijuana; more likely to be threatened, physically fight, be forced to have sex, and not go to school due to feeling unsafe; more likely to get insufficient physical activity and more likely to be overweight. Further, students with disabilities are more likely to report feelings of hopelessness and to consider and attempt suicide than their non-disabled peers. Although many students in RI participate in risky behaviors, the data indicate that students with disabilities participate in these behaviors earlier, more consistently, and to a more dangerous level than their peers. The Office of Special Health Care Needs in the Health Disparities and Access to Care Team leads the charge in highlighting the risk behaviors of students with disabilities and systematically addressing them through the levels of the MCH and Equity pyramids by increasing the following: infrastructure building services such as well-integrated academic interventions; enabling services such as positive social and recreational activities; populations and individual based education and counseling programs that support self-determination and student leadership; and direct health care interventions that address behavioral health concerns.

Priority: Increase the percentage of women who have a preventive care visit in the last year.

SPM 5: Percent of women who have a preventive care visit in the last year. Related National Performance Measures include: 6, 8, 15, 16, 18.

This priority is expected to improve health outcomes by improving the focus on prevention, reducing the likelihood of developing a chronic disease, and increasing utilization of primary care as women establish a relationship with a primary care provider. This may also reduce health care costs by reducing utilization of the emergency department for preventable conditions.

The Women's Health Advisory Committee advises HEALTH's Office of Women's Health on statewide priorities and policies to address social determinants of health as well as build infrastructure to support women's health. It envisions a Rhode Island where women live to their optimal level by achieving an ideal state of health by promoting a gender-informed, coordinated, comprehensive, primary prevention approach to women's health across the lifespan. Work is targeted to eliminate health disparities across all dimensions of age, ability, geography, race, ethnicity, sexual orientation, economics and education. Enabling services for children and families can assist women in accessing necessary care. Accessing direct health care services and clinical interventions can ensure all women are able to achieve optimal health.

***/2013/ Also, the RI Task Force on Premature Births made recommendations addressing all levels of the MCH and healthy equity pyramids including: meeting the state's standards for***

***comprehensive family life and sexuality education in schools, supporting state policies and programs that ensure access to comprehensive primary and preventive health care services for women, expanding the range of services in all settings where women, receive health care to include improved identification of health risks, health information, and referrals for health risks associated with preterm birth, and enhancing comprehensive, relationship family support programs to improve outcomes for women and their children and prevent subsequent teen pregnancy //2013//.***

Priority: Initiate prenatal home visiting program.

SPM6: Percent of pregnant women determined to be at risk for poor outcomes, residing in selected communities who receive a home visit during the prenatal period. Related National Performance Measures include: 4, 5, 8, 11, 12, 13, 14, 15, 17, 18.

Rhode Island has high rates of prematurity and low birth weight rates, as well as, high rates of infant mortality in participating core cities. Rhode Island has limited home visiting capacity to serve pregnant women using an evidence-based model.

Currently First Connections Home Visiting Program provides direct health care, education and counseling, through four community based agencies to almost 50% of families with newborns who have specific risk profiles created from information collected at birthing hospitals. Home visitors provide general parenting information, conduct home assessments, educate parents about infant care, and link families to appropriate resources. The DCFHE is implementing an intensive home visiting model as well as prenatal home visiting through First Connections in an effort to build a strong infrastructure for home visiting as well as to inform policies that affect the social determinants of health for participating families served.

Priority: Increase access and capacity to evidence based parent education and family support programs.

SPM 7: Number of parents with children in early childhood that enroll in evidence based parenting education/support programs. Related National Performance Measures include: 1, 2, 4, 7, 9, 11, 12, 13,14, 15, 17.

This priority is overarching across all of the MCH population groups although the measure is specific to early childhood. More evidence-based programs that demonstrate outcomes are needed to ensure that resources are allocated to programs that improve outcomes. Evidence based programs can address the social determinants of health by building the knowledge and skills of parents to address their families' needs. Additionally evidence based program approaches can help inform policy development to strengthen the State's capacity and infrastructure to support families.

Priority: Adopt the social determinants of health into public health practice.

SPM 8: Percent of Rhode Island adolescents who report food insecurity. Related National Performance Measures include: 5, 9, 11, 13, 14, 17, 18.

Food insecurity is a proxy measure for poverty. Income is a social determinant of health status. McDonough et al. used data from the Panel Study of Income Dynamics for the years 1968 to 1989; they used fourteen ten-year panels to analyze predictors during the first five years and vital indicators during the second five years of each panel. They found that "Income level was a strong predictor of mortality, especially for persons under the age of 65" and they concluded that "income and income stability should be addressed in population health policy" (McDonough et al., 1997, p. 1476).

This priority is overarching across all MCH populations and reflects a lifecourse perspective. Direct health care and education can help inform healthy nutritional choices and advocacy for access to healthful choices. Enabling services such as transportation can help ensure access. Policies that limit access to unhealthy food and increase access to healthy choices create an

infrastructure that support health practices as the default choice.

Priority: Adopt the social determinants of health into public health practice.

SPM 9: Percent of Rhode Island high school students who earn a high school diploma or diploma equivalent in the six core cites. Related National Performance Measures include: 2, 3, 4, 5, 6, 8, 9, 10, 12, 13, 14, 15, 16, 17, 18.

Grossman and Kaestner cite a number of studies (Auster et al., 1969; Grossman, 1972; Grossman, 1975; Grossman & Benham, 1974; Silver, 1972) that suggest, "years of formal schooling completed is the most important correlate of good health" (Grossman & Kaestner, 1997, p. 73). Their examples show schooling to be a more important determinant of health than income or occupation, and this holds true when controlling for the reverse causality occurring when poor health leads to poverty.

This priority is overarching across all MCH populations and reflects a lifecourse approach. The interrelationship between health and academic achievement is cyclical. Children who come to school ready to learn become children who leave school ready to lead productive lives, which is why increasing the high school graduation rate to 90% is an official health objective for the nation for the year 2010 (U.S. DHHS, 2006). Children who are healthy can learn better. Children who enjoy learning are more likely to stay in school. Children who stay in school have better health outcomes in their adult lives. Adults who practice healthful behaviors can teach children the value of a healthy lifestyle (Bogden, 2003). School and community based efforts, along with the development of policies and systems of care will address every level of the MCH and Equity pyramids to ensure positive health outcomes across the MCH populations.

***/2013/ The new federal USDOE and USDHHS Race to the Top's collaborative emphasis on the link between health and education in early childhood is an important step in supporting this link across the lifespan. Additionally, the emphasis of chronic absenteeism, as a Race to the Top indicator, demonstrates the measures' relationship to both health and education outcomes. The measure has fostered conversations among broad groups of health and education professionals on how health and education systems can work together for RI's school-aged youth. The DCFHE collaborated with RI Kids Count on a data brief regarding health disparities and social determinants of health including graduation from high school //2013//.***

Priorities, Capacity and Resource Allocation

After the development of the priorities, activities and projects are identified to address the priority strengths and needs through the Venture Capital Request (VCR) process. The VCR's describes the activity or project and includes required MCH information on how the VCR aligns with one or more of the set priority or priorities, type of population and type of service data, how the VCR will be measured and how it aligns with the application process or measures.

In addition, VCR reflects the four pillars of Community, Family Health and Equity's (CFHE) new approach for public health: health equity, the social and environmental determinants of health, the life course approach and integrations of programs. MCH Block grant resources are allocated based on the interventions from the health equity framework. This ensures that Federal Maternal and Child Health Block Grants funds are utilized to improve maternal and child health, reduce disparities and achieve health equity for all Rhode Islanders. The DCFHE, as the designated Title V administrator for Rhode Island, looks forward to developing capacity and expertise to address these priorities and measures over the next five years.

***/2013/ The DCFHE's Office of Minority Health (OMH) will continue to support the Community Health Worker Association of Rhode Island (CHWARI) to support racially and ethnically diverse community activation around integrative public health, including MCH, efforts. Local support and outreach programs such as PPEP, family resource counselors,***

**Americorp Volunteers, and Life Span Community activists are included in the CHWARI system, which includes career ladders, core competency training, and CHW certification.**

**The OMH will continue to educate community partners on the social and environmental determinants of health through quarterly "Equity Dialogues" targeting youth, tribal communities, southeast asian populations, and LGBT persons of color. The OMH will staff and support the Commission for Health Advocay & Equity by working with the Commission to set goals for health equity and to prepare a plan for Rhode Island to achieve health equity in alignment with other statewide planning activities. OMH, through the Commission, will educate state agencies on health disparities, including social factors that play a role in creating and/or maintaining thses dispartities. The OMH will help to support the preparation of biennial disparities impact and evaluation reports.**

**The DCFHE's Office of Language Assistance (OLA) distributed 8,083 "I Speak" cards in RI's top three languages letting patients know about their rights to a qualified and competent medical interpreter to CBOs and minority communities; conducted presentations on federal CLAS standards to all 6 DCFHE teams, CHDA, RIPIN, and Youth Works; and developed boilerplate language on CLAS standards that is attached to all HEALTH community contracts. During the upcoming year, the OLA will print "I Speak" cards in 7 additonal languages, conduct presentations of CLAS standards to all ambulatory care facilities in the state, draft revisions to the medical interpreter sections of the state's hospital regulations, and monitor, track, and document language violations by health care providers through consumer complaints //2013//.**

### **C. National Performance Measures**

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	99.5	99.6	99.6	99.6	99.6
Annual Indicator	100.0	100.0	100.0	96.0	100.0
Numerator	33	37	27	24	35
Denominator	33	37	27	25	35
Data Source		Newborn Screening Blood Spot DB			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	99.8	99.8	99.8	99.8

**Notes - 2010**

2010: Of the 25 infants screened positive and needing treatment, 24 received appropriate follow up. One family moved out of state prior to treatment.

**Notes - 2009**

Annual indicator continues to be 100%. Rhode Island is successful in making sure infants receive appropriate follow up.

2009: Nine infants were confirmed with Hemoglobinopathies [non sickling]. The infants did not require any treatment. Therefore, the numerator includes these 9 infants, since they did receive the appropriate follow up.

**a. Last Year's Accomplishments**

Data Discussion:

Annual data shows that Rhode Island continues to maintain high levels of newborn screening and follow up. ***/2013/ All newborns receive a newborn bloodspot screen prior to hospital discharge. Data for 2011 shows that 100% of babies born with a positive screen received timely follow up to a confirmatory diagnosis. The state has put quality assurance systems in place and policies and procedures to ensure that all newborns receive a newborn screening, diagnosis, and treatment services as soon as possible after a positive screen. Ensuring these high rates of screening and follow up is a high priority for the Newborn Screening Program //2013//.***

a. Last Year's Accomplishments

***/2013/ The DCFHE through the Newborn Screening Program continued to provide universal newborn screening for the 29 core disorders, including hearing impairment, developmental risk, and secondary conditions that can be detected in the diagnosis of core disorders. The Newborn Screening Program continued to assure screening, diagnosis, and treatment services for all newborns born in the state for the disorders screened.***

***The Newborn Screening Program continued to track all abnormal screenings to resolution of findings through confirmatory testing and initiation of treatment. This includes maintaining contracts with the New England Newborn Screening Laboratory in Massachusetts for the analysis and storage of bloodspots, the VNA of Care New England for tracking and follow-up of bloodspot results, and with Rhode Island Hospital for diagnosis and treatment of infants identified through bloodspot screening. The DCFHE continued to assure that newborns with developmental risks received appropriate follow-up care through the First Connections Program. In addition, the First Connections Home Visiting Program provided outreach services to families who were difficult to reach.***

***A Continuous Quality Improvement (CQI) plan for bloodspot newborn screening continued. The CQI Plan includes quality assurance site visits at the seven birth hospitals, data and system level quality issues, and ongoing review of policies and procedures by the Newborn Screening Advisory Committee. This Committee advised 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, representatives from the March of Dimes, public health experts, and***

*people involved in delivering services, follow-up, and treatment in the state. The Rhode Island Newborn Screening Advisory Committee continued to meet on a bi-monthly basis.*

*The Newborn Screening Program continued to use KIDSNET to identify true missed specimens, delayed specimens, and other important systems issues, which were addressed at the hospital level. Condition-specific reporting guidelines for the RI system are in development and will document reporting and follow-up processes for program staff //2013//.*

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided universal newborn screening for 29 core disorders including hearing impairment, developmental risk, and secondary conditions that can be detected in the diagnosis of core disorders.			X	
2. Assured newborn screening, diagnosis, and treatment services for all newborns born in the state for the disorders screened and tracked all abnormal screenings to resolution of findings through confirmatory testing and initiation of treatment.			X	
3. Provided home visiting services to families who are hard to reach through First Connections.	X			
4. Maintained a CQI Plan for bloodspot newborn screening that includes ongoing review of policies and procedures by the Newborn Screening Advisory Committee.				X
5. Used KIDSNET to identify true missed specimens, delayed specimens, and other important systems issues to be addressed at the hospital level.				X
6. Maintained a newborn screening fee to support the newborn screening system.				X
7. Worked to ensure that all newborns born at home receive both a hearing and bloodspot screening.			X	
8. Distributed informing brochures to families in English and Spanish and utilize PRAMS to monitor the impact of these efforts.		X		
9. Worked with the Newborn Screening Advisory Committee to evaluate the feasibility of adding new conditions such as Severe Combined Immunodeficiency Disease and Critical Heart Disease to the newborn screening panel.			X	
10.				

**b. Current Activities**

b. Current Activities

*//2013/ DCFHE continues to implement the activities described in last year's accomplishments section. This year, two newborn screening conditions called Severe Combined Immunodeficiency Disease (SCID) and Critical Congenital Heart Disease (CCHD) have been recommended for inclusion to the panel by the Newborn Screening Advisory Committee. Two workgroups have been formed to assist in the implementation and infrastructure of SCID and CCHD. The DCFHE, in partnership with the New England Genetics Collaborative and other New England states, applied for and was awarded a grant for a regional CCHD demonstration project. The project aims to enhance and expand existing networks among state public health departments and birthing facilities, to share resources and expertise in developing CCHD Disease screening protocols, developing*

*educational materials and program evaluation.*

*The AAP recently expanded its recommendations for reducing the risk of sudden, unexpected infant death to focus on a safe sleep environment that can reduce the risk of all sleep-related infant deaths, including those from SIDS. In response, HEALTH's Newborn Screening Program, along with the Center for Public Health Communication, is leading an effort to promote safe infant sleep practices among expecting and new parents and caregivers. During the last several months, an internal team has conducted research to inform the framework for a comprehensive "safe sleep" communication plan //2013//.*

**c. Plan for the Coming Year**

*//2013/ The DCFHE will continue to implement the activities outlined in last year's accomplishments and current activities sections. In addition, there will be an enhancement in KIDSNET to provide an online mechanism for RI specialty clinics to report newborn diagnoses, test results and treatment methods for infants with a confirmed newborn screening condition. Programming in KIDSNET is underway to allow on-line diagnostic reporting for newborn screening blood spot conditions. Newborn Screening results and needed follow-up are currently available in KIDSNET. The DFCHE will work with the Center for Health Data Analysis to complete programming in KIDSNET to operationalize all electronic reporting and primary care clinic staff will be trained to report in KIDSNET. RI will continue to reevaluate its bloodspot storage policy to determine whether bloodspots need to be kept for 23 years. The DCFHE will continue to work with the Newborn Screening Advisory Committee to evaluate the feasibility of adding new conditions such as Severe Combined Immunodeficiency Disease and Critical Congenital Heart Disease to the newborn screening panel, consistent with the national recommendations and evaluate the impact of the capacity to treat such conditions within the state.*

*HEALTH's Newborn Screening Program, along with the Center for Public Health Communication, will continue to lead an effort to promote safe infant sleep practices among expecting and new parents and caregivers //2013//.*

**Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated**

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	11671					
<b>Reporting Year:</b>	2011					
<b>Type of Screening Tests:</b>	<b>(A) Receiving at least one Screen (1)</b>		<b>(B) No. of Presumptive Positive Screens</b>	<b>(C) No. Confirmed Cases (2)</b>	<b>(D) Needing Treatment that Received Treatment (3)</b>	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	11671	100.0	4	2	2	100.0
Congenital Hypothyroidism	11671	100.0	27	13	13	100.0

(Classical)						
Galactosemia (Classical)	11671	100.0	3	2	2	100.0
Sickle Cell Disease	11671	100.0	4	4	4	100.0
Biotinidase Deficiency	11671	100.0	0	0	0	
Cystic Fibrosis	11671	100.0	2	2	2	100.0
Homocystinuria	11671	100.0	0	0	0	
Maple Syrup Urine Disease	11671	100.0	1	0	0	
beta-ketothiolase deficiency	11671	100.0	0	0	0	
Tyrosinemia Type I	11671	100.0	2	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	11671	100.0	0	0	0	
Argininosuccinic Acidemia	11671	100.0	0	0	0	
Citrullinemia	11671	100.0	0	0	0	
Isovaleric Acidemia	11671	100.0	0	0	0	
Propionic Acidemia	11671	100.0	0	0	0	
Carnitine Uptake Defect	11671	100.0	1	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	11671	100.0	2	0	0	
Methylmalonic acidemia (Cbl A,B)	11671	100.0	0	0	0	
Multiple Carboxylase Deficiency	11671	100.0	0	0	0	
Trifunctional Protein Deficiency	11671	100.0	0	0	0	
Glutaric Acidemia Type I	11671	100.0	0	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	11671	100.0	0	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	11671	100.0	1	0	0	
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	11671	100.0	1	1	1	100.0
Methylmalonic Acidemia (Mutase Deficiency)	11671	100.0	0	0	0	
S-Beta Thalassemia	11671	100.0	1	1	1	100.0
Sickle/Hemoglobin C Disease	11671	100.0	1	1	1	100.0
Hydroxymethylglutaric aciduria/HMG-CoA	11671	100.0	0	0	0	

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	70	61.4	61.4	61.4	63
Annual Indicator	61.4	61.4	61.4	61.4	75.5
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	75.5	75.5	75.5	78.5	78.5

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data Discussion:

According to data from the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 61.4% of families of CSHCN reported they are partners in decision making at all levels, and are satisfied with the services they receive. While this data represents a decline from the 2001 NS-CSHCN figure of 68.6%, RI remains significantly higher than the national average of 57.4%. As was discussed earlier in this application, RI's social welfare system has been under significant stress over the last several years. Difficult decisions to cut or limit

eligibility to services and supports were made without much family and provider input, leaving consumers feeling disempowered.

#### **a. Last Year's Accomplishments**

Data Discussion

***/2013/ According to data from the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), 75.5% of families of CSHCN reported they are partners in shared decision making for their child's optimal health. Although the indicator is not comparable across survey years, the family partnership measure in 2005/2006 NS-CSHCN was 61.4%. RI remains significantly higher than the national average of 70.3% //2013//.***

#### **a. Last Year's Accomplishments**

The OSHCN, in coordination with the RI Family Voices Program located at RIPIN, made resources available to parents of CSHCN and the professionals working with them. The OSHCN has made available the RI Resource Guide for Families of Children with Autism Spectrum Disorders (English and Spanish), RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, the Complete Care Notebook, Family Voices Resource Guide, RI Resource Guide to Mental Behavioral Services & Supports, ***/2013/ and the Ready Set Go Series for Adolescent Healthcare Transition //2013//***. All of these materials were disseminated to parents and professionals to drive best practice in the diagnosis and treatment of children and youth with special health care needs.

The PPEP was present in 24 pediatric primary and specialty practices to foster the communication and partnership between the parents and providers. Through the PPEP and Family Voices of RI, parent leaders have been cultivated and supported to lead policy initiatives, make systems improvements and champion principles of parent-professional partnerships. Through the Family Voices Leadership Team, the OSHCN addressed systems barriers to a coordinated service delivery system and developed a parent policy team to provide peer-to-peer support in addressing statewide policy, especially health reform, Global Compact Medicaid Waiver and cuts to the state Medicaid program. ***/2013/ Over forty family members //2013//*** have been trained on public policy, meet on an ongoing basis to discuss pending legislation, and prepare written and spoken testimony.

***/2013/ The Parent/Professional partnership Conference held in March 2011, focused on the changing system of care for CSHCN in RI and included presentations and exhibits on a full range of health, education, mental health, child welfare, financing, and transition topics. The conference offered local and national speakers and attracted nearly 250 RI parents and professionals //2013//.***

The OSHCN partnered with the Autism Project of RI to inform and support families in accessing best practice evaluation and treatment for their children with an Autism Spectrum Disorder (ASD) or other Developmental delays (DD). Nearly 300 families were networked with other families to reduce isolation and develop resiliency in parenting their children. Families also received The Parent Review Weekly for eight weeks and then every other week for 20 weeks. This electronic newsletter provides families with information about quality treatment and important considerations in parenting a child with an ASD.

HEALTH took the lead in establishing a Family Leadership Development Institute in RI (FLDI) to develop a network of family leaders in RI to make a positive impact on schools, communities and in health care arenas. Parent education and workshop sessions are provided through the RIPIN, Parent Support Network and Sherlock Center for Disabilities. ***/2013/ 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. There were over 500 parents and professionals trained in navigating the special needs service delivery system such as basic rights, college success for students with disabilities, options for medical assistance, policy 101, transition planning, etc. //2013//.***

Parent support groups are organized throughout the state and HEALTH contracted with RI's Family Voices to maintain a master calendar of support groups based on topic, age, and language. Parent consultants educated and empowered families in the Early Intervention Program, PPEP, WIC, Birth Defects, Immunization, Community Asthma, Distribution Center, Emergency Preparedness, TBI, and Health Information Center.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided ongoing dissemination of family-centered materials and resource guides.		X		
2. Placed trained parent consultants in pediatric primary care & speciality care settings throughout RI through PPEP to help families navigate the system of services for CYSHCN.	X			
3. Trained parent consultants and supported their participation in advisory and planning committees impacting CYSHCN.		X		
4. Convened a statewide CYSHCN conference for parents of CYSHCN and the professionals who work with CYSHCN and their families.		X		
5. Provided ongoing support to parents through the FLDI.		X		
6. Supported RI Family Voices to maintain a master calendar of support groups for CYSHCN and their families.		X		
7. Supported parent consultants to continue to education and empower families in CYSHCN programs.		X		
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

***//2013/ The DCFHE continues to make resources available to parents of children with special healthcare needs and the professionals working with them, promote family-centered care and parent consultant services through the PPEP, address systems barriers to a coordinated service delivery system and continues to maintain a parent policy team to provide peer-to-peer support in addressing statewide policy, provide parents of CSHCN with training opportunities to prepare them for participation on advisory and planning committees, provide parents of CSHCN with training opportunities to prepare them for participation on advisory and planning committees, partner with the Autism Project of RI, support the FLDI, maintain a master calendar of support groups, support the Parent/Professional partnership Conference, partner with RI Family Voices and the RI Family Voices Leadership Team to empower families and youth through education, peer-to-peer support, skill building and leadership development.***

***Ten additional pediatric primary and specialty care sites will be supported through the PPEP Program. These sites are being targeted for serving high numbers of CSHCN through the CEDARR program. The sites will receive a 5 hour per week parent consultant who will link families with necessary community based services/supports while assisting the practice in implementing the CMS health home CEDARR model //2013//.***

**c. Plan for the Coming Year**

c. Next Year's Activities

The DCFHE will continue to include consumer voices (including parents of CYSHCN) in all levels of program development and implementation. The OSHCN will continue to ensure that families with CYSHCN are engaged in program planning, implementation, and evaluation and that families are full partners in the development of policy affecting their lives and the lives of their children through distribution of materials within pediatric practices, involvement in the Global Compact Medicaid Waiver Workgroups and Family Voices Leadership Team. In addition, the DCFHE will continue to seek an increase in satisfaction among consumers through qualitative and quantitative evaluation of its programs and initiatives.

The OSHCN will continue to assess the need in the community for additional resource guides and distribute them to families and professionals. The OSHCN will continue to make available the RI Resource Guide for Families of Children with Autism Spectrum Disorders (in English and Spanish), the RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, the RI Complete Care Notebook, the Adolescent Healthcare Toolkit, the RI Family Voices Resource Guide, the RI Resource Guide for Behavioral Health Services and Supports and the Youth Transition Workbook.

The OSHCN will continue to promote family-centered care and parent consultant services through the PPEP. The PPEP will continue to work with funders, insurers and state leadership on the demonstrated impacts of the PPEP model of service delivery. The OSHCN will continue to provide technical assistance within the state and to other states regarding the engagement of consumers in all aspects of decision-making and its importance in the health care reform debate. Through the Family Voices Leadership Team, the OSHCN will address identified systems barriers to a coordinated service delivery system. The OSHCN will provide opportunities to demonstrate parent professional partnerships including an annual conference, policy meetings and ongoing committees.

The DCFHE will continue to support the development of a comprehensive system of family leadership through the FLDI. The DCFHE will continue to monitor the health reform roll-out for CYSHCN and other vulnerable populations. Future initiatives should provide up to date information to families and professionals on accessing health care, benefits explanation, and private vs. public options.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	55.2	50.9	50.9	50.9	55.5
Annual Indicator	50.9	50.9	50.9	50.9	44
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	44	44	44	46.5	46.5

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Data Discussion:

Data from the 2005/2006 National Survey of CSHCN indicate that 50.9% of CSHCN received coordinated, ongoing and comprehensive care within a medical home. While this represents a slight decline from the 2001 survey figure of 53.9%, RI's data remains well above the national average of 47.1%. As RI faces state budget constraints from a failing economy, systems of care for children and youth with special health care needs are threatened and fragmented.

**a. Last Year's Accomplishments**

Data Discussion:

***/2013/ Data from the 2009/2010 National Survey of CSHCN indicate that 44% of CSHCN received coordinated, ongoing and comprehensive care within a medical home. RI's data remains above the national average of 43%. There was a significant decrease from 2005/2006 NS-CSHCN data of 50.9% //2013//.***

a. Last Year's Accomplishments

***/2013/ The DCFHE's OSHCN worked to increase the number of CYSHCN in RI who have a medical home by partnering with PPEP, EOHHS (on CEDARR, EPSDT, and Medicaid policy), Health Plans, the RI Chapter of the American Academy of Pediatrics, the Academy of Family Physicians, and the Society of Adolescent Medicine //2013//.***

The PPEP -- a medical home enhancement project -- was expanded to include several community based organizations and specialty service providers. The Family Voices Leadership Team addressed barriers identified through the PPEP to a coordinated service delivery system and partnered with health plans to identify and reimburse medical home-type services. The DCFHE worked with RI health plans on appropriately reimbursing practices that provide a comprehensive medical home.

***/2013/ PPEP parent consultants in the Neonatal Intensive Care Unit (NICU) at Women & Infants Hospital, the Ventilator Integration Program at Hasbro Children's Hospital and the Neonatal Follow-up Program provided medical home services to infants and toddlers with complex medical conditions.***

***The OSHCN supported a Peer Resource Specialist position at the RI Hospital Transition Clinic, which provides medical home and transition services to YSHCN //2013//.***

The OSHCN participated on the CEDARR Interdepartmental Team, assisted ***/2013/ EOHHS //2013//*** in reprocurring the State's Medicaid Managed Care Contract, was engaged in distributing RI's EPSDT Schedule, supported existing medical home systems development in the communities of Newport, Washington County, Mt. Hope, and Pawtucket/Central Falls. ***/2013/ Further, the OSHCN partnered with EOHHS in transitioning the CEDARR program to a CMS Health Home based on federal permission in the fall of 2011. The OHHS/HEALTH Team presented the model of collaboration nationally and actively provided TA to other states.***

***The DCFHE continued to provide TA to Washington County and Woonsocket CATCH partners on the development of medical homes, pediatric behavioral health services, and prenatal care for hard-to-reach populations. The DCFHE and its Woonsocket CATCH partners utilized a model report of adolescent medical homes to develop and implement strategies to improve health outcomes //2013//.***

HEALTH's Center for Health Data and Analysis (CHDA) gathered data and determined the percent of RI children with medical homes.

