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RHODE ISLAND STATEWIDE INTEGRATED POPULATION HEALTH LEADING PRIORITIES, STRATEGIES, AND GOALS

THREE LEADING PRIORITIES

1. Address the Social and Environmental Determinants of Health in Rhode Island
2. Eliminate the Disparities of Health in Rhode Island and Promote Health Equity
3. Ensure Access to Quality Health Services for Rhode Islanders, Including Our Vulnerable Populations

FIVE STRATEGIES

1. Promote healthy living for all through all stages of life
2. Ensure access to safe food, water, and healthy environments in all communities
3. Promote a comprehensive health system that a person can navigate, access, and afford
4. Prevent, investigate, control, and eliminate health hazards and emergent threats
5. Analyze and communicate data to improve the public’s health

23 POPULATION HEALTH GOALS

1. Reduce obesity in children, teens, and adults
2. Reduce chronic illnesses, such as diabetes, heart disease, asthma, and cancer
3. Promote the health of mothers and their children
4. Promote senior health to support independent living
5. Promote behavioral health and wellness among all Rhode Islanders*
6. Support Rhode Islanders in ongoing recovery and rehabilitation for all aspects of health*
7. Increase access to safe, affordable, healthy food
8. Increase compliance with health standards in recreational and drinking water supplies
9. Reduce environmental toxic substances, such as tobacco and lead
10. Improve the availability of affordable, healthy housing and safe living conditions*
11. Improve access to care including physical health, oral health, and behavioral health systems
12. Improve healthcare licensing and complaints investigations
13. Expand models of care delivery and healthcare payment focused on improved outcomes*
14. Build a well-trained, culturally-competent, and diverse health system workforce to meet Rhode Island’s needs*
15. Increase patients’ and caregivers’ engagement within care systems*
16. Reduce communicable diseases, such as HIV and Hepatitis C
17. Reduce substance use disorders
18. Improve emergency response and prevention in communities
19. Minimize exposure to traumatic experiences, such as bullying, violence, and neglect*
20. Encourage Health Information Technology adoption among RI healthcare providers as a means for data collection and quality improvement
21. Enhance and develop public health data systems to support public health surveillance and action
22. Develop and implement standards for data collection to improve data reliability and usability
23. Improve health literacy among Rhode Island residents*

*These goals have been proposed through the State Innovation Model and are under review.
Dear Colleagues,

Welcome to the FY 2017-2018 edition of the Division of Community Health and Equity (CHE) booklet. This document describes the programs within CHE and how they contribute to the mission of the Rhode Island Department of Health (RIDOH), to prevent disease, and protect and promote the health and safety of the citizens of Rhode Island.

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

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

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

1. **Center for Chronic Care and Disease Management**: Uses a systems approach to reduce the incidence, burden, and associated risk factors related to arthritis, asthma, cancer, diabetes, heart disease and stroke to improve health outcomes.

2. **Center for Health Promotion**: Uses evidence-based and promising public health practices to create social, policy, and physical environments that support healthy living through all stages of life and for all people. Areas of focus include physical activity and nutrition, tobacco control, violence and injury prevention, including youth suicide prevention and drug overdose prevention.

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

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

This booklet describes who we are, what we do and our core values in reaching RIDOH’s mission. When we effectively communicate and work well together, we advance progress towards community change that will build stronger and healthier communities. Please visit [www.health.ri.gov/projects/healthequityzones](http://www.health.ri.gov/projects/healthequityzones) to learn about our community investment in Health Equity Zones (HEZs).

We believe when leaders and everyday citizens work together, collective action will make our state the best it can be, so together we make a difference in the lives of the people we serve in all 39 Rhode Island communities.

We look forward to working together to improve population health and move toward the vision of achieving optimal health for all Rhode Islanders. Every day, we have a choice.

Sincerely,

Carol Hall-Walker, MPA
Associate Director of Health
Division of Community Health and Equity
Rhode Island Department of Health
MISSION
In conjunction with the mission of the Rhode Island Department of Health (RIDOH), the Division of Community Health & Equity (CHE) strives to prevent disease, and protect and promote the health and safety of the people of Rhode Island.

