RHODE ISLAND DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH AND EQUITY
FY 2018–2019
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Dear Friends,

Everyone deserves an equal opportunity to harness their talents, achieve their dreams, and reach their full health potential regardless of their race, ethnicity, sexuality, gender orientation, ZIP code, or level of education or income. Achieving health equity, by addressing the social and environmental factors that contribute to health disparities, is crucial to the idea of everyone from every ZIP code living a life that is the best they can achieve and building a vibrant society. We have made some gains in this area in our state and across the country. However, our work is even more important, and every step needs to be stronger and more effective because of what’s at stake.

The Rhode Island Department of Health (RIDOH) Strategic Framework serves as the blueprint for everything we do. Our three leading priorities are to: 1) address the social and environmental determinants of health, 2) eliminate health disparities and promote health equity, and 3) ensure access to quality health services for all Rhode Islanders.

From these leading priorities, we developed five overarching strategies and implemented 23 population health goals, which set targets for RIDOH and the other State agencies and local partners with whom we collaborate. We can only achieve health equity if we are willing to sit at the same table, embrace a shared vision for a stronger, thriving Rhode Island, and work toward that vision together.

RIDOH is partnering with people from across the state to promote health equity through our Health Equity Zones (HEZ) -RIDOH’s place-based initiative designed to build healthy communities. If we are truly going to make a difference in the health of Rhode Islanders, we need to start that change at the community level, where people live, learn, work, and play.

I thank our many colleagues and partners who are working collectively to eliminate the injustice of health disparities and to make Rhode Island a healthier, safer, more enjoyable place to live for all of us. I look forward to our continued collaboration.

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

23 POPULATION HEALTH GOALS

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

*These goals have been proposed through the State Innovation Model and are under review.
http://www.health.ri.gov/about
Dear Colleagues,

It is with great enthusiasm that the Division of Community Health and Equity (CHE) shares the FY 2018-2019 division booklet with you. The purpose of the booklet is to share our mission, vision, program work and to connect our efforts so that together, we can help build stronger and healthier communities for everyone.

As we continue our work to catalyze social change that will lead to a more productive, just, inclusive, safe, and healthy environment for all Rhode Islanders. In partnership with you, we will create conditions that will help people thrive and achieve their optimal health.

With support from the Centers for Disease Control and Prevention, Health Resources Services Administration, United States Department of Agriculture, Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families, payers, foundations, and state funding, CHE is advancing RIDOH’s three leading priorities and statewide population health goals included in this document.

Working with our community partners towards building healthier neighborhoods, please visit www.health.ri.gov/programs/detail.php?pgm_id=1108 to learn about our local investment in Health Equity Zones (HEZs). We believe this investment with leaders and citizens working together, using a collective-action approach, can make a difference in the health and well-being of all Rhode Islanders. We look forward to collaborating with you to achieve this end.

Sincerely,

Carol Hall-Walker, MPA
Associate Director of Health
Division of Community Health and Equity
Rhode Island Department of Health
MISSION

In conjunction with the mission of RIDOH, CHE strives to prevent disease and protect and promote the health and safety of the people of Rhode Island.

VISION

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

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

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

WHAT WE DO

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

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

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

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

4. CENTER FOR PREVENTIVE SERVICES: Uses evidence-based practices to improve the quality of preventive care by increasing access to vulnerable populations, diminishing ethnic and racial health disparities, and enhancing community partnerships. Areas of focus include adolescent and school health, family planning and preconception health, immunization, and oral health.
The social and environmental determinants of health, life-course approach, integration of programs, and social and emotional competencies are the four pillars of CHE’s approach to public health. When allocating resources and making data-driven decisions on what interventions should be implemented, CHE uses the following tool to help prioritize its work.

The example below uses the Physical Activity and Nutrition 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.

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The Health Impact Pyramid, April 2010, Vol 100, No. 4, American Journal of Public Health. This pyramid is adapted from Thomas Frieden, MD, MPH presentation at the Weight of the Nation conference, Washington D.C., July 27, 2009
1. COUNSELING AND EDUCATION

Health education is 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

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 poor health and inequities in health. These actions would directly impact the physical, social, cultural, and economic environments and the availability and accessibility of health services 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.

1. Prevention Institute, Health Equity Primers
Health Equity Zones (HEZs)
Geographical areas designed to achieve health equity by eliminating health disparities using place-based (where you live) strategies to promote healthy communities.