The OSHCN partnered with the Chronic Disease Team on workforce capacity to support the medical home, including ***/2013/ parent consultants, resource specialists, peer navigators //2013//***, asthma educators, diabetes educators, Living Well Self-Management programs, cancer peer navigators, and cardiovascular disease educators.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked to increase the number of CYSHCN who have a medical home by partnering with other organizations and programs.				X
2. Supported the PPEP and is working to include PPEP in Rhode Island's health care reform efforts.				X
3. Assisted OHHS in implementing an enhanced medical home focus within its care coordination CEDARR program that was awarded CMS Health Home Status.				X
4. Supported PPEP parent consultants in the NICU at Women & Infants Hospital and the Ventilator Integration Program at Hasbro Children's Hospital and Neonatal Follow-Up Program.		X		
5. Collaborated with Family Voices Leadership Team to address systems barriers to a coordinated service delivery system &				X

participated on the CEDARR Interdepartmental Team overseeing RI's care coordination system for CYSHCN				
6. Supported CHDA to gather data and determine the percentage of RI's CYSHCN with a medical home.			X	
7. Partnered with the Chronic Disease Team on workforce capacity to support the medical home.		X		
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

***/2013/ OSHCN continues to work to increase the number of CYSHCN who have a medical home by partnering with PPEP, EOHHS (on CEDARR, EPSDT, and Medicaid policy), health plans, the RI-AAP, the RI-AFP, and the SAM //2013//.***

OSHCN and partners are working to include PPEP in RI's Health Reform efforts. A Peer Navigator model (based on the PPEP) is being supported through Medicaid Managed Care for high ED users.

***/2013/OSHCN assists EOHHS in implementing an enhanced medical home focus within its care coordination CEDARR program. OSHCN supports the training and implementation of the CMS Innovations Challenge Grant with the WIH Program for medically complex CSHCN //2013//.***

PPEP parent consultants in the NICU at WIH, the Ventilator Integration Program at Hasbro Children's Hospital and the Neonatal Follow-up Program continue to provide medical home services to infants and toddlers with complex medical conditions.

OSHCN collaborates with Family Voices to address the systems barriers to a coordinated service delivery system; participates on the CEDARR Interdepartmental Team overseeing RI's care coordination system for CYSHCN; and supports the preventative and screening functions of the medical home through RI's revised EPSDT Schedule.

CHDA continues to gather data and determine the percent of CSHCN with medical homes. OSHCN continues to partner with the Chronic Disease Team on workforce capacity to support the medical home //2013//.

**c. Plan for the Coming Year**

c. Plan for the Coming Year

***/2013/ The DCFHE will continue to work to increase the number of CYSHCN in RI who have a comprehensive medical home. To accomplish this, the DCFHE will continue to improve and expand its current programming through PPEP as well as partner with state and community agencies, including EOHHS (on CEDARR and other initiatives), the RI Chapter of the American Academy of Pediatrics, the Academy of Family Physicians, and the Society of Adolescent Medicine.***

***The OSHCN will continue to promote access to a medical home for CSHCN through the PPEP. The plan for the PPEP is to access public and private insurance reimbursement for purposes of sustainability and to continue program evaluation. The OSHCN will continue to enhance medical homes for young adults through the Rhode Island Transition Clinic.***

***The OSHCN will continue to support the training and implementation of the CMS Innovations Challenge Grant with the Women & Infants Hospital Program for medically complex CSHCN in Rhode Island. Under the recently awarded CMS Innovations Challenge,***

*these programs (including an OSHCN trained and supported parent consultant) will be expanding for medically complex infants with special health care needs in Rhode Island.*

*The OSHCN will continue to participate on the CEDARR Interdepartmental Team and in convening consumer input opportunities. Through these partnerships, the state will address care coordination for CYSHCN and additions to the Medicaid package. DCFHE is ensuring support of the medical home through RI's EPSDT Schedule.*

*The OSHCN will continue to collaborate with Family Voices Leadership Team to address the systems barriers to a coordinated service delivery system and support the preventative and screening functions of the medical home through RI's revised EPSDT Schedule.*

*HEALTH's Center for Health Data and Analysis (CHDA) will continue to gather data and determine the percent of RI's CSHCN with medical homes.*

*The OSHCN will continue to partner with the DCFHE's Chronic Disease Team on workforce capacity to support the medical home, including parent consultants, resource specialists, peer navigators, asthma educators, diabetes educators, Living Well Self-Management programs, cancer peer navigators, and cardiovascular disease educators.*

*DCFHE will continue to provide TA to Woonsocket and Washington County CATCH partners and identify 2 more communities to pilot the adolescent medical home model //2013//.*

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	70.2	68.2	68.2	68.5	70.2
Annual Indicator	68.2	68.2	68.2	68.2	65
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>

Annual Performance Objective	65	65	65	68.5	70
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**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data Discussion:

Data from the 2005/2006 National Survey of CSHCN indicates that 68.1% of families with CSHCN have adequate private and/or public insurance to pay for the services they need. This percentage is largely consistent with the 2001 National Survey results of 68.9%. RI has a high rate of insured children as a result of the state's collective commitment to the RIteCare Program. This performance measure reminds RI that insurance status alone does not mean that families can pay for all the services they need.

**a. Last Year's Accomplishments**

Data Discussion:

***/2013/ Data from the 2009/2010 National Survey of CSHCN indicates that 65% of families with CSHCN have adequate private and/or public insurance to pay for the services they need. This percentage is a decrease from 2005/2006 NS-CSHCN results of 68.1% //2013//.***

RI has a high rate of insured children as a result of the state's collective commitment to the RIte Care Program. This performance measure reminds RI that insurance status alone does not mean that families can pay for all the services they need.

a. Last Year's Accomplishments

The OSHCN worked collaboratively with the state's Medicaid office to enhance the EPSDT benefit and availability of services. The DCFHE continued to work to increase the percentage of CSHCN with adequate insurance to pay for the services they need.

***/2013/ The PPEP assisted numerous families with CYSHCN on issues concerning insurance, education, and access to mental health services. Many of these families required direct assistance in accessing insurance.***

***The First Connections Program continued to identify families with no or inadequate health insurance and refer them to appropriate programs and services, including Medicaid, SSI, and Katie Beckett.***

***The DCFHE supported the toll-free Family Health Information Line, which continued to refer families to appropriate resources, including Medicaid, SSI, and Katie Beckett. The Family Health Information Line is a statewide resource for all families, including those with***

**CSHCN, and is staffed by bi-lingual information specialists. Culturally appropriate informational materials for families were distributed through HEALTH's centralized distribution center //2013//.**

The OSHCN provided Complete Care Notebook to families to track expenses and determine adequacy of insurance. The DCFHE distributed and evaluated the use of condition-specific resource guides which detail financing options for families raising CYSHCN. The DCFHE worked to ensure accurate information concerning federal health care reform reaches community providers and consumers.

The OSHCN worked with community partners, advocacy organizations and local providers to increase access to care and address barriers to enrollment. Specifically, the OSHCN contracts with the RI Family Voices Program to provide outreach and education concerning financing health care for children with special health care needs and their families. The Family Voices conducts workshops, presentations and information and referrals to thousands of parents and professionals on an annual basis.

DCFHE staff continued to participate in the Rlte Care Consumer Advisory Committee. This committee is convened monthly by /2013/ **OHHS and is charged with ensuring that Rlte Care families' needs are at the center of program decision-making.**

**DCFHE staff participated in several Health Care Reform Implementation Committees organized through the Lt. Governors' Office //2013//.**

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with the Health Insurance Commissioner to ensure that private health insurers fund necessary services.				X
2. Supported the PPEP, First Connections, and MIECHV Program, which link families with CSHCN to Medicaid, SSI, and Katie Beckett.		X		
3. Worked with the state's Medicaid Office to enhance the EPSDT benefit and availability of services.				X
4. Supported a Family Resource Specialist position in the Katie Beckett unit of OHHS to help respond to families' concerns and questions.	X			
5. Supported the toll-free Family Health Information Line and RIPIN Resource Center to link families with CYCHCN to health insurance options.			X	
6. Distributed and evaluated the Complete Care Notebook and other CYSHCN resource guides.		X		
7. Participated in health care reform implementation committees organized through the Lt. Governors' Office.				X
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

HEALTH working with the Health Insurance Commissioner to ensure the state's private insurance providers fund necessary services.

OSHCN is working collaboratively with the state's Medicaid office to enhance the EPSDT benefit and availability of services. OSHCN successfully worked with the Joint Commission for Educating Children with ASD to pass private insurance mandated coverage for the identification and treatment of children with an ASD.

***/2013/ PPEP, First Connections, and MCHB funded MIECHV programs screen and refer eligible families for Medicaid, SSI and Katie Beckett.***

***OSHCN works with community partners, advocacy organizations and local providers to increase access to care and address barriers to enrollment. OSHCN supports a Family Resource Specialist position in the Katie Beckett unit within the EOHHHS to assist the state in responding to families' concerns and questions //2013//.***

The Family Health Information Line and the RIPIN Resource Center links callers to health insurance options.

/2103/ OSHCN continues to distribute and evaluate the use of condition-specific resource guides, including the Complete Care Notebook, which detail financing options for families raising CYSHCN. It also works to ensure accurate information concerning federal health care reform reaches community providers and consumers.

DCFHE staff continue to participate in several Health Care Reform Implementation Committees organized through the Lt. Governors' Office //2013//.

### **c. Plan for the Coming Year**

#### **c. Plan for the Coming Year**

The DCFHE will continue to work to increase the percentage of CSHCN, ages 0-18, whose families have adequate private and/or public insurance to pay for the services they need.

***/2013/ The Department of Health will continue to work with the Office of the Health Insurance Commissioner to ensure the state's private insurance providers fund necessary services.***

***The OSHCN will continue to working collaboratively with the state's Medicaid office to enhance the EPSDT benefit and availability of services.***

***PPEP, First Connections, and MCHB funded MIECHV programs will continue to screen and refer eligible families for Medicaid, SSI and Katie Beckett.***

***The OSHCN will continue to work with community partners, advocacy organizations and local providers to increase access to care and address barriers to enrollment. The OSHCN will continue to support a Family Resource Specialist position in the Katie Beckett unit within the OHHS to assist the state in responding to families' concerns and questions.***

***The toll-free Family Health Information Line and the RIPIN Resource Center will continue to link callers to health insurance options.***

***The DCFHE will continue to distribute and evaluate the use of condition-specific resource guides, including the Complete Care Notebook, which detail financing options for families raising CYSHCN. The DCFHE will also continue to work to ensure accurate information concerning federal health care reform reaches community providers and consumers.***

***DCFHE staff will continue to participate in several Health Care Reform Implementation***

**Committees organized through the Lt. Governors' Office. DCFHE will continue to ensure that equity remains a priority in state health care reform discussions //2013//.**

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	80	87.6	87.6	87.6	88
Annual Indicator	87.6	87.6	87.6	87.6	71.2
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	71.2	71.2	71.2	75.2	75.2

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and

the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Data Discussion:

According to the 2005/2006 National Survey of CSHCN, 87.6% of families of CSHCN reported that services are organized in ways they can be easily used. While this represents an 11.2% increase from the 2001 figure of 78.8%, RI remains lower than the national average of 89.1%. Over the past several years, RI state government has undergone a consolidation and reorganization process and developed a few key points of entry into the system. More attention to informing families of these centralized resources is required for RI to improve on this measure.

**a. Last Year's Accomplishments**

Data Discussion:

***/2013/ According to the 2009/2010 National Survey of CSHCN, 71.2% of families of CSHCN can easily access community based services. RI's rate is higher than the national average of 65.1% //2013//.***

**a. Last Year's Accomplishments**

***Through consolidation of health and human service agencies, RI is addressing fragmented services and points of entry into social services, especially for CYSHCN and their families. /2013/ The OSHCN is committed to assisting families in navigating the special needs service delivery system as this was one of the goals of the PPEP, Family Voices contract, and the development of several resource guides //2013//.***

DCFHE continued to build PPEP, which assists families of CYSHCN in accessing medical and community services. Services were expanded to several new sites. PPEP Resource Specialists were instrumental in training the central points of entry within the EOHHS.

DCFHE continued its participation in the implementation and ongoing quality assurance activities for CEDARR, the state's care coordination system for CYSHCN and the implementation of the Global Medicaid Waiver. OSHCN staff contributed to program oversight and quality improvement through the CEDARR Interdepartmental Team.

OSHCN disseminated the Complete Care Notebook for Raising CYSHCN. The Notebook was developed in response to requests from families for a portable organizer to record and file their child's important health information. The Notebook also includes a community and state resource guide. The Notebook was distributed to families through the WIH NICU, Hasbro Children's Hospital Children's Neurodevelopment Center, and Early Intervention (EI) providers.

HEALTH took the lead in establishing a FLDI to develop a network of family leaders in RI to make a positive impact on schools, communities and in health care arenas. Through the FLDI, parents and caregivers throughout the system of care have access to systematic navigation of the state special needs programs of the DOH, ***/2013/ EOHHS //2013//***, RIDE, DCYF and BHDDH. The FLDI provides consistent training and support needed to provide peer assistance and effectively advocate for person / family centered care at the individual, local, systems and policy level. Parent education and workshop sessions are provided through the RIPIN, Parent Support Network and Sherlock Center for Disabilities. Through this collaboration, 35 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. There were 472 parents and professionals trained in navigating the special needs service delivery system such as basic rights, college success for students with disabilities, options for medical assistance, policy 101, transition planning, etc.

Parent support groups are organized throughout the state and HEALTH contracted with Family Voices to maintain a master calendar of support groups based on topic, age, and language. ***/2013/ Resource Specialists educate and empower families in the EI Program, PPEP, WIC,***

**Birth Defects, Immunization, Community Asthma, Distribution Center, Emergency Preparedness, TBI, and Health Information Center. RI's 2012 Parent Professional Conference was dedicated to understanding the Changing System of Care for CYSHCN and Their Families and had over 250 participants //2013.**

**/2013/ Successful Start worked to improve and coordinate the state's systems of early childhood services, with a special focus on systems serving CSHCN. Successful Start is an early childhood system building initiative with over 200 stakeholders, including leadership from state and community agencies. In 2003-2005 a strategic plan for early childhood system and services were developed, with the DCFHE facilitating the components of the plan since 2005. The five system components are medical homes, social and emotional health, early care and education, parent education, and family support. The Steering Committee worked to ensure that state agencies have consistent policies; funding streams are maximized and blended; gaps in services are identified; and families are able to access and receive needed services.**

**DCFHE and its Woonsocket CATCH partners developed a report and implemented strategies to improve adolescent medical homes, including establishing a satellite office of Thundermist Health Center at Woonsocket High School //2013//.**

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with OHHS on integration initiatives including a modernization initiative that streamlines the application process for Medicaid/public welfare services and supports.			X	
2. Worked with OHHS and other state partners to address fragmentation of services and points of entry into social services for CYSHCN.				X
3. Supported the PPEP to support parent/peer consultants in pediatric primary/specialty care practices to collect data on systems barriers and help families access resources.		X		
4. Contributed to CEDARR oversight and quality improvement through participation in the CEDARR Interdepartmental Team.				X
5. Linked parents of CYSHCN with training and support needed to provide peer assistance and advocate for person/family centered care.		X		
6. Provided families with resources to ease systems navigation including the Complete care Noebook and other resource guides.		X		
7. Maintained a master calendar of support groups through RI Family Voices.			X	
8. Supported Resource Specialists to educate and empower families.		X		
9. Supported Successful Start to improve and coordinate the state's system of early childhood services, with a focus on systems serving CSHCN.				X
10.				

**b. Current Activities**

b. Current Activities

RI is addressing the ease of navigating services for families of CYSHCN through integration

initiatives within DCFHE and OHHS including a Modernization Initiative that streamlines the application process for Medicaid / public welfare services and supports.

***/2013/The OSHCN continues to work with EOHHS and other state partners to address fragmentation of services and points of entry into social services for CSHCN.***

***OSHCN continues to support PPEP. Parent / peer consultants (in 35 pediatric primary /specialty care practices) collect data on system barriers and assist families in accessing resources.***

***OSHCN continues to contribute to CEDARR oversight and quality improvement through participation in the CEDARR Interdepartmental Team.***

***The FLDI continues to link parents of CYSHCN with consistent training and support needed to provide peer assistance and effectively advocate for person / family centered care at the individual, local, systems and policy level.***

***OSHCN continues provide families with resources to ease in system navigation including the Complete Care Notebook.***

***Family Voices continues to maintain a master calendar of support groups.***

***Resource Specialists continue to educate and empower families in several programs.***

***Successful Start continues to work to improve and coordinate the state's systems of early childhood services.***

***/2013/ DCFHE continues to work with its Woonsocket and Washinton County CATCH partners on adolescent medical homes //2013//.***

### **c. Plan for the Coming Year**

#### **c. Plans for Coming Year**

***/2013/OSHCN will continue to work with EOHHS and other state partners to address fragmentation of services and points of entry into social services for CSHCN.***

***OSHCN will continue to support PPEP.***

***OSHCN will continue to contribute to CEDARR oversight and quality improvement through participation in the CEDARR Interdepartmental Team.***

***The FLDI will continue to link parents of CYSHCN with consistent training and support needed to provide peer assistance and effectively advocate for person / family centered care.***

***OSHCN will continue provide families with resources to ease in system navigation, including the Complete Care Notebook.***

***Family Voices will continue to maintain a master calendar of support groups.***

***Resource Specialists will continue to educate and empower families in several programs.***

***Successful Start will continue to work to improve and coordinate the state's systems of***

*early childhood services, with a special focus on systems serving CSHCN.*

*//2013/ DCFHE will continue to work with Woonsocket and Washington County CATCH partners to provide TA and tools on adolescent medical homes and identify 2 more communities to pilot the adolescent medical home model //2013//.*

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	6.4	37.6	37.6	37.6	38.4
Annual Indicator	37.6	37.6	37.6	37.6	43.7
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	43.7	43.7	43.7	46.5	46.5

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006

CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

#### **Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

#### Data Discussion:

According to the NS-CSHCN, youth with SHCN who received the services necessary to make appropriate transitions to adult health care, work and independence was 37.6% in 2005/2006. RI's percentage remains lower than the national average of 41.2%. Increasing the successful transition from pediatric to adult healthcare has been identified by the DCFHE as a primary objective.

#### **a. Last Year's Accomplishments**

##### Data Discussion:

***/2013/ According to the NS-CSHCN, youth with SHCN who received the services necessary to make appropriate transitions to adult health care, work and independence was 43.7% in 2009/2010. RI's percentage increased from 2005/2006 data and, for the first time, it has surpassed the national average. Increasing the successful transition from pediatric to adult healthcare has been identified by the DCFHE as a primary objective //2013//.***

##### a. Last Year's Accomplishments

DCFHE developed a strategic plan to address all transitions from pediatric to adult health care by strengthening efforts on adolescent medical home. OSHCN, in collaboration with the RI-American Academy of Pediatrics (AAP), developed and administered a survey to all licensed practicing primary care pediatricians to further understand the health care transition process from the perspective of physicians. The findings of the survey were analyzed to develop outreach, training, and education strategies for youth, families, and health care professionals.

PPEP sites have been working on identifying youth with special health care needs (YSHCN) in need of transition support. OSHCN made presentations of the adolescent healthcare transition toolkit to physician, family, advocacy, legislative, and education groups. The OSHCN developed and disseminated a youth / parent self-assessment series entitled "Ready? Set... Go!" used to encourage independence, personal responsibility, principles of self-determination, and adolescent development.

DCFHE worked with the adult and pediatric rehabilitation units at RI Hospital to facilitate a seamless transition to adult rehabilitative care. OSHCN partnered with the Adolescent Leadership Council, the MedPeds Clinic at RIH and the Hasbro Children's Hospital on a Transition Clinic that served 45 youth with complex special needs in need of specific transition medical consultation. The clinic provided youth with a transition plan, medical summary for youth / family and referring provider / group, preliminary contacts with adult care specialists, Emergency Health Record, and resources. DCFHE sponsored an interactive session at the 2010 Parent / Professional Partnership meeting with national and local transition specialists on transition issues.

***/2013/OSHCN worked closely with EOHHS in the implementation and evaluation of the CEDARR Initiative and the transitioning of CSHCN from fee-for-service Medicaid to Medicaid managed care. In 2011, OSHCN provide TA to the EOHHS on enhancing CEDARR's role in the transition of youth with special health care needs from pediatric to adult services and supports //2013//.*** OSHCN ensured that YSHCN in Medicaid Managed Care

were provided assistance in transitioning from pediatric to adult medicine.

DCFHE continued to participate on the RI Transition Council comprised of state departments, special educators, and family members that provides technical assistance to the state's regional transition centers and monitors the transition system. ***/2013/ OSHCN participated in the National Secondary Transition Technical Assistance Center's (NSTTAC) State Planning Session as a part of RI's State Team. The Team wrote transition goals concerning student leadership development and incorporating Dare to Dream initiative activities.***

***In May of 2009, OSHCN and the Council sponsored a statewide initiative and the first youth with disabilities or special health care needs leadership conference entitled Dare to Dream. The goal of the conference was to provide a forum for high school students with disabilities or special health care needs to begin to explore transition from school to adult life and develop self-determination and self-advocacy skills. Held on a college campus, the conference days' event included a plenary session where a selected adult motivational speaker with a disability shares their life experience as a motivation to encourage students to set goals for their own future.***

***Dare to Dream has evolved to not only include an annual youth conference but also ongoing leadership development opportunities, youth development materials, and through the initiative proposed here, to a mentoring program //2013//.***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminated an adolescent healthcare toolkit to providers, families, and youth through PPEP and other venues.		X		
2. Disseminated the Youth Transition Workbook to help youth better understand their disability in relation to life goals.		X		
3. Supported the TALC and Transition Clinic at RI Hospital for youth with complex SHCN in need of medical transportation services.	X			
4. Worked with RIAAP and Hasbro Children's Hospital to define EPSDT requirements for transition planning.			X	
5. Supported the Dare to Dream Student Leadership Initiative, including a youth conference and leadership development.		X		
6. Employed and train 10 youth with disabilities as Youth Head coaches.		X		
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

OSHCN is addressing adolescent transition through strengthening the medical home for all adolescents. OSHCN continues to disseminate adolescent healthcare toolkit to providers, families and youth including the self-determination checklists, physician checklist, and youth leadership opportunities directory. PPEP sites are implementing the adolescent healthcare toolkit and the Physician Checklist.

OSHCN developed the RI Youth Transition Workbook to introduce the concepts of transition by using activities to help youth better understand their disability in relation to life goals and

determine the steps to take in community membership.

OSHCN continues to support the TALC and Transition Clinic at RI Hospital for youth with complex special health care needs in need of medical transition support.

OSHCN is working with the RI AAP and the Hasbro Children's Hospital on defining the EPSDT requirement for transition planning. To date, transition principles, transition products, and procedure codes have been identified.

OSHCN continues the Dare to Dream Student Leadership Initiative including an annual youth conference and ongoing leadership development opportunities. ***//2013/ The 2012 Dare to Dream Conference was attended by 743 youth. OSHCN and RIPIN received a job training grant to employ/train 10 youth with disabilities as Youth Health Coaches. The youth (ages of 16 through 24) will be trained as workshop leaders of the Healthy Lifestyles curriculum //2013//.***

**c. Plan for the Coming Year**

Plan for the Coming Year

The DCFHE will continue to prioritize the transitioning from pediatric to adult health care, work, and independence.

OSHCN plans to partner with the Transition Council, PPEP, and TALC addressing and sponsoring activities concerning the health and wellness of young adults with disabilities and chronic conditions. The educational component of the health and wellness activities will explore responsibility, decision-making, healthy lifestyles, and reducing secondary conditions to be incorporated in the Directory of Youth Leadership Development Opportunities.

OSHCN will continue to make the adolescent healthcare toolkit available to youth, parents and physicians and provide technical assistance as indicated. OSHCN will continue to participate on the Rhodes To Independence, Youth In Transition Subcommittee, the RI Transition Council and the Adolescent Leadership Council. OSHCN plans to expand the scope and reach of the Dare to Dream Student Leadership Initiative by providing technical assistance to schools and community youth groups in developing a youth leadership organization / club. ***//2013/OSHCN will continue to grow the use of Youth Health Coaches //2013//.***

OSHCN will continue to work to include OSHA standards in worksites and collaborate with the RI Department of Labor and Training on rights for teen workers.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	80.5	84.5	80.9	84.9	68.5
Annual Indicator	80.0	79.5	70.0	75.3	81.9
Numerator	10152	9834	8660	9059	9350
Denominator	12690	12370	12371	12031	11416
Data Source		National	National	National	National

		Immunization Survey	Immunization Survey	Immunization Survey	Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	82.5	82.5	85.7	85.7	85.7

#### Notes - 2011

Although data for 2011 is provisional, there is an increase in immunization rate from 2010.

#### Notes - 2010

2010 Data: HRSA recommended states to use the coverage rate for the 4:3:1:3:3 series for NPM #7 (for Rhode Island = 76.3%). However, Rhode Island decided to report the coverage rate of the 4:3:1:3:3:1 series to be consistent with previous years.

Denominator is estimated based on number of resident births that occurred two years prior [2008 births].

#### Notes - 2009

Starting with 2009, the National Immunization Survey [NIS] no longer reports on the 4:3:1:3:3 series.

Rhode Island's coverage rate for the 4:3:1:3:3:1 series was enormously impacted by the HIB shortage, which started in December 2007. Therefore the 2009 data reported are from National Immunization Survey's 4:3:1:3:3:1. The Varicella vaccine was added to the complete series. The coverage rate meets the Healthy People 2010 target for the PM at 80%.

Denominator is estimated based on number of resident births that occurred two years prior.

#### a. Last Year's Accomplishments

Data Discussion

***//2013/ Historically, Rhode Island's coverage rates have been among the nation's highest. In 2010, the National Immunization Survey estimated coverage rates in RI were greater than 90% for most vaccines, surpassing Healthy People 2020 goals. However, recent data reveal a disturbing trend in the second year of life. For the sixth consecutive year, Rhode Island's fourth dose of DTaP coverage rate remained below 90% (this rate changed from 94.7% in 2004 to 82.3% in 2009 to 85.8% in 2010). Coverage rates for the combination 4:3:1:3:3:1:4 series (68.9%) were below the national average (70.2%) in 2010. This trend can be attributed to the level of timely completion of the fourth dose of DTaP vaccine in the second year of life //2013//.***

a. Last Year's Accomplishments

DCFHE continued to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and the public. DCFHE focused its improvement rates on populations new to the country and state through its support of the St. Joseph's Free Immunization Clinic that serves mostly uninsured and immigrant children. DCFHE continued to offer injectable and intranasal influenza vaccine for children ages six months through 18 years and conducted a statewide school-based influenza vaccination program for students in grades K-12. RI's influenza vaccination coverage rates for the 2010-2011-flu season ranked highest in the U.S. at 75%, compared to 44% nationally.

DCFHE continued its assessment of immunization rates of children receiving care through home childcare providers. Evening trainings were held in the Fall to update childcare providers on immunization requirements and offered help in filling out the immunization survey, as well as informed and educated providers about vaccine --preventable diseases. DCFHE maintained its partnership with DCYF and offers incentive credit for all licensed providers that attend the trainings.

DCFHE utilized the Newborn Developmental Risk Assessment Screening to capture maternal Hepatitis B information and newborn Hepatitis B vaccination and treatment information, which is stored in KIDSNET. Infants born to Hepatitis B positive mothers were referred to the Perinatal Hepatitis B Program for case management, to ensure completion of the Hepatitis B vaccination series.

The Newborn Developmental Risk Assessment Screening Program and KIDSNET continued to capture and store maternal Hepatitis B information. KIDSNET released a guide for HL7 immunization transactions to submit electronic immunization data to KIDSNET in standard format. The HL7 data exchange was successfully tested with one community health center and one electronic medical record.

The WIC Program assessed the immunization status of children receiving WIC services based on DTaP at certification appointments. Referrals, by a nutritionist to the provider, are made for those clients who appear not up to date. The Child Care Support Network continued to provide immunization informational materials to families accessing center and home-based child care services.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided all recommended vaccines for all children in RI, including influenza vaccine during influenza season, for all children ages 6 months through 18 years.			X	
2. Provided free immunizations to uninsured and newly immigrated children.	X			
3. Revised and distributed culturally and linguistically appropriate immunization materials to families, health care providers, child care providers, and schools.			X	
4. Updated the Immunization Program website to include specific sections for health care professionals, child care providers, school personnel, and culturally diverse families.			X	
5. Hosted a biennial conference for school nurse teacher to provide up-to-date information on a variety of health topics, including immunizations.		X		
6. Used KIDSNET to track children's immunization status.				X
7. Provided TA, consultation, and resource materials to child			X	

care providers to ensure that children in child care are up-to-date on their immunizations.				
8. Provided Tdap vaccine to birthing hospitals to vaccinate post-partum women prior to discharge.	X			
9. Continued to enroll new pediatric and other providers of services to children and families in KIDSNET.			X	
10.				