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

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

WHAT WE DO
CHE’s four Centers collaborate and integrate to promote and advance public health priorities:

1. CENTER FOR CHRONIC CARE AND DISEASE MANAGEMENT: Uses a systems approach to reduce the incidence, burden, and associated risk factors related to diabetes, asthma, arthritis, cancer, heart disease, and stroke to improve health outcomes.

2. CENTER FOR HEALTH PROMOTION: Uses evidence-based and promising public health practices to create social, political, and physical environments that support healthy living through all stages of life and for all people. Areas of focus include physical activity and nutrition, tobacco control, violence and injury prevention, youth suicide prevention and prescription drug overdose prevention.

3. CENTER FOR PERINATAL AND EARLY CHILDHOOD HEALTH: Supports healthy birth outcomes, positive early childhood development and school readiness, and preparation for healthy productive adulthood by providing and assuring mothers, children and adolescents access to quality maternal and child health services.

4. CENTER FOR PREVENTIVE SERVICES: Uses evidence-based practices to improve the quality of preventive care and community service by increasing access to vulnerable populations, diminishing ethnic and racial health disparities, providing performance standards, and enhancing community partnerships. Areas of focus include adolescent and school health, family planning and preconception health, immunization and oral health.
OUR CORE VALUES

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

The social and environmental determinants of health, life course approach, integration of programs and social and emotional competencies are the four pillars of the Division of Community Health and Equity’s approach to public health. CHE uses the equity framework when allocating resources and making data driven decisions on what interventions should be implemented across programs.

The Health Impact Pyramid, April 2010, Vol 100, No. 4, American Journal of Public Health. This pyramid is adapted from Thomas Frieden, MD, MPH presentation at the Weight of the Nation conference, Washington D.C., July 27, 2009
In a community system of family-centered medical homes, these MCH Checkpoints are organized into a coherent, connected, longitudinal system. That Family Health system recognizes and addresses risks and protective factors that will influence children’s healthy development, as it responds to acute needs, and offers prevention opportunities for all generations.

Domains of Healthy Child and Family Development:

**Environmental** – Poverty
  - Employment
  - Safety
  - Stress
  - Toxins

**Social** – Communication
  - Education
  - Social Support
  - Mobility

**Behavioral** – Mental Health
  - Tobacco / EtOH / Drugs
  - Diet / Fitness

**Genetic** – Familial Factors
  - Geo-Ethnic ff
  - Personal

**Medical** – Chronic Disease
  - Infections
  - Disabilities

Wm Hollinshead - Sept 2007
The Center for Chronic Care & Disease Management uses a systems approach to reduce the incidence, burden, and associated risk factors related to arthritis, asthma, cancer, diabetes, heart disease and stroke to improve health outcomes.

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**Women's Cancer Screening Program ::** Brenda DiPaola, BS, 401.222.1161

**ARTHRITIS**

The goal of the Arthritis Program is to empower adults with arthritis to live productive, healthy lives through the delivery of arthritis-appropriate evidence-based interventions in a statewide, accessible system that is integrated through community-clinical linkages. The Arthritis Program will meet this goal by increasing accessibility in Rhode Island to the Chronic Disease Self-Management Program, Tomando Control de su Salud, and Walk with Ease.

**Key Initiatives**

- Increase the number of arthritis-appropriate evidence-based interventions statewide (Chronic Disease Self-Management, Tomando Control de su Salud, Walk with Ease Group Led, Walk with Ease Self-Directed)
- Increase the number of Rhode Islanders enrolled in arthritis-appropriate evidence-based interventions
- Embed arthritis-appropriate evidence-based interventions into multi-site delivery systems
ASTHMA CONTROL

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

**Key Initiatives**

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

**CANCER REGISTRY PROGRAM**

The Cancer Registry (CR) tracks the incidence and mortalities associated with cancer in Rhode Island. The CR produces the official cancer statistics for the State in collaboration with the Hospital Association of Rhode Island. The CR participates in the North American Association of Central Cancer Registries that set cancer data standards and provides online access to cancer rates for all member registries.

