

RHODE ISLAND DEPARTMENT OF HEALTH
**DIVISION OF COMMUNITY,
FAMILY HEALTH, AND EQUITY**
FY 2013-2014



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Dear Friends,

Welcome to the FY 2013–2014 edition of the Division of Community, Family Health, and Equity (CFHE) booklet. As with last year's edition, this booklet aims to describe the different programs within CFHE and how they contribute to the broad mission of the Rhode Island Department of Health (HEALTH) to prevent disease and protect and promote the health and safety of the people of Rhode Island. While we have a long history of leadership and excellence in responding to that mission, today's public health landscape at the national, state, and local levels bring new challenges and the need for new approaches.

As a state and a nation, we continue to move forward with the implementation of the Affordable Care Act, looking for new solutions and approaches to reduce health care costs, transform the health care delivery system and improve population health outcomes. While we recognize that we have made significant progress towards meeting some of the Healthy People 2010 goals, the same cannot be said of the overarching goal of eliminating health disparities. As such, we must renew our commitment to work on establishing and achieving a new set of goals with a focus on eliminating disparities and achieving health equity.

This booklet explains who we are, what we do, and our core values in reaching HEALTH's mission. It also highlights our achievements during the past year and the challenges for the upcoming year.

Please join us in making our state a healthier place to live, work, and play, so that together we can make a difference in the health and lives of the people who live in all Rhode Island communities.

We look forward to charting the future of public health in collaboration with you.

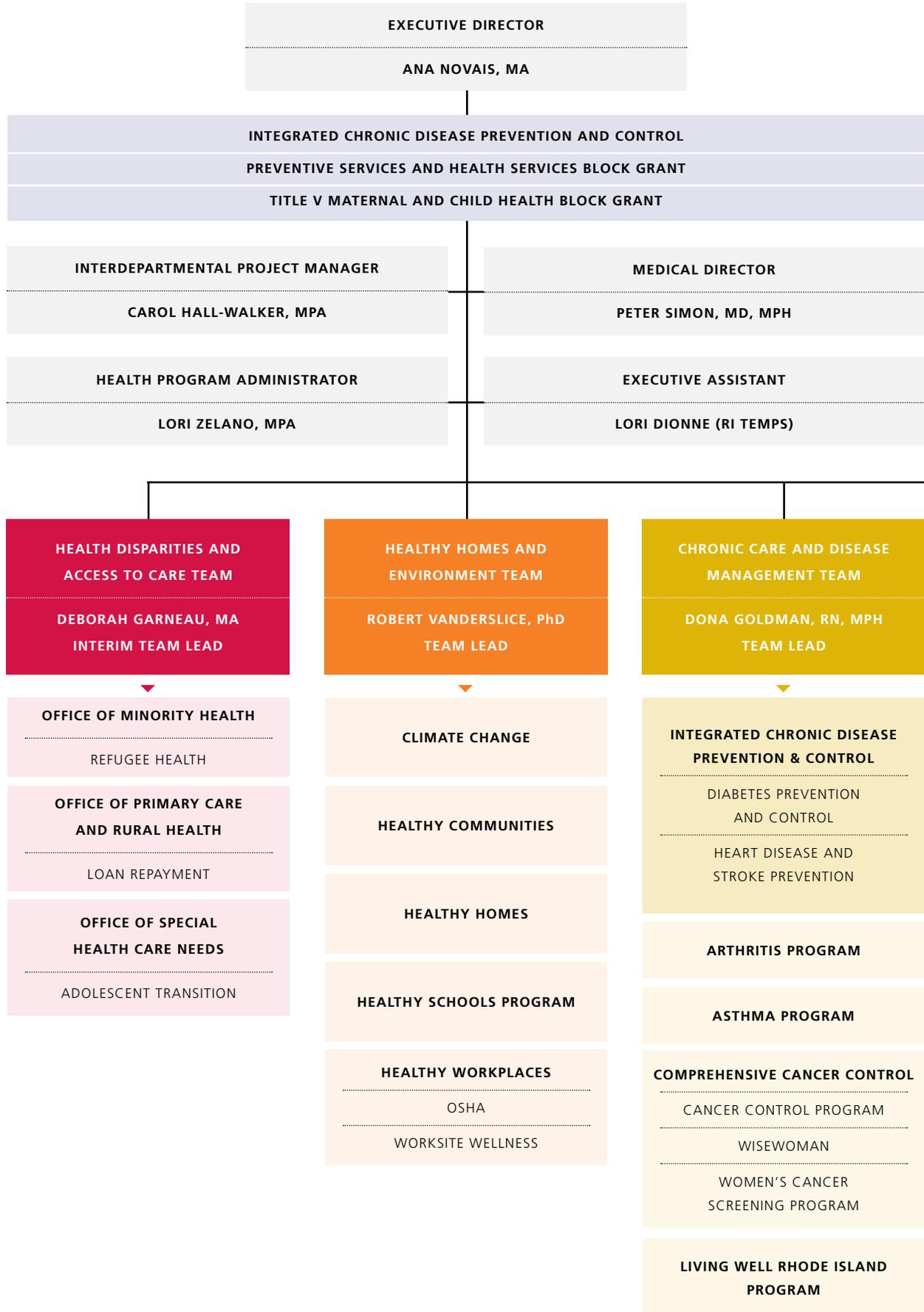
Sincerely,

A handwritten signature in black ink that reads "Ana Novais".

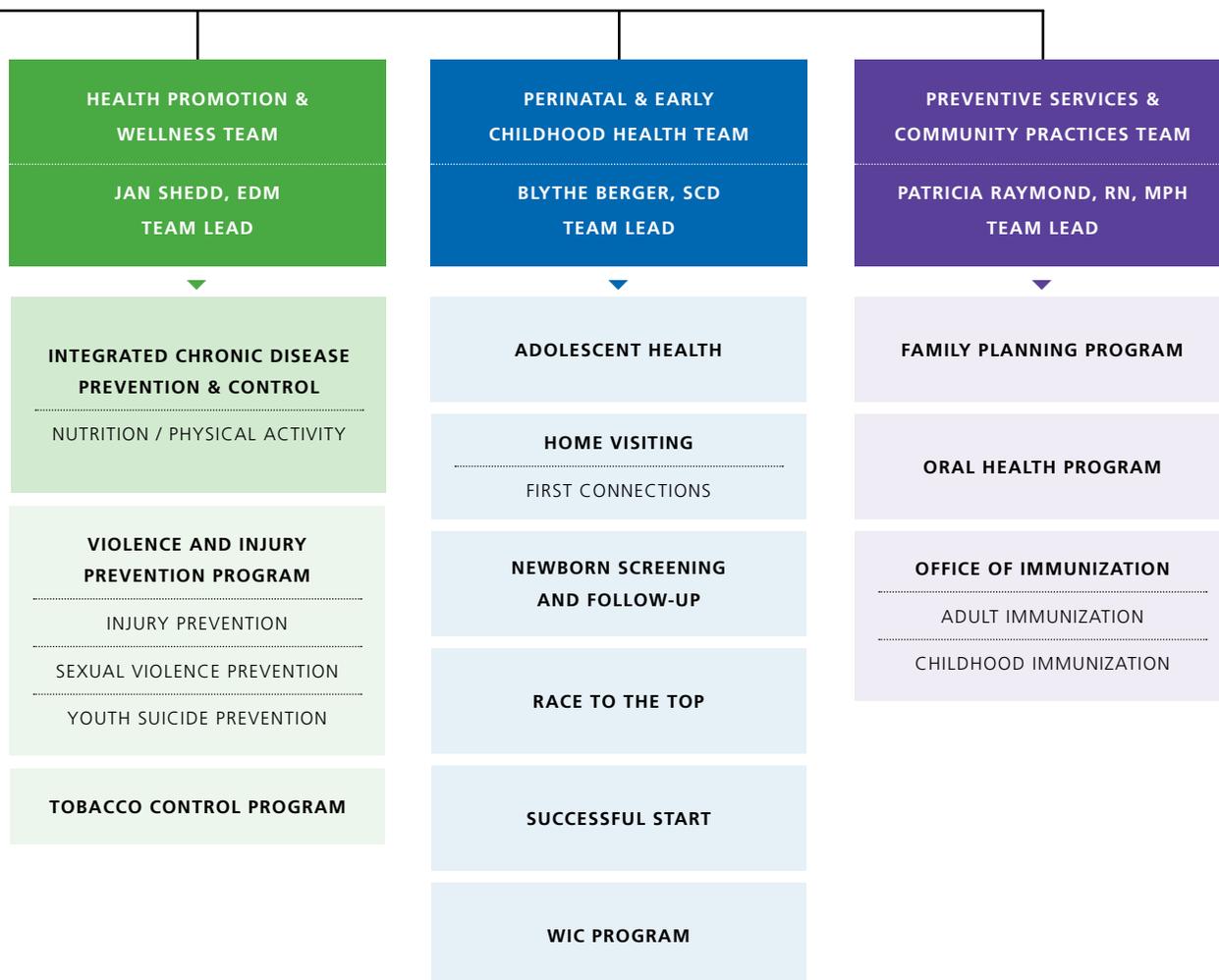
Ana P. Novais, MA
Executive Director of Health
Community, Family Health, and Equity
Rhode Island Department of Health



OVERVIEW OF ORGANIZATIONAL STRUCTURE



The Executive Director of the Division of Community, Family Health, and Equity (CFHE), provides leadership, vision, communication and policy direction to the administrative staff, team leads, program leads, and support staff across all six teams. Evidence-based public health strategies focus on all members of our community to achieve health equity and eliminate health disparities throughout Rhode Island. Integration between public health programs, including social, political, and economic policies play a key role in improving the lives of all Rhode Islanders. It is through this collective effort that CFHE offers quality programs and continues to assure that all Rhode Islanders will achieve optimal health throughout the lifespan.



EXECUTIVE ADMINISTRATION TEAM



The connection between health and dwelling is one of the most important that exists. ~ *Florence Nightingale*

« PETER SIMON, MD, MPH, MEDICAL DIRECTOR



Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. ~ *World Health Organization*

« CAROL HALL-WALKER, MPA, INTERDEPARTMENTAL PROJECT MANAGER



When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied. ~ *Herophilus*

« LORI ZELANO, MPA, HEALTH PROGRAM ADMINISTRATOR





EQUITY FRAMEWORK: PRIORITIES

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, Family Health & Equity's (CFHE) approach to Public Health. When allocating resources and making data driven decisions on what interventions should be implemented, CFHE uses the following tool to help prioritize its work.

The example below uses the the Initiative for a Healthy Weight Program:

1. **Education and Counseling:** (targeting individual behaviors), e.g., encourage eating five servings of fruits and vegetables each day.
2. **Clinical Interventions:** e.g., outreach to medical providers to counsel their patients about diet.
3. **Long-lasting Protective Public Health Approach:** e.g., screening/collecting BMI for all kids at school.
4. **Changing the Context—Healthy Behaviors as the Default:** e.g., offering juice, not soda, in vending machines.
5. **Social and Environmental Determinants of Health:** e.g., ensuring access to affordable, healthy foods in neighborhoods affected by poverty.



1. COUNSELING AND EDUCATION

Health education provided during clinical encounters as well as education in other settings. This level also includes education of health professional staff and public health supportive workers*. Education in other settings includes, but is not limited to, the following locations/channels:

- Schools
- Workplaces
- Places of worship
- Recreational Venues
- Media campaigns

Activity at this level relies heavily on long term behavioral change of individuals.

*Public health supportive workers include patient navigators, community health workers, diabetes educators, and family and peer resource specialists.

2. CLINICAL INTERVENTIONS

This level of the pyramid represents one-on-one health professional staff interaction with a consumer to address a specific disease or health condition. Health professional staff includes doctors, nurse practitioners, dentists, dental hygienists, nurses, physician assistants, social workers, mental health counselors, and public health supportive workers.

3. LONG LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS

These are systematic interventions that bring together long term protection to populations by reaching a large number of individuals. Two examples of systematic interventions include dental sealants and immunizations.

4. CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT

The creation and implementation of policies, practices and regulations designed to change the environmental context* to make healthy behaviors the default choice. Since these actions impact the population, individuals would have to expend significant effort to not benefit from these policies, practices or regulations.

*Environmental context in this level relates to policy activity in for-profit, not-for-profit, and government sectors that impact where people live, learn, work, play, and pray.

5. SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH

This level refers to interventions and specific policy changes that address the root causes of health and inequities in health. These actions would directly impact the physical, social, cultural, and economic environments and the availability and accessibility of health services¹ and resources. Activities on this level would increase the physical and social assets, reduce toxicity, and enhance the civic engagement of individuals and communities allowing for greater quality of life.

The Division of Community, Family Health, and Equity (CFHE) aims to achieve health equity for all populations, through eliminating health disparities, assuring healthy child development, preventing and controlling disease and disability, and working to make the environment healthy.

For the past decade, we have made strides in achieving Rhode Island goals for Healthy People 2010. However, disparities still persist and more importantly, for the first time in modern years, the next generation (our children's generation) has a lower life expectancy.

How do we reverse this trend? As we move forward establishing new targets and goals for the next decade we believe CFHE's Equity Framework will:

- Improve our population health outcomes
- Improve the efficiency and comprehensiveness of our programs and interventions
- Increase the impact of our investments at the local level

CFHE Health Equity Framework is a four aim approach that:

- Focus on the social determinants of health as its framework for health planning and evaluation
- Uses the Life Course developmental approach across all programs
- Integrates Chronic Disease, Maternal and Child Health, and Environmental Health
- Builds emotional and social competencies internally and with external partners

This means that all programs and services within the division work with the following assumptions:

- Health trajectories are particularly affected during critical or sensitive periods (Timing)
- Today's experiences and exposures influence tomorrow's health (Timeline)
- The broader environment—biological, physical, and social—strongly affects the capacity to be healthy or unhealthy (Environment)
- While genetic make-up offers both protective and risk factors for disease conditions, inequality in health reflects more than genetics and personal choice – it's reflective of unequal distribution of resources and assets (Equity)

The visual tool for this approach is our "Equity Pyramid" adapted from the "health impact pyramid" developed by Dr. Thomas Frieden, Director of the Department of Health and Human Services, Centers for Disease Control and Prevention. This pyramid promotes the concept of comprehensive public health programs as those that encompass a range of strategies, from those with the lowest impact at the population level and that require the most individual effort (level 1 strategies) to those with the highest impact and that require the least individual effort (level 5 strategies). These strategies, described on the previous pages, are:

- Level 1: Counseling and education (targeting individual behaviors)
- Level 2: Clinical interventions
- Level 3: Long-lasting protective public health approaches
- Level 4: Changing the context, making the healthy choices by default
- Level 5: Social and environmental determinants of health.

All programs and teams within the division must respond to four key questions:

1. What does “achieving health equity” mean for your specific program/team?
2. How comprehensive are the interventions (meaning, are the interventions reaching all five levels of the Equity Pyramid?)
3. If the program/team is not addressing all levels of the pyramid, why not? What else is the program/team doing?
4. What support will the program/team need in order to develop a comprehensive public health program that addresses all levels of the pyramid?

CFHE is committed to moving forward with four major strategic challenges that are crucial for the successful implementation of the Health Equity Plan of Action:

1. Build a shared public health equity agenda across the state.
2. Adopt a community development frame for our work.
3. Transform the service delivery system and culture of service delivery.
4. Build collaboration capacity internally and externally.

At times this may feel like “one more thing” to do in an already stretched workload. However, we believe, the continuous and intentional use of this new lens in how we deliver public health is how we will reverse the trend and improve health outcomes for our population and our children.





WHO WE ARE

CFHE works to eliminate health disparities by assuring healthy child development, and preventing and controlling disease and disability.

CFHE uses a life course development approach and addresses the determinants of health as a framework for health planning.

CFHE recognizes that social, political, and economic policies and conditions determine health outcomes.

CFHE values the community as a core partner in public health and works to assure that equity in health is a reality.

CFHE plans, develops, and evaluates programs and systems of care, which are comprehensive, community-based, culturally competent, coordinated, and effective.

WHAT WE DO

CFHE's six teams represent priority areas that promote synergy, collaboration, integration and coordination among programs:

Health Disparities and Access to Care Team assures equitable systems, empowers communities, and builds capacity to promote access to comprehensive, high quality services that are responsive to the needs of Rhode Island's diverse populations so they may achieve their optimal state of health.

Healthy Homes and Environment Team protects the health and safety of children, workers, and the general public by identifying and decreasing environmental hazards.

Chronic Care and Disease Management Team uses a systems approach to reduce the incidence, burden, and associated risk factors related to diabetes, asthma, cancer, heart disease, and stroke to improve health outcomes.

Health Promotion and Wellness Team is committed to promoting the health and well-being of all Rhode Islanders by changing social, political, and physical environments to support healthy lifestyles. We focus on physical activity and nutrition, tobacco control, and violence and injury prevention.

Perinatal and Early Childhood Health Team 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.

Preventive Services and Community Practices Team improves the quality of preventive care and community services through immunization, oral health, and family planning services. This is achieved by increasing access and availability to vulnerable populations by diminishing ethnic/racial health disparities, providing performance standards, enhancing community partnerships, and applying evidence based, effective programming.

OUR CORE VALUES

1. We respect and embrace the **diversity** of our staff and the communities we serve.
2. We value **community** involvement and participation at all levels.
3. We are committed to eliminating **racial and ethnic health disparities**.
4. We believe in health **equity and social justice**.
5. We value **teamwork** and the unique skills and contributions of each team member.
6. We value **integrative** work both within and between teams.
7. We recognize the value of ongoing **professional development** for all levels of staff.
8. We believe in open, two-way **communication** at all levels of the organization.
9. We make decisions based on our **values and science-based** research.
10. We are **accountable** to each other and to our communities.



**TITLE V
MATERNAL AND
CHILD HEALTH
BLOCK GRANT
RHODE ISLAND
AT A GLANCE 2013**

WHAT WE DO

The Rhode Island Department of Health (HEALTH) Division of Community, Family Health, and Equity (CFHE) uses Title V funds to achieve state and national maternal and child health priorities. We look at how social, environmental, political, and economic conditions affect health outcomes among families and children—to frame our health planning. Collaborating with many partners across the state, we work to eliminate health disparities and to help women and children achieve optimal health throughout their lives.¹

THE ROLE OF TITLE V BLOCK GRANT FUNDING

Title V of the Social Security Act of 1935 authorizes a federal-state partnership focused on improving the health and well being of all mothers and children. Grantees—which include 59 states and jurisdictions—must conduct comprehensive needs assessments every five years and use their findings to identify priorities, engage stakeholders, allocate resources, and implement and evaluate programs.

State Priorities

1. Increase capacity of and access to evidence-based parent education and family support programs.
2. Reduce tobacco initiation among middle school students.
3. Increase the percentage of adolescents who have a preventive care visit each year.
4. Decrease the percentage of high school students with disabilities who report feeling sad or hopeless.
5. Increase the percentage of women who had a preventive care visit within the past year.
6. Initiate a prenatal home visiting program.
7. Adopt social determinants of health into public health practice.

HOW WE ARE USING TITLE V BLOCK GRANT DOLLARS

In Fiscal Year 2013, Rhode Island received \$1.5 million to support programs for infants, children, and teens younger than 22 years, children with special healthcare needs, and pregnant women.

Category	Percentage
CHILDREN WITH SPECIAL HEALTHCARE NEEDS	36%
INFANTS, CHILDREN, AND TEENS YOUNGER THAN 22 YEARS	36%
PREGNANT WOMEN	10%
ADMINISTRATIVE	10%
OTHER*	8%

¹ See <https://mchdata.hrsa.gov/TVISReports/StateMchAppsAndContactInfoMenu.aspx>
 * Other includes cross-cutting special projects that impact priority population groups.

FUNDING FOR THIS PROJECT WAS PROVIDED THROUGH A COOPERATIVE AGREEMENT WITH HEALTH AND SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) MATERNAL AND CHILD HEALTH BUREAU BLOCK GRANT. ITS CONTENTS ARE SOLELY THE RESPONSIBILITY OF THE AUTHORS AND DO NOT NECESSARILY REPRESENT THE OFFICIAL VIEWS OF HEALTH OR HRSA.

1. HEALTH INFORMATION LINE

Goal: Support a statewide toll-free telephone resource for all Rhode Island families.

Population Impacted: Rhode Island women and children, especially from low-income, racially and ethnically diverse communities.

Strategy: Offer multilingual services and information to callers. Provide culturally and linguistically appropriate consumer materials and resources to callers.

2. FAMILY VOICES

Goal: Provide healthcare information and referral services to families and professionals.

Population Impacted: Children and youth with special healthcare needs (birth through 18 years) and their families.

Strategy: Offer support groups, leadership development, and education to parents and professionals on family-centered care.

3. HEALTHY HOMES

Goal: Foster support for a coordinated and sustainable approach to developing healthy homes, neighborhoods, and communities.

Population Impacted: Children, pregnant women, and low-income families.

Strategy: Advocate for safe housing using a comprehensive approach to control all housing hazards. Focus on reducing radon, asbestos, and secondhand smoke exposure, especially among young children.

4. HOME VISITING

Goal: Ensure optimal birth outcomes and improve the health and development of young children, pregnant and post-partum women, and their families through home-based screening, assessment, referral, and follow-up.

Population Impacted: Pregnant and post-partum women, children, and low-income families.

Strategy: Provide an evidence-based program through home visits to support families, educate them about healthy pregnancies and child development, and link them with appropriate services.

5. FAMILY AND PEER RESOURCE SPECIALIST PROGRAM

Goal: Bring the perspective of adults and children with special healthcare needs and their families into policy development and medical home implementation. Help consumers to access community resources such as specialty care, independent living, education, employment, and vocational training.

Population Impacted: Adults and children with special healthcare needs, families, and primary care and specialty providers.

Strategy: Employ 100 trained parent consultants to provide outreach and medical home services.

6. YOUTH IN TRANSITION

Goal: Develop and promote resources to support youth in transition from pediatric to adult primary care.

Population Impacted: Parents and youth, especially youth with special healthcare needs.

Strategy: Inform and educate youth, parents, physicians, educators, and other professionals to support youth in transition. Promote healthy adolescent development through statewide systems, policies, and initiatives that promote self-determination within youth with special healthcare needs.

7. ADOLESCENT HEALTH

Goal: Increase the number of adolescents who receive a preventive health visit.

Population Impacted: Adolescents between the ages of 12 and 22 years old.

Strategy: Develop and support adolescent medical home models to improve the quality and accessibility of healthcare for youth.

FOR MORE INFORMATION OR TO GET INVOLVED

Maternal and Child Health:

Ana Novais, MA, Executive Director, CFHE
401-222-5118, ana.novais@health.ri.gov

Children with Special Health Care Needs:

Deborah Garneau, MA, Chief
Office of Special Health Care Needs, CFHE
401-222-5929, deborah.garneau@health.ri.gov



**PREVENTIVE
HEALTH AND
HEALTH SERVICES
BLOCK GRANT**
RHODE ISLAND
AT A GLANCE 2013

WHAT WE DO
The Rhode Island Department of Health (HEALTH) Division of Community, Family Health, and Equity works in partnership with a local Prevention Block Grant Advisory Committee to set funding priorities. We fund local initiatives that have no other source of state or federal funds—or that need additional funds to address a health problem. Current priorities include health disparities, health promotion, community interventions, integrate chronic disease efforts and address risk factors that contribute to poor population health outcomes. As programs become self-sustaining, we redirect funds to other public health priorities.