**b. Current Activities**

b. Current Activities

/2013/ Vaccination coverage for the 4:3:1:3:3 series (4 DTaP, 3 Polio, 3 Hib, and 3 HepB) among children 19-35 months of age is 76.3% + 6.9%, according to the 2010 National Immunization Survey // 2103//. DCFHE provides all ACIP recommended vaccines to providers, free immunizations to uninsured children, and education materials to providers / public. Vaccine is delivered directly to provider offices.

KIDSNET tracks the immunization status of children who receive state supplied vaccine. Providers may generate reports on their patients' immunization status and exchange information with managed care organizations.

The Child Care Support Network offers health consultation to childcare centers/ family childcare homes. Nurses review child health records (including immunization status), provide staff training and preventative health/safety TA, distribute educational materials, and refer families to community services and resources. EI sites are being connected to KIDSNET. WIC sites view KIDSNET to access children's immunization status. KIDSNET captures newborn developmental risk screening and stores maternal Hepatitis B information.

The Chronic Care and Disease Management programs, in its quality improvement work through the RI Chronic Care Collaborative, has pneumonia and flu vaccine for children and adults as a quality measure and through media campaigns, targets people with chronic disease to obtain flu and pneumonia vaccine.

**c. Plan for the Coming Year**

c. Plan for the Coming Year

DCFHE will continue to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and to the public. DCFHE will continue to offer both injectable and intranasal influenza vaccine for children ages six months through 18 years.

DCFHE continues to provide technical assistance and training for all Vaccine for Children-certified providers. DCFHE will distribute patient and provider educational and resource materials and host its biennial school nurse teacher conference and Provider Breakfast.

DCFHE plans to visit childcare centers in every community across the state to assess child immunization rates.

KIDSNET will continue to track the immunization status of all children who receive state supplied vaccine. Messages about the importance of immunizations will be included in KIDSNET-generated cards mailed to families of newborns.

KIDSNET will continue to update the immunization algorithm and data quality reports so that all reports and displayed data reflect current guidelines. Reports regarding invalid doses will be moved to the web for easy accessibility to immunization providers.

KIDSNET will monitor the use of the immunization report that pediatric providers generate, and will continue to share the use of such reports in a monthly newsletter, at quarterly stakeholder meetings and as a performance measure. KIDSNET will continue to work with managed care plans to exchange immunization information for health plan performance (HEDIS) reporting and allow health plans direct access to the KIDSNET system.

The Newborn Developmental Risk Assessment and Screening Program and KIDSNET will continue to capture and store maternal and newborn Hepatitis B information. The Perinatal Hepatitis B Program will continue to provide follow-up and case management for all Hepatitis B positive women and their infants.

The Perinatal Hepatitis B Program will work with Vital Records to identify home births and assess the HBsAg status of the mother. Hepatitis B positive women who deliver at home will be referred to the Perinatal Hepatitis B Program for case management, to assure completion of the baby's Hepatitis B vaccination series.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	19.3	18.3	18	17.3	13.7
Annual Indicator	18.0	17.4	17.7	13.7	12.0
Numerator	386	364	366	284	249
Denominator	21390	20885	20688	20688	20688
Data Source		Vital Records Birth File			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	11.8	11.5	11.6	11.6	11.2

**Notes - 2011**

Provisional data for 2011 continues to show a decline in birth rates for teens 15 to 17 from 13.7 per 1,000 in 2010 to 12.0 per 1,000 in 2011. Data reflects calendar year and 2010 Census data used for denominator

**Notes - 2010**

Data for 2010 shows a decline in birth rates for teens 15 to 17 from 17.7 per 1,000 in 2009 to 13.7 per 1,000 in 2010. Data reflects calendar year and 2010 Census data used for denominator

## Notes - 2009

2009 - Data reflects calendar year. Census 2010 data used for denominator.

### a. Last Year's Accomplishments

#### Data Discussion

Teen pregnancy is a statewide problem in Rhode Island. Although there is more disparity in the core cities, every community is affected by teen pregnancy. ***/2013/ In 2011, the rate of birth for teenagers aged 15 through 17 years in RI was 12.0 per 1,000 //2013//***. Locally and nationally, Hispanic girls have the highest rates of teen pregnancy. Rhode Island teen birth rates are highest in New England and have dropped at the slowest rate in New England. The City of Providence has the third highest rate of second births among 18-19 year olds in cities with less than 100,000 population. DCFHE's goal for adolescents is to ensure that all graduate from high school healthy and ready to be productive citizens. Reducing Rhode Island's teen pregnancy rate is an important outcome to achieve that goal. DCFHE will utilize community activations strategies to enable local capacity development to support adolescent health.

#### a. Last Year's Accomplishments

The DCFHE is committed to reducing teen birth rates and other risk behaviors through a three-pronged approach: 1) access to health care services, within the context of an adolescent medical home including family planning, 2) youth development programming that prepares adults and institutions to meet the developmental needs of youth, and engages youth in building skills, attitudes, knowledge and experience that prepare them for the present and future, and 3) ***/2013/ school and community-based activation strategies to support adolescent health. Current efforts are also framed around Medicaid expansion, insurance reimbursement, and patient centered medical homes as part of health care reform //2013//***.

DCFHE received USDHHS Personal Responsibility Education Program (PREP) funds to implement evidence-based teen pregnancy prevention curriculum. The DCFHE selected Wyman Center's Teen Outreach Program, a youth development program with demonstrated results in preventing teen pregnancy and supporting positive academic and health behaviors. The DCFHE designed two competitive processes to identify local implementation partners and one statewide professional development partner.

***/2013/ The DCFHE hosted the unveiling of the RI Alliance for Teen Pregnancy Prevention statewide strategic plan.***

***DCFHE continued to provide technical assistance to Woonsocket and Washington County CATCH partners on the development of adolescent medical homes, pediatric behavioral health services, and prenatal care for hard-to-reach populations //2013//***.

DCFHE's Vaccinate Before You Graduate was offered in every Rhode Island high school. Students are able to receive vaccine, including HPV, at school with parental permission. This effort provides a strong foundation for adolescent health statewide.

The DCFHE supported Title X family planning clinics to provide reproductive health services to teens. ***/2013/ Family Planning Program provided no cost pregnancy testing and preconception counseling to teens in Title X clinics; those with a negative pregnancy test were provided with family planning services; those with a positive test were referred to the Adolescent Self-Sufficiency Program //2013//***. Teens with identified health risks (i.e. smoking, nutrition, mental health services, intimate partner violence, etc.) were referred to appropriate follow-up services.

***/2013/ The DCFHE engaged community partners and began development of a preconception health strategic plan to enhance the health of all Rhode Islanders and to maximize healthy pregnancies and pregnancy outcomes.***

**The RI Task Force on Premature Births began first year implementation of revised recommendations to address the mission of improving the health of children in Rhode Island by reducing the rate of premature birth. The Task Force's workgroups address recommendations directed at meeting the state's standards to identify strategies to reduce teen pregnancy, support state policies and programs that ensure access to comprehensive primary and preventive health care services for women, expand the range of services in all settings where women receive health care to include improved identification of health risks, health information, and referrals for health risks associated with preterm birth, and enhance comprehensive, relationship family support programs to improve outcomes for women and their children and prevent subsequent teen pregnancy //2013//.**

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported Title X family planning services including pregnancy testing for teens.	X			
2. Supported a statewide preconception health plan.				X
3. Staffed and participated across multiple work groups of the Task force on Premature Births.			X	
4. Participated in the Alliance for Teen Pregnancy Prevention strategic plan efforts.			X	
5. Planned for the implementation of the evidence-based Teen Outreach Program approach to teen pregnancy prevention in 7 communities.	X			
6. Participated in the conference for youth providers titled Game On: Supporting the Sexual Health Needs of RI Adolescents.			X	
7. Supported the First Connections and MIECHV home visiting programs to refer teens in need of family planning services to such services.	X			
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

Family planning services including pregnancy testing continue to be provided to teens. **//2013/ DCFHE, in conjunction with external partners, is finalizing a statewide preconception health plan to systematically address preconception health through implementation of health care practices and promotion, comprehensive health policies, and public health initiatives. Provider education and increased access to confidential care for adolescents are two strategy areas in the plan.**

**DCFHE continues to participate across multiple work groups of the RI Task Force on Premature Births. The RI Task Force on Premature Birth convened a steering committee implement its strategic plan recommendations.**

**DCFHE continues to participate in the RI Alliance for Teen Pregnancy Prevention strategic plan efforts.**

**DCFHE is establishing contracts with nine local community partners to implement the evidence-based Teen Outreach Program in 7 RI communities. A statewide plan for PREP**

**funding was approved to implement the Teen Outreach Program, an evidence-based approach to teen pregnancy prevention in communities.**

**DCFHE staff participated in an upcoming conference for youth providers titled: Game On: Supporting the Sexual Health Needs of RI Adolescents.**

**DCFHE continues to provide TA to Washington County and Woonsocket CATCH partners.**

**DCFHE supports the First Connections and MIECHV home visiting programs to refer teen mothers in need of family planning and other support services //2013//.**

**c. Plan for the Coming Year**

c. Plan for the Coming Year

**//2013/ DCFHE will continue to provide teens with access to family planning services, pregnancy testing, and preconception counseling. DCFHE will begin implementation of the preconception health strategic plan to assure that youth and young adults seeking pregnancy tests receive referrals to risk prevention services and family planning as appropriate //2013//.**

The Task Force on Premature Birth will continue to work on implementing its recommendations. Specifically, the Task Force will address teen pregnancy reduction through collaborative efforts with RIDE and recommend expanding the use of evidence-based teen pregnancy prevention models in schools and in the community.

**//2013/ DCFHE will provide training in Teen Outreach Program to nine community partners to enable the implementation of this evidence-based program //2013//.**

DFCHE will develop opportunities to work with communities on adolescent health issues, developing assets and reducing health risks. DFCHE will seek new opportunities to engage youth in action research in a variety of health risk areas.

DCFHE will continue to track births to teens and examine trends by demographic factors.

**//2013/ DCFHE will continue to support the First Connections and MIECHV home visiting programs to, among other things, refer teen mothers in need of family planning and other support services.**

**DCFHE will continue to provide TA to its CATCH partners //2013//.**

**Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.**

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	34.3	36.3	36.9	39.5	41.1
Annual Indicator	36.3	38.6	38.6	40.1	39.1
Numerator	4625	4625	4625	1335	4088
Denominator	12740	11987	11987	3332	10456
Data Source		Oral Health	Oral Health	Oral Health	Oral Health Program

		Program	Program	Program	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	42.1	43.2	45	45	45

**Notes - 2011**

\*39.1% is Weighted data: adjusted to reflect the probability of sampling and response rate in the survey.

During the 2010-11 school year, the Rhode Island Department of Health Oral Health Program conducted a statewide oral health screening survey of third graders. Screenings were completed at 79 randomly-selected elementary schools with 68 percent of enrolled third grade students in participating schools screened. In total, about a third of Rhode Island's third grade children (3,266 of 10,709 children) were screened. To read more details about the survey methodology and outcomes, please see "The Oral Health of Rhode Island's Children 2012" at: <http://www.health.state.ri.us/publications/reports/2012OralHealthOfRhodeIslandChildren.pdf>

**Notes - 2010**

During the 2010-2011 school year, the Rhode Island Department of Health Oral Health Program conducted a statewide oral health screening survey of third graders. Screenings of 3,332 students were completed at 81 randomly selected elementary schools. The reporting figures are not population estimates, which means the raw data are not yet adjusted to account for the survey sampling design and school/student participation rates.

**Notes - 2009**

2009 data are estimated. Denominator from 2008 Population Estimate.

The Basic Screening Survey (BSS) was conducted in the fall of 2007. The BSS was funded by the CDC and conducted in 35 States.

In Rhode Island, 31 public elementary schools were randomly selected and 66 percent of the enrolled 3rd grade students were screened. The actual number of 3rd graders screened was 1303.

The Oral Health Program is working with the RI Department of Education (RIDE) and the RI Oral Health Commission to standardize screening forms utilized by school dentists. RIDE will be revising their Rules & Regulations Pertaining to School Health Programs, and the Oral Health Program is working with school dentists to include presence of sealants in the Rules & Regulations. Once included, we will be developing a standardized form based on the required screening conditions, as outlined in the Rules & Regulation, and will recommend that all school dentists utilize the form and return it to the Oral Health Program for input and analysis. It is anticipated that, once established, this procedure will provide the Oral Health Program with data to support more accurate tracking of the Title V National Performance Measure related to placement of dental sealants in RI children.

Additionally, to support RI's ability to increase the number of children receiving dental sealants, the 2010 Title V budget application will include funding for school-based dental programs to increase the number of children receiving services, including dental sealants.

**a. Last Year's Accomplishments**

Data Discussion

The 2010-2011 RI third grade oral health basic screening survey revealed that 39.1% of third graders living in Rhode Island's core cities had dental sealants on at least one molar tooth (although these data are not population estimates, which means the raw data are not yet adjusted to account for the survey sampling design and school/student participation rates). These results indicate that RI has met the annual performance objective; however RI needs to continue to promote delivery systems and use of dental sealants as an important preventive measure among medical and dental practitioners. Annual MCH Title V reports require annual data collection to measure RI's performance. Institution of the proposed project to expand the dental sealant program will assure collection of this data on schedule.

a. Last Year's Accomplishments

***/2013/ The DCFHE continued to work with numerous state agencies and community partners to improve children's access to oral health services and prevent dental caries in children //2013//.***

Parents of young children receiving home visiting services through the First Connections Home Visiting Program continued to receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care.

***/2013/ Families receiving WIC services were provided with information about early childhood caries. All local WIC staff were offered technical training on oral health topics. Education materials addressing oral health issues were developed by the WIC Program in conjunction with HEALTH's Oral Health Program and they are currently used during counseling during WIC certification appointments. Through this grant, HEALTH promotes "common sense" oral health practices for young children by teaching parents and Head Start providers about early childhood tooth decay prevention. The "common sense" practices include drinking fluoridated water, daily brushing with fluoridated toothpaste, proper use of bottles and sippy cups, healthy nutrition, and annual visits to a dentist, starting at age one.***

***The DCFHE continued to participate on and hold positions of leadership on the Rhode Island Oral Health Commission, a statewide coalition of public, private, and not-for-profit stakeholders working to improve the oral health of all Rhode Island residents, including school-age children, and CSHCN. Additionally HEALTH and the Commission are working to increase access to primary and preventive dental services for children and families covered by Medicaid and underserved Rhode Islanders.***

***The Center for Health Data and Analysis (CHDA) continued to survey mothers of two year-olds via the Toddler Wellness Overview Survey (TWOS), which includes questions related to oral health. In collaboration with CHDA, the Oral Health Program analyzed and published PRAMS data on oral health and pregnancy. The Oral Health Program coauthored a paper on early childhood preventive dental visits in Medicaid in collaboration with the RIDHS //2013//.***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the First Connections and MIECHV home visiting programs and WIC to provide culturally competent information to families about early childhood caries/prevention.	X			
2. Supported the Child Care Support Network to provide oral health consultation to child care centers conducting child health record reviews.				X

3. Supported school-based dental/sealant programs.	X			
4. Collaborated with school-based health centers to refer teens to oral health services.		X		
5. Supported the annual Oral Health Summit.			X	
6. Supported the implementation of the Oral Health Plan for RI.				X
7. Supported interdisciplinary oral health education specifically targeting pediatric health care providers and the Oral Health Commission's plans to implement an oral health literacy campaign targeting young children.			X	
8. Supported the Mission of Mercy initiative which provides free dental care to uninsured, low-income residents.	X			
9. Supported the collection and analysis of TWOS, PRAMS, BRFSS, and Medicaid oral health data.			X	
10.				

**b. Current Activities**

b. Current Activities

***/2013/ First Connections, MIECHV, and WIC provide culturally appropriate information about early childhood caries/prevention //2013//.*** The Child Care Support Network's Child Care Health Consultants offer health consultation to child care centers.

/ 2013/ Title V funds have allowed expansion and sustainability of existing school-based dental/sealant programs. Through this funding, an additional 17 high risk schools have been served by the sealant program. Three school-based health centers refer adolescents to oral health services as necessary.

DCFHE, in collaboration with the Oral Health Commission, hosts annual state Oral Health Summits. In FY2011, the Oral Health Plan for 2010-2016 was released and widely disseminated to policy makers and oral health stakeholders statewide.

the Oral Health Program (OHP) is working with partners on interdisciplinary oral health education, specifically targeting primary pediatric health care providers. In addition, OHP is partnering with the Oral Health Commission on an oral health literacy campaign targeting early childhood caries awareness and prevention for high risk populations.

The OHP and HEALTH's Center for Public Health Communications participated in the inaugural Mission of Mercy initiative, which provided free dental care to uninsured, low-income Rhode Islanders.

TWOS, BFFSS, & PRAMS data continue to be collected and analyzed //2013//.

**c. Plan for the Coming Year**

c. Plan for the Coming Year

***/2013/ DCFHE will continue to work to prevent dental caries and increase children's access to oral health services by integrating education into DCFHE programs and by working with other internal and external partners to strengthen the state's dental services infrastructure.***

***Parents of young children who receive home visiting services through the First Connections and MIECHV home visiting programs will continue to receive culturally and linguistically appropriate information and education about early childhood caries and the***

**importance of preventive dental care.**

**Families receiving WIC services will continue to be provided with culturally and linguistically appropriate information about early childhood caries and the importance of preventive dental care and their first dental visit by age one.**

**School-based health centers and school-based sealant programs will continue to provide dental services to children and youth //2013//.**

The Child Care Support Network will continue to offer health consultation to child care centers and family child care homes throughout the state. Oral/dental health will be included in the range of physical and developmental health issues that the health consultants will address.

**/2013/ The OHP will continue to monitor progress made on goals and objectives outlined in the Oral Health Plan. The OHP will continue to integrate oral health into all general health materials (intake forms, questionnaires, educational materials, etc.) utilized by CSHCN counselors through the Support to States for Oral Health Workforce Activities. OHP will continue collaboration with internal and external partners on interdisciplinary oral health education, oral health literacy, and access to oral health services across the lifespan.**

**CHDA will continue to conduct the TWOS survey and analyze responses to the oral health questions and the Oral Health Program will continue to analyze data sources, including, but not limited to, BRFS, PRAMS, YRBS, Hospital Discharge data, and Medicaid //2013//.**

**Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.**

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	1.5	1.5	1.5	1	1
Annual Indicator					
Numerator					
Denominator	181152	173303	170753	170753	170753
Data Source		Vital Records Death File			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	2.1	1	1	1	1

**Notes - 2011**

Data for 2011 reflect children aged 1 -14.  
Denominator is from the 2010 Census.

Issue: Rhode Island has not been able to report on PM 10 due to the number of events. There are fewer than 5 events over the last year and the average of the last 3 years is also fewer than 5.

**Notes - 2010**

Data for 2010 reflect children aged 1 -14.  
Denominator is from the 2010 Census.

Issue: Rhode Island has not been able to report on PM 10 due to the number of events. There are fewer than 5 events over the last year and the average of the last 3 years is also fewer than 5.

**Notes - 2009**

Data for 2009 reflect children aged 1 -14.  
Denominator is from the 2010 Census.

Issue: Rhode Island has not been able to report on PM 10 due to the number of events. There are fewer than 5 events over the last year and the average of the last 3 years is also fewer than 5.

**a. Last Year's Accomplishments**

Data Discussion

*/2013/ According to data from the Rhode Island Vital Records data base, there were no deaths of children ages 14 and younger from motor vehicle accidents in Rhode Island in 2009. This figure represents a decline from the 2007 figure of 3 deaths among this age group from motor vehicle accidents and continues to be lower than the national death rate. According to data from the Centers for Disease Control and Prevention, National Centers for Injury Prevention & Control Web-Based Injury Statistics Query and Reporting System (WISQARS™), nationally, the death rate for children ages 14 and younger from motor vehicle accidents decreased from 3.71 per 100,000 in 2001 to 2.80 per 100,000 in 2007; while the Rhode Island death rate has decreased during this time period from 1.93 to 1.59 //2013//.*

a. Last Year's Accomplishments

The number of deaths to children ages 14 years and younger caused by motor vehicle crashes in Rhode Island is very small. First Connections continued to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low-income families receiving home visits were referred to the RI Safe Kids Coalition, which provides free car seats to low-income families.

Healthy Child Care Rhode Island, through the Child Care Support Network, continued to provide informational materials to families with children in child care and child care providers on the proper use of car seats, air bag safety, and the safest location in the car for children.

Deaths to children caused by motor vehicle crashes where the driver was impaired due to alcohol and/or drug intoxication is a public health concern in Rhode Island as well as the rest of the

country. **/2013/ In Rhode Island 40% of all motor vehicle fatalities are alcohol related (FARS, 2009) //2013//**. RI Governor Lincoln Chafee signed a primary seat belt law on June 30, 2011. This law allows police officers to ticket a driver solely on the basis that the driver is not wearing a seatbelt and makes enforcement of the law that covers children up to 18 years of age more likely.

Recommendations made by the RI Task Force on Premature Births included encouraging development of additional substance abuse treatment programs where women are not separated from their children and where parental relationships for women in treatment are preserved.

DCFHE staff continued to participate on the Child Death Review Team, a multidisciplinary team led by the State Medical Examiner's Office that reviews childhood deaths to identify risk factors and trends, and to inform prevention efforts. In Rhode Island, all deaths under 18 years of age regardless of cause must be reported to the Medical Examiner's Office. The team is committed to the systematic, multidisciplinary review of these deaths. Encourage community-based partners, legislators, and public policymakers to take action to prevent other deaths and improve the safety and wellbeing of all children. The ultimate goal of the team is to reduce the number of child deaths in the state.

DFCHE and CHDA participated with RIDE on the development of a new school based survey for students, teachers and parents.

***/2013/ The DCFHE worked with the Injury Prevention Center at RI Hospital (the host agency of RI Safe Kids) to prevent accidental childhood injury. Free bike helmets are distributed to any child seen in the ER due to a bike, roller blade, skateboard, snow sport, or scooter injury. Children seen in Hasbro Children's Hospital and the Children's Neurologia Center are screened by nurses regarding helmet use. Children who do not have a helmet are provided with one. RI Hospital's Kohl's Cares for Kids Car/Booster Seat Program provides education on car/booster seat safety and car/booster seat inspections. Families may receive a car/booster seat free of charge. Reducing Youthful Dangerous Driving is an educational program provided to court-referred youth ages 16-20 years old. Youth are required to complete workshops and volunteer at RI Hospital or in the community. The Safe Playground and Sportsfield Project provides resources to make these sites safe. The Safety Store initiative provides families with CYSHCN with injury prevention education and appropriate safety equipment //2013//.***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported First Connections and MIECHV home visiting programs to provide pregnant women and families with young children with information about car safety and make referrals to the RI Safe Kids Coalition as needed.	X			
2. Supported First Connections and MIECHV home visiting programs to assess pregnant women and families with young children for alcohol and drug abuse and to make referrals for evaluation and treatment as needed.	X			
3. Supported the Child Care Support Network child care health consultants to provide informational materials about care safety to child care providers and families with children in child care.		X		
4. Supported the Family Planning Program to refer women with risks related to alcohol and drug abuse for evaluation and treatment.	X			
5. Supported the Preconception Health Strategic Plan, which				X

includes alcohol and drug abuse a key health indicators to be routinely screened as part of preconception care.				
6. Supported the work of the Task Force on Premature Births to develop a collaborative strategy with DCYF to identify pregnant women who misuse substances and maintain intact families.				X
7. Tracked children's deaths caused by motor vehicles and examined trends by demographic factors.			X	
8. Participated on the Child Death Review Team led by the State Medical Examiner.			X	
9. Worked with Injury Prevention Center at RI Hospital (the host agency of RI Safe Kids) to prevent accidental childhood injury.			X	
10.				

**b. Current Activities**

b. Current Activities

***/2013/ First Connections and MIECHV programs provide families with young children information regarding car safety //2013//. Referrals are made to the RI Safe Kids Coalition as necessary. /2013/ These programs also assess families for substance abuse. Women identified to be at risk for substance abuse are referred to assessment and treatment programs as appropriate //2013//.***

The Child Care Support Network provides informational materials regarding overall injury prevention to child care providers and families. Health consultants in child care centers provide information and technical assistance on a variety of child health and safety topics, including automobile safety.

***/2013/ The Family Planning Program continues to refer women with risks related to substance abuse for appropriate evaluation and/or treatment services.***

***The DCFHE preconception health strategic plan includes substance abuse screening as key health indicators to be routinely screened as part of preconception care.***

***The Task Force on Premature Births is developing a collaborative strategy with DCYF to develop effective and appropriate screening policies and procedures in order to identify pregnant women who misuse substances //2013//.***

DFCHE will continue to track children's deaths caused by motor vehicles and to participate on the Child Death Review Team.

***/2013/ The DCFHE continues to work with the Injury Prevention Center to prevent accidental childhood injury //2013//.***

**c. Plan for the Coming Year**

c. Plan for the Coming Year

First Connections and ***/2013/ MIECHV home visiting programs //2013//*** will continue to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat). ***/2013/ They will also continue to assess pregnant women and mothers with young children for alcohol and drug abuse. Women identified to be at risk for alcohol or drug abuse will continue to be referred to assessment and treatment programs as appropriate //2013//.***

The Child Care Support Network will continue to provide informational materials regarding the

proper use of car seats, air bag safety, and the safest location in the car for children to families with children in child care and to child care providers.

***/2013/ The Family Planning Program is working with the Prematurity Task Force to identify a set of core health risks associated with preterm birth for integration in routine screening and to develop a referral resource of proven intervention strategies. The Family Planning Program will continue to provide free pregnancy testing and preconception counseling to women receiving pregnancy testing services in Title X family planning sites. As a part of preconception counseling, women are assessed for risks related to substance abuse and referred for appropriate substance abuse evaluation and/or treatment services.***

***The Task Force on Premature Births work group will continue to work with the DCYF to develop effective and appropriate screening policies and procedures in order to identify pregnant women who misuse substances with the goal of decreasing prematurity and maintaining intact families //2013//.***

DCFHE personnel will continue to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable.

***/2013/ The DCFHE will continue to work with the Injury Prevention Center to prevent accidental childhood injury //2013//.***

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	31.5	32.5	42.5	42.5	44.7
Annual Indicator	43.4	40.4	40.4	45.1	38.0
Numerator	5507	4997	4997	5579	4572
Denominator	12690	12370	12370	12371	12031
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data				Provisional	Provisional

Provisional or Final?					
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	40.5	42.2	45.8	47.2	47.2

**Notes - 2011**

Data Source: CDC National Immunization Survey [NIS] , 'Breastfeeding Report Card, Outcome Indicators'.

Reporting method changed in 2011. Data prior to 2009, reflect children surveyed each year that were born 2 years prior to the survey. From 2009, data reflect children surveyed each year that were born about 3 years prior to survey.

Although data are provisional, there appears to be a significant decrease between 2010 and 2011 for breastfeeding at 6 months.

Denominator for 2011 is Rhode Island resident births for 2008.

**Notes - 2010**

Data Source: CDC National Immunization Survey [NIS] , 'Breastfeeding Report Card, Outcome Indicators'.

There is an increase between 2010 and 2009 for breastfeeding at 6 months.

Children surveyed each year are born about 3 years prior to survey. Therefore, denominator reflects Rhode Island resident births for 2007.

**Notes - 2009**

Data Source: CDC National Immunization Survey [NIS] , 'Breastfeeding Report Card, Outcome Indicators'.

Reporting method changed in 2011. Data prior to 2009, reflect children surveyed each year that were born 2 years prior to the survey. From 2009, data reflect children surveyed each year that were born about 3 years prior to survey.

Therefore, denominator for 2009 is Rhode Island resident births for 2006. Data for 2008 reflects the same numerator and denominator as 2009.