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<tr>
<th>Backbone Agency, HEZ Coordinators</th>
<th>Description</th>
<th>RIDOH Project Officer</th>
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| **Providence HEZ: Citywide**      | Focuses on improving community health around the city’s recreation centers, improving nutrition, developing community gardens, offering Providence Summer Food Service program, developing healthy food policies for public facilities, increasing access to physical fitness programs for adults and youth in public places, conducting activities to increase health and safety in parks and recreation centers, offering diabetes prevention and self-management programs, and improving environmental health by implementing green infrastructure projects. providenceri.com/healthy-communities | Erin Bertoldi, M.Ed 401-222-7635 Erin.Bertoldi@health.ri.gov  
Evaluator: Morgan Orr 401-222-1250 Morgan.Orr@health.ri.gov |
| **Pawtucket and Central Falls HEZ: Citywide** | Focuses on resident engagement around increased access to healthy affordable food, diabetes prevention and other self-management programs, adoption of nutrition guidelines where food is sold, healthy housing and empowering tenants, increasing landlord accountability, community kitchen development, improving transportation efficiency, creating linkages to job training, supporting small and micro businesses, establishing youth coalitions, and facilitating positive relationships across diverse neighborhood populations. LISC also focuses on adolescent and behavioral health while supporting culturally competent health services. rilisc.org/hez/ | Mia Patriarca, MA 401-222-1225 Mia.Patriarca@health.ri.gov  
Evaluator: Elise George, MPH 401-222-2030 Elise.George@health.ri.gov |
| **North Providence HEZ - Neighborhood** | Focuses on the Marieville Elementary School and Birchwood Middle School neighborhoods and the identified health needs of students and their families. Focus areas include: the environment, safe routes to school, Walking School Bus, youth center activities, recreational facilities, greener school yards, affordable fruits and vegetables, asthma, offering diabetes prevention and other self-management programs, obesity, mental and behavioral health, oral health, tobacco use and exposure, substance abuse, and violence. nphez.org/ | Christina Batastini, M.Ed 401-222-3646 Christina.Batastini@health.ri.gov  
Evaluator: Elise George, MPH 401-222-2030 Elise.George@health.ri.gov |
| **Providence HEZ - Olneyville Neighborhood** | Focuses on increasing and promoting physical activity, access to healthy affordable foods, farmers markets and community gardening, redevelopment of distressed and vacant properties, addressing public safety issues, improving public transportation, offering diabetes prevention and other self-management programs, opportunities for resident financial stability, and community engagement through community pride events and initiatives in efforts to build a more collective and cohesive community. ovhez.com/ | Deb Golding 401-222-5954 Deb.Golding@health.ri.gov  
Evaluator: Morgan Orr 401-222-1250 Morgan.Orr@health.ri.gov |