THE ROLE OF BLOCK GRANT FUNDING

The Centers for Disease Control and Prevention (CDC)'s Preventive Health and Health Services (PHHS) Block Grant gives states control of funding so they can tailor prevention and health promotion programs to the diverse, complex, and constantly changing public health needs of their individual communities. Grantees—which include all 50 states and the District of Columbia, two American Indian tribes, and eight US territories—are expected to align their programs with Healthy People 2020 national health goals. Grantees also work to meet four overarching health goals*:

1. Achieve health equity and eliminate health disparities by influencing social determinants of health.
2. Decrease premature death and disabilities that are due to chronic diseases and injuries by focusing on the leading preventable risk factors.
3. Build healthy communities by supporting local health programs, systems, and policies.
4. Provide opportunities to address emerging health issues.

HOW WE ARE USING PHHS BLOCK GRANT DOLLARS
In Fiscal Year 2013, Rhode Island is expected to receive \$310,055 to fund integration of chronic disease and health promotion efforts, fund local investments to achieve healthy communities, and fund rape/sexual violence prevention programs.

Program Category	Funding Amount
Health Improvement Planning	\$224,109
Culturally-Appropriate Community Health Promotion Programs	\$40,000
Rape Prevention	\$23,535

* CDC worked with state PHHS Block Grant coordinators, CDC epidemiologists and program evaluators, representatives from state health departments, the National Association of Chronic Disease Directors, and the Directors of Health Promotion and Education to develop these goals.

FUNDING FOR THIS PROJECT WAS PROVIDED THROUGH A COOPERATIVE AGREEMENT WITH HEALTH AND SUPPORTED BY THE CDC PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT. ITS CONTENTS ARE SOLELY THE RESPONSIBILITY OF THE AUTHORS AND DO NOT NECESSARILY REPRESENT THE OFFICIAL VIEWS OF HEALTH AND CDC.

LOCAL INVESTMENT TO ACHIEVE HEALTHY COMMUNITIES

CENTERS FOR HEALTH EQUITY AND WELLNESS

GOAL: Achieve health equity and eliminate health disparities by impacting social determinants of health, and support local health programs, systems, and policies to achieve healthy communities.

This is an integrated effort with multiple federal funding from CFHE programs.

POPULATION IMPACTED: 100,000 low-income, racially and ethnically diverse adults and children in three communities with higher rates of illness and disability.

STRATEGIES

COMPONENT 1, HEALTHY AND SAFE SUSTAINABLE COMMUNITIES: Work with eight competitively-selected community-based agencies to support the advancement at the local level of the National Strategic direction “to create, sustain and recognize communities that promote health and wellness through prevention”. Agencies will collaborate to develop strategies and policies that impact the availability of resources to meet daily needs (housing; education and job opportunities, food security); that impact the community structure (parks, transportation); that impact the natural environment.

COMPONENT 2, IMPLEMENTATION OF EVIDENCE-BASED PROGRAMS ADDRESSING CHRONIC DISEASE AND ITS RISK FACTORS, AND MATERNAL AND CHILD HEALTH PRIORITIES: 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 Maternal Child Health priorities.

PARTNERS: City of Providence – Healthy Communities Office, Olneyville Housing Corporation, West Elmwood Housing Development Corporation, Clinica Esperanza Hope Clinic, Family Service of Rhode Island, The Providence Center, and The Providence Plan – Ready to Learn Program.

PROJECT DELIVERABLES

COMPONENT 1: Increase access to healthy foods, and turn unused city property into urban farms, transform land and unused property to affordable, quality housing,

construct and/or maintain parks and other open spaces for recreation, and encourage walking, biking, and use of public transportation. Reduce diet related health disparities and improve eating behaviors of residents through the implementation of a multi-component neighborhood-wide intervention.

COMPONENT 2: Build environment, systems and policy changes through the development of pocket parks, formation and facilitation of a Neighborhood Policy Group, health and financial education and physical activities. Implement self-management chronic disease education programs. Replicate the Harlem Children’s Zone’s Asthma Initiative in neighborhoods in low-income neighborhoods. Provide families in low income communities with the “Incredible Years” parenting groups.

INTEGRATED CHRONIC DISEASE PREVENTION AND CONTROL

GOAL: Decrease premature death and disabilities due to chronic diseases and injuries by focusing on the leading preventable risk factors.

POPULATION IMPACTED: 200,000 racially and ethnically diverse adults and children with higher rates of morbidity and mortality, behavioral risks, infectious disease, maternal and child health issues, and poor access to health care services.

STRATEGIES: Expand the internal integration efforts of the Division of Community, Family Health and Equity programs slow and reverse the trends in chronic disease and associated risk factors. Coordinate efforts to address multiple diseases and risk factors simultaneously. This work will include strategic thinking and planning to develop a Rhode Island Collaborative for Health Equity Network, training and technical assistance will be provided by national consultants to advance this effort. Goal areas to be addressed include:

GOAL 1: Enhance capacity in leadership, management, advocacy, communication, surveillance, evaluation, and community mobilization to promote a culture of collaboration and advance disease prevention and health promotion.

GOAL 2: Create and integrated surveillance system that provides information on health-related risk and protective factors across the life span.

GOAL 3: Advance environmental strategies to improve individual level health behaviors.

GOAL 4: Enhance services and systems in place that expand access to and utilization of coordinated health care services and reduce morbidity and mortality of preventable chronic diseases and risk factors.

GOAL 5: Expand access to community-based preventive services and strengthen linkages with clinical care.

PARTNERS: The Collaborative Network is comprised of 65 external partners and 15 Department of Health Program staff. The external partners represent education, health care, faith-based groups, social services, volunteer groups, businesses, and local and state government.

RAPE AND SEXUAL PREVENTION PROGRAMS

GOAL: Decrease Rhode Island’s forcible rape and attempted rape rate from 30.8 per 100,000 in 2011 to 28.8 per 100,000 in 2013.

POPULATION IMPACTED: 200,000 women and children with sexual and violence-related injuries.

STRATEGIES: Provide school-based education on safety, bullying, relational aggression, healthy relationships, and gender stereotyping to middle-school students, teachers, and parents in school districts serving predominantly high-risk populations. Develop protocols and train medical and police personnel on routinely identifying, treating and properly referring victims of sexual assault, child abuse, and domestic violence.

PARTNERS: Day One, Rhode Island Department of Children, Youth, and Families, Rhode Island Department of Education, Rhode Island hospitals and police departments, and SafeRI Violence and Injury Prevention Program.

PROJECT DELIVERABLES: Provide abuse and prevention programs for 600 students, teachers, counselors, and parents; six trainings for medical personnel at Rhode Island hospitals and emergency rooms; and training and informational workshops for two police departments and other law enforcement personnel dealing with sexual assault victims. Recruit nine new volunteer advocates who work directly with sexual assault victims at hospitals and police departments.



INTEGRATED CHRONIC DISEASE PREVENTION AND CONTROL

BACKGROUND

The Integrated Chronic Disease Prevention and Control effort in the Executive Director's Office supports health promotion, epidemiology, and surveillance activities and targeted strategies that will result in measurable impacts to address school health, nutrition and physical activity risk factors, obesity, diabetes, and heart disease and stroke prevention.

This effort is supported by core public health activities such as partnership engagement, workforce development, guidance and support for programmatic efforts, strategic communication, surveillance and epidemiology, and evaluation. This collaborative approach builds capacity for integrating programmatic, policy and surveillance activities for chronic disease prevention, management, and health promotion. A state plan identifies ways to improve policies, environments, programs and infrastructure to achieve measurable improvements across the lifespan while applying a health equity framework and a social justice lens. This approach is applied across all programs within the division to advance our public health work.



OBJECTIVES FOR COORDINATED INFRASTRUCTURE:

OBJECTIVE 1: Sustain an internal collaborative HEALTH management and administrative infrastructure that:

- Prioritizes coordinated Integrated Chronic Disease Prevention and Control activity
- Identifies, prioritizes and acts on grant opportunities to support State Plan implementation
- Coordinates continuous evaluation and quality improvement to measure health outcomes, State Plan progress, and ensure quality

OBJECTIVE 2: Develop, coordinate, and support a Rhode Island Collaborative for Health Equity Network to leverage partnerships, set cross-program priorities and foster cross-program advocacy.

OBJECTIVE 3: Train internal staff and external partners in health equity principles and evidence based chronic disease prevention and health promotion practices to be applied across the lifespan.

FOUR KEY DOMAINS: CDC has prioritized four key domains to coordinate and align the strategic direction and use of resources of state chronic disease prevention and health promotion programs.

1. Surveillance and epidemiology capacity
2. Strategies that support and reinforce healthful behaviors
3. Health systems change
4. Community-clinical linkages enhancement

Funded by: CDC - State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity, and Associated Risk Factors and Promote School Health

KEY DOMAIN 1

SURVEILLANCE AND EPIDEMIOLOGY CAPACITY

Making the investment in epidemiology and surveillance provide states with the necessary expertise to collect data and information to develop, monitor, and deploy effective interventions, identify and address gaps in program delivery, and monitor and evaluate progress in achieving program goals. Data and information come with the responsibility to use it routinely to inform decision makers and the public, regarding the effectiveness of preventive interventions and programs, the burden of chronic diseases and their associated risk factors, and the public health impact. The need to publicize widely the results of RI's work in public health and demonstrate to the people the return on their investment in prevention has never been greater.

KEY DOMAIN 3

HEALTH SYSTEMS CHANGE

Health systems interventions improve the clinical environment to more efficiently deliver quality preventive services and help people more effectively use and benefit from those services. As a result, some chronic diseases and conditions will be avoided completely, and others will be detected early or managed better to avert complications and progression, leading to improved health outcomes. Health system and quality improvement changes, such as electronic health records, systems to prompt clinicians and deliver feedback on performance, and requirements for reporting on outcomes. For example, control of high blood pressure and the proportion of the population up-to-date on chronic disease screenings, can encourage providers and health plans to focus on preventive services. Effective outreach to consumers and reducing barriers to accessing these services is important, as coverage alone will not ensure use of preventive services.

KEY DOMAIN 2

STRATEGIES THAT SUPPORT AND REINFORCE HEALTHFUL BEHAVIORS

Improvements in social and physical environments make healthy behaviors easier and more convenient for people. A healthier society delivers healthier students to our schools, healthier workers to our business and employers, and a healthier population to the health care system. These types of interventions support and reinforce healthy choices and healthy behaviors and make it easier for people to take charge of their health. They have broad reach, sustained health impact, and are cost effective for public health.

KEY DOMAIN 4

COMMUNITY-CLINICAL LINKAGES

Community-clinical linkages help ensure that people with or at high risk of chronic diseases have access to community resources and support to prevent, delay, or manage chronic conditions once they occur. Interventions, such as clinician referral, community delivery and third-party payment for effective programs, increase the likelihood that people with heart diseases, diabetes or pre-diabetes, and arthritis will be able to "follow the doctor's orders" and take charge of their health. These interventions have the potential to improve quality of life, avert or delay onset or progression of disease, avoid complications (including during pregnancy), and reduce the need for additional health care.

HEALTH DISPARITIES AND ACCESS TO CARE TEAM



Assure equitable systems, empower communities, and build capacity to promote access to comprehensive, high quality services that are responsive to the needs of Rhode Island’s diverse populations so that they may achieve their optimal state of health.

« **DEBORAH GARNEAU, MA, INTERIM TEAM LEAD**

Health Disparities and Access to Care Team :: Deborah Garneau, MA, Interim Team Lead, 401.222.5929

Office of Special Health Care Needs :: Deborah Garneau, MA, Chief, 401.222.5929

Office of Minority Health :: Angela Ankoma, Chief, 401-222-7630

Office of Primary Care and Rural Health :: Ana Novais, MA, 401-222-5940

ADOLESCENT TRANSITION

The Office of Special Healthcare Needs is responsible for assisting youth with chronic health conditions and disabilities to transition to the adult systems of primary and specialty care, education, employment, and insurance. The Adolescent Healthcare Transition program makes resources available for physicians, parents, and youth regarding the timeline and necessary components of transition that support self-determination.