**Key Initiatives**

- Supports hospital tumor registries and promotes cancer programs accredited by the American College of Surgeons in acute care hospitals throughout Rhode Island.
- Develops queries and analyzes the cancer registry to provide surveillance reports for the Rhode Island Comprehensive Cancer Control, Women’s Cancer Screening, and Colorectal Cancer Programs, as well as the media, health care system, consumers and response for all request for cancer data.
- Develop and implement Evaluation Plans for the RIDOH Comprehensive Cancer Control, Women’s Cancer Screening, and Colorectal Cancer Programs.
- Prepares and publishes extensive technical and statistical written reports and publications related to Rhode Island Cancer Registry Data and National SEER (Surveillance, Epidemiology, and End Results Program) Data, as well as website publications.
COLORECTAL CANCER PREVENTION

The goal of the Colorectal Cancer Screening Program (CRC) is to increase CRC screening rates among persons aged 50 to 75 within partner health systems. This goal is accomplished through the implementation of four key evidence-based interventions: Provider Assessment and Feedback, Provider Reminders, Client Reminders, and Reducing Structural Barriers using small media and patient navigation.

Key Initiatives

- Upon request, work with Data Consultant Contractor to provide all Federally Qualified Health Centers (FQHCs) technical assistance with their Electronic Health Records (EHRs) and/or methods on how to improve clinical workflow.
- Provide resources, training, and guidance to identified colorectal patient navigators within each FQHC with the goal of helping patients overcome barriers to colorectal cancer screening. Also, closely track patient navigation activities in order to identify best practices and to measure effect on screening rates.
- Offer assistance to FQHCs, in conjunction with the American Cancer Society, in establishing and building on current colonoscopy referral infrastructures with gastroenterology practices and hospitals. Our collective goal is for all age-appropriate patients to have the ability to get screened for colorectal cancer, regardless of insurance status.
The goal of the Comprehensive Cancer Control (CCC) Program is to assess and reduce the burden of cancer in Rhode Island; use policy, systems, and environmental change strategies to guide sustainable cancer control; and to create and implement the state's multiyear cancer prevention and control plan. The CCC Program works to reduce the burden of cancer by working with a statewide coalition, The Partnership to Reduce Cancer in Rhode Island, comprised of more than 250 individuals and organizations, and with other community based cancer control groups. The CCC Program develops, implements, and evaluates programs to improve the quality of cancer care and address the needs of cancer survivors. The CCC Program promotes primary prevention and recommended cancer screenings, monitors and releases information on Rhode Island's cancer epidemiology, organizes and supports community-based efforts to reduce cancer, and strives to enhance cancer survivors’ quality of life.

**Key Initiatives**

- Organize and support the work of the Partnership to Reduce Cancer in Rhode Island.
- Issue surveillance briefs and educational materials describing the burdens of cancer in Rhode Island.
- Identify opportunities to decrease cancer-associated incidence and mortality rates.
- Promote palliative care and survivorship care as two means of improving the quality of life of cancer survivors.
- Promote community-based cancer screening initiatives supported by evidence-based guidelines.
- Organize policy, systems, and environmental change strategies to support comprehensive cancer control activities.
- Promote community utilization of comprehensive cancer control strategies (including those employed in prevention, screening and detection, survivorship, and palliative care).
The mission of Diabetes, Heart Disease and Stroke Prevention (DHDSP) is to prevent and reduce death and disability due to diabetes, heart disease and stroke. DHDSP is committed to healthcare transformation to improve chronic disease management and prevention for those with or at risk for prediabetes, diabetes and hypertension. Key initiatives work together synergistically and on multiple levels (i.e., individual, health system, environmental, community, state) to constitute a comprehensive systems approach to prevention and control.

Key Initiatives

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

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

Key Initiatives

- Offer WISEWOMAN Program within practices statewide, including within Health Equity Zone communities.
- Continue to assure all eligible women are identified and offered WISEWOMAN screening and health behavior support opportunities.
- Provide lifestyle programs to WISEWOMAN participants at no cost to address diet, physical activity, tobacco use, and other disease prevention and management behaviors.

WOMEN’S CANCER SCREENING

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

Key Initiatives

- Promote greater awareness among all populations to increase breast and cervical cancer screening rates throughout the state conducting public education and targeted outreach.
- Support practices and health system change to promote and support high quality screening for all age appropriate clients.
- Promote the use of evidenced-based interventions including patient and provider reminders, provider assessment and feedback, and conducting Patient Navigation activities.
The Center for Health Promotion uses evidence-based and promising public health practices to create social, policy, and physical environments that support healthy living through all stages of life and for all people. Areas of focus include physical activity and nutrition, tobacco control, violence and injury prevention, including youth suicide prevention, and drug overdose prevention.