**a. Last Year's Accomplishments**

Data Discussion:

*/2013/ Rhode Island continues to prioritize supporting breastfeeding. Rhode Island is working with birthing hospitals to increase the number that are baby friendly since research shows that increasing the number of women who initiate breastfeeding will impact the number of those continuing to breastfeed at 6 months of age. RI has made working with employers to support breastfeeding a priority, recognizing employers who provide a place for women to breastfeed as well as distributing hospital grade electric breast pumps to WIC clients who are fully breastfeeding and are returning to work //2013//.*

a. Last Year's Accomplishments

*/2013/ The DCFHE continued to work to increase the percentage of mothers who breastfeed their infants at birth and at six months of age.*

*The WIC Program continued to support a lactation support program for WIC participants six days a week in a birthing hospital. Mothers who receive adequate lactation support after giving birth are more likely to continue breastfeeding after they leave the hospital. WIC also continued to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support to WIC participants at 10 of the 10 WIC*

*agencies. Peer counselor trainings were held every six months to minimize service interruptions.*

*The DCFHE maintained partnerships with the RI Breastfeeding Coalition (RIBC) and the Physicians' Committee for Breastfeeding in RI (PCBRI) and collaborated with these groups to update and carry out the initiatives of the statewide breastfeeding promotion plan. The DCFHE actively promoted adoption of the Baby-Friendly Hospital Initiative, a global program developed to encourage and recognize hospitals that offer an optimal level of care for lactation. The WIC program continued an electronic breast pump program to provide pumps to fully breastfeeding women who are returning to work or school, while expanding this program to women who are breastfeeding medically needy children and may be separated from the babies (i.e. Special care nursery), when insurance will not pay. The DCFHE Initiative for a Healthy Weight (IHW) direction is outlined in its Eat Smart Move More Plan for Action 2010-2015, which includes objectives to promote DHHS's Business Case for Breastfeeding and recognizes worksites that effectively accommodate breastfeeding mothers. IHW continued to provide funds to the RI Breastfeeding Coalition to increase worksites that support breastfeeding mothers.*

*During World Breastfeeding Week the DCFHE engaged state officials and the local media to recognize employers as Breastfeeding-Friendly Workplace Award in partnership with PCBRI. The WIC Program provided local WIC agencies with special funds to purchase sustainable breastfeeding promotion materials and to sponsor breastfeeding promotion events at their clinics.*

*The DCFHE continued to support the toll-free Family Health Information Line. Bilingual staff took calls from breastfeeding women and referred them to appropriate community resources. The DCFHE continued to distribute culturally and linguistically appropriate materials to health care providers and low-income families through hospitals, agencies, and private practices to facilitate the provision of accurate and consistent breastfeeding messages. WIC breastfeeding brochures were distributed within and beyond WIC sites. The DCFHE continues to update the breastfeeding resource website for parents, employers and health care providers.*

*KIDSNET continued to track the percent of mothers that breastfeed through First Connections Program and newborn developmental screening data. The DCFHE conducted both RI PRAMS and TWOS surveys which asks respondents about breastfeeding practices. PRAMS asks the mother whether she ever breastfed, whether she is still breastfeeding, and about barriers to breastfeeding. TWOS asks if the respondent ever breastfed and the duration she breastfed.*

*PRAMS survey data was collected and analyzed //2013//.*

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported WIC lactation support services in birthing hospitals, a WIC mother-to-mother peer counselor program, certified lactation counselor training for WIC peer counselors and nutritionists, a peer counselor program, and a breast pump loan program.		X		
2. Supported the RI Breastfeeding Coalition's efforts to help worksites support breastfeeding mothers.		X		
3. Supported First Connections and MIECHV home visiting programs to educate pregnant women about the importance of		X		

breastfeeding and to link new mothers with certified lactation counselors and other breastfeeding resources and support.				
4. Supported the Family Health Information Line to refer breastfeeding mothers and health care providers who serve breastfeeding mothers to breastfeeding resources and support.			X	
5. Supported CHDA to collect and analyze PRAMS and TWOS surveys, which ask respondents about breastfeeding practices.			X	
6. Distributed consumer breastfeeding informing materials and resource guides to health care providers and families through hospitals, agencies, and private practices.		X		
7. Maintained and updated a breastfeeding website.			X	
8. Supported KIDSNET and MIECHV to track the percentage of mothers who breastfeed through First Connections and MIECHV programs.			X	
9. Supported the Child Care Network health consultants to provide child care providers with information promoting breastfeeding and help in how to support mothers who want to breastfeed when their child is in an out of home child care setting.		X		
10.				

**b. Current Activities**

b. Current Activities

*//2013/ WIC supports a "mother-to-mother" peer counselor program, Certified Lactation Counselor training for WIC peer counselors and nutritionists, a peer counselor program, and a statewide breast pump loan program which has been expanded to provide pumps to mothers who are separated from their infants because of a medical condition.*

*IHW partners with the RI Breastfeeding Coalition to help worksites support breastfeeding mothers.*

*The First Connections and MIECHV home visiting programs will continue to link new mothers with Certified Lactation Counselors who support mothers who want to breastfeed their babies.*

*The Family Health Information Line refers breastfeeding women/health care providers to resources. A Breastfeeding Resource Directory and Breastfeeding Pocket Guide for Providers are made available to providers. A breastfeeding website is updated and maintained.*

*KIDSNET continues to track the percent of mothers that breastfeed through First Connections Program and newborn developmental screening data. MIECHV program data also includes breastfeeding data.*

*CHDA collects and analyzes both RI PRAMS and TWOS surveys which asks respondents about breastfeeding practices.*

*The Child Care Support Network health consultants provide child care providers with information about promoting breastfeeding for families and also assistance in how to help support mothers who want to breastfeed their child while he/she is in out of home child care //2013//.*

**c. Plan for the Coming Year**

c. Plan for the Coming Year

*/2013/ DCFHE will continue to work to increase the percentage of mothers who breastfeed their infants at birth and at six months of age. The First Connections MCH home visiting team will continue to consist of staff that are Certified Lactation Counselors who support mothers who want to breastfeed their children.*

*The WIC Program will continue to support visits by lactation consultants to WIC participants in two of the state's birthing hospitals. WIC will also continue to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support at WIC sites. Peer counselor trainings and Certified Lactation Counselor Certificate training will continue to ensure skilled and consistent breastfeeding services.*

*WIC will continue to co-sponsor educational talks and events for health care providers and will continue to provide a statewide electric breast pump loan program.*

*The Child Care Support Network health consultants will provide child care providers with information about promoting breastfeeding for families and also assistance in how to help support mothers who want to breastfeed their child while he/she is in out of home child care.*

*IHW will continue to partner with the RIBC on helping work sites assist breastfeeding mothers through support of the Business Case for Breastfeeding toolkit promotion, breastfeeding-friendly workplace awards, partnerships with RI workplaces, and promoting the mini-grants to eligible work places.*

*DCFHE will continue to support World Breastfeeding Month activities and media promotion to encourage women to breastfeed their infants. The WIC Program will also continue to provide WIC agencies with special funds to purchase breastfeeding promotion materials and to sponsor World Breastfeeding Month events.*

*DCFHE will continue to support the toll-free Family Health Information Line to refer breastfeeding women and providers to appropriate community resources, and to distribute culturally and linguistically appropriate breastfeeding materials to health care providers and low-income families through hospitals, agencies, and private practices and will continue to update the breastfeeding website.*

*KIDSNET will continue to track the percentage of mothers who breastfeed through First Connections and newborn developmental screening data.*

*The Child Care Support Network health consultants will provide child care providers with information about promoting breastfeeding for families and also assistance in how to help support mothers who want to breastfeed their child while he/she is in out of home childcare //2013//.*

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	96.5	97.3	98.9	99.4	99.4
Annual Indicator	98.8	97.8	94.0	98.8	98.9
Numerator	12971	12073	11086	11507	11468
Denominator	13133	12343	11798	11647	11598
Data Source		Universal NewBorn Screening	Universal NewBorn Screening	Universal NewBorn Screening	Universal NewBorn Screening
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	99.6	99.6	99.6	99.6	99.6

**Notes - 2011**

2011: Data was provided by the Universal New Born Screening Program and reflects total screened before DISCHARGE. Prior to 2008, data reflected total screened by one month old. Denominator reflects births occurring in Rhode Island minus 117 screenings with invalid or unknown screening dates. Some of these records maybe corrected by next year.

**Notes - 2010**

2010: Data was provided by the Universal New Born Screening Program and reflects total screened before DISCHARGE. Prior to 2008, data reflected total screened by one month old. Denominator reflects births occurring in Rhode Island minus 196 screenings with invalid or unknown screening dates.

**Notes - 2009**

2009 : Data was provided by the Universal NewBorn Screening and denominator reflects births occurring in Rhode Island minus 432 invalid screening dates.

Data will be updated if screening dates are corrected.

**a. Last Year's Accomplishments**

Data Discussion:

*/2013/ Annual data shows that Rhode Island continues to maintain high rates of newborn hearing screening. Ninety-nine percent (99%) of all babies born in Rhode Island receive a hearing screen. Babies with positive or inconclusive results are referred for a re-screen. The state has put quality assurance systems in place to ensure that these high rates of screening are maintained. It is tabulated for the national performance measure "screened by one month of age". In 2010, there were 11,843 births. 11,507 (97%) babies were screened prior to discharge, 67 died, and 269 were not screened by hospital discharge for*

**other reasons. Of the 111,723 screened, 11,555 (98.6% of all births) were screened by one month of age. There are systems in place to track and assure that every baby is screened and the screening rates are very high. Very few infants are ever discharged without a screen and there is a system in place to identify home births in need of screening. In 2010, only 50 infants were lost to follow up //2013//.**

a. Last Year's Accomplishments

The RI Hearing Assessment Program (RIHAP) ensures that all newborns receive hearing screening prior to hospital discharge. The DCFHE utilizes KIDSNET to track RIHAP screening information, which originates through the newborn screening process. Infants with confirmed hearing impairment are referred to Early Intervention. First Connections Program home visitors also continue to track infants who are lost to follow-up by RIHAP. The newborn hearing screening database is pre-populated with birth information collected on an integrated newborn developmental risk assessment and birth certificate system then sent to KIDSNET. Two way data exchange between KIDSNET and RITrack allows RIHAP to match birth data to assure that all infants have a hearing screen with a result in KIDSNET. RIHAP and KIDSNET follow up when a child was missed or if the data was never entered into KIDSNET. Rhode Island-specific Newborn Hearing Screening process algorithms adopted from the American Academy of Pediatrics Early Hearing Detection and Intervention (EHDI) guidelines were mailed to primary care providers caring for infants. A system was put into place to mail the algorithm to providers when a newborn in their practice requires follow-up related to the newborn hearing screen.

Informing brochures continued to be distributed in English and Spanish at three time points (prenatal, perinatal, postnatal). The brochures include information on several programs including bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET. RI PRAMS continues to collect data on parental awareness that babies are tested in the hospital for hearing loss.

The Birth Defects Program and KIDSNET continues to work with the Newborn Screening Program to ensure that a final diagnosis of hearing loss in an infant is recorded and reported to the Birth Defects Program.

***//2013/ The newborn hearing screening quality assurance committee continued to meet. Representatives from the Newborn Screening Program, RIHAP, and the Early Intervention Program meet as needed to assure that every baby referred has had audiological evaluation and that every baby diagnosed with a hearing loss is enrolled in Early Intervention (or the parents have chosen not to participate). A parent consultant at RIHAP follows up with families who did not receive screening and or diagnostics before hospital discharge //2013//.***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensured universal newborn hearing screening prior to hospital discharge.			X	
2. Ensured that infants identified with hearing impairment are referred to the RI School for the Deaf and Early Intervention.		X		
3. Supported First Connections to track infants lost to follow-up by the RI Hearing Assessment Program.		X		
4. Utilized KIDSNET to track hearing screening information and refer newborns who do not have a hearing screening to the RI Hearing Assessment Program for follow-up.				X
5. Worked to ensure that a final diagnosis of hearing impairment is			X	

recorded and reported to the the Birth Defects Program.				
6. Collected and analyzed information on family awareness about newborn screening through PRAMS.			X	
7. Distributed integrated culturally and linguistically appropriate brochures that include hearing screening.		X		
8. Continued efforts to connect all pediatric audiologists in KIDSNET.				X
9.				
10.				

**b. Current Activities**

b. Current Activities

All newborns receive hearing screening prior to hospital discharge. Infants identified with hearing loss are referred for services. First Connections tracks infants lost to follow-up.

KIDSNET continues to send RIHAP electronic birth records to assure all newborns were screened. RIHAP provides hearing results to parents prior to discharge along with the newborn screening brochure. If follow up is necessary an appointment is scheduled prior to discharge. Audiologists are connected to KIDSNET. ***//2013/ Training audiologists to report on-line through KIDS NET is ongoing //2013//.***

DCFHE continues to distribute integrated newborn screening brochures to families when the hearing screening is completed along with a system for distribution of similar brochures at the prenatal and postnatal time points.

***//2013/ A system to cross check birth records with vital records to identify home births is in place //2013//.*** DCFHE received HRSA funding to reduce loss to follow up by coordinating with home visiting services to provide screenings in the home.

2013/A pilot test and validation of sending results electronically directly from screening equipment to RITRACK is in process *//2013//.*

**c. Plan for the Coming Year**

c. Plan for the Coming Year

Data systems in KIDSET will support new activities implemented with new HRSA funding. 2013/ Electronic submission of results from hearing screening equipment to RITRACK will be rolled out to all home births and hospitals following the pilot project and validation process. RIHAP will continue to assure that all newborns receive hearing screening prior to hospital discharge. The DCFHE will utilize KIDSNET to track RIHAP screening information, which originates through the newborn screening process. Infants who are identified with hearing loss will continue to be referred to Early Intervention. A parent consultant will continue to follow up on all children who need it. First Connections Program home visitors will also continue to track infants who are lost to follow-up by RIHAP, and will work with RIHAP to begin to implement new in-home screening in conjunction with home visiting activities. Specifications for an on-line referral and tracking system for in-home screening in KIDSNET will be developed *//2013//. Staff from DCFHE and RIHAP will participate in a learning collaborative and will also begin to work with Early Head Start providers to support them as they conduct hearing screening.*

***//2013/ KIDSNET will continue efforts to train all pediatric audiologists to access newborn hearing screening results and Early Intervention information and to use on-line diagnostic reporting into KIDSNET //2013//.***

The DCFHE will continue to distribute integrated newborn screening brochures to families at the prenatal, hospital, and postnatal time periods. This brochure discusses the importance of following up on recommendations received following newborn hearing screening and is available in English and Spanish. A family version of the newborn hearing-screening algorithm will be distributed in English and Spanish to families of infants requiring follow-up after the newborn hearing screen. Upgrades to the HEALTH and RIHAP websites will be completed. The DCFHE will continue to distribute the Resource Guide for Families of Children who are Deaf or Hard of Hearing to assist families in navigating and accessing services.

The Birth Defects Program will continue to work with the Newborn Screening Program and KIDSNET to ensure that a final diagnosis of hearing loss in an infant is recorded and reported. In addition, RI PRAMS will continue to survey recent mothers regarding parental knowledge that babies are tested in the hospital for hearing loss. PRAMS will provide data to evaluate if introduction of the brochures or family algorithm is related to an increase in awareness, particularly among subpopulations such as Spanish-speakers.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	7.5	5.7	8.8	7.3	5.9
Annual Indicator	8.8	7.9	6.6	5.3	6.3
Numerator	20944	18644	15000	12000	14109
Denominator	238000	236000	226000	226000	223956
Data Source		CPS - Table HIA-5	CPS - Table HIB-5	CPS - Table HIB-5	Estimated
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	6.5	6.2	6.2	6.2	6.5

**Notes - 2011**

Data are estimated. Denominator is from the 2010 Census.

**Notes - 2010**

2010 Data is from US Census Bureau March Current Population Survey [CPS]:  
Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided. Both numerator and denominator are from Table HIB-5.

## **Notes - 2009**

2009 Data is from US Census Bureau March Current Population Survey [CPS]:  
Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided. Both numerator and denominator are from Table HIB-5.

### **a. Last Year's Accomplishments**

Data Discussion:

***/2013/ Between 2008 and 2010, 6.3% of Rhode Island's children under age 18 were uninsured, compared with 9.7% of children in the United States. Rhode Island ranks 13th best in the nation, with 93.7% of children with health insurance. About 73% of the estimated 17,053 uninsured children in Rhode Island were eligible for Rite Care coverage based on their family incomes, but were not enrolled. The National Health Care Reform Law will provide Rhode Island with new opportunities to expand access to health care coverage for children //2013//.***

#### **a. Last Year's Accomplishments**

***/2013/ Family Health Information Line Information Specialists continued to refer callers without health insurance to Rite Care.***

***The PPEP assisted families with CYSHCN on issues concerning health insurance, education services, and access to mental health services. Through this program, trained parent consultants are placed in pediatric and specialty care practices to assist families with CYSHCN in accessing community resources, to assist physicians and families in accessing specialty services, and to identify barriers to coordinated care.***

***The First Connections Program home visiting program referred uninsured and underinsured families with newborns and young children to Rite Care, SSI, and Katie Beckett, and other health care options, including community health center services and hospital charity care, as appropriate. In addition, First Connections ensured linkages to many other community based resources including, but not limited to, WIC and Early Intervention.***

***First Connections Program workers provided information to all families receiving a home visit about new Medicaid recertification requirements. First Connections workers worked with the Department of Human Services to streamline the recertification process.***

***DCFHE provided TA to Woonsocket and Washington County CATCH partners to build the capacity of medical homes and link children to needed health and human services. DCFHE was also a key partner in Covering Kids RI, a coalition of partners working statewide and locally to ensure that all children and adults eligible for Rite Care were enrolled and retained their coverage.***

***The Child Care Support Network also referred uninsured or underinsured families with young children to Rite Care, SSI, and Katie Beckett, and other health insurance options, , SSI, and Katie Beckett, and other health insurance programs, as appropriate. Child care health consultants worked with licensed child care providers to ensure that all of the children in their care have access to health insurance and facilitate the enrollment of those who are eligible but not enrolled.***

***The Title X Family Planning Program continued to provide affordable family planning services to adolescents in need of confidential services. The Task Force on Premature Births continued to advocate for an income-based family planning State Plan Amendment to enable low-income women, men and adolescents who wouldn't otherwise be eligible for Medicaid to obtain family planning services.***

**PRAMS continued to survey women two to four months after delivery and asked about their baby's health insurance status. The TWOS survey also included questions regarding health insurance. Data from the National Survey of Children's Health were also analyzed to determine insurance coverage among children in Rhode Island.**

**One recommendation made by the Rhode Island Task Force on Premature Birth included supporting state policies and programs that ensure access to comprehensive primary and preventive health care services for women and children, specifically that Rlte Care eligibility standards for children, parents, and pregnant women and Rlte Care's comprehensive benefits package be preserved.**

**The Office of Primary Care and Rural Health conducted a survey of Primary Care Physicians statewide, to identify areas of underservice and gather information on access to care for uninsured and underinsured populations, particularly low-income and minority populations. The Office managed legislative grants made to RI Community Health Centers to defray uncompensated care costs due to increases in uninsured populations //2013//.**

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the toll-free Family Health Information Line which refers families without health insurance to Rlte Care and other community resources.		X		
2. Supported the PPEP to assist families with CYSHCN on issues concerning health insurance, education services, and mental health services.		X		
3. Supported First Connections and MIECHV home visiting programs to refer pregnant women and families with young children to Rite Care and other health care services for which they may be eligible.	X			
4. Supported the Child care Support Network to assure that child care providers refer uninsured and underinsured families with young children to Rlte Care and other health care services for which they may be eligible		X		
5. Supported Minority Health Promotion Centers to refer uninsured and underinsured families to Rlte Care and other health care services.	X			
6. Supported the Title X Family Planning Program to provide confidential family panning services to teens.	X			
7. Supported the Task Force on Premature Births to advocate for expansion of coverage made possible through national health care reform.				X
8. Supported the Rural Health Systems Building Grants and HPSA/DPSA designation activities.			X	
9. Served on the Full Service Community School Alliance Board to connect families with school age children to services, including health care coverage.				X
10. Worked with key stakeholders and community partners to implement recommendations included in the Adolescent Access to Care Report.				X

**b. Current Activities**

b. Current Activities

***/2013/ The Family Health Information Line refers callers without health insurance to Rlte Care.***

***PPEP assists families with CYSHCN on issues concerning health insurance, education services, and access to mental health services.***

***First Connections and MIECHV refer families to Rlte Care.***

***Child Care Support Network refers uninsured or underinsured families with young children to Rlte Care.***

***DCFHE continues to work with its Woonsocket and Washington County CATCH partners on medical homes.***

***Title X provides affordable family planning services to teens in need of confidential services.***

***PRAMS & TWOS survey women about health insurance status. Data from the National Survey of Children's Health are also analyzed to determine insurance coverage among children.***

***OPCRH provides grants to increase outreach to rural uninsured and Medicaid-eligible populations. OPCRH analyzes primary care physician shortages and submits updates to maintain federal HPSA designations and eligibility for federal support through the CHC and NHSC programs.***

***DCFHE staff serves on the Full Service Community School Alliance Board. Full service schools provide a wide array of services for children and families including connecting families to health insurance.***

***The DCFHE's Refugee Health Program is working to increase the increase the percentage of refugees for whom a health screening form is submitted within 30 days of the refugee's arrival.***

***DCFHE produced an Adolescent Access to Care Report //2013//.***

c. Plan for the Coming Year

c. Plan for the Coming Year

***/2013/ The Family Health Information Line will continue to refer callers without health insurance to Rlte Care.***

***The PPEP will continue to assist families with CYSHCN on issues concerning health insurance, education services, and access to mental health services.***

***First Connections, MIECHV, and the Child Care Support Network will continue to refer uninsured and underinsured families with newborns and young children to Rlte Care.***

***DCFHE will continue to work with its Woonsocket and Washington County CATCH partners on medical homes.***

***The Title X Family Planning Program will continue to provide affordable family planning services to adolescents in need of confidential services.***

*The DCFHE's MHPCs will continue to refer underinsured and uninsured individuals to health insurance and other resources in the community.*

*PRAMS will continue to survey women two to four months after delivery and will ask about their baby's health insurance status. TWOS survey will continue to include questions regarding health insurance. CHDA will continue to analyze data from the National Survey of Children's Health to determine insurance coverage among children in Rhode Island.*

*The Rhode Island Task Force on Premature Births will continue to advocate for supporting state policies and programs that ensure access to comprehensive primary and preventive health care services for women and children. The upholding of the National Health Care Reform Law will provide Rhode Island with new opportunities for expanding access to health insurance.*

*The OPCRH will continue to administer Rural Health Systems Building grants to coalitions/networks in each of the four non-metro areas of the state, to expand and enhance systems of care including strengthening partnerships between health care providers and community-based supports to increase outreach to uninsured and Medicaid-eligible populations outside urban areas.*

*The DCFHE will design and implement an adolescent health summit to inform near term strategies to support adolescent health statewide. A broad-based group of adolescent health partners will plan, implement, and evaluate these efforts.*

*The DCFHE's Refugee Health Program will continue to work to increase the percentage of refugees for whom a health screening form is submitted within 30 days of the refugee's arrival.*

*The DCFHE will continue to support the Community Health Worker Association (CHWA) to develop a system for CHWs, including career ladders, core competency training, and higher wages. CHWs are established, yet growing health care assets in Rhode Island. CHWs will support community activation around integrative public health efforts. Local support and outreach programs such as PPEP, Family Resource Counselors, Americorp Volunteers, and Lifespan Community Advocates are included in the CHWA Network //2013//.*

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	36.2	35.9	32.3	32.3	32.1
Annual Indicator	35.6	34.3	33.3	33.2	34.3
Numerator	4443	4629	4614	4754	4807
Denominator	12482	13498	13850	14303	14033
Data Source		WIC Database	WIC Database	WIC Database	WIC Database
Check this box if you cannot report					

the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	34	34.5	34	34.5	34

**Notes - 2011**

Percentage of WIC children with BMI >= 85th percentile remained about the same from 2008 and 2011.

Records with missing data (age, gender, height or weight ) are excluded in both numerator and denominator.

**Notes - 2010**

Percentage of WIC children with BMI >= 85th percentile remained about the same for 2009 and 2010.

Records with missing data (age, gender, height or weight ) are excluded in both numerator and denominator.

**Notes - 2009**

Percentage of WIC children with BMI >= 85th percentile appeared to decline from 34.3% in 2008 to 33.3% in 2009. It is not clear whether this decline is real or if it's due to the improvement of data quality.

Records with missing data (age, gender, height or weight ) are excluded in both numerator and denominator.

**a. Last Year's Accomplishments**

Data Discussion

***/2013/ Height and weight data are now transferred daily from the WIC information system to KIDSNET. KIDSNET programming was completed to calculate BMI and percentile using that data. In addition, a healthy weight page was programmed in KIDSNET to display a history of height and weight including an option to see the data plotted on a stature and weight for age or BMI for age chart as well as green, yellow and red color indicators for normal, overweight, and obese BMI percentiles respectively. This information is available to authorized users who coordinate care for these children //2013//.***

a. Last Year's Accomplishments

***/2013/ The IHW direction is outlined in its Eat Smart Move More Plan for Action 2010-2015, which includes objectives to:***

- ***Enable and require licensed childcare menus that are consistent with the Dietary Guidelines for Americans***
- ***Ensure coverage and capacity for nutrition counseling, behavioral counseling, and patient reimbursement of weight management program costs by RI's major health insurers.***
- ***Promote the DHHS's Business Case for Breastfeeding and recognize worksites that effectively accommodate breastfeeding mothers.***

***WIC works with IHW in promoting healthy foods in Providence. WIC has focused training***

*on Client Centered techniques and reviewed staff competence through observations and trainings. WIC continued to provide WIC sites with technical assistance and training on accurate assessments regarding overweight children and follow-up. The Breastfeeding Program conducted a range of activities to educate and promote breastfeeding and provided direct breastfeeding support to women enrolled in WIC. Reduction of high BMI's was a performance measurement for WIC local agencies. WIC provided hospital grade electric pumps to fully breastfeeding women who are returning to work or school or for those with a medical necessity.*

*The Farmer's Market Nutrition Program continued to offer families vouchers to buy fresh fruits and vegetables each summer. WIC partnered with Johnson & Wales University to provide nutrition education classes that provided information on incorporating fruits and vegetables as part of a healthy diet. WIC continued to provide nutrition information to community partners (hospitals, health centers, daycares, Early Intervention Programs) to provide consistent messages to parents and enhance communication among community partners.*

*During FY2010, CHDA staff worked closely with the DCFHE's IHW on issues related to data and surveillance, and analyzed data to determine trends of obesity between 2-5 year-olds participating in WIC //2013//.*

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported hospitals in adopting the baby friendly hospital initiative lactation support and promotion activities.		X		
2. Modified WIC WEBS to encourage client centered counseling and trained local WIC agency staff in this technique.				X
3. Conducted the Farmers Market Nutrition Program.	X			
4. Analyzed WIC data to determine trends of obesity between 2-5 year olds participating in WIC.			X	
5. IHW conducted pediatric provider trainings to help providers identify overweight and obesity issues and provide counseling and referrals.		X		
6. Convened a Health Policy Council to initially addresses obesity prevention.				X
7. Conducted a web-based survey of Olneyville residents to assess access to healthy foods and physical activity resources.			X	
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

*//2013/ DCFHE supports hospitals in adopting the Baby-Friendly Hospital Initiative, lactation support and promotion activities. Direct support and counseling is provided to breastfeeding WIC clients.*

*WIC WEBS has been modified to encourage client centered counseling and local agency staff was trained in this technique as part of the VENA training.*

***The Farmer's Market Nutrition Program is currently underway for summer 2012 and is partnering with Johnson & Wales University for nutrition education and cooking demonstrations.***

***CHDA analyzes WIC data to determine trends of obesity between 2-5 year-olds participating in WIC. IHW is also conducting pediatric provider trainings to help providers identify overweight and obesity issues, counsel and refer patients and families.***

***DCFHE has convened a Health Promotion Policy Council made up of senior level, highly influential state and local decision makers to define a strategic legislative agenda that is initially addressing obesity prevention.***

***The IHW is conducting a web-based survey of Olneyville urban community residents to assess access to healthy foods and physical activity resources //2013//.***

**c. Plan for the Coming Year**

**c. Plan for the Coming Year**

***/2013/ In FY2013, the DCFHE will continue to work to reduce childhood obesity through IHW partnerships to build infrastructure and by promoting good nutrition through the WIC and Breastfeeding programs. The IHW is funded with a grant from the Centers for Disease Control and Prevention for implementation of its state Plan, providing additional resources to support obesity prevention in the state. The IHW is a recipient of a 24-month CDC ARRA CPPW physical activity funds to implement a statewide model for integrating active living into all local planning decisions through policy and environment change.***

***The Health Promotion Policy Council will continue to advance a strategic legislative policy agenda to address obesity prevention, including addressing regulation of the nutrition in child care centers.***

***The DCFHE will continue to lead the state's breastfeeding promotion initiatives, including the Baby-Friendly Hospital Initiative and training of First Connections Program home visitors. Home visitors will begin to offer lactation visits. The DCFHE will also continue to provide support and counseling to breastfeeding WIC clients.***

***The DCFHE, Kids First organization, and the RI Department of Education will continue to provide technical assistance to School District Health and Wellness Subcommittees to improve school environments to support better nutrition and more physical activity.***

***WIC staff will continue to provide additional training on VENA and client centered counseling and will monitor counseling strategies in the clinics.***

***The RI WEBS system will be enhanced to accommodate the new federal regulations concerning using the WHO growth charts and new risks associated with the growth patterns.***

***WIC will partner with Johnson & Wales University in the Farmer's Market Nutrition Program. WIC staff will educate WIC participants about increasing fruit and vegetable consumption. WIC has authorized Farmers' Markets to accept the cash value voucher for fruits and vegetables.***

***The WIC Parent Consultant will continue to interview WIC participants regarding their perception of and experiences with WIC nutrition education services. This information will***

*be shared with local WIC agencies to help them improve the nutrition education services they provide and identify staff training needs.*

*CHDA staff will continue to work on analyzing WIC data to determine trends of obesity between 2-5 year-olds participating in WIC.*

*The new Child Health Consultants will coordinate with WIC and refer children in childcare, and their families who would benefit from WIC.*

*The Diabetes Prevention and Control Program plans to continue through the efforts of the Diabetes and Children's Work group to coordinate with the IHW to prevent childhood obesity and the development of type 2 Diabetes //2013//.*

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	11.5	12.9	11.4	11	9.5
Annual Indicator	12.4	10.8	9.4	9.7	10.2
Numerator	1432	1205	1013	1033	1066
Denominator	11542	11166	10734	10602	10466
Data Source		PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	9.7	9.2	9.2	9.2	9

**Notes - 2011**

Data are estimated.