2012 Accomplishments and Milestones

- Launched the Dare to Dream Student Leadership Conference & Youth Development Initiative for Rhode Island’s youth ages 14-21, including an annual conference and ongoing leadership development opportunities
- Published Transition Toolkits for adolescents/youth, families, and providers that outline practical steps, milestones, and reasonable timelines for transitions

CLAS INITIATIVE

In an effort to reduce health disparities and better serve our state’s Limited English Proficient (LEP) communities, HEALTH develops policies, guidance, and tools to implement the National Standard for the Provision of Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care : A Blueprint for Advancing and Sustaining CLAS Policy and Practice. The enhanced National CLAS Standards, developed by the Office of Minority Health in the United States Department of Health and Human Services, “is intended to advance health equity, improve quality, and help eliminate health disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services”¹. HEALTH collaborates with partners in health and health care to improve access to high quality language assistance services, promote culturally

¹National Standards for CLAS in Health and Health Care: *A Blueprint for Advancing and Sustaining CLAS Policy and Practice*. United States Department of Health and Human Services, Office of Minority Health (April 2013)

competent care, and implement organizational supports that allow all people accessing health services to receive equitable and effective treatment in a culturally and linguistically appropriate manner.

2012 Accomplishments and Milestones

- Funded a campaign (I SPEAK) in ten languages to educate Rhode Island patients and health care consumers about their rights and responsibilities in requesting qualified medical interpreters
- Developed a tool to assist health care administrators and policy makers in designing language access policies that conform with federal law, state law, and accreditation standards

DISABILITY AND HEALTH

The Disability & Health Program promotes the health and wellness of people with disabilities through inclusive self-management evidence based programs; provides professional development for practitioners working with people with disabilities, including training, targeted technical assistance, and access to assistive technology; addresses special needs of people with disabilities in health promotion programs, health strategic planning, emergency preparedness, preventative health screening programs, and healthcare facility access; and increases access to quality of health-related data of people with disabilities in RI and utilize epidemiology and evaluation analysis to monitor the health disparities.

2012 Accomplishments and Milestones

- Secured Centers for Disease Control funding for three years
- Development of a Disability Community Planning Group

FAMILY/PEER RESOURCE SPECIALIST PROGRAM

The Family and Peer Resource Specialist Program brings the perspective of parents, youth, and consumers into policy development and medical home implementation. Resource Specialists strengthen CFHE's capacity to deliver effective services, to address critical health issues, and to involve the community in the discussion that leads to effective program planning for the State's disabled and culturally diverse populations. In addition, the program assists consumers in accessing community resources such as specialty care, independent living, education, employment, and vocational training.

2012 Accomplishments and Milestones

- More than 300 primary care and specialty service providers accessed a Peer/Family Resource Specialist in 2012.

HOSPITAL CHARITY CARE

State regulations codify the long-standing tradition of non-profit hospitals providing free or discounted care to the uninsured poor. This initiative educates health care providers and patients, reviews hospital compliance with regulations, and identifies opportunities for improvement in order to maximize utility of this invaluable community resource.

2012 Accomplishments and Milestones

- Investigated over two dozen complaints about the provision of charity care and the application process
- Provided educational programs to several hundred community workers on the system of Charity Care

- Joined with the Department of Behavioral Health, Developmental Disabilities and Health to create a task force to address prolonged waiting times for inpatient psychiatry beds for the uninsured

MINORITY HEALTH PROMOTION PROGRAM

The Minority Health Promotion Program works to eliminate racial and ethnic health disparities to assure that racial and ethnic minority populations have equal access to high quality health services. The program's activities focus on health system enhancements and programming related to disease prevention, health promotion, service delivery, and monitoring the health status of racial and ethnic minority populations. Funded community-based organizations address the Department of Health's priorities of reducing disparities and eliminating childhood obesity by providing health promotion, disease prevention, and referral services to the community.

2012 Accomplishments and Milestones

- MHPP coordinated with the Division to release a request for proposals for local investment grants to achieve healthy communities. The Center for Health Equity and Wellness (CHEW) grants has a deliberate and strategic focus on achieving health equity and eliminating health disparities by addressing the social determinants of health.
- Transitioned the Minority Health Advisory Committee to the legislatively mandated Commission for Health Advocacy and Equity (CHAE). The CHAE's purpose is to advocate for the integration of all relevant activities of the state to achieve health equity.

REFUGEE HEALTH

The Refugee Health program works to ensure that refugees and asylees enter into a comprehensive system of care that adequately responds to their unique health care needs by addressing the



coordination of care, surveillance, epidemiology, education, and training. This program convenes partners to identify and resolve system barriers to appropriate care for refugees. Trained providers initiate a comprehensive health assessment within 30 days of arrival. The Refugee Health Program works in conjunction with the Refugee Resettlement Agencies and has a large network of partners.

2012 Accomplishments and Milestones

- 90% of refugee children were screened for dental services within two months of arrival.
- The Refugee Health Program assisted 184 refugees with the medical screening requirements for the adjustment of status process.

PEDIATRIC SPECIALTY SERVICES

Pediatric Specialty Services works to provide medical home enhancement for children and youth with special healthcare needs including children and youth with Autism Spectrum Disorder. The Pediatric Practice Enhancement Project (PPEP) ensures a coordinated system of care for children and youth with special needs, and their families, by placing trained Parent Consultants in pediatric primary and specialty care practices to assist families in accessing community resources, to assist physicians and families in accessing specialty services, and to identify barriers to coordinated care.

2012 Accomplishments and Milestones

- The PPEP was recognized as a promising practice through the Association of Maternal & Child Health Programs.
- PPEP expanded to 24 pediatric primary and specialty practices throughout the state.

PRIMARY CARE AND RURAL HEALTH

The Office of Primary Care and Rural Health (OPCRH) focuses on increasing 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. The Primary Care Office is responsible for assessing primary care, psychiatric, and oral health care capacities in the state, delineating geographic and specialty specific shortages, seeking and maintaining federal shortage designations, and developing plans to address those shortages. Similarly, the State Office of Rural Health grant strengthens rural/non-metro health care delivery systems. The OPCRH is the primary state contact for the National Health Service Corps and works with state and federal partners to strengthen the recruitment and retention of qualified health professionals serving low-income, uninsured, and underinsured populations. Also, the OPCRH staffs the Primary Care Physician Advisory Committee (PCPAC), which provides recommendations to the Department of Health on medical and policy matters impacting the quality and distribution of primary care services statewide.

2012 Accomplishments and Milestones

- Awarded two mini-grants to organizations serving non-metro communities to support community assessment and strategic planning around improving rural health systems, with a focus on enhancing medical homes and maternal and child health services
- Updated RI's Health Provider Shortage Area designation process

HEALTHY HOMES AND ENVIRONMENT TEAM



Protect the health and safety of children, workers, and the general public by identifying and decreasing environmental hazards

« ROBERT VANDERSLICE, PhD, TEAM LEAD

Healthy Homes and Environment Team :: Robert Vanderslice, PhD, Team Lead, 401.222.7766

Climate Change :: Julia Gold, Manager, 401-222-7746

Healthy Communities :: David Spink, Manager, 401.222.7756

Healthy Homes :: James Bruckshaw, Manager and Deputy Team Lead, 401.222.7745

Healthy Schools :: Thomas Caruolo, Industrial Hygienist, 401.222.7748

Healthy Workplaces :: James Bruckshaw, Manager, 401.222.7745

CLIMATE CHANGE

The Rhode Island Climate and Health Project is part of a national effort to anticipate and prepare for human health effects related to global and local climate change. The project is supported by the Climate-Ready States & Cities Initiative of the Centers for Disease Control and Prevention’s Climate and Health program. Our mission is to bring experts and resources together to better understand potential climate changes in Rhode Island, predict and monitor health effects, identify the populations most vulnerable to these effects, and develop programs to protect the public’s health. Using the CDC Building Resilience Against Climate Effects (BRACE) program, we are incorporating the best available science into a unified climate and health adaptation strategy for Rhode Island.

2012 Accomplishments and Milestones:

- Hosted a stakeholder workshop: Exploring Climate Change Impacts on Vector-Borne Disease
- Participated in the RI Climate Change Commission and co-chaired the Health and Welfare Working group

HEALTHY COMMUNITIES

The Healthy Communities program advocates for environmental change as part of a comprehensive strategy for advancing public health. The Program provides public health guidance for issuing advisories regarding unhealthy air quality, blue-green algae blooms and fish tissue contaminants. Statewide planning efforts around housing, water, solid waste, sustainability, economic development and climate change provide numerous opportunities for the Program to advance a “health in all policies” approach to community development.

2012 Accomplishments and Milestones

- Climate change: Represented the Department on the RI Climate Change Commission, co-chaired the Health and Welfare Subcommittee, and assisted in writing major sections of the Commission's report, ADAPTING TO CLIMATE CHANGE IN THE OCEAN STATE: A STARTING POINT. Received funding for further climate change and health activities with a four-year grant from the Centers for Disease Control
- Formalized an agreement with Brown University's Superfund Basic Research Program, and served as co-lead for their Community Engagement and Research Translation Core. This program links academic research to the real problems facing Rhode Island residents living near contaminated sites.

HEALTHY HOMES

CHILDHOOD LEAD POISONING PREVENTION PROGRAM

To protect the health and safety of children, workers and the general public by identifying and decreasing environmental hazards.

2012 Accomplishments and Milestones

- Developed a Healthy Homes in Healthy Communities Strategic Plan 2012-2017
- In 2012, CDC's Lead and Healthy Homes Program budget was cut from \$29 million to just \$2 million. For Rhode Island, the grant funding was cut to zero. Rhode Island will be challenged over the coming year to meet state and federal mandates for lead poisoning prevention while attempting to help many more families of children with elevated blood lead levels.
- Revised Lead Screening Guidelines based on CDC's recommendation to define child blood lead levels of greater than or equal to 5mcg/dL as elevated
- Setting $\geq 5\text{mcg/dL}$ as an elevated blood lead level, the number of incident cases in RI in 2011 increased from 200 cases to 1,279. The incidence rate increases from 0.8% to 5.3% The incidence rate in the core cities of Central Falls, Pawtucket, Providence and Woonsocket is 7.4%
- Setting $\geq 5\text{mcg/dL}$ as an elevated blood lead level, the statewide prevalence increased from 1.02% (when based upon a BLL of greater than or equal to 10 mcg/dL) to 7.54%
- Published 2012 Healthy Housing Databook
- In accordance with the Centers for Disease Control changed the blood lead level of concern to greater than or equal to 5mgc/dL from greater than or equal to 10mgc/dL

LEAD TRAINING AND COMPLIANCE

Lead Training and Compliance Program works to protect the Rhode Island public from exposures to environmental lead through hazard assessment and lead hazard reduction or control by licensed professionals following safe work practices. The program is responsible for implementing the provisions of the Rhode Island Rules and Regulations for Lead Poisoning Prevention. Provisions include: requirements for identifying and decreasing environmental lead hazards in residential rental units, residences of children under six years old, and childcare facilities; procedures to

ensure that lead hazard reduction or control activities are performed in a safe manner; licensing and certification of lead professionals (including training providers), inspectors, contractors, supervisors, workers, renovators and others. Other program activities include responding to complaints from tenants and the general public; prioritizing inspections of lead hazard reduction and lead hazard control projects; lead training course curriculum development; conducting audits of certified training providers; technical review of lead professional license applications; and conducting outreach activities.

2012 Accomplishments and Milestones

- Consent agreement with property owner/management to perform lead hazard control work necessary to obtain Certificates of Conformance for 193 apartments in an 1890 mill conversion
- Increased the number of lead hazard reduction and lead hazard control site inspections for two EPA grants from 30 in grant year FY11 to 59 in FY12

HEALTHY SCHOOLS PROGRAM

The Healthy Schools Program seeks to provide technical assistance to Rhode Island schools to implement the Environmental Protection Agency Tools for Schools Program, to address indoor air quality and environmental issues in educational settings.