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PHYSICAL ACTIVITY AND NUTRITION

The mission of the Physical Activity and Nutrition Program (PAN) is to promote health and prevent chronic disease through good nutrition and physical activity throughout the life course. PAN works with federal, state, and local partners to make healthy eating and active living the norm for all Rhode Island residents, with a focus on those communities that experience disparities in health outcomes. PAN provides funding and management of specific initiatives that inform policy, systems, and environmental changes.

Key Initiatives

- Support Health Equity Zone (HEZ) grantees and partners with data and best practices, training, technical assistance, and funding to implement comprehensive obesity prevention initiatives.
- Provide RIDOH review, input, and approval and/or recommendations for School District Wellness policies.
- Provide training and individualized technical assistance on developing and implementing Complete Streets to Rhode Island municipalities.
- Increase the number of middle and high school students that implement the Presidential Youth Fitness Program (PYFP) and a Comprehensive School Physical Activity Program (CSPAP).
DRUG OVERDOSE PREVENTION

The purpose of the Rhode Island Drug Overdose Prevention Program (DOPP) is to advance and evaluate comprehensive state-level interventions for preventing drug overuse, misuse, abuse, and overdose. The program engages a multi-sector collaboration of partners with shared authority to prevent drug overdoses, and has a key role in leading and informing the Governor's Overdose Prevention and Intervention Task Force.

Key Initiatives

- Increase use of the Prescription Drug Monitoring Program (PDMP) by making it easier to use, and providing academic detailing, continuing medical education events, and other outreach on responsible prescribing.
- Improve access to drug overdose and resources data through the web site [www.PreventOverdoseRI.org](http://www.PreventOverdoseRI.org) and dissemination of drug overdose data briefs.
- Provide Community Health Navigators to high risk populations in state ‘hot spots’ to help users connect with recovery resources.
- Evaluate state level policies such as mandatory prescriber PDMP registration, naloxone access laws, Good Samaritan law, and 48-Hour Opioid Overdose Reporting regulation.
- Convene a Drug Overdose Death Review Team and award mini-grants to targeted communities to raise awareness around prevention.
- Implement hospital Emergency Department Discharge Standards for overdose patients.
- Ensure access to naloxone, especially to high risk populations.

TOBACCO CONTROL

The mission of the Tobacco Control Program (TCP) is to protect and promote health, and prevent chronic disease and death among all Rhode Islanders using a comprehensive approach to reduce tobacco initiation and use, and exposure to second-hand smoke. TCP informs policy decisions that support and reinforce tobacco free living in home and community environments, making it harder for people to start using and continue using tobacco and nicotine products, and easier to quit. TCP works with federal, state, and local partners to make tobacco free living the norm, with a focus on those communities that experience disparities in health outcomes.

Key Initiatives

- In partnership with Tobacco Free Rhode Island, a statewide network of organizations and individuals working to reduce tobacco use, provide technical assistance to community partners to educate and inform local communities about the public health benefits of local tobacco control policies (e.g., local smoke-free/tobacco-free air, tobacco retail licenses).
- Recruit new health care providers to make referrals to Quitworks to help their patients quit.
- Promote availability of Quitline services through media, including use of the localized CDC Tips from Former Smokers campaign.
- Outreach to private affordable multi-unit housing companies and Public Housing Authorities, providing group technical assistance about implementing and enforcing smoke-free policies.
**VIOLENCE AND INJURY PREVENTION**

The Violence and Injury Prevention Program (VIPP) gives communities and policy-makers the information, including data and research, and resources they need to develop life-saving policies and implement evidence-based programs to reduce injuries and death caused by child abuse and neglect, intimate partner/sexual violence and suicide, and those caused by motor vehicle crashes and sports injury, such as Traumatic Brain Injury (TBI). Injury prevention programs in schools provide students with the skills they need to sustain healthy relationships. VIPP also provides training to adults and youth in school and community settings so they can identify youth at risk for suicide, and get them the professional help they may need.