Data collection for 2010 PRAMS will not be completed until end of June 2012 and the weighted data will not be available until the fall 2012.

**Notes - 2010**

Rhode Island PRAMS shows the percent of women who smoked in the last three months of pregnancy remains about the same for 2009 and 2010.

**Notes - 2009**

Rhode Island PRAMS for 2009 shows a decline in the percent of women who smoked in the last three months of pregnancy from 10.8% in 2008 to 9.4% in 2009.

**a. Last Year's Accomplishments**

Data Discussion

***/2013/ According to 2010 PRAMS data 9.7% percent of women reported smoking in their last trimester. While the rate has been trending down since 2006, pregnant women remain a priority in terms of priority populations for reducing tobacco use, due to multiple vulnerabilities faced by both women, their unborn children, and other children in the home. While the decreasing rate is promising, disparities still remain among subgroups of pregnant women. For example, rates of smoking during pregnancy vary significantly by age, educational level, marital status, race/ethnicity, household income, and health insurance. The DCFHE continues to develop, support, and review a variety of prevention and screening activities and will continue its efforts to reduce smoking during pregnancy, particularly among at-risk populations //2013//.***

a. Last Year's Accomplishments

***/2013/ The DCFHE supported the Tobacco Control Program (TCP) to conduct a variety of activities to prevent children from ever starting to use tobacco and to help smokers and users of smokeless tobacco quit. The Tobacco Control Program administered the toll-free smokers' helpline (telephone Quit Line, 1-800-QUIT-NOW), which directed smokers and/or those who care about smokers to the cessation program that will work best for them including a choice of information materials, web-based counseling, or telephone counseling.***

***The Department's Health Information Line referred callers with questions about smoking to 1-800-QUIT-NOW.***

***The CHDA continued to conduct PRAMS and determine the percentage of respondents who reported they had smoked during the last trimester of their pregnancy.***

***The DCFHE participated on the Rhode Island Task Force on Premature Birth. One of the Task Force's recommendations is to "support statewide tobacco and nicotine cessation programs and media campaigns to ensure access for all women of reproductive age with emphasis on pregnancy." Through the participation of the Tobacco Control Program's Cessation Coordinator, ongoing dialogue, stateside coordination, collaboration and linkages took place.***

***First Connections provided families with information about the dangers of tobacco use and second hand smoke and referred women and other family members who smoke to tobacco cessation services //2013//.***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partnered with Health Centric Advisors on health systems change efforts in RI.				X
2. Supported the Quitline and website.			X	
3. Supported the Task Force on Premature Births to support statewide tobacco cessation programs and media campaigns to support pregnant women who smoke.				X
4. Supported First Connections and MIECHV home visiting programs to provide families with information about the dangers of tobacco use and second hand smoke and to make referrals to tobacco cessation services.	X			
5. Conducted outreach to pregnant women in WIC.		X		

6. Analyzed PRAMs data on women who smoke during pregnancy.			X	
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

*/2013/ DCFHE is partnering with Health Centric Advisors (HCA) on health systems change efforts in RI. HCA conducts outreach to Women and Infants Hospital, the premier birthing hospital in the state, to encourage them to systemically adopt brief tobacco cessation intervention protocols.*

*The DCFHE continues to support the TCP to conduct prevention and cessation activities and to administer the Quitline and website <http://www.quitnowri.com/> providing information for those who want to quit.*

*The DCFHE, in partnership with Women & Infants Hospital, is currently working with the RI Task Force on Premature Births to support statewide tobacco and nicotine cessation programs and media campaigns to ensure access for all women of reproductive health age with an emphasis on pregnant women who smoke. One work group of the Task Force is working to develop a universal preconception screening tool.*

*First Connections Program and MIECHC provide families with information about the dangers of tobacco use and second hand smoke and refer them to smoking cessation resources in the community.*

*Outreach to at-risk pregnant women continues to occur in WIC sites across the State. At-risk pregnant women who do not meet the eligibility criteria for other programs may be referred to First Connections.*

*CHDA conducts RI PRAMS and analyzes data on women who smoke during pregnancy //2013//.*

**c. Plan for the Coming Year**

c. Plan for the Coming Year

*/2013/ The DCFHE RI Tobacco Control Program will continue to administer the Quit Line and webpage <http://www.quitnowri.com/>.*

*DCFHE will support TCP efforts to prevent young women from initiating smoking by using Title V funds to build state capacity to enforce laws related to tobacco sales to minors. Additional work will continue to be done to educate decision makers on how to improve coordination of services for at risk communities and identify and provide comprehensive services to improve outcomes for families that reside in at risk communities.*

*First Connections & MIECHV will continue to provide families with information about the dangers of tobacco use and second hand smoke and will refer them to smoking cessation resources in the community.*

*CHDA will continue to conduct PRAMS and analyze data on women who smoke during*

**pregnancy.**

**A data collection protocol associated with First Connections home visitors will provide data for the KIDSNET data system at HEALTH. The data will be analyzed in order to provide information on how many clients smoke and how many receive referrals and follow up on referrals. This added analysis will help to close the loop on the brief tobacco cessation intervention that is currently taking place, as currently there is no mechanism for verifying whether clients have been referred, whether they have followed up on the referral, and what the cessation attempt outcomes are. While the brief tobacco cessation protocols have been developed, the ability to retrieve and utilize the data will be developed in the upcoming year //2013//.**

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	5	3.7	3.7	1	1
Annual Indicator					
Numerator					
Denominator	81557	79678	80046	80046	80046
Data Source		Vital Records Death File			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1.7	1.5	1.5	1	1

**Notes - 2011**

Provisional data for 2011 reports 3 events and a total of 11 events for 2009 thru 2011. Therefore, there are 11 events for the year and the average of the last 3 years is also 11 events.

Denominator from 2010 Population Census.

**Notes - 2010**

For 2010 there were 4 events and a total of 12 events for 2008 thru 2010. Therefore, there are 12 events for the year and the average of the last 3 years is also 12 events.

Denominator from 2010 Population Census.

## Notes - 2009

For 2009 there were 4 events and a total of 10 events for 2007 thru 2009. Therefore, there are 10 events for the year and the average of the last 3 years is also 10 events.

Denominator from 2010 Population Census.

### a. Last Year's Accomplishments

#### Data Discussion

Youth suicide is a serious but largely preventable public health problem. After falling over 28% during the period 1990-2003, suicide rates in America for males and females aged 10-24 climbed 8% in 2004, the largest single one-year rise in 15 years. Although youth suicide rates have dropped slightly since 2004, they remain above predicted levels. Suicide is the 3rd leading cause of death among youth 15-24 years of age in Rhode Island (RI) and the nation.

#### a. Last Year's Accomplishments

***/2013/ With support from a three-year Substance Abuse & Mental Health Services Administration (SAMHSA) grant (2008-2011), Safe Rhode Island's Youth Suicide Prevention Project was able to successfully apply for a second three-year grant (2011-2014). Using these grants, the Rhode Island Youth Suicide Prevention Project has established the infrastructure to support the implementation of a comprehensive, multifaceted suicide prevention and early intervention program for adolescents and youth adults aged 15-24 in Rhode Island's core city high schools and community-based organizations. The objective is to connect a minimum of 400 youth with new or enhanced services over the next three-year grant period. The Rhode Island Youth Suicide Prevention Project (RIYSPP) successfully: 1) Trained 1858 gatekeepers in the six core cities targeted for intervention in Question, Persuade, Refer (QPR) evidence based prevention program; 2) Identified 290 at risk youth, provided referrals for services, and documented access to services for youth identified; 3) Secured commitment and began implementing the American Foundation for Suicide Prevention's Interactive Screening Program at the University of Rhode Island. 4) Assessed referral resources and created and disseminated a Community Resource Guide. 5) Trained 123 youth in the Signs of Suicide (SOS) evidence-based peer gatekeeper training program in Providence high schools and community-based organizations; 6) Conducted a means-restriction awareness campaign utilizing radio and television PSA's targeting parents of youth aged 15-24 in the core cities; 7) Secured commitment from graduate level course "Injury as a Public Health Problem" at Brown University to include suicide prevention coursework in Fall 2012; 8) Built online suicide prevention educator resource in conjunction with Brown University entitled "Suicide Prevention Information and Resources for Educators" to encourage graduate level Public Health and Medical School faculty to integrate suicide prevention into their courses in order to educate the future workforce about suicide as a preventable public health problem //2013//.***

The DCFHE Office of Special Health Care Needs (OSHCN) added a disability indicator to the Youth Behavior Risk Survey (YRBS) to enable comparison of YSHCN with their typical peers. Data demonstrated that YSHCN engage in significantly riskier behaviors and experience more depression than their peers. The OSHCN made this data available to several intervention providers and educators. DFCHE also included a sexual orientation question and analysis of that data revealed significant differences in most of the health risks. DFCHE participated in the LGBTQQ Task Force to support best practices related to these health risks.

***/2013/ DCFHE supported Washington County and Woonsocket CATCH projects on adolescent medical homes //2013//.***

The DCFHE managed thrive, in partnership with the RI Department of Education. This partnership focused on strengthening the statewide infrastructure to address school guidance,

counseling, and social services; school environment; and school climate to assure safe, caring, and nurturing schools.

DCFHE personnel continue to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable. Suicides are included in these reviews. CHDA analyzed Vital Statistics death file data to track the rate of suicides among teens.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the RI Youth Suicide Program.				X
2. Supported First Connections and MIECHV home visiting programs to assess teen mothers for depression and refer them for evaluation and treatment	X			
3. Participated on the Child Death Review Team.			X	
4. Analyzed YRBS data.			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

***/2013/ The RI Youth Suicide Prevention Program includes: Question, Persuade, Refer (QPR) adult gatekeeper training, Signs of Suicide (SOS) youth gatekeeper training, the American Foundation for Suicide Prevention (AFSP) Interactive Screening Program (ISP) an internet-based self administered screening tool to identify students at risk and refer them to their college counseling center for follow-up, integration of suicide prevention course content in Brown University's MPH and medical clerkship curricula, and a statewide lethal means restriction media campaign //2013//.***

First Connections & MIECHV assess teen mothers of newborns and/or young children for depression and refers those that may be at risk for depression for mental health evaluation and treatment services.

DCFHE participates on the Child Death Review Team and analyzes Vital Statistics death files. YRBS data tracks teen suicide rates, and related indicators.

***/2013/ DCFHE continues to support Washington County and Woonsocket CATCH projects.***

***Addressing the emotional "literacy" needs of young children is the foundation for perceiving and communicating emotions and establishing health relationships later in life. Using DCFHE rural health funding, the Washington County Coalition for Children is implementing its "Feeling Groovy" campaign with rural 2nd graders using a lesson plan based on the award-winning book "The Way I Feel". Students also design a bookmark illustrating their feelings //2013//.***

### **c. Plan for the Coming Year**

#### c. Plan for the Coming Year

***/2013/ In the coming year, the RI Youth Suicide Prevention Program will implement: QPR to train a minimum of 425 additional adults in schools and community-based organizations and will as expand QPR training to at least 1 new community high school in RI, SOS to train a minimum of 150 additional youth in schools and community-based organizations in the core cities, AFSP ISP in a minimum of 1 additional RI college/university, integration of suicide prevention course content in a minimum of 2 additional courses within the Brown University's Master of Public Health and medical clerkship curricula, and a statewide lethal means restriction media campaign //2013//.***

The DCFHE SafeRI Violence and Injury Prevention Program will expand implementation of the SAMHSA grant to address teen suicide prevention to reach non-core MCH planning cities that have high rates of teen suicide ( East Providence and Cranston). The program will be expanded to identify young veterans and young people on active military duty and to reach young people in the RI Training School. A media campaign supporting this effort will also be implemented in participating cities.

The DCFHE will also continue leading the state suicide prevention task force.

The DCFHE will continue to participate on the Child Death Review Team. The DCFHE will continue to analyze data from Vital Statistics death files and the Youth Risk Behavior Survey.

The OSHCN will continue to review youth engagement and risk behavior to assess the specific needs of youth with special health care needs. The Office will continue to provide youth opportunities for healthy development, acquiring coping skills and increasing protective factors in youth with special health care needs.

DCFHE will continue to work with the RI Association of School Principals and the RI AAP on strategic activities to link the work of the two organizations to support health and academic achievement among school aged children. ***/2013/ The DCFHE in partnership with the RI Association of School Principals developed a mental health toolkit aligned with professional development. The toolkit will continue to be offered to school administrators //2013//.***

First Connections & MIECHV will continue to assess teen mothers of newborns and/or young children for depression and refers those that may be at risk for depression for mental health evaluation and treatment services.

CHDA will conduct and analyze the YRBS data to collect information on issues related to suicide (intent, attempts, etc.).

The DCFHE will continue to manage Thrive, in partnership with the RI Department of Education.

***/2013/ DCFHE will continue to support Washington County and Woonsocket CATCH projects. The Washington County Coalition for Children will continue to implement its "Feeling Groovy" campaign for 2nd graders //2013//.***

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	94.2	92.8	94.5	94.5	93
Annual Indicator	92.5	93.6	92.6	91.5	93.2
Numerator	198	161	174	151	150
Denominator	214	172	188	165	161
Data Source		Vital Records Birth File			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	93.7	95	95.6	95.6	95.6

**Notes - 2011**

Provisional data for 2011 shows a slight increase which is not significant. Numerator reflects VLBW resident infants born at Women & Infant's Hospital. The Denominator reflects all VLBW resident infants born in all of the Rhode Island hospitals. Hospital of birth is not entered for Rhode Island resident births occurring out-of-state

**Notes - 2010**

Data for 2010 shows a slight decline which is not significant. Numerator reflects VLBW resident infants born at Women & Infant's Hospital. The Denominator reflects all VLBW resident infants born in all of the Rhode Island hospitals. Hospital of birth is not entered for Rhode Island resident births occurring out-of-state.

**Notes - 2009**

Data reflects VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for Rhode Island resident births occurring out-of-state.

**a. Last Year's Accomplishments**

Data Discussion

***//2013/ Women & Infants Hospital is the regional perinatal center for Rhode Island and all of southeastern New England and serves as the primary location for high-risk deliveries. The Neonatal Intensive Care Unit (NICU) at Women & Infants Hospital in Providence, serves as the sole Level III NICU in Southeastern New England. The majority of infants admitted to the NICU are low birth weight, premature infants. In 2011, 93.2% of very low birth weight infants were born at this hospital //2013//.***

a. Last Year's Accomplishments

The DCFHE is committed to ensuring that high-risk mothers deliver at Women & Infants Hospital, so that appropriate, comprehensive, and expert care can be provided through their NICU.

***//2013/ The Family Planning Program provided no cost pregnancy testing and***

***preconception counseling to women in federally funded Title X family planning clinics; those with a negative pregnancy tests were provided with family planning services; those with a positive pregnancy test were referred to prenatal care and other community-based supports early in pregnancy //2013//.***

A RI Task Force on Premature Birth recommendation focused on developing a coordinated medical home for preterm infants and their families at Women & Infants Hospital's NICU. The CHIP (Comprehensive Health Integration for Premies) Program, now called Transition Home Plus, has been implemented and has been successful in decreasing re-hospitalization rates and emergency room usage. Another recommendation focused on implementing changes to the vital statistics birth record to include methodology used to calculate gestational age and the use and type of fertility treatment(s) to achieve pregnancy. The Office of Vital Records started collecting this new data for babies born effective February 2010.

DCFHE continues to support the implementation of prenatal home visiting in Rhode Island. The First Connections Home Visiting Program offered services on a limited basis to at-risk pregnant women and connected them to prenatal care and other community resources and supports. Outreach to pregnant women in local WIC offices began in the winter of 2010.

A pediatric developmental physician worked as a consultant for the DCFHE at the Hasbro Children's Hospital Children's Neurodevelopmental Center providing training to personnel at the Women & Infants' NICU to help ensure that high-risk infants were referred to the Early Intervention Program prior to discharge. Physician materials developed by the DCFHE for the Early Intervention Program were provided to NICU staff.

Families with infants born weighing 1,500 grams or less are offered Part C Early Intervention services as well as the Transition Home Plus Program at discharge. Transition Home Plus a specialized care program to transition NICU graduates into primary care and is focused on high-risk, very low birth weight infants (less than 1,500 grams) with complex special health care needs. Project outcomes include decreasing the rates of emergency room visits and re-hospitalizations.

***//2013/ The DCFHE placed a PPEP Parent Consultant in the Women and Infants' NICU to review community resources available to families upon discharge and provides training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program and other programs as appropriate. The PPEP at Women & Infant's Hospital Neonatal Follow-up Clinic provides assistance to families of at-risk newborns through peer support services, systems navigation, and family-to-family linkages.***

***The DCFHE engages community partners and began development of a preconception health strategic plan to enhance the health of all Rhode Islanders and to maximize health pregnancies and outcomes //2013//.***

The RI Task Force on Premature Births developed and implemented an educational campaign for providers and patients addressing previous preterm birth. Providers were encouraged to assess the risk for preterm birth with each pregnant woman during prenatal care. If a previous preterm birth is documented, 17-hydroxyprogesterone caproate (17-OHP) may be offered.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported First Connections and MIECHV home visiting programs.	X			
2. Supported the Task Force on Pemature Births.				X

3. Supported the Family Planning Program to provide no cost pregnancy testing, preconception counseling, and referrals to women receiving pregnancy testing.	X			
4. Supported a statewide preconception health plan to address preconception health through implementation in health care practices and promotion, comprehensive health policies, and public health initiatives.				X
5. Implemented the birth certificate worksheet which includes fertility questions.			X	
6. Supported the PPEP parent consultant in the NICU to assure that infants are linked to Early Intervention.		X		
7. Supported the PPEP at the Neonatal Follow-up Clinic to provide assistance to families of at risk newborns through peer support services, systems navigation, and family to family linkages.		X		
8. Supported the Newborn Screening Program's thyroid protocol to identify infants with delayed hypothyroidism and ensure proper treatment and follow-up.			X	
9.				
10.				

**b. Current Activities**

b. Current Activities

***//2013/ First Connections and MIECHV provide home visiting services to mothers of newborns with a stay in the NICU and provide them with information and education designed to prevent another high risk birth. Home visitors refer mothers with risk factors to appropriate community resources.***

***The DCFHE supports the Task Force on Premature Births, which continues to work to reduce premature births in Rhode Island.***

***The Family Planning Program continues to provide no-cost pregnancy testing, preconception counseling, and referrals to women receiving pregnancy testing services in Title X family planning clinics.***

***The DCFHE, in conjunction with external partners, is finalizing a statewide preconception health plan to systematically address preconception health through implementation of health care practices and promotion, comprehensive health policies, and public health initiatives //2013//.***

The new birth certificate worksheet includes fertility questions.

***//2013/ The OSHCN continues to support the PPEP Parent Consultant in the NICU to help ensure that high-risk infants are linked to EI. The PPEP at the Neonatal Follow-Up Clinic provides assistance to families of at-risk newborns through peer-support services, systems navigation, and family-to-family linkages //2013//.***

Rhode Island's Newborn Screening Program initiated a new thyroid protocol to identify infants with delayed hypothyroidism and ensure proper treatment and follow-up.

**c. Plan for the Coming Year**

c. Plan for the Coming Year

***/2013/ First Connections and MIECHV will provide home visiting services to mothers of newborns with a stay in the NICU and provide them with information and education designed to prevent another high risk birth. Home visitors will refer mothers with risk factors to appropriate community resources.***

***DCFHE will continue to support Title X family planning clinics to make referrals to prenatal care and other community-based supports early in pregnancy.***

***DCFHE will continue to work with health care providers, allied professionals, insurers, consumers, policy makers and other key stakeholders to begin implementation of the statewide preconception health strategic plan to improve pregnancy outcomes //2013//.***

Families born with infants born at very low birth weight (less than 1,500 grams) will continue to be offered Part C EI services, as well as, the Transition Home Plus Program at discharge. Transition Home Plus, a specialized care program to transition NICU graduates into primary care, focused on high-risk very-low birth weight infants with complex special health care needs. Project outcomes include decreasing the rates of emergency room visits and re-hospitalizations. The RI Task Force on Premature Birth will identify and implement strategies to support the progress of the Transition Home Plus Program.

The PPEP Parent Consultant working in the NICU ***/2013/ and the Neonatal Follow-up Clinic //2013//*** will continue to provide assistance to families in accessing community resources. ***/2013/ The PPEP will provide training to NICU personnel on family centered care practices and community linkages //2013//.*** DCFHE will work with KIDSNET to print a monthly report of infants born at 1,500 grams or less who have been referred to Early Intervention and have not engaged in services.

**Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	85	82.5	84.5	85.4	86.7
Annual Indicator	82.0	81.9	85.2	86.5	87.9
Numerator	9910	9539	9471	9399	9169
Denominator	12083	11651	11120	10868	10427
Data Source		Vital Records Birth File			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	88	88.2	87.2	87.2	87.2

**Notes - 2011**

Provisional data for 2011 reflects calendar year.

Data shows an increase from 86.5% in 2010 to 87.9% for women receiving prenatal care in the first trimester. There has been a slight increase each year since 2008.

Birth records with unknown month of prenatal care are excluded.

**Notes - 2010**

Data for 2010 reflect calendar year.

Data reflect an increase from 81.9% in 2008 to 86.5% for women receiving prenatal care in the first trimester.

**Notes - 2009**

Data reflect calendar year 2009.

**a. Last Year's Accomplishments**

Data Discussion

According to PRAMS data, the percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester has increased from 82.0% in 2007 to 87.9% in 2009. After a downward trend from 91.8 % in 2004, this is promising information. Disparities remain among sub-populations; the DCFHE will continue to support integrated efforts that ensure early access to care for pregnant women, with special focus on at-risk populations.

a. Last Year's Accomplishments

The DCFHE continued efforts to ensure that high-risk mothers and newborns are provided the appropriate level of care to support their unique needs. The NICU at the Women & Infants Hospital will continue to provide Level III subspecialty care to these women and their newborns.

*//2013/The DCFHE funded a Gestational Diabetes Mellitus (GDM) pilot project with Women & Infants Hospital of Rhode Island (WIHRI) and Providence Community Health Centers for the early identification, referral, and/or treatment of women who are diabetic, pre-diabetic, or at risk of developing diabetes. The WIHRI Registered Nurse identified women with gestational diabetes who attended the WIHRI pre-natal clinic and provided education about controlling blood glucose and the importance of post-partum testing. She continued to follow these women until they returned for an oral glucose tolerance test (OGTT). A Patient Navigator provided the same services for women with gestational diabetes who received their prenatal care at PCHC. These efforts resulted in an almost 20% increase in the number of women who returned for the post-partum OGTT -from 44% to 63% in the first year of the project.*

*The DCFHE supported the Family Planning Program, which provides no-cost pregnancy testing and preconception counseling to women receiving services in federally-funded Title X family planning clinics. Through the program, pregnant women with identified health risks will be referred to prenatal care and other community-based supports early in pregnancy //2013//.*

The PPEP Parent Consultant working in the NICU continued to provide assistance to families in accessing community resources and provided training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program prior to discharge.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the Gestational Diabetes Mellitus pilot project for the early identification, referral, and treatment of pregnant women who are diabetic, pre-diabetic, or at risk of developing diabetes.	X			
2. Supported the Family Planning Program which refers newly identified pregnant women to prenatal care.	X			
3. Supported the Task Force on Premature Births to develop a universal risk assessment and referral tool for pregnant women.				X
4. Supported the MIECHV Program to work with pregnant women to ensure that they enter and remain in prenatal care.	X			
5. Analyzed PRAMS and Newborn Developmental Risk Screening data to determine adequacy of prenatal care among pregnant women.			X	
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

*//2013/The DCFHE continues to support the GDM pilot project to improve the percentage of women with gestational diabetes who return for the OGTT and are referred to appropriate pre-diabetes or diabetes services.*

*The Family Planning Program continues to provide no-cost pregnancy testing and preconception counseling to women receiving services in Title X family planning clinics with referrals made to prenatal care/community-based supports early in pregnancy.*

*The DCFHE is working closely with the RI Task Force on Premature Births to develop a universal risk assessment and referral tool.*

*The DCFHE, in conjunction with external partners, is finalizing a statewide preconception health plan to systemically address preconception health through the implementation of health care practices and promotion, comprehensive health policies, and public health initiatives //2013//.*

The toll-free bi-lingual Health Information Line continues. Culturally and linguistically appropriate informational materials are distributed through the Distribution Center.

CHDA continues to administer the PRAMS survey, and Newborn Developmental Risk Screening data are collected and analyzed regarding the adequacy of prenatal care among pregnant women.

*//2013/ MIECHV programs work with pregnant women to assure that they enter and remain in prenatal care //2013//.*

**c. Plan for the Coming Year**  
 b. Plan for the Comming year

***/2013/The DCFHE will continue to support the GDM pilot project to improve the percentage of women with gestational diabetes who return for the OGTT and are referred to appropriate pre-diabetes or diabetes services.***

***The Family Planning Program will continue to provide no-cost pregnancy testing and preconception counseling to women receiving services in Title X family planning clinics with referrals made to prenatal care/community-based supports early in pregnancy.***

***The DCFHE will working closely with the RI Task Force on Premature Births to develop and implement a universal risk assessment and referral tool.***

***The DCFHE, in conjunction with external partners, will implement a statewide preconception health plan to systemically address preconception health through the implementation of health care practices and promotion, comprehensive health policies, and public health initiatives //2013//.***

The toll-free bi-lingual Health Information Line will continue. Culturally and linguistically appropriate informational materials will continue to be distributed through the Distribution Center.

CHDA continues to administer the PRAMS survey, and Newborn Developmental Risk Screening data are collected and analyzed regarding the adequacy of prenatal care among pregnant women.

***/2013/ MIECHV programs will continue to work with pregnant women to assure that they enter and remain in prenatal care //2013//.***

**D. State Performance Measures**

**State Performance Measure 1:** *The percent of Rhode Island resident families with at risk newborns that recieve a home visit during the newborn period (<=90 days)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					52.2
Annual Indicator		45.0	45.1	48.6	52.0
Numerator		3165	3086	3298	3458
Denominator		7030	6840	6788	6652
Data Source		Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	55.2	58	59	60.4	61.2

**Notes - 2011**

Provisional data for 2011 reports a slight increase in home visiting to risk positive infants. About 52% received home visits in 2011 compared to 48.5% in 2010. In 2011, 3,265 infants\women eligible for home visits did not receive a home visit.

**Notes - 2010**

Data for 2010 reports a slight increase in home visiting to risk positive infants. About 48.6% received home visits in 2010 compared to 45.4% in 2009. In 2010, 3,510 infants\women eligible for home visits did not receive a home visit. Of the total, 1736 families refused a home visit and 1436 could not be located.

**Notes - 2009**

Data for both 2008 and 2009 report about 45% of infants screened risk positive, received home visits. Of the total infants\women eligible for home visits in 2009, 3048 refused home visits.