2012 Accomplishments and Milestones

- Expanded collaboration and coordination made with the Department of Education to identify and prioritize participating schools
- Established functioning Tools for Schools programs in East Providence, Providence, North Providence and East Greenwich
- Along with the RI Department of Education and Apeiron Institute for Sustainable Living, established the Rhode Island Sustainable School Summit, held at Nathan Bishop School, one of Providence Public School's energy efficient green buildings. Sessions included: Enhancing indoor air quality for better learning; school green teams and action plans; environmental education and literacy; energy efficiency and conservation; and school gardens/healthy local food systems.
- Program staff recruited to serve on the selection committee of the RI Department of Education Green Ribbon Schools Award Program. This national recognition award honors schools that are exemplary in reducing environmental impacts and costs; improving the health and wellness of students and staff; and providing effective environmental and sustainability education. Classical High School and Nathan Bishop Middle School were two of 78 schools in 29 states that were selected for this prestigious environmental award.

INDOOR AIR QUALITY

ASBESTOS CONTROL PROGRAM

The Indoor Air Quality: Asbestos Control Program works to protect the Rhode Island public from exposures to carcinogenic airborne asbestos through hazard assessment and abatement of asbestos containing building materials by licensed professionals following safe work practices. The program is responsible for implementing the provisions of the Rhode Island Rules and Regulations for Asbestos Control. Provisions include: requirements for identifying and abating asbestos hazards in schools



and other regulated buildings; procedures to ensure that abatement activities are performed in a safe manner; licensing and certification of asbestos professionals (including training providers), analytical labs, consultants, contractors, site supervisors, workers and others. Other program activities include prioritizing inspections of schools located in Environmental Justice Areas as defined by Environmental Protection Agency; conducting audits of certified training providers; technical review of asbestos abatement/management plans; and conducting outreach activities.

2012 Accomplishments and Milestones

- Reviewed 100% of the asbestos abatement plans submitted by companies involved in asbestos removal
- Conducted an on-site quality assurance inspection in over 30% of the facilities that submitted an asbestos abatement plan, with an emphasis on high risk properties
- Conducted a comprehensive asbestos inspection in 50 RI schools, exceeding program goals

RADON CONTROL PROGRAM

The Indoor Air Quality: Radon Control Program works to protect Rhode Islanders from lung cancer due to radon exposure by ensuring that no homes, schools, or other high priority public buildings have unacceptable radon levels. Program activities include: Implementation and enforcement of the mandatory radon testing and mitigation requirements for public and high priority buildings, certification and quality control of the licensed radon professional infrastructure, promote radon

testing and mitigation in residential properties through education and outreach campaigns, promote radon resistant new construction in homes, schools and public buildings, and manage and maintain a comprehensive radon database of public/high priority and residential test results. The Program also collaborates with and supports the U.S. Environmental Protection Agency's initiative, Protecting People and Families from Radon: A Federal Action Plan for Saving Lives.

2012 Accomplishments and Milestones

- Since 1994 increased the mitigated (reduced level of radon) homes with unacceptable radon levels from 40% to 87%
- Since 2000, increased the proportion of persons who live in homes tested for radon concentrations from 5% to 10%, reaching the program's Healthier RI Environmental Quality Objective 8-5

OSHA CONSULTATION PROGRAM

The OSHA 21(d) Consultation Program provides safety and health consultation services to promote the safety and health of Rhode Island's working men and women in small to medium size private businesses (less than 250 employees) by identifying hazards and ensuring their timely abatement. Workplace safety and health is provided stressing the continued monitoring of conditions and improvement in workplace safety and health. All evaluations are done to provide employers with a resource and expert evaluation to comply with current workplace safety regulations in a confidential, preventive, and proactive approach. Employers who maintain injury and illness rates below their peers nationally, and have complied with all OSHA consultation recommendations, are recognized in the rigorous Safety and Health Achievement Recognition Program (SHARP).

2012 Accomplishments and Milestones

- Increased the number of companies in our Safety and Health Achievement Recognition Program (SHARP) to 12 employers
- Conducted 487 visits to small employees to provide assistance on safety and health management system requirements

WORKSITE WELLNESS PROGRAM

The Worksite Wellness Program has been created to improve the health of workers in small to medium sized business through addressing issues of nutrition, obesity, smoking, physical activity, and other "wellness" initiatives.

2012 Accomplishments and Milestones

- Worked with 147 small to medium size employers in improving the quality of wellness and providing presentations on the importance of employee choices and the impact on the workplace



CHRONIC CARE AND DISEASE MANAGEMENT TEAM



Reduce the incidence, burden, and associated risk factors related to diabetes, asthma, cancer, heart disease and stroke to improve health outcomes.

« DONA GOLDMAN, RN, MPH, TEAM LEAD

Chronic Care and Disease Management Team :: Dona Goldman, RN, MPH, Team Lead, 401.222.6957

Asthma Control Program :: Nancy Sutton, MS, RD, LDN, Manager, 401.222.4040

Arthritis/Living Well Programs :: Darren Kaw MPH, Manager and Deputy Team Lead, 401.222.7622

Comprehensive Cancer Control Program :: Kathleen Heneghan MPH, Manager, 401.222.2589

Integrated Chronic Disease Prevention and Control :: Virginia Paine RN, MPH, 401-222-3367

Women’s Cancer Screening/WISEWOMAN Programs :: Brenda DiPaolo, BS, Manager, 401.222.1161

ASTHMA CONTROL PROGRAM

The Asthma Control Program works to provide leadership to improve health outcomes of all Rhode Islanders with asthma. Work includes increasing access to quality health care, asthma education, community resources, and services. In addition, the program addresses environmental determinants by advocating for healthy environments where people with asthma live, work, learn, and play. The Asthma State Plan addresses all persons with asthma regardless of age, race/ethnicity, gender, socioeconomic status, or geographic area. Specific target populations include: Hispanic and Black non-Hispanic children, Medicaid recipients, and children and adults of low income residing in the core cities (with a special focus on the City of Providence). These target groups were chosen based on current data and available resources in order to reduce disparities among populations disproportionately affected by asthma.

2012 Accomplishments and Milestones

- Home Asthma Response Program (HARP) was included in the New England Asthma Innovation Collaborative. The Collaborative, led by the Asthma Regional Council of New England, will work jointly with HEALTH, Hasbro Children’s Hospital, and St. Joseph’s Health Services to expand HARP to include a targeted total of 502 children with asthma through 2015.
- The number of asthma patients in the RI Chronic Care Collaborative registry increased from 2332 in 2011 to 4441 in 2012.
- The Breathe Easy at Home Program expanded to the city of Woonsocket. The cities of Providence and Pawtucket also participate in the program.
- 79 pediatric patients and their families received asthma home visits through the HARP.

CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS

Chronic Disease Self-Management (CDSMP) is a low-cost, evidence based disease prevention model that utilizes state of the art techniques to help those with chronic diseases to manage their conditions, improve their health status, and reduce their need for more costly medical care. The program consists of a six week workshop series of two and a half hours per week. The program helps participants develop the skills and coping strategies they need to manage their symptoms through action planning, interactive learning, behavior modeling, problem solving, decision making, and social support for change.

ARTHRITIS PROGRAM

The Arthritis Program works to develop a multi-site delivery system of evidence-based interventions for people with arthritis. The supported interventions include Stanford University's Chronic Disease Self-Management Program (known as "Living Well Rhode Island" in Rhode Island), the Arthritis Foundation Exercise Program, and the Arthritis Foundation Walk with Ease Program. All programs are offered through delivery system partners, which are key community partners who offer programs through multiple delivery sites. Delivery system partners include the Arthritis Foundation, YMCA of Greater Providence, senior centers and other senior agencies, Veterans Affairs, and health care providers. The Arthritis Program supports delivery system partners through the training of program facilitators, workshop implementation, and marketing activities. The Community Health Network, a collaborative of internal and external partners who offer evidence-based disease management and self-management programs, works with delivery system partners to link people to community-based programs.

2012 Accomplishments and Milestones

- Started the Community Health Network for healthcare providers to refer their patients to evidence-based programs
- Started academic detailing visits to health care providers to market the Community Health Network
- 176 people participated in a Chronic Disease Self-Management Program in either English or Spanish. 112 people participated in an Arthritis Foundation Exercise Program or Walk with Ease program.

LIVING WELL RHODE ISLAND

The Living Well Rhode Island (LWRI) Program provides free small group workshops on chronic disease self-management in English and Spanish to participants statewide. LWRI workshops focus on problems common to individuals suffering from chronic diseases, e.g., heart disease, diabetes, asthma, and arthritis. The overall goal of LWRI is to provide participants skills to help them take control of their health and manage their chronic health conditions. Three specific types of workshops are offered: Chronic Disease Self-Management/Tomando Control de su Salud, Diabetes Self-Management Program/Tomando Control de su Diabetes, and Chronic Pain Self-Management. Stanford University Education Research Institute developed these evidence-based workshops with proven results in increasing self-efficacy, reducing depression, and reducing health care costs among people with chronic conditions. This initiative is a partnership of the Division of Elderly Affairs, Department of Human Services, HEALTH and AARP.

2012 Accomplishments and Milestones

- Trained 21 Leaders for Living Well RI programs
- 25 LWRI workshops were held with 293 participants

COMPREHENSIVE CANCER CONTROL PROGRAM

The goal of the Comprehensive Cancer Control (CCC) program is to assess the burden of cancer, uses policy, systems, and environmental changes to guide sustainable cancer control, and to implement the state's cancer plan. The CCC program strives to reduce the burden of cancer by coordinating a statewide coalition, The Partnership to Reduce Cancer, which is comprised of over 150 individuals and agencies. 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, and strives to enhance cancer survivors' quality of life.

2012 Accomplishments and Milestones

- Funded seven Rhode Island Chronic Care Collaborative (RICCC) Health Centers to improve the quality of colorectal screening rates with over 987 referrals for colonoscopies
- Worked closely with the SCUP pilot project (Screening Colonoscopies for Underserved Persons) to align referrals for Colorectal Cancer Screening (CRC) and CCC utilizing patient navigation techniques; SCUP has provided 294 colonoscopies, with a higher than the state and national average for positive results, and removed cancerous polyps in two patients resulting in fully cancer free diagnoses.
- The Partnership to Reduce Cancer in RI supported policy changes to reduce access to tobacco for minors, improved access to adolescents for human papilloma virus vaccination; and provided providing free skin cancer screening at three recreational events.
- The Partnership and the CCC program supported all of the RI Hospitals in achieving and maintaining American College of Surgeons (ACOS) certification for their Cancer Centers.

WOMEN'S CANCER SCREENING PROGRAM

The Women's Cancer Screening Program (WCSP) works to reduce the burden (mortality and morbidity), 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 RI (specifically the refugee population). The WCSP has developed a strong network of providers to assure that the delivery of breast and cervical cancer screening, follow-up, treatment, and support services are available for enrolled clients.

2012 Accomplishments and Milestones

- 2,363 women entered the RI Women's Cancer Screening Program (WCSP) as new enrollees.
- 4,805 WCSP clients were screened for breast cancer with mammography and 201 of those women had an abnormal screening result requiring a biopsy. Of those 201 women, 160 had a benign breast condition and 41 were diagnosed with breast cancer.

- 3,302 WCSP clients were screened for cervical cancer with a Pap test and 227 of those women had an abnormal screening result requiring a biopsy. Of those 227 women, 30 needed treatment for a precancerous cervical condition and 2 were diagnosed with invasive cervical cancer.
- 214 women were enrolled in Medicaid through the WCSP for treatment of a precancerous condition of the breast/cervix or a diagnosis of breast or cervical cancer. Of the 41 women diagnosed with breast cancer in 2012, 37 were enrolled Medicaid. Both women diagnosed with invasive cervical cancer in 2012 were enrolled in Medicaid.
- The WCSP is a grantee of the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The RI program met or exceeded the guidelines for all 11 NBCCEDP core performance measures of timeliness, adequacy and completeness of care performed for WCSP clients by its contracted medical providers.