For general information about Health Equity Zones (HEZs) contact: Christopher Ausura | 401-222-1383 | christopher.ausura@health.ri.gov  
www.health.ri.gov/projects/healthequityzones
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<th>Providence HEZ: Neighborhoods</th>
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<th>RIDOH Project Officer</th>
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<td>Southside, Elmwood, West End</td>
<td>Focuses on increasing enrollment and implementation of the Incredible Years Parent Program (promoting young children's social, emotional, and academic lives), creating solutions for greater resident engagement, community organization, and neighborhood ecosystem support, reducing violence, and improving distressed and vacant properties. <a href="http://cycprovidence.org/">cycprovidence.org</a></td>
<td>Deb Golding 401-222-5954 <a href="mailto:Deb.Golding@health.ri.gov">Deb.Golding@health.ri.gov</a> Evaluator: Morgan Orr 401-222-1250 <a href="mailto:Morgan.Orr@health.ri.gov">Morgan.Orr@health.ri.gov</a></td>
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<tr>
<td>Providence Children and Youth Cabinet</td>
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<td>Rebecca Boxx 401-662-1637 <a href="mailto:Rebecca_Boxx@brown.edu">Rebecca_Boxx@brown.edu</a></td>
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<td><strong>Washington County HEZ</strong></td>
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<td>South County Health South County Healthy Bodies, Healthy Minds</td>
<td>Focuses on and promotes programs related to childhood obesity and mental health. Programs include: 5-2-1-0, an evidence-based program, encouraging families to keep a healthy weight, Reach Out and Read, promoting reading aloud to children daily, and Youth Mental Health First Aid, for those interacting with adolescents, and LAUNCH, serving families with children birth to 8 years of age. The HEZ also focuses on connecting residents to local farmers markets accepting SNAP and WIC benefits for access to healthy food. <a href="http://bodiesminds.org/">bodiesminds.org</a></td>
<td>Deb Golding 401-222-5954 <a href="mailto:Deb.Golding@health.ri.gov">Deb.Golding@health.ri.gov</a> Evaluator: Morgan Orr 401-222-1250 <a href="mailto:Morgan.Orr@health.ri.gov">Morgan.Orr@health.ri.gov</a></td>
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<td>EVALUATOR Tamara Calise, DrPH Med, <a href="mailto:tcalise@si.co">tcalise@si.co</a></td>
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<td><strong>West Warwick HEZ: Citywide</strong></td>
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<td>Thundermist Health Center</td>
<td>Focuses on improving walkability and transportation, access to recreation, increased access to healthy affordable fresh food, weekly farmers markets, community garden and orchard, summer meal and school meal programs, addressing high rates of substance use and overdose through rescue, treatment, and recovery strategies, naxolone training, Police Department behavioral health pilot, medication assisted treatment, peer recovery supports, adolescent healthcare with school and community support links, trauma and toxic stress mitigation, diabetes prevention and other self-management programs. Works with 10 engaged neighborhood leaders acting as HEZ citizen ambassadors. <a href="http://thundermisthealth.org">thundermisthealth.org</a></td>
<td>Lauren Conkey, MPH 401-222-7622 <a href="mailto:Lauren.Conkey@health.ri.gov">Lauren.Conkey@health.ri.gov</a> Evaluator: Elise George, MPH 401-222-2030 <a href="mailto:Elise.George@health.ri.gov">Elise.George@health.ri.gov</a></td>
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<td><strong>Woonsocket HEZ: Citywide</strong></td>
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<td>Thundermist Health Center</td>
<td>Focuses on access to healthy affordable fresh food, year-round farmers markets, addressing high rates of substance use and overdose through rescue, treatment, and recovery strategies, opened The Serenity Center (free community drop-in center for adults in recovery), naxolone training, medication assisted treatment, peer recovery supports, teen health, adolescent medical homes, trauma awareness, physical activity, pedestrian walking plan “Woonsocket Walks - A City on the Move”, and offering diabetes prevention and other self-management programs. Works with 10 engaged neighborhood leaders acting as HEZ citizen ambassadors. <a href="http://thundermisthealth.org">thundermisthealth.org</a></td>
<td>Lauren Conkey, MPH 401-222-7622 <a href="mailto:Lauren.Conkey@health.ri.gov">Lauren.Conkey@health.ri.gov</a> Evaluator: Elise George, MPH 401-222-3030 <a href="mailto:Elise.George@health.ri.gov">Elise.George@health.ri.gov</a></td>
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<td><strong>Bristol HEZ: Townwide</strong></td>
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<td>Town of Bristol</td>
<td>Focuses on improving nutrition and access to healthy food, promoting physical activity, facilitating community public health events, adopting Complete Streets policies, facilitating health literacy classes and health screenings, and offering diabetes prevention programs. Bristol is also working with community providers to implement interventions that will improve local healthcare systems. <a href="http://horsleywitten.com/BristolHEZ/">horsleywitten.com/BristolHEZ/</a></td>
<td>Mia Patriarca, MA 401-222-1225 <a href="mailto:Mia.Patriarca@health.ri.gov">Mia.Patriarca@health.ri.gov</a> Evaluator: Elise George, MPH 401-222-2030 <a href="mailto:Elise.George@health.ri.gov">Elise.George@health.ri.gov</a></td>
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<td>Emily Pearce-Spence, M.Ed 401-253-1611, <a href="mailto:emily.spence@bwrsd.org">emily.spence@bwrsd.org</a> Craig Pereira 401-272-1717, <a href="mailto:cpereira@horsleywitten.com">cpereira@horsleywitten.com</a> Walter Burke 401-253-1611, <a href="mailto:wburke@bristolri.us">wburke@bristolri.us</a></td>
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<td><strong>Newport HEZ - Citywide</strong></td>
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<td>Women's Resource Center</td>
<td>Focuses on mobilizing residents and resources of the Broadway and North End neighborhoods, improving transportation, increasing healthy food access, creating economic opportunity, securing open space, parks and, trails; embracing arts and culture, and developing physical and emotional health through two new neighborhood Wellness Hubs that will house evidence-based programs, offering diabetes prevention and other self-management programs, and LAUNCH. <a href="http://newporthalthequity.com">newporthalthequity.com</a></td>
<td>Erin Bertoldi, M.Ed 401-222-7635 <a href="mailto:Erin.Bertoldi@health.ri.gov">Erin.Bertoldi@health.ri.gov</a> Evaluator: Morgan Orr 401-222-1250 <a href="mailto:Morgan.Orr@health.ri.gov">Morgan.Orr@health.ri.gov</a></td>
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CAROL HALL-WALKER, MPA
ASSOCIATE DIRECTOR OF HEALTH
401.222.5935

“Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”
Martin Luther King

AILIS CLYNE, MD, MPH
MEDICAL DIRECTOR
401.222.5928

“The true measure of any society can be found in how it treats its most vulnerable members”
Mahatma Gandhi

PATRICIA RAYMOND, RN, MPH
INTERDEPARTMENTAL PROJECT MANAGER (DEPUTY)
401.222.5921

“If you have health, you probably will be happy, and if you have health and happiness, you have all the wealth you need, even if it is not all you want.”
Elbert Hubbard

MELANIE WILSON
HEALTH PROGRAM ADMINISTRATOR (FISCAL)
401.222.4640

“He who has health, has hope; and he who has hope, has everything.”
Thomas Carlyle

DONNA CEPRANO
CHIEF IMPLEMENTATION AIDE (ADMINISTRATIVE SUPPORT)
401.222.1624

“Cheerfulness is the best promoter of health and is as friendly to the mind as to the body.”
Joseph Addison
The Center for Chronic Care and Disease Management uses a systems approach to reduce the incidence, burden, and associated risk factors related to arthritis, asthma, cancer, diabetes, heart disease, and stroke to improve health outcomes.

NANCY SUTTON, MS, RD, CENTER CHIEF

**Center for Chronic Care and Disease Management**

**Team ::** Nancy Sutton, MS, RD, Center Chief, 401.222.6957

**Arthritis Program ::** Jasmine Franco, BS, 401.222.4520

**Asthma Control Program ::** Julian Drix, AB, 401.222.7742

**Cancer Registry Program ::** Junhie Oh, BDS, MPH, 401.222.4577

**Colorectal Cancer Prevention Program ::** Eric Lamy, BA, 401.222.2227

**Comprehensive Cancer Control Program ::** CKelly Smith, MSW, 401.222.7899

**Diabetes, Heart Disease, and Stroke Prevention Program ::**

Randi Belhumeur, MS, RD, LDN, CDOE, 401.222.3667

**WISEWOMAN ::** Adelaide Lafferty-Ritt, MHA, 401.222.4040

**Women’s Cancer Screening Program ::**

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**ARTHITIS**

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

**Key Initiatives**

- Increase the number of arthritis-appropriate, evidence-based interventions statewide (Chronic Disease Self-Management, Tomando Control de su Salud, Walk with Ease Group-Led, Walk with Ease Self-Directed).
- Increase the number of Rhode Islanders enrolled in arthritis-appropriate, evidence-based interventions.
- Embed arthritis-appropriate, evidence-based interventions into multi-site delivery systems.
The Asthma Control Program works to reduce overall asthma burden and asthma health disparities in Rhode Island. It aims to lower asthma-related hospitalizations, emergency room visits, health inequalities, and missed days of work and school. The program addresses the social and environmental determinants of health by advocating for healthy environments where people with asthma live, work, learn, and play, focusing on the four high-poverty core cities of Providence, Pawtucket, Central Falls, and Woonsocket.

**Key Initiatives**

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

**CANCER REGISTRY**

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

**Key Initiatives**

- Support hospital tumor registries and promote cancer programs accredited by the American College of Surgeons in acute-care hospitals throughout Rhode Island.
- Develop queries and analyze the cancer registry to provide surveillance reports for the Rhode Island Comprehensive Cancer Control, Women's Cancer Screening, and Colorectal Cancer Prevention Programs, as well as the media, healthcare systems, and consumers.
- Develop and implement evaluation plans for the RIDOH Comprehensive Cancer Control, Women's Cancer Screening, and Colorectal Cancer Prevention Programs.
- Prepare and publish extensive technical and statistical written reports and publications related to Rhode Island Cancer Registry Data and National Surveillance, Epidemiology, and End Results Program (SEER) data, as well as website publications.
The goal of the Colorectal Cancer Prevention Program (CRC) is to increase CRC screening rates among persons age 50 to 75 within partner health systems. This goal is accomplished through the implementation of four key evidence-based interventions: provider assessment and feedback, provider reminders, client reminders, and reducing structural barriers using small media and patient navigation.