**a. Last Year's Accomplishments**

a. Last Year's Accomplishments

***//2013/ KIDSNET captured information about developmental risk factors that trigger a referral for a home visit as well as home visiting data. As evidence-based- home visiting programs are implemented, KIDSNET will be enhanced to capture additional data from these home visiting programs.***

***DCFHE supports a continuum of home visiting services including evidence-based parent education and family support. Expanding home visiting programs will help to improve and strengthen programs and activities carried out under Title V, improve coordination of services to improve outcomes for families at risk. HEALTH submitted a grant to HRSA - Maternal, Infant and Early Childhood Home Visiting Program to expand that capacity within the state to provide evidence-based home visiting services.***

***HEALTH contracts with four community based agencies to provide First Connections Home Visiting Program for families of newborns at-risk for negative outcomes. First Connections uses home visits to support families and their children during the early years of childhood development by giving them the information and services they need to be as healthy as possible. Home visiting provides general parenting info, home assessments, infant care education, and links to families to appropriate resources. Home visiting also serves as follow-up for Newborn Screening, Lead Poisoning Prevention, and Immunization Programs. Community partners can refer older children (aged > 3) for home visiting services. First Connections links with local WIC sites to engage families that may initially refuse home visiting services //2013//.***

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Captured information through KIDSNET about developmental risk factors that trigger a referral for a home visit as well as home visiting data.			X	
2. Supported First Connections to provide home visiting services to at risk families with newborns.	X			
3. Prepared and submitted a grant to HRSA MCHB MIECHV Program to provide evidence-based home visiting services to pregnant women and families with young children (including newborns) in communities at risk for poor outcomes.				X

4. Linked First Connections and WIC to engage families that may have initially refused home visiting services.	X			
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

DCFHE continues to support First Connections. In addition, the DCFHE was awarded MCHB Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding to implement three evidence-based home visiting programs for pregnant women and families with children up to age three in the state's six urban core communities. The three evidence-based models being implemented are Nurse Family Partnership, Healthy Families America, and Parents as Teachers. Significantly, the MIECHV funding allows the DCFHE to expand home visiting services to pregnant women. MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network.

**c. Plan for the Coming Year**

c. Plan for the Coming Year

DCFHE will continue to support First Connections and the three evidence-based MCHB MIECHV programs in FY2013.

**State Performance Measure 2:** *Percent of middle school students who have initiated tobacco use.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					16.5
Annual Indicator		16.2	17.0	17.2	16.5
Numerator		5035	5248	5345	4395
Denominator		31167	30847	30995	26557
Data Source		YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	16.2	16.7	16.7	16.7	16.2

**Notes - 2011**

Data for 2011 shows a slight decline, from 17% in to 2009 to 16.5% in 2011, in the percent of middle school students who initiated tobacco use.

**Notes - 2010**

Data are estimated. The YRBS is conducted every other year and the YRBS for middle schools began with 2007.

**Notes - 2009**

The YRBS is conducted every other year and the YRBS for middle schools began with 2007.

**a. Last Year's Accomplishments**

**a. Last Year's Accomplishments**

*/2013/ The initiation rate for middle school youth is 16.5%. HEALTH began collecting middle school-specific YRBS data in 2007, so it is not possible to yet track a trend in tobacco initiation rates for this age-group. HEALTH will continue to ask this question on the Middle School YRBS to ascertain what kind of change in initiation rates will be seen over time.*

*The Rhode Island Tobacco Control Program (TCP) has a history of success with dramatically decreasing the youth smoking prevalence rate. Rhode Island has decreased its youth smoking rate from 35% in 1998 to 11% in 2011. This represents a decrease of 68%. Rhode Island has been and continues to be a national leader in tobacco control with the third lowest youth smoking rate as of the 2009 YRBS national data released. DCD will be releasing the 2011 national data in the first week of June, 2012, at which time Rhode Island will learn where its youth smoking rate ranks. TCP successes are attributable to the policy, systems and environmental change in which the TCP and its community-based partners have been engaged. For example RI has the second highest tax rate on cigarettes, a comprehensive ban on indoor smoking, and a law that prohibits the sale of tobacco to minors.*

*Despite Rhode Island's successes, tobacco-related disparities do exist, particularly among groups that are poor, have low levels of education, are African American, pregnant, LGBT, aged 18-24 years old, and mentally ill. Despite our relatively low smoking rates, we will continue to aggressively protect our youth from initiation and will continue to use evidence-based strategies to reduce tobacco initiation and use in disparately impacted communities as well as statewide.*

*What's more, the tobacco industry is ever-vigilant at responding to the tactics of tobacco control and currently has a campaign to initiate youth to tobacco products through youth-aimed emerging products such as fruit-flavored cigarillos, dip, and other non-cigarette products. Through the emerging tobacco and nicotine products, youth get hooked on the nicotine and become users of both cigarettes and other tobacco products. To this end, Rhode Island is working on policy and environment change to protect youth not only from cigarettes, but also from emerging tobacco products.*

*Between March 2010, the Tobacco Control Program collaborated with the City of Providence on implementing a 3.3 million dollar Communities Putting Prevention to Work (CPPW) grant. The grant focused on policy, systems, and environment change in Providence to ultimately reduce youth initiation and prevalence of cigarette and other tobacco use by youth (and adults) who are residents of the City of Providence. The City of Providence successfully passed several point of sale policies aimed at protecting youth by banning flavored other tobacco products (flavored cigarettes are already banned nationally). Other policies banned the sale of loose cigarettes, with local jurisdiction over its enforcement. Another policy aimed at reducing youth access to tobacco was to prohibit all tobacco use on all Providence school campuses including use by staff and all visitors.*

*The Tobacco control Program successfully launched a youth media campaign aimed at warning youth about the dangers of other tobacco products and warning youth to be original and to "not become replacements" for the tobacco users who are dying to tobacco-related illness //2013//.*

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported YRBS to collect and analyze data to track this indicator.			X	
2. Implemented the second highest tax on tobacco in the nation.			X	
3. Implemented a comprehensive ban on indoor smoking.			X	
4. Implemented a prohibition of the sale of tobacco to minors.			X	
5. Collaborated with the City of Providence on implementing a Communities Putting Prevention to Work initiative.			X	
6. Implemented a youth media campaign.			X	
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

*//2013/ The TCP continues to work with its community-based partners and with the RI Tobacco Control Network to educate statewide stakeholders about the dangers of emerging tobacco products. The TCP has initiated a campaign to help public housing developments adopt policies. This activity helps contribute to the social norms change that shapes the social and emotional environment in the state. With increasingly making smoking difficult to do, this sends a message to young people that smoking is not an acceptable behavior in our state. It is very apparent that RI has a strong tobacco control culture when one visits other states.*

*The TCP applied for an FDA media and health communication grant, which it hopes to begin implementing in the month of September 2012 pending receipt of the award //2013//.*

**c. Plan for the Coming Year**

c. Plan for the Coming Year

*//2013/ If the TCP receives the FDA grant, we will be engaged in implementing the grant which is focused on LGBT youth and youth with disabilities. The TCP plans to continue partnering with community-based organizations to continue to support policy, systems, and environment change in RI to make smoking even less normalized than it currently is. The TCP plans to continue to collaborate across programs in the Division, including Youth with Special Healthcare Needs, to promote the CDC goal of preventing youth initiation //2013//.*

**State Performance Measure 3:** *Percent of insured adolescents who receive an annual preventive care visit.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective					70
Annual Indicator		62.1	61.2	64.6	63.5
Numerator					60593
Denominator					95491
Data Source		Combined health plan data			
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	64	67	70	70	70

**Notes - 2011**

Data for 2011 is the aggregate percent of adolescents enrolled in Medicaid and private health plans who received a preventive care visit. Data was received from Blue Cross/Blue Shield, Neighborhood Health Plan, CIGNA and United Healthcare.

**Notes - 2010**

This is a combined percentage from RI's three health plans that include both private and Medicaid insured adolescents. Numerators and denominators were provided by two of the three plans.

**a. Last Year's Accomplishments**

a. Last Year's Accomplishments

*Rhode Island has a low rate of uninsured children including adolescents. /2013/ In 2011, the aggregate percent of adolescents enrolled in Medicaid and private health plans who received a preventive care visit was 63.5%, a small decrease from 2010. Even though only 6.3% of Rhode Island's children under age 18 were uninsured during the period 2008 - 2010, approximately 40% of adolescents did not receive a well child visit in the previous year. There was no difference between private and public health insurance plans in terms of adolescent well care visits. The HEDIS national benchmark measure for adolescent well care visits is under 60%, which may explain why the health care utilization for adolescent well care is not better. Health insurance can provide access to care yet it does not capture provider characteristics (e.g. adolescent friendly, wellness promotion/risk reduction verses traditional visit); health plan incentives (e.g. do enrolled members use the services), youth and parent engagement strategies (support for visit and how they align with adolescent developmental needs) as well as policies (such as required for high school, more rigorous HEDIS measure) to increase the number of adolescents receiving well child visits need to be considered to develop supportive systems of care for adolescents.*

*The DCFHE worked with external stakeholders to identify potential barriers and support to adolescents receiving care and best approaches to enable adolescents to access preventive care. Over 30 key informant interviews were held with topics including background health objectives for adolescents, health care delivery settings, barriers to care, needs of specific subpopulations of adolescents focused on disparities, provider training, practice guidelines/content of adolescent care, privacy/confidentiality, health insurance for preventive health services, and measuring quality/effectiveness of care. Focus groups with adolescents are planned. The DCFHE also unveiled the Rhode Island Alliance for Teen Pregnancy Prevention statewide strategic plan.*

*The DCFHE supported Woonsocket CATCH grant partners to establish on-site health*

**services at Woonsocket High School through Thundermist Health Center. TA included adolescent medical home development and family planning //2013//.**

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with external stakeholders to identify potential barriers and support to adolescents receiving care and best approaches to enable adolescents to access preventive care.			X	
2. Unveiled the Rhode Island Alliance for Teen Pregnancy Prevention statewide strategic plan.				X
3. Supported Woonsocket CATCH grant partners to establish on site health services at Woonsocket High School through Thundermist Community Health Center.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

DCFHE convened an Adolescent Transition working Group of the Successful Start Steering Committee to expand the early childhood systems work to children and adolescents.

DCFHE continued to support two school-based health centers in West Warwick and Providence. The West Warwick site is supported with state legislative community support grants and the Providence center is supported through state funds, grants, and reimbursement for services.

***//2013/ The DCFHE produced an Adolescent Access to Health Care Report including literature review, quantitative and qualitative data to inform recommendations to improve access to care among adolescents in RI.***

***The DCFHE continues to support Woonsocket CATCH grant partners to establish on-site health services at Woonsocket High School through Thundermist Health Center. Technical assistance included adolescent medical home development and family planning //2013//.***

**c. Plan for the Coming Year**

c. Plan for the Coming Year

The DCFHE will develop opportunities to work with communities on adolescent health issues, developing assets and reducing health risks. The DCFHE will seek new opportunities to engage youth in action research in a variety of health risk areas.

*/2013/ The DCFHE will continue to work with state and community level groups on issues related to access including the Rhode Island Alliance for Teen Pregnancy Prevention, Preconception Health Strategic Plan, the Rhode Island Task Force on Premature births, and the Covering KIDS RI Workgroup.*

*The DCFHE will design and implement an adolescent health summit to inform near term strategies to support adolescent health statewide. A broad-based group of adolescent health partners will plan, implement, and evaluate these efforts.*

*The DCFHE will continue to work on medical homes for teens with Woonsocket CATCH grant partners as well as the Washington County Coalition for Children CATCH project in Westerly which focuses on teen pregnancy, delayed prenatal care, and food insecurity //2013//.*

**State Performance Measure 4:** *Percent of high school students with special needs who report feeling sad or hopeless*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					41.8
Annual Indicator		40.8	42.1	42.1	38.8
Numerator		3901	3857	3889	3908
Denominator		9556	9166	9242	10071
Data Source		YRBS 2007	YRBS 2009	YRBS Estimate	YRBS 2011
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	40.7	40.2	39.8	39.5	39.5

**Notes - 2011**

Data from Youth Risk Behavior Survey [YRBS] which is conducted every other year. Data for 2011 reflects a decline in the percent of high school students with special needs who report feeling sad or hopeless. Percent in 2009 was 42.1% compared to 38.8% in 2011.

**Notes - 2010**

Data are an estimate only. The Youth Risk Behavior Survey [YRBS] is conducted every other year. Next survey will be conducted in fall of 2011.

**Notes - 2009**

Data from Youth Risk Behavior Survey [YRBS] which is conducted every other year. Data for 2009 reflects the results of the YRBS conducted in 2009.

**a. Last Year's Accomplishments**

a. Last Year's Accomplishments

*/2013/ Youth with disabilities in comparison to their typical peers are more likely to report feelings of hopelessness and to consider and attempt suicide than their non-disabled peers 2011 YRBS data indicate 41.7% of youth with disabilities report feeling sad or hopeless as opposed to only 17% of their non-disabled peers //2013//.*

The DCFHE, through OSHCN, is actively engaged in a positive youth development program for

youth with special needs / disabilities and their families. Through a positive youth development approach, students explore, develop, and showcase concepts of leadership to increase positive outcomes of achieving successful transition to adulthood, developing deeper connections to their communities and peers, and feel more in control of their lives.

OSHCN partners with community organizations and state agency leaders in highlighting the risk behaviors of students with special needs and systematically addresses them through increasing the following: well-integrated academic intervention; positive social and recreational activities; programs that support self-determination and student leadership; interventions that address behavioral health care needs; effective transition planning from school to adulthood including academic, vocational and healthcare; connections to appropriate adult role models; and support for community based experiences such as employment.

***//2013/ Since May of 2009, OSHCN and its partners have sponsored a statewide initiative for youth with disabilities or special health care needs entitled Dare to Dream (D2D). Held on a college campus, the conference day's event includes a young adult motivational speaker with a disability sharing their life experience //2013//.*** As students hear from a peer who has succeeded, their expectations and aspirations are raised. They learn to put their disability in perspective and not let it define who they are. Most important of all, from a transition perspective, students begin to see the future as a set of options that they control, not a predetermined set of events.

Preparing for the conference is the culmination of a year planning for the state and an exercise in teamwork for the participating school district students. Since students with disabilities have few chances for leadership in traditional high schools, a major outcome of the conference is that students in special education are provided with the opportunity to be leaders, self advocates, and teachers to their peers. Students are encouraged to bring information gained from their conference experience back to their own schools. As a result, many student participants have made presentations to teachers, parents, younger students, and school boards of education.

***//2013/ Since 2009, the annual D2D conference has touched the lives of thousands of students //2013//.*** Teachers, counselors, transition coordinators, and youth leaders continue to support the opportunity the conference provides for students to spend time reflecting on who they are, where they are going in the future, and how they might get there.

***//2013/ In 2010, D2D was expanded to include ongoing youth leadership development/membership opportunities in each community and across a variety of interests. The RI Transition Council produced a Directory of Youth Leadership Development Opportunities to provide teachers, guidance counselors, transition stakeholders, youth workers, community organizers, youth and families with local and national resources to build youth leadership. The Directory was presented to D2D supporters at a luncheon in the summer of 2010. The 2011 D2D conference was held on May 24th at URI, with a registration of over 625 youth and participation from 25 of the 35 school districts in the state. The 2011 conference highlighted opportunities for continued local participation by rolling out the D2D Start-Up Kit.***

***The 2012 D2D Student Conference was held on May 22nd at URI with a registration of over 740 youth and participation from 31 of the 35 school districts. The 2012 conference revealed the Dream Team as the Master of Ceremonies and lead conference organizers. The Dream Team is comprised of 12 young adults with special needs from a variety of districts throughout the state who advise OCHCN on positive youth development //2013//.***

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. Implemented a positive youth development program (Dare to Dream) for youth with special needs/disabilities and their families.				X
2. Partnered with community organizations and state leaders in highlighting the risk behaviors of students with special needs and addressed them through several strategies.				X
3. Sponsored a statewide Dare to Dream conference.		X		
4. Worked with a RI Transition Council to produce a Directory of Youth Leadership Opportunities as a part of Dare to Dream.		X		
5. Held a luncheon for Dare to Dream supporters.		X		
6. Rolled out a Dare to Dream Start-Up Kit.		X		
7. Created a Dream Team comprised of 12 adults with special needs who advise the OSHCN on positive youth development.		X		
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities:

***/2013/ OSHCN is actively engaged in a positive youth development program for youth with special needs / disabilities and their families. Current activities include an expanded offering of Dare to Dream youth leadership opportunities on a regional basis throughout the state and TA to community and school youth programs on inclusion of youth with special needs/disabilities. OSHCN engages in youth empowerment learning through hosting parent and professional workshops, conferences, tailoring outreach efforts, and partnering with the state's regional transition centers in designing materials.***

***OSHCN and RIPIN partnered with the Department of Labor & Training Youth Works Summer Training Program for 10 youth to participate in an intensive job training program as Youth Health Coaches. Youth will be trained on the evidence-based Healthy Lifestyles for People with Disabilities curriculum. Youth Health Coaches will be deployed to schools and communities in the fall of 2012 //2013//.***

**c. Plan for the Coming Year**

c. Plan for the Upcoming Year:

The OSHCN will continue to engage in a positive youth development program for youth with special needs / disabilities and their families. ***/2013/ The OSHCN will continue to participate in the RI Transition Council and the State Special Education Advisory Committee in setting statewide policy for youth with special needs in transition. These collective bodies advise local special education programs //2013//.***

Through a positive youth development approach, students explore, develop, and showcase concepts of leadership to increase positive outcomes of achieving successful transition to adulthood, developing deeper connections to their communities and peers, and feel more in control of their lives.

The OSHCN partners with community organizations and state agency leaders will continue to highlight the risk behaviors of students with special needs and systematically address the needs through increasing the following: well-integrated academic intervention; positive social and recreational activities; programs that support self-determination and student leadership;

interventions that address behavioral health care needs; effective transition planning from school to adulthood including academic, vocational and healthcare; connections to appropriate adult role models; and support for community based experiences such as employment.

The OSHCN will continue to expand the Dare to Dream Student Leadership Initiative for transition age students (14-21). ***/2013/ It will expand the Youth Health Coach Program as appropriate and will provide inclusion opportunities for youth with disabilities to be supported and empowered in their schools and communities //2013//.***

**State Performance Measure 5:** *Percent of women with health insurance who had a preventive care visit in the past year.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					85.2
Annual Indicator		84.7	85.1	84.7	84.7
Numerator		341436	333206	334337	335200
Denominator		403112	391642	394571	395600
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	85.5	85.7	86	86	86

**Notes - 2010**

Data are estimated.

**Notes - 2009**

Data from Rhode Island BRFFS 2009 survey.

**a. Last Year's Accomplishments**

a. Last Year's Accomplishments

***/2013/ The Office of Women's Health (OWH) monitors annually, the percent of women who have had a preventive care visit in the last year /2013//. This figure has held steady, fluctuating insignificantly around 84% since 2006. To improve this indicator of access to and utilization of women's health, the OWH collaborates with a number of programs inside of and external to HEALTH. /2013/ The OWH participated on the Health Insurance Exchange Work Group of Rhode Island's Health Reform Commission //2013//.***

The Women's Health Advisory Committee (WHAC), the advisory committee to the Director of Health, and OWH submitted feedback during the Title V community input process for the needs assessment and encouraged HEALTH to improve access to preventive care for women. In its capacity, the WHAC has discussed, issued recommendations, and taken action upon several topics that impact women's health and their health care experience- fecal incontinence, preconception care, breast cancer screening among senior women, exercise & health, healthy relationships among teen girls, newborn screening, and state legislation that impacts the health of women and girls.

Similarly, the Primary Care Providers Advisory Committee (PCPAC) to the Director of Health, the body that provides recommendations to improve primary care capacity, delivery, and quality for women, children and men issued recommendations to the Director of Health and the Health

Insurance Commissioner related to commercial insurers' revenue investments in primary care infrastructure, provider recruitment, and the Patient Centered Medical Home. These recommendations, some of which are being implemented, will improve the quality of preventive and primary care services for women across the state.

In addition, the Health Disparities and Access to Care Team, which includes the OWH, helped establish and fund the Community Health Worker Association of RI. This benefits women's preventive health because community health workers (CHWs) have aggressively outreached at community based settings to inform residents of health care options for insured and uninsured persons and have signed residents up for Medicaid. The primary beneficiaries of CHW services in RI are women and children.

The Women's Health Council of RI is a unifying organization of providers, payers, policy makers, and community members dedicated to moving women's health care in RI from the traditional focus on breast and obstetrics/gynecological health towards an improved system of comprehensive, integrated care. The WHC-RI has developed an expanded definition of standards for women's health care, "Comprehensive and coordinated research, education, clinical care and policy/advocacy that improve the social, physical and mental health of women across their lifespan."

***//2013/ The Rural Health Program (RHP) issued a Systems Building RFP to improve and expand primary care in rural/non-metro areas of the state. Integrated funding from Primary Care, Rural Health, and Title V is being used to fund four Rural Health Systems Building Grants that are projected to begin February 2013, as well as a separate contract to evaluate the impact of the systems building grants //2013. This work will include developing methods and tools that could be utilized by other community partnership initiatives of HEALTH.***

***//2013/ The OWH co-presented with the WHC-RI at its inaugural Quality Conference in October 2010 under the theme "Better Questions -- Better Quality". Keynote speaker Miriam Nelson, PhD introduced her topic Strong Women Healthy Lives by offering a solution to the obesity epidemic -- shifting from a focus on numbers to instead change peoples' behaviors and their surroundings: changing from hoping for compliance to more collaborative engagement. Two subsequent learning sessions in May and June 2011 taught providers tools and strategies for screening and referring for intimate partner violence and tools and strategies for providers to promote smoking cessation.***

***In addition, OPC reviewed all National Health Service Corps (NHSC) applications received and recommended many for approval. The OPC also provided TA to primary care, dental, and behavioral health providers that were seeking to become approved sites for NHSC clinicians, thereby expanding access to health care in health professional shortage areas //2013//.***

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the DCFHE's Office of Women's Health (OWH) to monitor this indicator.			X	
2. Supported the OWH's Women's Health Advisory Committee (WHAC) to provide recommendations for improving the quality and access to health care for women.				X
3. Supported HEALTH's Primary Care Providers Advisory Committee (PCPAC) to make recommendations for improving women's access to health care.				X
4. Supported the Community Health Worker Association of		X		

Rhode Island to provide outreach to women on the community level and enroll them in Medicaid.				
5. Worked with the Women's Health Council (WHC) to develop an expanded definition of standards for women's health care.				X
6. Supported the DCFHE's Rural Health Program to improve and expand primary care in non-urban communities.				X
7. Co-presented with the WHC at the inaugural Women's Health Quality Conference.		X		
8. Reviewed National Health Service Corps (NHSC) applications and recommended many for approval.			X	
9. Provided TA to primary care, dental, and behavioral health care providers seeking to become approved NHSC sites.		X		
10. Participated on the Health Insurance Exchange Work Group of RI's Health Reform Commission.				X

**b. Current Activities**

b. Current Activities

*/2013/ The Office of Women's Health (through the Team Lead for Health Disparities and Access to Care) participates on the Health Insurance Exchange Work Group of Rhode Island's Health Reform Commission. This is the body that recommends minimum benefits to be covered by the RI Health Insurance Exchange. The OWH will advocate for comprehensive women's preventive health services to be required benefits under the state's health insurance exchange. This has tremendous potential to improve the static percent of women who have had a preventive care visit in the last year. The OWH continues to participate on the Health Insurance Exchange Work Group of Rhode Island's Health Reform Commission. It also participates on the Preconception Care Planning Collaborative.*

*The OWH participates on the Preconception Planning Collaborative and works to improve access to comprehensive, high quality primary care services for women and girls.*

*In an effort to provide dental care for adult refugees, including women, the DCFHE's Oral Health Program worked with St. Joseph Hospital, which agreed to see adult refugees in their dental clinic on Saturdays.*

*The DCFHE's Refugee Health Program is working to increase the increase the percentage of refugees for whom a health screening form is submitted within 30 days of the refugee's arrival.*

*The OWH continues to staff the Women's Health Advisory Committee to the Director of Health //2013//.*

**c. Plan for the Coming Year**

c. Plan for the Coming Year

*/2013/ The Office of Primary Care and Rural Health worked with the RI Health Center Association to raise \$125,000 in "state" (private) funds allowing the State to apply for the State Loan Repayment Program Grant from HRSA. If funded, HRSA will provide an equivalent \$125,000 match that will be used to attract additional primary care providers to come to or remain in practice in health professional shortage areas.*

*In FY13, the Office of Primary Care will continue to collaborate with key partners, other State agencies, and State recruitment efforts to incorporate National Health Service Corps resources (i.e., Scholars, Loan Repayors, and Ready Responders) in the State's strategy to*

*increase the number of health professionals serving in health professional shortage areas. Further, the Office of Primary Care will engage in activities that successfully recruit and retain clinical staff to work in safety net settings in RI, with a particular emphasis on community health center sites.*

*The Office of Women's Health will continue to serve on the Women's Health Council and will co-host the third annual Women's Health Quality Conference, which will focus on the social and economic determinants of women's health.*

*Finally, the OWH (through the Team Lead for Health Disparities and Access to Care) will continue to participate on relevant Health Reform Commission and Preconception Planning work groups in order to increase women's access to and utilization of preventive services.*

*The OWH will continue to participate on the Health Insurance Exchange Work Group of Rhode Island's Health Reform Commission. It will also continue to participate on the Preconception Care Planning Collaborative.*

*St. Joseph Hospital will continue to see adult refugees in their dental clinic on Saturdays. The DCFHE's Refugee Health Program will continue to work to increase the percentage of refugees for whom a health screening form is submitted within 30 days of the refugee's arrival.*

*The Office of Women's Health will continue to serve on the Women's Health Council and will co-host the third annual Women's Health Quality Conference, which will focus on the social and economic determinants of women's health //2013//.*

**State Performance Measure 6:** *Percent of pregnant women determined at risk for poor outcomes, residing in selected communities, who receive a home visit during the prenatal period.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					38.2
Annual Indicator				7.1	24.1
Numerator				25	83
Denominator				354	345
Data Source				Kidsnet Database	Kidsnet Database& Effors to Outcomes
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	40	50	52	55	57

**Notes - 2011**

Provisional data. For 2012 two additional communities will be added to the numerator [Newport and West Warwick].

**Notes - 2010**

Women are considered at highest risk if they are aged 18-20 and do not have a high school education and are on medicaid. The selected communities include 4 of the core cities.

This new state performance measure is hoping to show improved outcomes if prenatal services are provided to these women.

**a. Last Year's Accomplishments**

a. Last Year's Accomplishments

***//2013/ First Connections provided home visiting services to pregnant women on a limited basis. Rhode Island has high rates of premature births, low birth weight, infant mortality, and child maltreatment in its six core cities, which include Central Falls, Pawtucket, Providence, Newport, West Warwick, and Woonsocket. Families in these communities face multiple risk factors and have been identified as those most able to benefit from intensive, evidence based home visiting programs that will improve coordination of services. Rhode Island currently has limited capacity to provide evidence-based prenatal home visiting. Expanding home visiting programs will help to improve and strengthen programs and activities carried out under Title V, improve coordination of services to improve outcomes for families at risk. HEALTH submitted a grant to HRSA - Maternal, Infant and Early Childhood Home Visiting Program to expand that capacity within the state to provide evidence-based home visiting services . MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network //2013//.***

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported First Connections to provide home visiting services to pregnant women on a limited basis.	X			
2. Prepared and submitted a grant to HRSA MCHB Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program to create capacity for evidence-based prenatal home visiting services in communities at risk for poor outcomes.	X			
3. Created an infrastructure to support statewide home visiting services for pregnant women in communities at risk for poor outcomes through the Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

***//2013/ DCFHE continues to support First Connections. In addition, the DCFHE was awarded MCHB Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding to implement three evidence-based home visiting programs for pregnant women and families with children up to age three in the state's six urban core communities. The three evidence-based models being implemented are Nurse Family Partnership, Healthy Families America, and Parents as Teachers. Significantly, the MIECHV funding allows the***

**DCFHE to expand home visiting services to pregnant women. MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network //2013//.**

**c. Plan for the Coming Year**

c. Plan for the Coming Year

**/2013/ DCFHE will continue to support First Connections and the three evidence-based MCHB MIECHV programs in FY2013. It will also continue to support MIECHV infrastructure including a Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network. The DCFHE will work with state and local partners to create an integrated prenatal referral system for home visiting services //2013//.**

**State Performance Measure 7: Percent of parents with children in early childhood that enroll in evidence based parenting education\support programs.**

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					8.5
Annual Indicator				4.2	4.1
Numerator				1434	1375
Denominator				34040	33440
Data Source				Various	Various
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	4.5	5.2	6.2	7.2	8

**Notes - 2011**

The increase in parents enrolled in evidence based parent education programs was lower than expected. There were 2 main factors that contributed to this. One of the programs [HIPPPY] lost federal funding and the number of slots declined from 260 slots to 30. In addition, Rhode Island Department of HEALTH has awarded contracts to community agencies to implement such programs but in 2011 these programs were not yet available.