WISEWOMAN

The RI WISEWOMAN Program is a new four year grant with the goal to assure that cardiovascular screening is provided to 4,545 women aged 40-64 years who are enrolled in the state's Women Cancer Screening Program. Women will be screened for high blood pressure, high cholesterol, diabetes, obesity, physical inactivity and smoking. All women will receive health coaching to reduce risk factors, team based care to improve management and control of their diabetes and hypertension and evidence based disease and self management programs to improve the quality of their care.

INTEGRATED CHRONIC DISEASE PREVENTION AND CONTROL

DIABETES PREVENTION AND CONTROL

The Diabetes Prevention and Control Program (DPCP) coordinated the Rhode Island Statewide Diabetes Health System (RI-SDHS), which is comprised of over 700 agencies and individuals. The goal of the DPCP is to prevent and control diabetes and diabetes-related complications. The DPCP adopts, implements, evaluates, and institutionalizes programs to improve the quality of diabetes clinical care. It expands the workforce available to address the burden of diabetes in RI by supporting multicultural diabetes self-management programs, education and pre-diabetes care. These programmatic elements work together synergistically and on multiple levels (i.e., individual, health system, environmental, community, state) to constitute a comprehensive systems approach to diabetes prevention and control.

2012 Accomplishments and Milestones

- Five Rhode Island federally qualified health centers participated in the Rhode Island Chronic Care Collaborative and met or exceeded the National Committee on Quality Assurance (NCQA) guidelines for three clinical quality measures by 5%. These measures included blood pressure in control, hemoglobin A1C under 8% and LDL cholesterol under 100mg/dl.
- Among adults with diabetes enrolled in the Rhode Island Chronic Care Collaborative, 66% have documented self-management goals.

- The statewide Certified Outpatient Educator Workforce has an active membership of 330 Registered Dietitians, Nurses and Pharmacists.
- 1,028 adults with diabetes and other chronic diseases have completed the evidence-based Living Well/RI program.

HEART DISEASE AND STROKE PREVENTION

The Rhode Island Heart Disease and Stroke Prevention (HDSP) Program, funded by the CDC, developed plans and worked with partners to promote policy, environmental, and system changes to support cardiovascular health and education to increase awareness of the need for such changes. Priority areas included: prevention and increasing the control of high blood pressure and high blood cholesterol, increasing knowledge of signs and symptoms of heart attack and stroke, improving emergency response and the heart disease and stroke quality health care, and eliminating health disparities.

2012 Accomplishments and Milestones

- A primary stroke designation process was developed. As a result, there are eight designated Rhode Island Primary Stroke Centers in the state.
- The statewide Certified Outpatient Educator Workforce has an active membership of 74 certified Cardiovascular Outpatient Educators (CVDOEs).
- Six Rhode Island federally qualified health centers participating in the Rhode Island Chronic Care Collaborative were funded to improve the quality of cardiovascular care services.
- Six of Rhode Island's 39 communities have been designated as HeartSafe communities.
- One Rhode Island federally qualified health center participating in the Rhode Island Chronic Care Collaborative was funded to implement the Rhode Island Cardiovascular Screening and Risk Reduction Pilot Program modeled on the national Centers for Disease and Control (CDC) WISEWOMAN Program.



HEALTH PROMOTION AND WELLNESS TEAM

Health Promotion and Wellness Team changes social, political, and physical environments to support healthy living through the lifecourse. We focus on tobacco control, physical activity, nutrition, and violence and injury prevention.

« JAN SHEDD, EdM, TEAM LEAD

Health Promotion and Wellness Team :: Jan Shedd, EdM, Team Lead, 401.222.4872

Integrated Chronic Disease Prevention and Control

Nutrition / Physical Activity :: Eliza Lawson, MPH, Manager, 401.222.4847

Violence and Injury Prevention Program :: Beatriz Perez, MPH, Manager, 401.222.7627

Tobacco Control Program :: Erin Boles Welsh, MSW, Manager, 401.222.3207



INTEGRATED CHRONIC DISEASE PREVENTION AND CONTROL**NUTRITION / PHYSICAL ACTIVITY**

The mission of IHW is to prevent and reduce overweight and obesity in the Rhode Island population. IHW works with partners to improve the social, political, and physical environment to make healthy eating and active living easier choices for all Rhode Island residents. IHW helps partners succeed by providing training, data, tools, and individualized technical assistance; and funding. It also manages specific initiatives to inform and facilitate changes in policies, systems, or environments; informs political and community decisions around policy, systems, and environmental changes; streamlines state efforts by connecting partners with each other to share knowledge, expertise, and leverage resources; leads the surveillance of overweight, obesity and behavioral risk factors; and evaluates progress towards meeting the objectives in the Rhode Island Eat Smart Move More Plan for Action 2010–2015.

2012 Accomplishments and Milestones

- Assisted three municipalities with conducting community assessments and developing an action plan to better support healthy eating and active living. Recommendations for improvement came from the Healthy Communities Plan, which is a set of recommendations developed by the Initiative for a Healthy Weight as a guide to incorporate healthy eating and active living objectives in required municipal Comprehensive Plans.
- Provided written recommendations, based on the Healthy Communities Plan to four other municipalities to inform improvements to their Comprehensive Plans
- Informed a Rhode Island Department of Health department-wide policy to improve the nutritional quality of the foods and beverages served at HEALTH-run or sponsored meetings and events
- In partnership with other state agencies and community partners, Initiative for a Healthy Weight received a national award from First Lady Michelle Obama's Let's Move campaign for having the highest percent of child care providers enrolled in Let's Move Child Care.
- Launched a campaign to empower parents to reduce their children's consumption of sugar sweetened beverages, which reached 85 percent of the target population through television communications and 98 percent through radio communications

VIOLENCE AND INJURY PREVENTION PROGRAM

The Violence and Injury Prevention Program gives communities and policy-makers the data and technical assistance they need to provide effective Injury Prevention programs and to implement policies to reduce intentional injuries caused by violence and suicide, and unintentional injuries caused by falls, motor vehicle crashes, and prescription drug overdoses. The program also helps secure federal funds to address these key safety issues. Injury prevention programs in schools provide students with the skills they need to sustain healthy relationships and to prevent suicide, violence and rape. The program funds agencies to provide training to adults and youth in school and community settings so they can identify youth who may be at risk of injuring themselves, or

others, and getting them the professional help they may need to prevent suicide and other types of violence. It also funds primary care practices to provide falls risk assessments and community based agencies to provide exercise programs to prevent falls among older adults. Data and research information are provided to key decision makers about the effectiveness of a primary seat belt law, enforcing laws that stop Driving Under the Influence (DUI) and on other related issues that will save lives. A strategic plan to address prescription drug overdoses is currently being developed with key stake holders.

2012 Accomplishments and Milestones

- **Suicide Prevention:** Trained 458 high school staff and 495 community-based organization (CBO) staff on Question, Persuade, Refer suicide prevention program. Trained 256 high school youth on Signs of Suicide prevention program. Reached 83% of adults aged 35-54 with the suicide proofing your home media campaign. Received 4460 visits to the suicide proofing your home website
- **Rape Prevention:** Trained 4077 high school youth on root causes of sexual violence and healthy relationships. Trained 93 high school teachers and other staff in sexual violence prevention. Reached 80% of males ages 12-20 with winning PSA for Your Voice. Your View. sexual violence prevention media contest. Distributed 3500 Your Voice. Your View. informational packets to high schools.
- **Falls Injury Prevention:** Trained 250 older adults in a six session Matter of Balance exercise and falls prevention program. Trained 115 primary care providers in falls injury prevention. Initiated a falls risk assessment pilot project with five primary care practices.
- **Motor Vehicle Injury Prevention:** Passed a primary seat belt law in June 2011.

TOBACCO CONTROL PROGRAM

The Tobacco Control Program (TCP) works to eliminate tobacco-related disease by creating environments that make it harder for people to start using and continue using tobacco. Preventing tobacco use and exposure to second and third-hand smoke is critical to the health of our state and the TCP relies heavily on informative statewide educational initiatives, innovative traditional and social media campaigns, state and local data collection and dissemination, and funding of cessation services to accomplish this goal.

2012 Accomplishments and Milestones

- Provided technical assistance to 24 of the 25 public housing authorities and other housing organizations to advise them on the benefits of adopting and enforcing 100% smoke-free policies. In 2012, 18 public housing authorities have adopted smoke-free policies and others have announced they intend to adopt one in the near future.
- Maintained the Rhode Island Smoker's Helpline to connect Rhode Islanders with cessation services. 1-800-QUIT-NOW (1-800-784-8669). In 2012, the Rhode Island Smoker's Quitline has serviced over 19,000 people.
- Rhode Island has consistently increased the cigarette excise tax rate, making smoking difficult to afford. RI currently has the second highest tax rate in the US at \$3.50 per pack. High prices for

cigarettes increase quit attempts, especially among young and lower income smokers.

- Created www.QUITNOWRI.com to provide information on cessation resources available to all Rhode Islanders. The site also features video from the recent “Tobacco Made Me” media campaign, motivational ring tones and encouraging personal stories.
- The youth cigarette smoking rate has plummeted from 35% in 2001 to 11% in 2011. Rhode Island is proud to have the third lowest youth smoking rate in the US. (RI HS YRBS 2001, 2011)
- The Tobacco Control Program Partnered with the City of Providence Mayor’s Substance Abuse Prevention Council (MSAPC) under Communities Putting Prevention to Work (CPPW) to inform decision makers on CDC best practices in Tobacco Control. The information supported the Providence Housing Authority to adopt smoke-free policies in its high rise housing for elderly and disabled people and to pilot smoke-free policy in selected family developments in the City. During this time the Providence City Council passed an ordinance requiring that tobacco vendors have a local tobacco selling license, and passed a ban on flavored tobacco products and price promotions in stores that sell tobacco, protecting children and youth from these alluring products. Also under this partnership, the Providence School Department strengthened the statewide ban on tobacco use on Providence school grounds, and The Providence Community Health Centers provided tobacco cessation services to 376 individuals.



PERINATAL AND EARLY CHILDHOOD HEALTH TEAM

Support 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 maternal and child health services.

« BLYTHE BERGER, ScD, TEAM LEAD

Perinatal and Early Childhood Health Team :: Blythe Berger, ScD, Team Lead, 401.222.5949

Adolescent Health :: Kimberly Harris, LCSW, MSW, Manager, 401.222.4354

Early Childhood Developmental Screening and Follow-up Program :: Kristine Campagna, MEd, Manager, 401.222.5927

Home Visiting Programs :: Kristine Campagna, MEd, Manager, 401.222.5927

Newborn Screening and Follow-up Program :: Christelle Larose, Coordinator, 401.222.4606

Race to the Top :: Emily Eisenstein, Coordinator, 401.222.5924

Successful Start :: Blythe Berger, ScD, 401.222.5949

WIC Program :: Ann Barone, LDN, Chief, 401.222.4604

:: Ashley Baker, Breastfeeding Coordinator, 401.222.5919



ADOLESCENT HEALTH

The Adolescent Health program works to promote healthy adolescent development through statewide systems, policies, and initiatives, as well as targeted and integrated interventions to address health risks in high need communities. Build local capacity to support youth development initiatives. The program engages partners, including youth, to focus on medical home model for adolescents, social, emotional, behavioral health supports, and teen pregnancy prevention.

2012 Accomplishments and Milestones

- Provided training to 8 community-based agencies to begin implementing the Teen outreach program to reduce teen pregnancy

EARLY CHILDHOOD DEVELOPMENTAL SCREENING AND FOLLOW-UP

Early Childhood Developmental Screening and Follow-Up are programs designed to increase the number of young children (birth to age 8) receiving standardized, comprehensive, developmental and behavioral screenings (child wellness screen) in community-based settings consistent with current recommendations of the American Academy of Pediatrics (AAP). The purpose of these programs is to provide follow-up for young children who receive developmental and/or behavioral screening with results that were out of the normal range. Follow-up in the form of training and technical assistance support is also provided for their care providers, including child care providers, physicians, and families. Follow-up is provided to young children and their families in community-based settings, when possible. Early Childhood programs also provide consultation to child and primary care providers who see a high number of children with risk factors for poor developmental or mental health outcomes.