**Key Initiatives**

- Via a contract between RIDOH and Rhode Island Student Assistance Services (RISAS), integrate emotion regulation activities and content into the 1) Student Assistance Program (SAP) model; and 2) via a Memorandum of Understanding between the RIDOH, Center for Health Promotion VIPP and the RIDOH Center for Perinatal and Early Childhood Health, Family Visiting Program, integrate emotion regulation into the *Healthy Families America* program and the *Parents as Teachers* program.

- Via a contract between the RIDOH and the Brain Injury Association of RI, conduct ImPACT neuropsychological baseline testing for Rhode Island middle and high school age youth participating in school sports, and Rhode Island youth sports leagues in three communities.

- Inform and educate stakeholders about the public health benefits of enhancements to the Rhode Island Youth Sports Concussion (YSC) law requiring neuropsychological baseline testing.

- Via a contract with Day One, increase the number of youth exposed to the evidence-based sexual violence prevention program, *Your Voice Your View*.

- Via contracts with RISAS and Bradley Hospital, provide in-school trainings and resources to prevent youth suicide.
The Center for Perinatal & Early Childhood Health supports healthy birth outcomes, positive early childhood development and school readiness, and preparation for healthy productive adulthood by providing and assuring mothers, children and adolescents access to quality maternal and child health services.

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

Ann Barone, LDN, 401.222.4604

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**FAMILY VISITING**

Provides evidence based home visiting to mitigate or prevent poor health and developmental outcomes. The Maternal Infant Early Childhood Home Visiting (MIECHV) Program implements evidence-based home visiting programs for pregnant women and families with a child less than 4 years of age, focusing in communities at risk for poor maternal and child health outcomes through three (3) evidence-based models: Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. Communities served include Providence, Pawtucket, Central Falls, Woonsocket, Newport, East Providence, Cranston, Coventry, West Warwick, and Westerly and surrounding communities.

**Key Initiatives**

- Increase the number of WIC sites, health care centers and obstetric practices that refer to Family Visiting.
- Train professionals to use a trauma informed approach to identify and address adverse experiences.
- Use continuous quality improvement (CQI) to support Family Visiting Agencies to increase family engagement and retention.
FIRST CONNECTIONS

Supports families and their children prenatally through age three years by supporting child development and by giving them the information and connecting them with appropriate services to mitigate risk factors so that children can develop healthy and ready for school.

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

NEWBORN SCREENING AND FOLLOW-UP

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

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

Links Actions for Unmet Needs in Children’s Health (LAUNCH) works to ensure that children (birth to 8) in Woonsocket, Newport, and Washington County succeed in school by building social-behavioral capacities into community-based early childhood programs and systems of care in order to integrate physical and behavioral health wellness. The core components include developmental screening in primary care for children from birth to age eight, mental health consultation to primary care providers and/or in early child care and education setting, and building the capacity of parent support and education for children from age 3 to age 8 who are at risk of poor outcomes without support.

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

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

The WIC program provides supplemental foods, health care referrals, and nutrition education for low income pregnant women, breastfeeding and non-breastfeeding postpartum women, and infants and children up to age five who are at nutritional risk. Services include breastfeeding support and promotion, assessment of clients’ nutritional status and food prescription based on nutritional needs, and referrals to medical and social services in the community. WIC participants have improved health outcomes compared to their peers in the community. Pregnant women enrolled in WIC have a lower incidence of prematurity and low birth weight. Children are better immunized, are better connected with their primary care doctors and are more prepared to learn when beginning school.

Key Initiatives
- Increase breastfeeding initiation.
- Increase breastfeeding duration at three months, and six months.
- Provide education on physical activity and nutrition.
- Reduce obesity rate of WIC children.
The Center for Preventive Services uses evidence-based practices to improve the quality of preventive care by increasing access to vulnerable populations, diminishing ethnic and racial health disparities, and enhancing community partnerships. Areas of focus include adolescent and school health, family planning and preconception health, immunization, and oral health.

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ADOLESCENT/SCHOOL HEALTH

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

Key Initiatives
- Increase number of adolescents ages 12-17 who receive teen pregnancy prevention and positive youth development programming through the Teen Outreach Program (TOP).
- Develop an Adolescent Health Strategic Plan.
- Increase the number of middle and high school students connected to positive youth development (PYD) programs.
- Support Health Equity Zones with best practice, training, TA, and funding to implement substance use prevention strategies.