**a. Last Year's Accomplishments**

a. Last Year's Accomplishments

**/2013/ More evidence-based programs that demonstrate outcomes are needed to ensure that resources are allocated to programs that improve outcomes. During May 2011, HEALTH convened a meeting that highlighted evidence based programming and practices that improve child health outcomes. The efforts included: a training program for children, parents, and teachers that support the social-emotional competence of children at high risk, the Nurse Family Partnership program for home visiting to new families at high risk, and a youth development approach to teen pregnancy prevention. HEALTH submitted a grant to HRSA - Maternal, Infant and Early Childhood Home Visiting Program to expand that capacity within the state to provide evidence-based home visiting services. MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network. In addition, the DCFHE worked with the Successful Start Steering Committee to coordinate evidence-based parent education/support and support**

to parents //2013//.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prepared and submitted a grant to HRSA MCHB Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program to create capacity for evidence-based prenatal and early childhood home visiting services in core communities.	X			
2. Worked with the Successful Start Steering Committee to coordinate evidence-based parent education/support programs and support parents.				X
3. Created an infrastructure to support statewide home visiting services for pregnant women and families with young children through the Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network.				X
4. Convened, with KIDSNET, a meeting to highlight evidence-based programs and practices that improve child health outcomes.		X		
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

***//2013/ DCFHE was awarded MCHB Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding to implement three evidence-based home visiting programs for pregnant women and families with children up to age three in the state's six urban core communities. The three evidence-based models being implemented are Nurse Family Partnership, Healthy Families America, and Parents as Teachers. Significantly, the MIECHV funding allows the DCFHE to expand home visiting services to pregnant women and families with young children in communities at risk for poor outcomes. MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network.***

***The DCFHE continues to work with the Successful Start Steering Committee to coordinate evidence-based parent education/support and support to parents.***

***In addition, DCFHE received federal Race to the Top Early Learning challenge funds to work with other state agencies to improve early learning and development opportunities for young children. The team will support 90 pediatric practices to implement standardized developmental screening and will also provide supports to PCPs to address the needs of families in their practice that arise as a result of the screening //2013//.***

**c. Plan for the Coming Year**

c. Plan for the Coming Year

***/2013/ DCFHE will continue to support the three evidence-based MCHB MIECHV programs and the Race to the Top Early Learning Challenge activities in FY2013. It will continue to support MIECHV infrastructure including a Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network. It will also continue to work with the Successful Start Steering Committee to coordinate evidence-based parent education/support and support to parents //2013//.***

**State Performance Measure 8:** *Percent of RI adolescents who report food insecurity.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					11
Annual Indicator					3.6
Numerator					1488
Denominator					41291
Data Source					YRBS
Is the Data Provisional or Final?					Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	3.2	3	3	3.2	3.5

**Notes - 2011**

Data from the YRBS. The YRBS is conducted every other year and the food insecurity questions were collected for 2010/2011 school year.

**Notes - 2010**

SPM #8: Percent of Rhode Island adolescents who report food insecurity.

Data not available and no estimate is available. Question was added to YRBS survey for the 2011 school year. Data on this question should be available by June 2012.

**a. Last Year's Accomplishments**

a. Last Year's Accomplishments

The Initiative for a Healthy Weight (IHW) initiated the development of a statewide Food Council (FC). The purpose of the FC is to increase and expand the state's current food system, which would result in greater access to healthy and affordable foods for all Rhode Islanders. The FC was awarded funds from the Van Beuren Foundation and the Rhode Island Foundation to develop a food systems assessment that will identify gaps in the RI food system.

IHW partnered with the Environmental Justice League of RI (EJLRI) to implement the Providence Healthy Corner Store Initiative. The EJLRI worked with youth in the low income Southside Providence neighborhood to highlight the need for healthier foods in local stores. EJLRI worked with 3 store owners to change the product mix, incorporating more fruits and vegetables, whole grains, and low fat dairy products. Store owners also participated in a "store makeover" to change product placement of healthy and unhealthy items.

IHW received a \$3M CPPW grant to integrate health into local community policies. As part of this grant, IHW began to identify healthy community indicators, including those related to food access (access to full service supermarkets, corner stores, farmers markets.) IHW also worked with the Division of Planning and the Department of Environmental Management on food access recommendations for local governments to include in their comprehensive plans as a way to ensure that communities plan for residents' access to food.

***//2013/ WIC provided pregnant teens, breastfeeding teen mothers, and post-partum teen mothers with access to healthy foods through WIC and WIC Farmers Markets. WIC implemented a new WIC food package with increased fruits and vegetables, more culturally appropriate foods, and lower fat foods //2013//.***

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Initiated, through the DCFHE's Initiative for a Healthy Weight (IHW), development of a statewide Food Council.				X
2. Partnered with the Environmental Justice League of RI to implement the Providence Healthy Corner Store Initiative.		X		
3. Received a CPPW grant to identify healthy community indicators, including those related to food access.			X	
4. Worked with the Division of Planning and the Department of Environmental Management to address food access recommendations for local communities to include as part of their local comprehensive plans.				X
5. Supported WIC to provide pregnant teens, breastfeeding teen mothers, and post-partum teen mothers with access to healthy foods through WIC and WIC Farmers Markets.	X			
6. Implemented a new WIC food package with increased fruits and vegetables, more culturally appropriate foods, and lower fat foods.	X			
7. Supported Woonsocket CATCH grant partners to establish on site health services at Woonsocket High School through Thundermist Community Health Center.	X			
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

IHW is currently participating in the Food Council design team to develop the food system assessment. IHW's role is specific to access to healthy and affordable food in underserved communities. IHW is also leading National Food Day efforts in RI. Food Day will bring attention to the need for policies and programs to ensure that all Rhode Islanders have access to healthy and affordable foods.

***//2013/ WIC provides pregnant teens, breastfeeding teen mothers, and post-partum teen mothers with access to healthy foods through WIC and WIC Farmers Markets. WIC continues to offer a new WIC food package with increased fruits and vegetables, more culturally appropriate foods, and lower fat foods //2013//.***

**c. Plan for the Coming Year**

c. Plan for the Coming Year

IHW has funded 3 municipalities to implement the Healthy Community recommendations, which include recommendations around food access. IHW will continue to be active in the development of the food assessment and the development of resulting policy priorities around food access.

***//2013/ WIC will continue to provide pregnant teens, breastfeeding teen mothers, and post-partum teen mothers with access to healthy foods through WIC and WIC Farmers Markets. WIC will continue to offer a new WIC food package with increased fruits and vegetables, more culturally appropriate foods, and lower fat foods //2013//.***

**State Performance Measure 9:** *Percent of Rhode Island high school students who earn a high school diploma or diploma equivalent in the six core cities.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					65.2
Annual Indicator			63.5	64.7	66.7
Numerator			2532	2527	2577
Denominator			3990	3908	3862
Data Source			Dept of Education	Dept of Education	Dept of Education
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	67	66.1	66.2	66.2	66.7

**Notes - 2011**

Data from the Rhode Island Department of Education Infoworks and reflects the 4 year graduation rate.

**Notes - 2010**

Data from the Rhode Island Department of Education Infoworks and reflects the 4 year graduation rate.

**Notes - 2009**

Data from the Rhode Island Department of Education Infoworks and reflects the 4 year graduation rate.

**a. Last Year's Accomplishments**

a. Last Year's Accomplishments

***//2013/ According to the RI Department of Education, the four year graduation rate in Rhode Island's six core cities is 66.7% //2013//.*** Student achievement and graduation rates can be improved by using data to identify at-risk students during elementary and middle school. By the first quarter of the ninth grade or earlier, course failure patterns, poor behavior and attendance problems can be used to identify high risk students who are "off track" for graduation. Early warning systems that lead to the provision of personalized and timely academic and social

support can help students get "on track" for graduation.

The United States Department of Health and Human Services Healthy People 2020 objectives for the nation include high graduation rate along with literacy and numeracy indicators of achievement for school aged children. This inclusion underscores the interrelationship between positive health and education outcomes. Health research studies have shown that accountability for education outcomes has increased within an environment of complex social problems. Schools need support for building a broader context that includes ways for schools to have a positive influence on factors not always directly in their control and beyond traditional education approaches.

Data from the YRBS indicated that youth who reported having a disability, gay lesbian bisexual or unsure, or poor academic performance were all at higher risk for many of the health risk behaviors. Public health agencies can play a primary role in ensuring that students graduate from school by building systems approaches to address health concerns. Graduation from high school is a strong predictor of positive health outcomes in adulthood. The new Race to the Top funding stresses early childhood collaboration and is a model to build on for older youth.

DCFHE and KIDSNET works with the Full Service Community School (FSCS) in Providence to connect families with chronically absent children to health services.

2013/ DCFHE received USDHHS Personal Responsibility Education Program (PREP) funds to implement evidence-based teen pregnancy prevention curriculum. DCFHE selected Wyman Center's Teen Outreach Program, a youth development program with demonstrated results in preventing teen pregnancy and supporting positive academic and health behaviors. DCFHE designed two competitive processes to identify local implementation partners and 1 statewide professional development partner.

DCFHE hosted the unveiling of the RI Alliance for Teen Pregnancy Prevention statewide strategic plan.

DCFHE collaborates with RI Kids Count on an issue brief titled: Disparities in children's Health, which makes the connection between disparities in education outcomes and health disparities among other issues.

The DCFHE continued to support Woonsocket CATCH grant partners to establish on-site health services at Woonsocket High School through Thundermist Community Health Center. The DCFHE continued to provide TA on adolescent medical home development and family planning //2013//.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with the Full Service Community Schools initiative in Providence to connect families with chronically absent children to health services as a way to improve school attendance.		X		
2. Used USDHHS Personal Responsibility Education Program (PREP) funds to implement evidence-based teen pregnancy prevention curriculum (Teen Outreach Program).	X			
3. Hosted the unveiling of the RI Alliance for Teen Pregnancy Prevention statewide strategic plan.				X
4. Collaborated with KIDSCOUNT on an Issue Brief titled Disparities in Children's Health, which makes the connection			X	

between disparities in education outcomes and health disparities.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

b. Current Activities

DCFHE continued to implement PREP funding for evidence-based youth development approach to teen pregnancy prevention.

***/2013/ DCFHE produced an Adolescent Access to Care Report including literature review, quantitative and qualitative data to inform recommendations to improve access to care among adolescents in RI //2013//.***

DCFHE continues to support 2 school based health centers in West Warwick and Providence. The West Warwick site is supported with state legislative community support grants and the Providence center is supported through state funds, grants, and reimbursement for services.

DCFHE participates on the FSCS Alliance including the RI Department of Education and the State's 10 Child Opportunity Zones sites. A \$50,000 grant was received from the RI Foundation to support work of the Alliance to develop capacity for full service community schools in Rhode Island.

DCFHE continued to partner with RIDE on capacity building to support thrive, RI's coordinated school health effort.

***/2013/ The DCFHE continues to work on teen medical homes with Woonsocket CATCH grant partners to establish on-site health services at Woonsocket High School through Thundermist Health Center. The DCFHE continues to provide TA on medical home development and family planning. The DCFHE also continues to support the Washington County Coalition for Children's CATCH project in Westerly that focuses on teen pregnancy, delayed prenatal care, and food insecurity //2013//.***

**c. Plan for the Coming Year**

c. Plan for the Coming Year

The DCFHE will develop opportunities to work with communities on adolescent health issues, developing assets and reducing health risks. The DCFHE will seek new opportunities to engage youth in action research in a variety of health risk areas.

The DCFHE will continue to track births to teens and examine trends by demographic factors.

***/2013/ DCFHE will continue to participate on the Full Service Community Schools Alliance Board //2013//.***

DCFHE will explore opportunities to build partnerships with RIDE to support the connections between education and health outcomes at the State and local level.

***/2013/ DCFHE will provide training in the Teen Outreach Program to 9 community partners***

*to enable the implementation of this evidence-based program.*

*DCFHE will design and implement an adolescent health summit to inform near term strategies to support adolescent health statewide. A broad-based group of adolescent health partners will plan, implement, and evaluate these efforts.*

*The DCFHE will continue to work on teen medical homes with Woonsocket CATCH grant partners as well as the Washington County Coalition for Children CATCH project in Westerly that focuses on teen pregnancy, delayed prenatal care, and food insecurity //2013//.*

## **E. Health Status Indicators**

### Health Status Indicators

There are 23 Health Status Indicators that assist the DCFHE's ability to provide information on Rhode Island residents, assist in directing public health effort; serve as part of a surveillance and monitoring system and provide as an evaluative measure of current public health efforts to support maternal and child health. This section provides an interpretation of the data, key policy and program influences on Rhode Island's ability to maintain or improve the indicator and efforts to continuously improve each health status indicator. All data is provisional.

HSI #01A: The percent of live births weighing less than 2,500 grams

HSI #01B: The percent of live singleton births weighing less than 2,500 grams

HSI #02A: The percent of live births weighing less than 1,500 grams

HSI #02B: The percent of live singleton births weighing less than 1,500 grams

As part of a needs assessment process, the DCFHE, in partnership with the Center for Health Data and Analysis (CHDA), tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from the Office of Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the State. This data is also shared at the local WIC level to ensure that those children who are enrolled in WIC and are low birth weight

are offered or engaged in community-based services.

Successful Start uses this data to raise awareness of community health needs, facilitate and inform action to improve performance, and develop recommendations about targeting resources to areas of highest need.

The First Connections Home Visiting program uses this data to identify children who will be offered home visits due to low birth weights and to follow up on children who were automatically referred to Early Intervention.

Integration of community health data into new venues, such as community based partnerships and city and town planning departments, are highly effective disseminators of such information and critical to the long term mission of public health intervention.

HSI #03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

HSI #03B: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.

HSI #03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

HSI #04A: The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.

HSI #04B: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.

HSI #04C: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Motor vehicle crashes are the leading cause of death for all Rhode Islanders ages 1-44. The leading contributors to motor vehicle crash deaths are not wearing a seatbelt and drunk driving.

The DCFHE is responsible for injuries in school age children and young adults. DCFHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Safe RI - Violence and Injury Prevention Program works with the Department's Center for Health Data and Analysis to track, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Safe Rhode Island (SRI): SRI partnered with the Traffic Safety Coalition (TSC) and the Injury Prevention Center at RI Hospital to successfully advocate for the passage of legislation eliminating a major loophole in the state's drunk driving laws to cover individuals who refuse to submit to a breathalyzer test. The social host law was also strengthened to deter adults who knowingly provide alcohol to minors on their property. Rhode Island's Graduated Driver Licensing (GDL) law was improved to include a limit on cell phone use by youth less than 18 years while driving and a ban on texting while driving. Additionally, a voluntary two hour parent education class was integrated into the Community College of Rhode Island Driver Education Program curriculum. ***//2013/ The governor signed a primary seat belt law on June 30, 2011. This law allows police officers to ticket a driver solely on the basis that the driver is not wearing a seatbelt and makes enforcement of the law that covers children up to 18 years more likely //2013//.***

The Rhode Island Department of Health Traumatic Brain Injury Service Linkage Program (TBISLP) collects Traumatic Brain Injury (TBI) data. This data is used to track the prevalence of TBI in Rhode Island, identify survivors of TBI and connect these survivors, their families and caregivers with the appropriate community-based services and support. The Rhode Island Department of Health used data from the TBI Registry to develop the TBI Childhood Falls Awareness Media Campaign. ***/2013/ The target audience of the campaign included parents, caregivers, and child care & healthcare providers. The media campaign had 3 goals: to promote awareness that childhood falls is a preventable public health problem, to promote efforts to reduce childhood falls resulting in Traumatic Brain Injury, and to raise awareness about the dangers of childhood falls. The media campaign launched on 06/27/2011 and ended on 09/25/2011 //2013//.*** The media venues used were bus kings, rails and shelters displayed throughout the state. There are educational materials (fact sheets, posters, website) and promotional items (band-aid dispensers & t-shirts).

HSI #05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia

HSI #05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia

Narrative:

***/2013/ The DCFHE is responsible for monitoring, tracking and working to improve the health of school age children through child and adolescent medical home efforts and administration of the state's Title X Family Planning Program. The Family Planning Program is a member of the Region I Infertility Prevention Project (IPP), which is a collaboration between the Centers for Disease Control (CDC) and the Office of Population Affairs (OPA). The overall goal of IPP is to assess and reduce the prevalence of Chlamydia and gonorrhea and reduce related sequelae such as pelvic inflammatory disease (PID), infertility and ectopic pregnancy. Positive Chlamydia and gonorrhea cases are reported by the RI State Laboratory to the STD Program and IPP. This data is critical to being able to identify the needs of subpopulations and to develop effective planning and prevention interventions. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, Annual Needs Assessment Summary and materials developed by the STD program. The data is used to identify trends in subpopulations and is reported in the context of contributing factors that impact the numbers and rates. In order to measure the effectiveness of interventions and to determine progress towards meeting goals, the data is monitored over time //2013//.***

HSI #06A & B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race, and ethnicity

As part of a needs assessment process, the DCFHE, in partnership with the Center for Health Data and Analysis tracks, on an annual basis, subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. For example, teen birth rates are highest among Hispanic populations, which also have high rates of poverty. Teen pregnancy prevention efforts, therefore, are focused on the Hispanic community. Data are drawn from Vital Records, Department of Administration Statewide Planning, U.S. Bureau of the Census, and other population estimate sources. This information is used to calculate rates of various maternal and child health indicators. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

***/2013/ Some of the new 10-year census data (2010) are now available by age, race and ethnicity, an additional data will be made available during CY2012./2013//***

In addition, date of birth, race, and ethnicity are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. Age, and when possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island.

Survey data including PRAMS, TWOS, Youth Risk Behavior Survey, and Behavioral Risk Factor Surveillance, vital records data, maternal and child health program data, hospital inpatient and emergency room data, and STD data enumerated by age, race and ethnicity are available for data analysis. WIC, the Immunization Program, the newborn screening programs, healthy childcare programs, adolescent health, and other MCH programs use data enumerated by age, race and ethnicity to identify coverage rates and gaps in service, target outreach and service delivery, evaluate effectiveness of program activities, prepare of state plans, rank relative community needs, identify disparities and needs by race and ethnicity, and disseminate information to key stakeholders.

HSI #07A & B: Live births to women (of all ages) enumerated by maternal age, race and ethnicity

As part of a needs assessment process, the DFCHE in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, live births to women (of all ages) enumerated by maternal age, race, and ethnicity. These data are used to calculate fertility rates among women of all ages. They are also used to calculate overall pregnancy rates and teen pregnancy rates. Data are drawn from Vital Records. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. WIC and other MCH programs use data enumerated by maternal age, race and ethnicity to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions, to determine progress towards meeting goals, and in the preparation of state plans and for ranking relative community needs

All live births, maternal date of birth, race, and ethnicity are collected in the integrated electronic birth certificate/developmental risk screening system (VR2000) and stored in KIDSNET.

***/2013/ The Maternal, Infant and Early Childhood Home Visiting Initiative has relied extensively on this data for planning for expanded home visiting in Rhode Island./2013//***

HSI #08A & B: Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity

As part of a needs assessment process, the DCFHE's in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities to populations most in need. The DCFHE tracks data by cause of death, age, and geographical areas and looks at insurance status and other variables. Data are drawn from Vital Records. The DCFHE and the Center for Health Data and Analysis works with programs to identify causes of death and to identify effective prevention strategies. The Center for Health and Data and Analysis and the SafeRI- Violence and Injury Prevention Program participates on the Rhode Island Child Death Review Team focused on preventable deaths among all children and adolescents. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual

Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Deaths to infants that occur prior to discharge from a maternity hospital are collected in the integrated electronic birth certificate/developmental risk assessment system (VR2000) along with date of birth and race/ethnicity data and stored in KIDSNET. KIDSNET also works with Vital Records and other processes to record infant and child death in KIDSNET.

HSI #09A & B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity

As part of a needs assessment process, the DCFHE tracks subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. The DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various state programs enumerated by race and ethnicity. Data are drawn from program reports, the U.S. Bureau of the Census, Rhode Island Kids Count, the Department of Human Services/Medicaid, Juvenile Justice, and Vital Records. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Race/ethnicity data are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. KIDSNET includes program-level data for children born on or after January 1, 1997 for the following programs: Early Intervention, Family Outreach (home visiting), WIC, Immunization, Lead Poisoning Prevention, and Newborn Screening (metabolic, hearing, and developmental risk). KIDSNET generates program data enumerated by race and ethnicity for program use.

WIC, the Immunization Program, early childhood programs including Successful Start and Project Launch, Adolescent Health, and other MCH programs use data enumerated by race and ethnicity to support federally funded Vaccine for Children (VFC) activities, identify coverage rates and gaps in service, target outreach and service delivery, evaluate effectiveness of program activities, prepare state plans, rank relative community needs, identify disparities and needs by race and ethnicity, determine translation needs/requirements for educational materials, develop recommendations for early childhood systems and services about targeting resources to areas of highest need, and disseminate information to key stakeholders.

Access to the Department of Human Services data warehouse beginning in 2011 will increase capacity to report miscellaneous data relevant to MCH programs enumerated by race and ethnicity.

***/2013/ Heights, weights and BMI for WIC participants aged less than six can now be enumerated by race and ethnicity in KIDSNET. The capacity to record and enumerate developmental screening to young children will be added to KIDSNET during 2012.//2013//***

HSI #10: Geographic living area for all resident children aged 0 through 19 years

As part of a needs assessment process, the DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, the geographic living area for all resident children aged 0 through 19 years in order to conduct cross-tabulations by geographic area to target prevention activities. For example, teen birth rates are highest in the core MCH planning cities,

which have high rates of minority populations, poverty, and school failure. Teen pregnancy prevention efforts, therefore, are focused on those communities. Data are drawn from Vital Statistics Records and U.S. Bureau of the Census data. The RI Department of Health has implemented a geographical information system for use by all staff. Databases are gradually being geo-coded for mapping purposes. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Address at the time of birth is collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When possible, address information is also collected in KIDSNET when new records are opened on children not born in Rhode Island. Address information is updated by KIDSNET users such as home visitors, the lead program, primary care providers, and others aware of address changes. KIDSNET data can be analyzed at the zip code, region, or city/town level. This data can then be shared with home visiting agencies and local coalitions working to address public health issues within communities. Geographic data has also been used to inform policymakers and planners working on disaster plans such as pandemic flu. KIDSNET, in collaboration with the Center for Health Data and analysis Geographic Information System (GIS) Program, now has the capacity to report data by any geographic level allowing for refined geographic analysis and production of maps.

***//2013/ KIDSNET has added address standardization software and geocoding that will improve the quality of address information.//2013//***

The DCFHE, in partnership with the Center for Health Data and Analysis, has an established practice of comparing data in core cities (where childhood poverty is 15% or greater) compared to other areas in the state.

WIC, the Immunization Program, First Connections Home Visiting Program, adolescent health and other MCH programs use geographic data to monitor coverage rates and gaps in service in cities and towns, target outreach and service delivery, evaluate effectiveness of program activities, prepare state plans, rank relative community needs, identify disparities and needs by race and ethnicity, target resources to areas of high need and density, and disseminate information to key stakeholders

***//2013/ Some of the new 10-year census data (2010) are now available by age, race and ethnicity, an additional data will be made available during 2012.//2013//***

HSI #11: Percent of the State population at various levels of the federal poverty level  
HSI #12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level

As part of a needs assessment process, the DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, the percent of the population (state and child) at various levels of the federal poverty level in order to conduct cross-tabulations by poverty to target prevention activities in areas most in need. Poverty is a risk factor for nearly every poor health outcome and therefore must be addressed as part of strategic planning to improve health and wellbeing of maternal and child populations. For example, poverty is a risk factor for teen pregnancy and school failure. Teen pregnancy prevention efforts, therefore, must incorporate strategies to give youth hope for the future and skills to meet the demands of a 21st century workforce. Data are drawn from the U.S. Bureau of the Census and other survey and program data. The information is shared with community partners through the publication of our annual

Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

WIC, Early Childhood, Adolescent Health, and other MCH programs use poverty data to monitor coverage rates and gaps in service, target outreach and service delivery, evaluate effectiveness of program activities, preparation of state plans, ranking relative community needs, identify disparities and needs by race and ethnicity, target resources to areas of highest need and density, develop recommendations, and disseminate information to key stakeholders

***/2013/ Some of the new 10-year census data (2010) are now available by age, race and ethnicity, an additional data will be made available during 2012 //2013//.***

## **F. Other Program Activities**

### F. Other Program Activities

DCFHE initiatives and activities that were not fully discussed within the context of the National and State Performance Measures are described below.