2012 Accomplishments and Milestones

- Screened, on average, 75% of children who were eligible for developmental screens

HOME VISITING PROGRAMS

Maternal and child home visiting programs focus on improving the well-being of families with young children. These programs send trained nurses, social workers, community health workers, or other professionals to meet with families in their homes at times convenient for the family. Visits are based on the needs of the parent and child and are different for every family. Home visitors can answer all types of questions, including questions on prenatal care, caring for a new baby, breastfeeding, sleeping, child development, health and nutrition and family supports. Home visitors can also link families to community-based resources such as the Women, Infants, and Children (WIC) Program, Early Intervention, family support services, and more. HEALTH supports First Connections, Healthy Families America, Nurse-Family Partnership and some Parents as Teachers sites.

2012 Accomplishments and Milestones

- Affiliated the first five Healthy Families America sites in Rhode Island
- Expanded the capacity of Nurse-Family Partnership and Parents as Teachers in Rhode Island

FIRST CONNECTIONS PROGRAM

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 and successful as possible.

2012 Accomplishments and Milestones

- In 2012, four First Connections agencies visited over 3,000 newborns and their families statewide.
- Collaborated with WIC to increase the number of referrals to home visiting for pregnant women and families with young children

HEALTHY FAMILIES AMERICA

The goals of Healthy Families America, a long term, evidence-based home visiting program, are to build and maintain partnerships in communities that engage families in home visiting, either prenatally or at birth; promote and strengthen positive parent-child relationships; promote positive growth and development in children; build the strengths of families and their protective factors.

2012 Accomplishments and Milestones

- Affiliated the first five Healthy Families America sites in Rhode Island
- Began providing services to pregnant women and families with young children in Providence and Woonsocket

NURSE-FAMILY PARTNERSHIP

The mission of Nurse-Family Partnership, a long-term, evidence-based program available to first time mothers is to improve pregnancy outcomes by helping women engage in good preventive health practices; improve child health and development by helping parents provide responsible and competent care; and improve the economic self-sufficiency of families by helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work.

2012 Accomplishments and Milestones

- Graduated its first clients in Rhode Island. 15 clients and their children completed the program
- 100% of clients who gave birth completed a post-partum OB/GYN visit
- Expanded capacity to begin providing services in Newport, West Warwick and Woonsocket

PARENTS AS TEACHERS

The goals of Parents as Teachers, a long term, evidence-based home visiting program, are to increase parent knowledge of early childhood development and improve parenting practices; provide early detection of developmental delays and health issues; prevent child abuse and neglect; increase children's school readiness and school success.

2012 Accomplishments and Milestones

- Affiliated one new Parents as Teachers site in Rhode Island
- Provided funding for services in Central Falls and Pawtucket and increased the number of families able to be served in Woonsocket

NEWBORN SCREENING AND FOLLOW-UP

To screen 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.

2012 Accomplishments and Milestones

- The Rhode Island Department of Health Newborn Screening Program was awarded funds to implement a demonstration program to assess the feasibility of pulse oximetry screening on newborns prior to hospital discharge to detect Critical Congenital Heart defects.
- Achieved 100% screening rates for all newborns in Rhode Island

RACE TO THE TOP EARLY LEARNING CHALLENGE

The Race to The Top Early Learning Challenge program works to provide support for primary-care providers in implementing a system of regular developmental screening (at 9, 18, & 30 months) consistent with the enhanced Early Periodic Screening, Diagnosis & Treatment (EPSDT) Schedule. In addition, the program supports community-based, evidence-based interventions on early literacy, social emotional development, and family engagement in health settings. There are seven projects within Race to The Top Early Learning Challenge focused on developing high quality and accountable programs, promoting early learning and development outcomes for children, building a great early childhood workforce, and measuring outcomes and progress.

2012 Accomplishments and Milestones

- Added developmental screening to the KIDSNET data system, which will link data among state agencies and capture long-term outcomes
- Provided physician/staff training and education to health centers and pediatric offices in the state to integrate developmental screening into practice
- Integrated developmental screening into Pediatric Patient Centered Medical Homes

SUCCESSFUL START

Successful Start is an early childhood system building initiative focused on development and implementation of a system of recognition, response, and intervention to improve outcomes for children who have experienced toxic stress and/or trauma.

Rhode Island will develop the capacity to screen children birth to three in different types of community based settings to identify children who are at risk for, or experiencing, toxic stress and/or trauma and make appropriate referrals. RI will enhance statewide screening and referral systems to identify children at birth through hospital based systems. RI will enhance screening and referral systems in primary care, and other community settings that serve children birth to three, to better identify and respond to children and families who are at risk for, or experiencing toxic stress and/or trauma.

2012 Accomplishments and Milestones

- the Early Childhood Comprehensive System grant was funded

- state agency partners were convened to create a multi-state agency response to toxic stress during early childhood
- efforts were combined with Home Visiting to create a coordinated response and maximize resources

WOMEN, INFANTS, AND CHILDREN (WIC)

WIC's primary mission, as an adjunct to good healthcare, is to provide education for optimal nutrition during critical stages of growth and development. The program provides an array of support for families including breastfeeding support and promotion; referrals to needed medical and social services in the community; and assessment of client nutritional status. WIC also provides checks for healthy foods based on the clients' nutritional needs. WIC recipients show higher birth weight, lower infant mortality, improved blood iron levels and diets, improved brain and neurological development, and lower use of intensive care nurseries compared to infants born to lower income mothers that have not benefited from proper nutritional food supplements.

2012 Accomplishments and Milestones

- Supported breastfeeding mothers returning to work or school by providing hospital-grade electric breast pumps free of charge; provided 40 pumps in 2011 and 60 pumps in 2012
- Implemented medical necessity breast pump program to assist moms with medical emergencies that cannot receive pumps through their insurer
- Increased the percentage of WIC mothers who initiated breastfeeding from 58% to 63%
- Expanded the use of the fruit and vegetable voucher to allow its use at WIC-approved Farmer's Markets statewide

BREASTFEEDING PROGRAM

In collaboration with healthcare providers and community members and organizations, the Breastfeeding Program provides consistent and accurate breastfeeding education and support to all women during the prenatal period, upon delivery, and through the early years of a child's life. The program works to ensure that each woman is able to meet her personal infant feeding goal.

2012 Accomplishments and Milestones

- Expanded the Women, Infant's and Children (WIC) breast pump program, to provide hospital-grade breast pumps to women with a medical necessity
- Collaborated with the Rhode Island Home Visiting Program to improve breastfeeding support to all women state-wide
- Developing a strategic plan to identify deficiencies and potential areas of improvement around breastfeeding education and support, in collaboration with members from the State's birthing hospitals, the Rhode Island Breastfeeding Coalition, and other programs within the Rhode Island Department of Health



PREVENTIVE SERVICES AND COMMUNITY PRACTICES TEAM



Improve the quality of preventive and community services through integration of internal and external program resources by increasing access and availability to vulnerable populations.

« PATRICIA RAYMOND, RN, MPH, TEAM LEAD

Preventive Services and Community Practices Team :: Patricia Raymond, RN, MPH, Team Lead, 401.222.5921

Family Planning Program :: Sounivone Phanthavong, Manager, 401.222.4609

Office of Immunization :: Tricia Washburn, BS, 401-222-5922

Oral Health Program :: Laurie Leonard, MS, Manager, 401.222.2433

FAMILY PLANNING PROGRAM

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.

2012 Accomplishments and Milestones

- Increased the percentage of family planning users by 8.8%
- Increased the number of HIV tests provided to family planning users by 11.8%
- Developed a statewide strategic plan to improve preconception health through public health initiatives, comprehensive health policies, healthcare practices and promotion, and consumer awareness

OFFICE OF IMMUNIZATION

The primary 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. Implementing systems for vaccine purchase and distribution; quality assurance; public and provider education; information dissemination; surveillance and community collaboration. The Office of Immunization includes a universal pediatric program that provides all recommended vaccines to providers for children birth through 18 years of age, as well as an adult immunization program that currently provides influenza, pneumococcal, Tdap and hepatitis vaccines to providers for individuals 19 years of age and older.

2012 Accomplishments and Milestones

- Implemented the first statewide influenza vaccination mandate for health care workers, increasing coverage rates among healthcare workers from 65% to 90%
- Ranked highest (73%) in the US for influenza vaccination of pregnant women to prevent flu-related complications in newborns
- Ranked highest (74.5%) in the US for influenza vaccination among children 6 months-17 years of age
- Achieved greater than 95% vaccination coverage rates among children entering kindergarten
- Achieved top rankings in US adolescent vaccination coverage rates for tetanus/diphtheria/pertussis (Tdap), meningitis (MCV4) and human papilloma virus (HPV) vaccines
- Implemented an online vaccine ordering system for healthcare providers. OSMOSSIS, the Ocean State Management of State Supplied Immunizations System, has replaced a paper based ordering system and was designed to increase efficiency and improve accountability
- Implemented a web-based school vaccination reporting system to monitor coverage rates among children entering kindergarten and 7th grade

ORAL HEALTH PROGRAM

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:

- Increasing access to and utilization of preventive interventions such as dental sealants for children and appropriate water fluoridation for all Rhode Islanders
- Assuring sound policy decisions through education of policy makers
- Promoting and providing continued education for health professionals to enhance community efforts to prevent, control, and reduce oral diseases
- Promoting community capacity for high quality, culturally sensitive oral health services

2012 Accomplishments and Milestones

- The SEAL RI! Project, funded through the Maternal & Child Health Title V program, supported dental screenings for 815 children and provision of dental sealants for 454 children with indicated clinical need.
- 820 RI oral health professionals have received continued professional education through the OHP sponsored Annual RI Dentistry Mini-Residency Series (topics: pediatric dentistry, special care dentistry, geriatric dentistry, adolescent dentistry and the oral health-systemic health connection).

STAFF DIRECTORY BY TEAM

EXECUTIVE ADMINISTRATION TEAM		EXT	RM
Barron, Michelle	Coordinated Chronic Disease & Health Promotion	5827	304
DelFino, Ariana	Operations, Executive Director Office	4618	303
Dionne, Lori	Executive Director Office	5118	408
Hall-Walker, Carol	Executive Director Office	5935	302
Lundquist, Carla	Operations, Executive Director Office	7626	304
Novais, Ana	Executive Director Office	5117	408
Paiva, Kristi	Executive Director Office	1250	201
Sen, Ratha	Executive Director Intern	2227	408
Simon, Peter, MD	Executive Director Office	5928	408
Zelano, Lori	Operations, Executive Director Office	1583	302

CHRONIC CARE AND DISEASE MANAGEMENT TEAM		EXT	RM
Ariza, Cindy	Living Well Program	7636	404
Boehm, Lisette	Women's Cancer Screening	7632	409
Cesare, Susan	Coordinated Chronic Disease	4851	404
DiPaolo, Brenda	Women's Cancer Screening/ WISEWOMAN	1161	408
Dooley, Anne	Chronic Care & Disease Management Team	4779	409
Flanders, Sharon	Women's Cancer Screening	1151	403
Goldman, Dona	Chronic Care & Disease Management Team	6957	409
Heneghan, Katy	Comprehensive Cancer Control	2589	409
Kaw, Darren	Arthritis and Living Well Programs	7622	404
Kelly-Flis, Patty	Coordinated Chronic Disease	4354	404
LaCasse, Melissa	Women's Cancer Screening Program	7641	408
Loucks, Eric	Coordinated Chronic Disease	863-6283	201
Luther, Karen	Women's Cancer Screening Program	3044	408
Newell, Deborah	Coordinated Chronic Disease	4421	404
Paine, Virginia	Coordinated Chronic Disease	3667	404
Smith, C. Kelly	Comprehensive Cancer Control	7899	409
Sutton, Nancy	Asthma Control Program	4040	409
Towle, Meghan	Asthma Control Program	5977	201
Veazey, John	Women's Cancer Screening Program	6843	403
Volquez, Venus	Women's Cancer Screening Program	3283	404