FAMILY PLANNING

The Family Planning Program provides affordable, federally funded Title X family planning services including: contraceptives; contraceptive and reproductive health counseling; Sexually Transmitted Disease (STD) education; blood pressure check; physical exams; cervical cancer screenings; pregnancy testing; clinical breast exams; HIV counseling, testing, and referral services; and comprehensive health risk assessment and referral services to culturally diverse, low-income women and men, including adolescents.
Key Initiatives

- Support implementation of clinical recommendations of CDC/Office of Population Affairs MMWR “Providing Quality Family Planning Services.”
- Implement routine pregnancy intention screening with One Key Question® model.

IMMUNIZATION

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

Key Initiatives

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

The mission of the Oral Health Program (OHP) is to achieve optimal oral health for all by eliminating oral health disparities in Rhode Island while also integrating oral health with overall health. To achieve this mission, the OHP focuses on prevention of oral disease through assurance of state-level oral health and public health leadership, documentation of the burden of oral disease in Rhode Island, and collaboration with statewide partners and the Rhode Island Oral Health Commission. In association with these partnerships, the OHP implements goals and objectives identified in the Rhode Island Oral Health Plan, which include: improve access to oral healthcare services; integrate the dental and medical care systems; increase the oral health literacy of Rhode Island residents; sustain the oral health workforce; and inform and support productive oral health policy decisions.

Key Initiatives

- Continue promotion of SEAL RI! (school-based dental sealants) program.
- Maintain effective Community Water Fluoridation in Rhode Island public water systems.
- Increase oral health messages delivered to pregnant women and infants.
- Increase the number of pregnant women in Medicaid who receive preventive oral health services in FQHCs as measured by billing data, dental claims data, chart review, or other timely evidence.
- Increase the use of direct referrals between primary care providers and dentists through Federally Qualified Health Centers (FQHCs) that have both types of providers in each facility as well as successfully have the family/home visiting programs adopt the new Efforts to Outcomes (ETO) oral health prompts to improve access to oral health care for those populations.
- Increase the number of children under two years of age who have a preventive oral health visit.
- Implement sustainable referral systems between dental providers and pediatricians.
- Increase parental knowledge of age one/early dental visit.
- Increase dental provider knowledge and comfort level providing services for young children.
- Increasing providers understanding of and willingness to see adults (and children) with Medicaid through educational modules (building off the Learning Collaborative).
- Provide reimbursement for case management codes for providers that complete the related modules.
- Increase Medicaid enrollees awareness of dental benefits through informational handouts and better explanation on exchange and website.
- Restructure adult dental Medicaid program from fee-for-service to a managed care benefit or other innovative model.
• Created the “Own Your Health” collaborative – Arthritis Program
• Received a one year extension on the arthritis grant
• Arthritis Program CDC project officers—Rhode Island had “one of the best” site visits
• Launched the Comprehensive Integrated Asthma Care System to provide comprehensive asthma services
• Colorectal Cancer Program received funds to purchase tablets for Patient Navigators at partner health systems

The Health Equity Zones (HEZ) were featured in the Rhode Island Medical Journal on Equity

• Women’s Cancer Screening Program eliminated racial disparity in breast cancer mortality rates in 2001 between black and white women and this is still reflected in the most current mortality data available
• WISEWOMAN Program established an electronic, web-based data collection system and the number of screenings doubled in the first half of Year 4 more than doubled, compared to the first half of Year 3
• As of January 2017, 553 Rhode Islanders have participated in the Diabetes Prevention Program
• Comprehensive Cancer Control Program and the Partnership to Reduce Cancer in RI’s SkinCheck program screened 516 people for skin cancer, and detected 4 melanomas and 6 other skin cancers.

Co-led the department wide collaboration to host the 2016 Health Equity Summit where 550 participants engaged in networking to advance health equity

The Association of State and Territorial Health Officials (ASTHO) featured a Health Equity Zone Webinar

• Comprehensive Cancer Control Program and American Cancer Society convened Palliative Care Roundtable, engaging 68 healthcare and homecare providers in meaningful dialogue to improve access to palliative care.
• Rhode Island Cancer Summit engaged 230 providers, survivors, caregivers, and advocates in day-long learning about evidence-based cancer control practices.
• Comprehensive Cancer Control Program worked with Pawtucket School Department to integrate skin cancer prevention content into their K-5 curricula, district-wide.
• The Community Health Network has received 2,144 referrals to evidence-based programs from November 2012-March 2017
Center for Health Promotion