Toll-Free Department of Health Information Line

***/2013/ The Department of Health Information Line (HIL) is a statewide toll-free telephone resource for Rhode Islanders. Bi-lingual information specialists answer families' questions in English, Spanish and Portuguese about HEALTH programs, as well as about a wide variety of health topics, such as mold and mildew. Calls in other languages are answered using a contracted vendor for language access. Staff refers callers to appropriate community resources. Callers to the Department of Health Information Line include consumers, health care providers, school personnel, and community-based agencies. In addition, HIL specialists help health care professionals renew their licenses over the telephone. To better assist callers, the specialists have been provided with access to several HEALTH databases including vital records, KIDSNET, and L2K (the health care professional licensing database). In calendar year 2011, the HIL received 46,192 calls.***

### ***The Rhode Island Health Information Exchange and KIDSNET***

***RI's Health Information Exchange (HIE), known as Current Care, is being implemented and the operations, management, and maintenance responsibilities of Current Care are now the responsibility of the RI Quality Institute (the state's designated health information organization). Current Care provides secure access to patient health information from a variety of local public and private information systems to authorized users. Current Care is operational and contains laboratory data from 6 hospitals and 1 large private laboratory, with at least 1 more private laboratory to start sending data in June 2012. Current Care contains hospital registration data (ADT feeds) from 3 hospitals, with the 7 remaining hospitals to start sending data in the next few months.***

***The ADT information is sent to Current Care and Current Care will then notify the primary care provider, via direct messaging, that their patient is in the hospital (or being discharged from the hospital). Additionally, clinical summary data from 5 provider practice***

**electronic health records and medication history data from 3 large chain pharmacies are currently part of Current Care and the number of data-sharing partners continues to grow. In 2008, the state passed the HIE Exchange Act, which requires that patients be provided with the choice to participate in Current Care (opt in) as well as choose who can access their data. To date, 226,000 individuals have enrolled in Current Care (about 26% of the population).**

**Current Care's goal is to reach 500,000 individuals in the next 18 months. Current Care allows providers to access various sources of health data so that it can be viewed in an integrated and uniform manner. The first end-user started using the system in April 2012 and it is anticipated that 100 sites will be able to access Current Care by the end of the calendar year. Future plans include helping to develop capacity to allow data from various sources to flow bi-directionally between EMRS and the HIE and create the ability to utilize the data for public health purposes, which includes evaluation and surveillance.**

**KIDSNET is actively participating in Current Care as a Data Sharing Partner. Through KIDSNET's communications channels, pediatric providers are informed about the HIE Project. The KIDSNET database includes aggregates data on a number of childhood preventive services for all children born after January 1, 1997. KIDSNET will participate in the HIE Project's data standards committee to facilitate the use of data standards in RI's healthcare transactions. The National Coordinator for Health Information Exchange has recommended using "DIRECT" as a secure method to transfer health information between health care providers. HEALTH will explore this option for the transfer of data within Current Care and potentially for the purposes of transferring immunization and other health data to KIDSNET. Some electronic health records send a continuity of care document (CCD) to the HIE. KIDSNET will explore the transfer of immunization and potentially other public health information from the CCD to KIDSNET.**

#### **Integrated MCH/Chronic Disease RFP**

**The elimination of health disparities in the state continues to be a major challenge in the face of the economic downturn and cuts to public safety net services. The residents of the 6 core communities have the highest rates of poverty and are at risk in almost every category. The DCFHE is planning to issue an \$800,000 RFP (each award will be up to \$100,000 for three years) requesting applications to initiate environmental system policy changes in the areas of social, political, physical, and environmental determinants of health through a community engagement process to make active living an easier choice for all residents. The RFP is composed of two components: 1) fostering healthy and safe sustainable community environments and 2) implementation of evidence-based programs addressing chronic disease and its risk factors and MCH priorities. The RFP will create new collaborations and established concrete goals and objectives regarding the elimination of health disparities.**

**The goal of Component 1 is to support the advancement at the local level of the National Strategic direction to create, sustain, and recognize communities that promote health and awareness through prevention. Applicants will be asked to collaborate to develop strategies and policies that impact the availability of resources to meet daily needs (housing, education, job opportunities, food insecurity, etc.), that impact the community structure (parks, transportation, etc.) and that impact the natural environment. Specifically, applicants will be asked to develop in response to their local assessments and community engagement a plan of action that will:**

- Promote inclusion of health criteria as a component of decision making -- appropriate decision making tools are the Healthy Communities Plan and the use of HIAs. These should lead to healthy community designation.**
- Convene diverse partners and promote strong cross-sector participation in planning, implementing, and evaluating community health effort. In the communities**

*where the DCFHE has funded MIECHV Program services, the community will be required to participate in LITs in the respective community.*

- *Work with local municipalities to implement policies and practices that promote healthy environments such as tobacco free policies, improving indoor air quality, addressing mold problems, reducing exposure to lead and pesticides (it should also include traffic, crime, and availability of healthy and affordable foods).*

*With respect to Component 2, evidence-based public health education and promotion programs should address health improvements that can be achieved through population-based as well as individual actions, systems-based, environmental, health service, or policy interventions. These interventions will further advance at the local level, the National Prevention Strategy and Rhode Island's MCH priorities. In the area of chronic disease, applicants may choose among the following programs:*

- *Self-Management Chronic Disease Education Programs*
- *Comprehensive Local Tobacco Control and Prevention Program*
- *Preventing Drug Abuse and Excessive Alcohol Use*
- *Healthy Eating Active Living*
- *Injury and Violence Free Living.*

*In the area of Maternal and Child Health applicants may choose among the following programs:*

- *Increase access to and capacity of evidence based parent education and family support programs*
- *Increase the social and emotional well-being of children and youth with a focus on children and youth with special health care needs*
- *Reproductive and Sexual Health //2013//*

## **G. Technical Assistance**

*/2013/ The following information represents a preliminary idea of the programmatic areas in which Rhode Island's Title V Program would like technical assistance (TA), consultation, or capacity building activities.*

*Request #1: Addresses: SPM #4 and NPMs #2-6. Description: Since its inception in 2009, MCHB has partnered with RI's Office of Special Health Care Needs in the Dare to Dream Conference. TA funds have been sought and accessed to fund the keynote speaker for the conference. The conference is held on a college campus and includes a youth motivational speaker and peer-led presentations from students with disabilities. The conference has touched the lives of thousands of students. Teachers, counselors, transition coordinators, and youth leaders continue to support the opportunity the conference provides for students to spend time reflecting on who they are, where they are going in the future, and how they might get there. Justification: Rhode Island's approach to addressing disparities in the social and emotional health of CSHCN is to promote opportunities for positive youth development, meaningful inclusion in school and community based activities, and assisting youth in the formation of leadership skills. Through the conference, students understand the power and responsibility of healthy decision making, learn effective critical thinking and conflict resolution skills, and practice healthy ways to deal with freedom & loneliness. The OSHCN is developing student leaders for youth membership advisory committees, policy discussions, boards and speaking bureaus. Suggested TA Provider and/or Organization: Jonathan Mooney.*

*Request #2: Addresses: SPM #4 and NPMs #2-6. Description: The Transition Annual Conference for Parents is an annual conference sponsored by the RI Parent Information Network and the Regional Transition Centers that attracts approximately 250 family members of transition age students (14-21). The conference leads families through the*

*transition process, equips them with valuable resources and provides an opportunity to meet with state program administrators. The TA request will pay for the keynote speaker. Justification: Rhode Island's approach to addressing disparities in social and emotional health among CSHCN is to promote opportunities for positive youth development, meaningful inclusion in school and community based activities, and assisting youth in the formation of leadership skills. Through the conference, family members will understand the transition process and make the necessary connections to assist their children in a smooth transition from secondary education to adulthood. Suggested TA provider and/or organization: Dan Habib.*

*Request #3: Addresses: SPM #5, NPM #8, NPM #15, and NPM #18. Description: In conjunction with community partners, the DCFHE is in the process of developing a statewide strategic plan to address preconception health. The mission is to systematically address preconception health through the implementation of health care practices and promotion, comprehensive health policies, and public health initiatives. The plan will be finalized in the fall of 2012 and implementation of the plan will be the next step. A preconception collaborative has been identified, but the actual process and logistics of implementation needs to be developed. Justification: The TA received will provide support for the implementation process of the strategic plan to successfully carry out the mission of the plan. Suggested TA provider and/or organization: Erin Dugan from Policy Studies, Inc.*

*Request #4: Addresses: SPM #5, NPM #8, NPM #15, and NPM #18. Description: There is a need for a facilitator to assist with the development of Rhode Island core standards for MCH and to develop subsequent training(s) of the core standards for staff and contracted providers of MCH programs who provide direct services in the community (i.e. community health workers, providers entering the home, etc.). Justification: The DCFHE is interested in identifying and conveying the core standards for MCH so all staff and direct service providers will understand the standards and build the information into their communication to the community. Suggested TA provider and/or organization: A representative from MCHB.*

*Request #5: Addresses: NPM #8, NPM #10, NPM #15, NPM #16, NPM #17, SPM #2, SPM #4 SPM #7 . Description: TA is desired to help staff and partners create a viable and sustainable RI Funders Convergence Partnership (Healthy Communities Fund), based on the MA model, that will provide funds for coordinated environmental and policy strategies at the state and community level. TA will also be used to create a multi-media Learning Collaborative to connect state and community health coalitions with the information and resources they need to succeed. Both the Healthy Communities fund and Learning Collaborative will help communities address performance measures above in a comprehensive approach. Justification: The TA will result in a coordinated state-wide infrastructure to fund and sustain evidence-based and best-practice strategies to support and reinforce healthy behaviors, healthy care system quality improvement, and community-clinical linkages at the state and community level to achieve healthy families living, learning, and working in healthy communities. It will also result in a comprehensive state resource for state and community partners to share best practices, lessons learned, and tools that support and reinforce healthy behaviors, healthy care system quality improvement, and community-clinical linkages at the state and community level to achieve healthy families living, learning and working in healthy communities. Suggested TA Provider and/or Organization: Health Resources in Action, located in Boston, MA.*

*Request #6: Addresses: NPM #11 and NPM #14. Description: TA is requested to provide TA and training for RI Child Care Nursing Consultants and Early Education professionals to become certified as lactation and infant feeding specialists. Justification: The TA desired will build capacity in child care settings to support breastfeeding mothers who return to work, build skills of existing child care nursing consultants workforce to become*

**teachers and supporters of healthy infant feeding practices, and build skills and knowledge of nursing consultants and early education professionals on infant feeding in early education settings. Suggested TA Provider and/or Organization: TBD.**

**Request #7: Addresses: SPM #1, SPM #4, SPM #7, NPM #2, NPM #5, and NPM #9**  
**Description: The Providence Full Service Community Schools (PFSCS) Initiative seeks to improve student learning through school-based supports for families in five South Providence elementary schools. The initiative is a collaborative effort of community based organizations, the Providence School District, the City of Providence, and the Department of Health and has been selected as the model to be applied at all "turn-around" schools. Services are integrated within existing school systems and curricula. Program components include: out of school time, family literacy, wraparound service care coordination, reading intervention, family engagement, and health outreach. The PFSCS initiative is a means to decrease education disparities that impact health over the life course by improving health access, advocacy, education, and habits. Justification: While a health focus has been embedded in PFSCS program implementation (e.g. increasing student physical activity), initiative partners are in the process of strategically envisioning the health component to better align it with other local efforts to improve early childhood outcomes. The TA provider will be responsible for supporting the creation of an aligned PFSCS Health Framework inclusive of policy, program, and data sharing & management expectations. This may include participating in the health strategy "envisioning" process, providing relevant literature reviews on health indicators, and ultimately creating an asset map to draw on the strengths of the FSCS communities. Suggested TA Provider and/or Organization: TBD //2013//.**

## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> <i>(Line1, Form 2)</i>	1770159	355405	1770159		1725040	
<b>2. Unobligated Balance</b> <i>(Line2, Form 2)</i>	1093295	1571818	1014131		528230	
<b>3. State Funds</b> <i>(Line3, Form 2)</i>	2274575	1878069	2150006		2035853	
<b>4. Local MCH Funds</b> <i>(Line4, Form 2)</i>	0	0	0		0	
<b>5. Other Funds</b> <i>(Line5, Form 2)</i>	2191258	2226973	2235641		1416184	
<b>6. Program Income</b> <i>(Line6, Form 2)</i>	16862654	16237867	17103557		19722824	
<b>7. Subtotal</b>	24191941	22270132	24273494		25428131	
<b>8. Other Federal Funds</b> <i>(Line10, Form 2)</i>	41451278	50399438	71972325		42605664	
<b>9. Total</b> <i>(Line11, Form 2)</i>	65643219	72669570	96245819		68033795	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	800566	584453	640019		635405	
<b>b. Infants &lt; 1 year old</b>	2856696	2295920	2732099		2759324	
<b>c. Children 1 to 22 years old</b>	12224472	10911514	11793204		13568301	
<b>d. Children with</b>	2517480	2117717	2329927		2446292	

<b>Special Healthcare Needs</b>						
<b>e. Others</b>	5483282	6071177	6507858		5673395	
<b>f. Administration</b>	309445	289351	270387		345414	
<b>g. SUBTOTAL</b>	24191941	22270132	24273494		25428131	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	238767		170504		171283	
<b>c. CISS</b>	145405		182160		207355	
<b>d. Abstinence Education</b>	0		0		0	
<b>e. Healthy Start</b>	70861		48647		0	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	6622726		26287008		0	
<b>h. AIDS</b>	9314759		8072014		1952052	
<b>i. CDC</b>	17523004		26766823		28280731	
<b>j. Education</b>	56145		37000		327828	
<b>k. Home Visiting</b>	0		0		5907677	
<b>k. Other</b>						
<b>DHHS - Admin of CYF</b>	0		0		641774	
<b>EPA</b>	495370		0		315401	
<b>Federal Medicaid</b>	0		0		398283	
<b>HRSA</b>	0		0		2233751	
<b>other (OSHA, NESHAP)</b>	0		0		2169529	
<b>DHHS - Admin of CYF</b>	0		447618		0	
<b>DHHS-Admin On Aging</b>	0		73943		0	
<b>EPA</b>	0		355346		0	
<b>Federal Medicaid</b>	1779693		3598470		0	
<b>HRSA</b>	3127306		3534880		0	
<b>Other (OSHA, NESHAP)</b>	0		2397912		0	
<b>Other (OSHA,NESHAP)</b>	2077242		0		0	

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	539835	406280	439002		99495	
<b>II. Enabling Services</b>	639877	485595	657325		323699	
<b>III. Population-Based Services</b>	17538872	16122215	17587736		19796746	
<b>IV. Infrastructure Building Services</b>	5473357	5256042	5589431		5208191	
<b>V. Federal-State Title V Block</b>	24191941	22270132	24273494		25428131	

<b>Grant Partnership Total</b>						
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## **A. Expenditures**

/2011/

### Federal Grant Monitoring Procedures

The Division of Community Family Health and Equity (DCFHE) maintains budget documentation for block grant funding/expenditures for reporting consistent with Section 505(a) and section 506(a)(1) for auditing. All federal grants are monitored both within the Division and by HEALTH's Office of Management Services (OMS). The DCFHE Chief Programs Operations meets with DCFHE team and program staff to review spending, performance, and quality assurance issues for each federal grant. The OMS reviews each federal grant monthly for cost and data reporting issues. Any non-compliance, such as delays in progress reports or personnel hiring or lack of billing, requires an immediate response by the DCFHE Chief Programs Operations. Federal financial status reports (FSRs) are due within three months of the close of a federal grant. HEALTH consistently submits FSRs correctly and on-time.

***/2013/ CFHE Operations monitors the federal MCH grant monthly by utilizing a detailed grant spreadsheet. The grant spreadsheet tracks expenditures by budget category and by project level. Quarterly reviews are performed with project managers to review project level expenditures and projected expenditures through the end of the grant period. If projects are not expected to be fully spent down, project funds are redirected to support other maternal and child health activities in order to avoid a large unobligated balance.***

//2013//

### HEALTH Policies for Contracting & Purchasing

Any purchase made with federal or state dollars requires prior approval. In addition, all purchases must be approved by the DCFHE Chief Programs Operations. Once approved, the request to purchase form must be signed by OMS staff and then approved by the state Office of Purchasing. There are detailed policies for allowable and non-allowable purchases. These policies include restrictions on types of purchases, like gifts and food, as well as travel guidelines. There are procedures in place for the State of Rhode Island to assure that competition exists between all providers for federal and state dollars. State departments are allowed to make some purchases without the approval of the Office of Purchasing under certain detailed guidelines.

There are detailed procedures for establishing and monitoring contracts and grants at HEALTH. HEALTH staff cannot enter into a contract with a provider without following certain steps. There are two mechanisms for awarding funds at HEALTH: 1) through a competitive request for proposals (RFP) process and 2) through a grant based on need, legislative requirements, or through a formula funding mechanism. There are detailed requirements for RFPs including appropriate language in the proposals, submission of offers, appeals, public review, and use of minority businesses. An RFP template must be followed for all RFPs and the document is reviewed by the DCFHE and the OMS before dissemination. The RFP process also requires a formal review of procedures used to select vendors, including an independent session with Office of Purchasing staff. A grant may be awarded to a Rhode Island-based non-profit agency for an identified need, if the agency is solely capable of addressing the need or if there is a legislative requirement to award funds to a particular agency or if HEALTH is awarding funds to all capable agencies through a funding formula. Once approval is received to enter into a grant, DCFHE staff must then follow procedures for establishing contracts.

Procedures for contract management includes the establishment and modification of contracts, which is the responsibility of the OMS, while the monitoring of contract compliance is a DCFHE responsibility. The DCFHE's Key Administrator meets with DCFHE Team Leads and Contract

Management staff to review contract compliance and other administrative issues. Contract monitoring includes approval and signatures for appropriate charges to each contract and contract performance and progress. The DCFHE has the ability to hold back payments or terminate contracts for issues related performance and progress. DCFHE program managers must review the appropriateness of all charges against a contract. Any variation in billing from the established contract must be requested in writing before reimbursements are made. DFH program managers are also responsible for the day-to-day oversights of contracts, monitoring performance, quality assurance, and billing procedures. The program managers regularly conduct performance reviews and customer satisfaction surveys for programs receiving state and federal funds.

#### Audits & Controls

Audits from both the state Office of the Auditor General and the state Bureau of Audits are conducted at HEALTH annually. The DCFHE has frequently been audited - the WIC Program is audited annually and the Immunization Program and Family Planning were both audited in the recent past.

*//2012/* The DCFHE has frequently been audited - the WIC Program is audited annually and the Immunization Program was audited in the recent past.*//2012//*

HEALTH's OMS conducts audits of DCFHE contracts regularly and monitors payments. In addition to external audits, the DCFHE routinely audits all of its sub-contracted agencies and requires formal audits to be sent to the DCFHE annually.

HEALTH's division managers must submit an annual financial audit review to monitor controls on contracts, personnel, budget, and other administrative policies. These financial audits are reviewed by the state's Financial Officer for compliance with existing state policies.

#### 2009 Expenditures

See the FY09 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Type of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Type of Services).

*//2012/* 2010 Expenditures *//2012//*

*//2012/* FY2010 Expended columns on Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Type of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Type of Services).

The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts shown, changes in the level of funding across years, and the sources of State Partnership funds and other Federal funds.*//2012//*

***//2013/ 2011 Expenditures //2013//***

***//2013/ FY2011 Expended columns on Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Type of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Type of Services).***

***The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts shown, changes in the level of funding across years, and the sources of State Partnership funds and other Federal funds.//2013//***

Form 3 (State MCH Funding Profile)

The final unobligated expended for FY09 is more than the original budget estimate by more than 10%.

The reason for this apparent discrepancy is that the original unobligated estimate was too low

due to the need to spend carry-over (unobligated funds) first before spending the federal FY09 allocation. An increase in the expended unobligated balance created a decrease in the amount of federal allocation expended. The total amount of FY09 unobligated balance and federal allocation is less than budgeted due to delays in project spending and offsetting MCH projects to other federal grants. The program income expended is less than budgeted due to less childhood and adult immunization spending with restricted funds.

/2012/ The final unobligated expended for FY10 is more than the original budget estimate by more than 10%. Carry-over funding (unobligated funds) were spent prior to spending the federal FY10 allocation. An increase in the expended unobligated balance created a decrease in the amount of federal FY10 allocation expended. The total amount of FY10 unobligated balance and federal allocation is less than budgeted due to delays in project spending and offsetting MCH projects to other federal grants. //2012//

***/2013/ One area of the 2011 expenditures warrants further narrative is the increase of unobligated balance expended compared to the federal allocation FY11. The unobligated balance expenditures were greater than the federal allocation expenditures due to the unobligated balances expended prior to the federal allocation. For FY12, MCH projects were budgeted to spend down the unobligated balance and the federal allocation which will increase the federal allocation portion compared to prior years. //2013//***

Form 4 (Budget Details by Type of Individuals Served) and Form 5 (State Title V Programs Budget and Expenditures by Type of Services)

Rhode Island has continued to be successful for FY 09 expended funds in meeting the budget requirements of at least 30% of our federal MCH funds was utilized for Preventive and Primary Care for Children (30%) and at least 30% for Children with Special Health Care Needs (41%). The proportion of federal MCH funds expended for FY09 is 9.5%, which is under the allowable 10%.

/2012/ Rhode Island has continued to be successful for FY 10 expended funds in meeting the budget requirements of at least 30% of our federal MCH funds was utilized for Preventive and Primary Care for Children (30%) and at least 30% for Children with Special Health Care Needs (44.8%). The proportion of federal MCH funds expended for FY09 is 9.3%, which is under the allowable 10%.//2012//

***/2013/ Rhode Island has continued to be successful for FY 11 expended funds in meeting the budget requirements of at least 30% of our federal MCH funds was utilized for Preventive and Primary Care for Children (33.5%) and at least 30% for Children with Special Health Care Needs (39.1%). The proportion of federal MCH funds expended for administration is 7.2%, which is under the allowable 10%.//2013//***

Both forms represent an overall decrease in state partnership spending and variances for distributions of funding among the MCH populations and services types due to a couple of reasons. The state funding included in the State Partnership was subject to state budget reductions. Secondly, the FY09 expended reflects variances among with disbursement of funds for MCH populations compared to the FY09 budgeted. For Pregnant Women, Children 1 to 22 years of age and Children with Special Health Care Needs, the HIV treatment, smoking cessation and tobacco prevention all reflect shifts in the disbursement of funds for these populations. As for type of services, the reason for the variance in type direct service is that for the FY09 budget, the HIV treatment program was reflected to be a portion provided under direct service for type of service and for the FY09 expended, HIV is 100% direct service. The shift in HIV expenditures also impacts the variance for enabling services and infrastructure services. In addition to the variance in HIV, the childhood and adult immunization budget funding also impacted the variance for infrastructure building services for FY09 expended. A portion of immunizations expenditures were not included in the FY09 budget as infrastructure services, but is in the FY09 expended. While there is an apparent variance in infrastructure, it is not as apparent for population based

services. While the HIV expenditures varied from the FY09 budget, the shift is obvious since the immunization FY09 budget funds shifted to population based services in FY 09 expended.

/2012/Form 4 and Form 5 present a decrease in state partnership spending due to budget reductions and a decrease in spending compared to the SFY10 budget. Reductions include program areas related to HIV and Worksite Wellness. FY10 spending for Newborn Screening, Child and Adult Immunization were decreased compared to the FY10 budget projection and restricted funds were rolled over to the next year.

The FY10 expenditures reflect variances among with disbursement of funds for MCH populations compared to the FY10 budgeted. The two significant variances are with Children 1 to 22 years of age and the "Others" populations. The difference for the variances is due to the shift of the Child Immunization program appropriately reflected under Children 1 to 22 years of age in the FY10 expenditure column compared to being reflected under the "Others" column in the FY10 budget.

//2012//

***/2013/Form 4 and Form 5 present a decrease in state partnership spending due to revenue reductions in newborn screening and childhood immunization restricted funding compared to the SFY11 budget. Revenue is based on the number of births for newborn screening and the health insurance assessment rates for childhood immunization. The FY11 expenditures reflect variances among with disbursement of funds for MCH populations compared to the FY11 budgeted due to the overall decrease in expenditures compared to the FY11 budget. One variance increase is with the "Other" population which reflects an increase in the adult childhood restricted account due to the purchasing of two additional adult vaccines. //2013//***

## **B. Budget**

/2011/ Budget Narrative

In FY2011, the Division proposes to spend \$1,770,159 including an estimated carry forward of \$1,093,295 from FY2010. Our Office of Children with Special Health Care Needs will continue to expand and address the needs of vulnerable young children and adolescent, investing in parent involvement and system building during FY11. Community, Family Health and Equity (CFHE) continues to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments. CFHE 2011 budget allocates \$1,770,159, of which 36.5% (\$646,975) will be expended on children with special care needs, 33.3% (\$589,943) will be expended on preventive services for children and 5.91% (\$104,561) was allocated for administrative cost. The Division's budget for FY2011 presents a decrease in funding with a budget of \$65,643,219 (not including \$1,773,489 of state Medicaid match funds) due to only one quarter of the WIC program funding included in the FY11 enacted budget since the program is expected to transfer to Office of Health & Human Services beginning Oct 1, 2010. In addition to the transfer WIC, CFHE has received seven new federal ARRA grants to be included in FY11 and also the addition of CNOM HIV and Women's Cancer Screening funding.

/2012/ Budget Narrative

In FY2012, the Division proposes to spend \$1,770,159 including an estimated carry forward of \$1,014,131 from FY2011. Our Office of Children with Special Health Care Needs will continue to expand and address the needs of vulnerable young children and adolescent, investing in parent involvement and system building during FY12. Community, Family Health and Equity (CFHE) continues to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments. CFHE 2012 budget allocates \$1,770,159, of which 37% (\$666,526) will be expended on children with special care needs, 34% (\$588,457) will be expended on preventive services for children and 7% (\$91,936) will be expended for administrative cost. The Division's budget for FY2012 represents an increase in funding with a budget of \$96,245,819 due to the WIC program funding restored at the full level in the Governor's recommended FY12 budget since the program did not transfer to Office of Health

& Human Services on Oct 1, 2010. In addition to the WIC funding being restored, CFHE has received nine federal ARRA grants and projected expenditures were included in the FY12 budget along with HIV and Women's Cancer Screening Cost Not Otherwise Matched (CNOM) federal share matching.//2012//

***/2013/ Budget Narrative***

***In FY2013, the Division proposes to spend \$1,725,040 including an estimated carry forward of \$528,230 from FY2012. Our Office of Children with Special Health Care Needs will continue to expand and address the needs of vulnerable young children and adolescent, investing in parent involvement and system building during FY13. Community, Family Health and Equity (CFHE) continues to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments.***

***CFHE 2012 budget allocates \$1,725,040, of which 37.07% (\$639,472) will be expended on children with special care needs, 35.11% (\$605,661) will be expended on preventive services for children and 9.92% (\$171,124) will be expended for administrative costs. The Division's budget for FY2013 represents a decrease in funding with a budget of \$68,033,795 due to the WIC program transfer to the Department of Human Services (DHS) in the enacted FY13 budget. However, WIC staffing and day to day programmatic and administrative functions currently remain at Health. Health has access to the WIC accounts under DHS budget and continues to process contracts and other purchases. In addition to the transfer of WIC funding, out of the nine federal ARRA grants CFHE received, three grants have closed out in SFY12 and four grants have ended and are expected to close out in SFY13.***

***CFHE has received new federal funding under the Affordable Care Act for Home Visiting and Coordinated Chronic Disease and Prevention. In addition, CFHE recently received new federal grants to fund initiatives for disabilities, arthritis and immunization vaccine management system. //2013//***

Our Maternal and Child Health investment for FY2009 was \$79,858,168 including \$6,706,155 of state and restricted newborn screening funding, excluding program income and private funds.

/2012/ Our Maternal and Child Health investment for FY2012 is \$96,245,819 including \$4,385,647 of state and restricted newborn screening funding, excluding program income and private funds.//2012//

***/2013/ Our Maternal and Child Health investment for FY2013 is \$68,033,795 including \$3,452,037 of state and restricted newborn screening funding, excluding program income and private funds. Funding is reduced compared to prior years due to the transfer of the HIV treatment state funding to Executive Office of Health & Human Services (EOHHS) in the enacted 13 budget. (FY12's budget was submitted based on the SFY12 Governor's recommended budget. The enacted SFY12 year budget transferred the HIV Care program to DHS and the enacted SFY13 budget transferred the HIV Care program from DHS to EOHHS. //2013//***

The maintenance of effort amount for FY2009 and for proposed FY2011 exceeds the FY89 level of effort of \$1,875,000. Our commitment to Kids Net, Parent Consultants, Newborn Screening, and Adolescent Health are some of the ways that RI commits state funds to maintain its match with HRSA, Title V. Rhode Island defines administrative costs as those costs associated with disbursing funds from a central office (e.g., budgeting, oversight) that fall within the purview of administration. This is consistent with a legal opinion on the subject obtained by the Association of Maternal and Child Health Programs.

/2012/ The maintenance of effort amount for FY2010 and for proposed FY2012 exceeds the FY89 level of effort of \$1,875,000. Our commitment to Kids Net, Parent Consultants, Newborn

Screening, and Adolescent Health are some of the ways that RI commits state funds to maintain its match with HRSA, Title V. Rhode Island defines administrative costs as those costs associated with disbursing funds from a central office (e.g., budgeting, oversight) that fall within the purview of administration. This is consistent with a legal opinion on the subject obtained by the Association of Maternal and Child Health Programs.//2012//

***/2013/ The proposed maintenance of effort for FY13 exceeds the FY89 level of effort of \$1,875,000. //2013//***

Rhode Island proposes to expend approximately \$5,473,357 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposed to expend \$17,538,872 on population based services which is consistent to the amount proposed for FY10. The proposed amount of \$539,835 for direct health care services is a 73% decrease from the previous year (FY10: \$1,996,609) due to a reduction in the overall budget from FY10 of \$26,153,082 to FY11 of \$24,191,941 while continuing to maintain consistency in the types of services categories for FY11 compared to FY10.

/2012/ Rhode Island proposes to expend approximately \$5,589,431 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposed to expend \$17,587,735 on population based services which is consistent to the amount proposed for FY11. The proposed budget amount for enabling services is \$657,325 and for direct health care services is \$438,002. For direct services, the proposed budget is an estimated 20% decrease from the previous year (FY11: \$539,835).//2012//

***/2013/ Rhode Island proposes to expend approximately \$5,208,191 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposed to expend \$19,796,746 on population based services which is slightly higher than the amount proposed for FY12. The proposed budget amount for enabling services is \$323,699, which is slightly less than 50% of the amount proposed in FY12. The reduction of enabling services reflects a shift to population based services. For direct health care services the proposed FY13 budget is slightly less than one-fourth the proposed FY12 budget (\$99,495) reflecting the shift of direct services to population based services.//2013//***

The Division's Executive Office guides the process of assuring that funded MCH grant projects are aligned with the MCH priorities. The Division's Title V Maternal and Child Health Block Grant uses a life course development approach in addressing the social determinants of health as a framework for health planning.

The Division plans to allocate its FY2011 award to meet the goals outlined in the annual plan by purchasing services from and contracting with other state agencies and community-based providers using standard purchasing procedures including RFPs, and sole/single source provider justifications. Every contract is managed by a Team Lead or program manager, as well as monitored by fiscal staff. Payment for services outlined in the contract is reviewed and approved by the contract officer and the division Chief Program Operations prior to reimbursement. //2011//

/2012/ The Division plans to allocate its FY2012 award to meet the goals outlined in the annual plan by purchasing services from and contracting with other state agencies and community-based providers using standard purchasing procedures including RFPs, and sole/single source provider justifications. Every contract is managed by a Team Lead or program manager, as well as monitored by fiscal staff. Payment for services outlined in the contract is reviewed and approved by the contract officer and the division Operations Administrator prior to reimbursement.//2012//

***/2013/ In FY13, operations will continue to monitor the expenditures monthly and on a quarterly basis coordinate with the Team Lead or Project Manager on project expenditure***

***projections.//2013//***

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.