HEALTH DISPARITIES & ACCESS TO CARE TEAM		EXT	RM
Ankoma, Angela	Office of Minority Health	7630	302
Becker, Elisabeth	Disability & Health Program	2030	201
Boucher, Carmen	Disability & Health Program	2107	304
Ciletti, Letizia	Health Disparities & Access to Care	2901	302
D'Errico, Jill	Rural Health & CLAS	1488	302
Francisco, Yudelky	RI Parent Information Network	5372	103
Garneau, Deborah	Health Disparities & Access to Care	5929	304
Golding, Deb	Adolescent Transition	5954	304
Hernandez, Diane	RI Parent Information Network	5953	302
Houle, Donna	RI Parent Information Network	5372	407
Jones, Peter	RI Parent Information Network	5887	304
Kuiper, Kathleen	RI Parent Information Network	5372	304
Laroche, Carla	RI Parent Information Network	5943	302
Moretti, Rose	RI Parent Information Network	3329	404
Polselli, Colleen	Pediatric Specialty Services	4615	304
Tavares, Monica	Office of Primary Care & Rural Health	5371	304
Thompson, Pauline	RI Parent Information Network	4963	304
Vallejo, Maria Luisa	Refugee Health Program	5952	304
Joanna Yeboah	Refugee Health Program Intern	5952	304

HEALTHY HOMES AND ENVIRONMENT TEAM		EXT	RM
Almeida, Michelle (Kollett)	Healthy Homes & Environment	7794	206
Bruckshaw, James	OSHA Consultation	7745	206
Cabral, Antonio "Tony"	OSHA Consultation	3611	206
Cardoza, Anne	Healthy Homes & Environment	7791	206
Caruolo, Thomas	Healthy Housing-Schools	7748	206
Cassani-Brandt, Bonnie	Healthy Homes & Environment	7784	206
Deluca, Gina	Worksite Wellness Program	2594	206
Ferreira, Helga	Healthy Homes & Environment	7750	206
Gold, Julia	Climate Change Program	7746	206
Johnston, David	Industrial Hygienist	7752	206
Murray, Tammie	Healthy Homes & Environment	7751	206
O'Brien, John	Industrial Hygienist	2440	206
Olteanu, Angela	Healthy Homes & Environment	7753	206
Primeau-Faubert, Anne	Healthy Homes & Environment	7747	206
Rodriguez, Shirley	Healthy Homes & Environment	7744	206
Spink, David	Healthy Homes & Environment	7756	206
Tahakjian, Martin	Healthy Homes & Environment	3613	206
Vanderslice, Robert	Healthy Homes & Environment Team	7766	206

HEALTH PROMOTION AND WELLNESS TEAM		EXT	RM
Andrade-Koziol, Jennifer	Injury Prevention	4964	402
Ausura, Christopher	Initiative for Healthy Weight	1383	408
Boles Welsh, Erin	Tobacco Control Program	3207	409
Collins, Erica	Tobacco Control Program	7635	408
Guardino, Geri	Tobacco Control Program	3497	409
Hill, Jeffrey	Youth Suicide Prevention	1173	409
King, Dorene	Health Promotion & Wellness Team	7464	409
Lawson, Eliza	Initiative for Healthy Weight	4847	408
McCants Derisier, Dana	Tobacco Control Program	7625	408
Patriarca-O'Flaherty, Mia	Initiative for Healthy Weight	1225	302
Pearlman, Deborah	Health Promotion & Wellness Team	5937	201
Perez, Beatriz	SafeRI-Violence & Injury Programs	7627	409
Roberts, Cynthia	Tobacco Control Program	5889	201
Santos, Benvinda	Tobacco Control Program	7637	409
Shedd, Jan	Health Promotion & Wellness Team	4872	409
PERINATAL AND EARLY CHILDHOOD HEALTH TEAM		EXT	RM
Aguiar, Stacey	Race to the Top	1087	302
Baker, Ashley	Breastfeeding Program	5919	302
Baldwin, Elizabeth	Perinatal & Early Childhood	4804	201
Barone, Ann	WIC Program	4604	302
Berger, Blythe	Perinatal & Early Childhood Health	5949	302
Campagna, Kristine	Newborn Screening Program	5927	302
Carter, Cristina	WIC Program	5918	302
DePina, Luisa	RI Parent Information Network WIC	4621	302
Eisenstein, Emily	Race to the Top	5924	302
Gast, Perry	First Connections & Home Visiting	4606	302
Harris, Kimberly	Adolescent Health	4354	302
Kaur, Gurpreet "Preet"	WIC Program	4633	302
Larose, Christelle	Newborn Screening Program	5950	302
Lauder, Michael	WIC Program	5930	302
Leclair, Cheryl	Home Visiting Program	5942	302
Liwanga, Maxwell	WIC Program	4630	302
Manzi, Anthony	WIC Program	5885	302
Piluso, Lauren	WIC Program	4637	302
Remington, Sara	Home Visiting Program	5946	302
Reynoso, Emma	WIC Program	4632	302
Silva, Max	Home Visiting Intern	401-241-6141	302

Tamburro, Denise	WIC Program	4642	302
Tavares, Bonventura "T"	WIC Program	1380	302
Then, Fiordaliza "Liza"	Newborn Hearing Screening	6146	302
Votta, Carol	Race to the Top	5354	302
White, Charles	WIC Program	5939	302
Yang, Sheng	WIC Program	4605	302
McNeilly, Barbara	Immunization & Newborn Screening	4641	304
PREVENTIVE SERVICES & COMMUNITY PRACTICES TEAM		EXT	RM
Acheampong, Benjamin	Immunization DataNet Intern	5988	
Cales, Carmen	Immunization Program	5945	309
Cappelli, Denise	Immunization Program	4610	309
Ciletti, Letizia	Preventive Services & Community Practices Team	2901	302
Duggan-Ball, Sue	Immunization Program	1580	309
Francesconi, Mark	Immunization Program	5988	309
Fuller, Deborah, DMD	Oral Health Program	7730	309
Koller, Elizabeth	Immunization DataNet Intern	5988	
Leonard, Laurie	Oral Health Program	2433	309
Marceau, Kathy	Immunization Program	4624	309
McNeilly, Barbara	Immunization & Newborn Screening	4641	304
Oh, Junhie	Oral Health Program	4577	201
Phanthavong, Sounivone	Family Planning	4609	302
Pichardo, Lourdes	RI Parent Information Network	5932	302
Porrazzo, Deborah	Immunization Program	7876	309
Raymond, Patricia	Preventive Services & Community Practices Team	5921	309
Reyes, Melanie	Immunization Program	5948	302
Villari, John	Immunization DataNet Intern	5988	
Wallace, Heidi	Immunization Program	4631	309
Washburn, Tricia	Immunization Program	5922	302
Yearwood, Safiya	Oral Health Program	4577	302

50 STAFF DIRECTORY—ALPHABETICAL

NAME	EXT	ROOM	NAME	EXT	ROOM	NAME	EXT	ROOM
Acheampong, Benjamin	5988		Hall-Walker, Carol	5935	302	Porrazzo, Deborah	7876	309
Aguiar, Stacey	1087	302	Harris, Kimberly	4354	302	Primeau-Faubert, Anne	7747	206
Almeida, Michelle (Kollett)	7794	206	Heneghan, Katy	2589	409	Raymond, Patricia	5921	309
Andrade-Koziol, Jennifer	4964	402	Hernandez, Diane	5953	302	Remington, Sara	5946	302
Ankoma, Angela	7630	302	Hill, Jeffrey	1173	409	Reyes, Melanie	5948	302
Ariza, Cindy	7636	404	Houle, Donna	5372	407	Reynoso, Emma	4632	302
Ausura, Christopher	1383	408	Johnston, David	7752	206	Roberts, Cynthia	5889	201
Baker, Ashley	5919	302	Jones, Peter	5887	304	Rodriguez, Shirley	7744	206
Baldwin, Elizabeth	4804	201	Kaur, Gurpreet "Preet"	4633	302	Santos, Benvinda	7637	409
Barone, Ann	4604	302	Kaw, Darren	7622	404	Shedd, Jan	4872	409
Barron, Michelle	5827	304	Kelly-Flis, Patty	4354	404	Simon, Peter, MD	5928	408
Becker, Elisabeth	2030	201	Koller, Elizabeth	5988		Smith, C. Kelly	7899	409
Berger, Blythe	5949	302	King, Dorene	7464	409	Spink, David	7756	206
Boehm, Lisette	7632	409	Kuiper, Kathleen	5372	304	Sutton, Nancy	4040	409
Boles Welsh, Erin	3207	409	LaCasse, Melissa	7641	408	Tahakjian, Martin "Marty"	3613	206
Boucher, Carmen	2107	304	Larose, Christelle	5950	302	Tamburro, Denise	4642	302
Bruckshaw, James	7745	206	Lauder, Michael	5930	302	Tavares, Bonventura "T"	1380	302
Cabral, Antonio "Tony"	3611	206	Lawson, Eliza	4847	408	Tavares, Monica	5371	304
Cales, Carmen	5945	309	Leclair, Cheryl	5942	302	Then, Fiordaliza "Liza"	6146	302
Campagna, Kristine	5927	302	Leonard, Laurie	2433	309	Thompson, Pauline	4963	304
Cappelli, Denise	4610	309	Liwanga, Maxwell	4630	302	Towle, Meghan	5977	201
Cardoza, Anne	7791	206	Loucks, Eric	(401)-863-6283	201	Vallejo, Maria Luisa	5952	304
Carter, Cristina	5918	302	Lundquist, Carla	7626	304	Vanderslice, Robert	7766	206
Caruolo, Thomas	7748	206	Luther, Karen	3044	408	Veazey, John	6843	403
Cassani-Brandt, Bonnie	7784	206	Manzi, Anthony	5885	302	Villari, John	5988	
Cesare, Susan	4851	404	Marceau, Kathy	4624	309	Volquez, Venus	3283	404
Ciletti, Letizia	2901	302	McCants Derisier, Dana	7625	408	Votta, Carol	5354	302
Collins, Erica	7635	408	McNeilly, Barbara	4641	304	Wallace, Heidi	4631	309
D'Errico, Jill	1488	302	Moretti, Rose	3329	404	Washburn, Tricia	5922	302
DeFino, Ariana	4618	303	Murray, Tammie	7751	206	White, Charles	5939	302
Deluca, Gina	2594	206	Newell, Deborah	4421	404	Yang, Sheng	4605	302
DePina, Luisa	4621	302	Novais, Ana	5117	408	Yearwood, Safiya	4577	302
Dionne, Lori	5118	408	O'Brien, John	2440	206	Zelano, Lori	1583	302
DiPaolo, Brenda	1161	408	Oh, Junhie	4577	201			
Dooley, Anne	4779	409	Olteanu, Angela	7753	206			
Duggan-Ball, Sue	1580	309	Paine, Virginia	3667	404			
Eisenstein, Emily	5924	302	Paiva, Kristi	1250	201			
Ferreira, Helga	7750	206	Patriarca-O'Flaherty, Mia	1225	302			
Flanders, Sharon	1151	403	Pearlman, Deborah	5937	201			
Francesconi, Mark	5988	309	Perez, Beatriz	7627	409			
Francisco, Yudelky	5372	103	Phanthavong, Sounivone	4609	302			
Fuller, Deborah, DMD	7730	309	Pichardo, Lourdes	5932	302			
Garneau, Deborah	5929	304	Piluso, Lauren	4637	302			
Gast, Perry	4606	302	PolSELLI, Colleen	4615	304			
Gold, Julia	7746	206						
Golding, Deb	5954	304						
Goldman, Dona	6957	409						
Guardino, Geri	3497	409						



MICHAEL FINE, MD, DIRECTOR OF HEALTH

RHODE ISLAND DEPARTMENT OF HEALTH

THREE CAPITOL HILL, CANNON BUILDING, PROVIDENCE, RHODE ISLAND 02908

INFORMATION LINE 401.222.5960 / RI RELAY 711

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