Partnered with the New England Public Health Training Center to develop/evaluate Equity 3.0 Pilot Training

- Secured CDC funding to support the Drug Overdose Prevention Program with five staff persons and community prevention resources
- Partnered with the Department of Behavioral Health, Developmental Disabilities & Hospitals to lead the Governor’s Task Force on Overdose Prevention and Intervention, and implement strategies included in Rhode Island’s Strategic Plan on Addiction and Overdose – Four Strategies to Alter the Course of an Epidemic
- Secured five years of continuation funding for the Core Violence & Injury Prevention Program to address child abuse & neglect, traumatic brain injury, intimate partner/sexual violence, and motor vehicle crash injury & death
- Trained more than 1,000 middle and high school staff professionals in the Questions Persuade, Refer model of gatekeeper youth suicide prevention; and trained more than 500 middle and high school students in the evidence-based Signs of Suicide - Suicide Prevention Peer Gatekeeper Program
- Reduced Rhode Island’s adult cigarette smoking rate to 12 percent and the youth rate to 4.8 percent
- Worked with Public Housing Authorities (PHA) and residents to ban smoking in 22 of the 25 PHA buildings thus reducing exposure to second hand smoke in the home
- Provided funding and staff support to 10 Health Equity Zones and the Health Equity Learning Community
- Facilitated implementation of built environment policies that support safety, physical activity, and access to healthy foods; and nutrition guidelines in public facilities, including schools

Completed one-page descriptions to acknowledge HEZ accomplishments and promote HEZ efforts

Successfully completed Health Equity Zone Year 2 Initiatives and launched Year 3
Center for Perinatal and Early Childhood Health

- Family Visitors and Women Infants and Children Staff are collaborating to achieve better outcomes
- The Newborn Screening Program met newborn screening rates 100%
- Family Visiting staff were accepted into National Home Visiting Community Associations Institute Project
- Revise Family Visiting data base streamline and added questions with equity lens

Collaborated with the Department of Corrections to coordinate public health education and services for incarcerated people

Submitted 2016 mandated program legislative reports to the RI General Assembly

- Continued to move advance work of the Neonatal Abstinence Syndrome Task Force
- Continue to expand evidenced-based services for young children
- Secured funding for Neonatal Abstinence Syndrome Task force for early childhood peer recovery coaches/ conference

- Worked in partnership with Rhode Island Breastfeeding Coalition to establish a Rhode Island Baby Café in Olneyville
- Presented the Bronze Breastfeeding Workplace Award to the Environmental Protection Agency in South Kingston, Rhode Island

Participated in the initiative with the Office of Regulatory Reform to meet requirements of the Administrative Procedures Act of 2016

Co-led submission of several innovative federal grant applications in partnership with multiple sister state agencies
Participated in the Performance Management pilot lead by the Department of Administration

- Planned and presented in the first “Weight and Wellness Summit” in partnership with the Rhode Island Medical Society

- Hosted 2016 Reproductive Health Summit for 75 health and social service professionals
- High immunization rates and #1 immunization coverage rates for HPV
- Improved access & reduced barriers to flu vaccine for Providers
- Implemented new vaccine assessment law for all payers
- Improved vaccine temperature monitoring in provider settings

- Hired a Rhode Island State Dental Director after a 20+ year vacancy
- Inclusion of Oral Health in Population Health Goals and Health Equity Zones
- Implemented the Perinatal and Infant Oral Health QI Project
- Convened the 2017 RI Prenatal & Pediatric Dentistry Mini-Residency for 110 oral health professionals
- Implemented the One Key Question initiative in community health centers across Rhode Island

- Improved/increased partnerships across adolescent health
- Worked with partners to complete the Adolescent Sexual Health Profile
- Hired State School Nurse Consultant
- Organized youth feedback sessions for the Personal Responsibility Education Program
- Conducted 3-day Teen Outreach Program (TOP) training and certified 15 new TOP facilitators

Staff in CHE are active members of the Rhode Island Task Force on Premature Births, which received a 2016 Virginia Apgar Prematurity Campaign Leadership Award. This award is for a 10.4% reduction in the statewide preterm birth rate from 2010 to 2015.
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