Key Initiatives

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

Key Initiatives

- Organize and support the work of the Partnership to Reduce Cancer in Rhode Island.
- Issue surveillance briefs and educational materials describing the burdens of cancer in Rhode Island.
- Identify opportunities to decrease cancer-associated incidence and mortality rates.
- Promote palliative care and survivorship care as two means of improving the quality of life of cancer survivors.
- Promote community-based, cancer-screening initiatives supported by evidence-based guidelines.
- Organize policy, systems, and environmental change strategies to support comprehensive cancer-control activities.
- Promote community utilization of comprehensive cancer-control strategies (including those employed in prevention, screening and detection, survivorship, and palliative care).
DIABETES, HEART DISEASE, AND STROKE PREVENTION

The mission of Diabetes, Heart Disease, and Stroke Prevention (DHDSP) is to prevent and reduce death and disability due to diabetes, heart disease, and stroke. DHDSP is committed to healthcare transformation to improve chronic disease management and prevention for those with or at risk for prediabetes, diabetes, and hypertension. Key initiatives work together synergistically and on multiple levels (i.e., individual, health system, environmental, community, state) to constitute a comprehensive systems approach to prevention and control.

Key Initiatives

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

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

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

WOMEN’S CANCER SCREENING

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

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

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PHYSICAL ACTIVITY AND NUTRITION

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

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

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

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

**TOBACCO CONTROL**

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

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

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

Key Initiatives

- Via a contract between RIDOH and Rhode Island Student Assistance Services (RISAS), integrate emotion-regulation activities and content into the 1) Student Assistance Program (SAP) model; and 2) via a Memorandum of Understanding between the RIDOH, Center for Health Promotion VIPP and the RIDOH Center for Perinatal and Early Childhood Health, Family Visiting Program, integrate emotion regulation into the Healthy Families America program and the Parents as Teachers program.
- Via a contract between the RIDOH and the Brain Injury Association of Rhode Island, conduct ImPACT neuropsychological baseline testing for Rhode Island middle and high-school-age youth participating in school sports, and Rhode Island youth sports leagues in three communities.
- Inform and educate stakeholders about the public health benefits of enhancements to the Rhode Island Youth Sports Concussion (YSC) law requiring neuropsychological baseline testing.
- Via a contract with Day One, increase the number of youth exposed to the evidence-based sexual violence prevention program, Your Voice Your View.
- Via contracts with RISAS and Bradley Hospital, provide in-school trainings and resources to prevent youth suicide.
The Center for Perinatal and Early Childhood Health supports healthy birth outcomes, positive early childhood development and school readiness, and preparation for healthy productive adulthood by providing and assuring mothers, children, and adolescents access to quality maternal and child health services.

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

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

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

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

NEWBORN SCREENING AND FOLLOW-UP

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

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

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

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

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

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

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

**PATRICIA RAYMOND, RN, MPH, CENTER CHIEF**

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**Adolescent/School Health**
Create a comprehensive and coordinated adolescent health system that supports families and communities in promoting positive adolescent development so that all children have access to appropriate high-quality healthcare, education, and social and community services, as needed, to support optimal healthy development and successful transition to adulthood.

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

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

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

**IMMUNIZATION**

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

**Key Initiatives**

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

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

Key Initiatives

- Continue promotion of SEAL RI! (school-based dental sealants) program.
- Maintain effective community water fluoridation in Rhode Island public water systems.
- Increase oral health messages delivered to pregnant women and infants.
- Increase the number of pregnant women in Medicaid who receive preventive oral health services in FQHCs as measured by billing data, dental claims data, chart review, or other timely evidence.
- Increase the use of direct referrals between primary care providers and dentists through Federally Qualified Health Centers (FQHCs) that have both types of providers in each facility as well as successfully have the family/home visiting programs adopt the new Efforts to Outcomes (ETO) oral health prompts to improve access to oral health care for those populations.
- Increase the number of children younger than age two who have a preventive oral health visit.
- Implement sustainable referral systems between dental providers and pediatricians.
- Increase parental knowledge of age one/early dental visit.
- Increase dental provider knowledge and comfort level providing services for young children.
- Increasing providers’ understanding of and willingness to see adults (and children) with Medicaid through educational modules (building off the Learning Collaborative).
- Provide reimbursement for case-management codes for providers that complete the related modules.
- Increase Medicaid enrollees’ awareness of dental benefits through informational handouts and better explanation on exchange and website.
- Restructure adult dental Medicaid program from fee-for-service to a managed-care benefit or other innovative model.
DIVISION HIGHLIGHTS

- Created the “Own Your Health” collaborative – Arthritis Program
- Received a one-year extension on the arthritis grant
- Arthritis Program CDC project officers—Rhode Island had “one of the best” site visits.
- Launched the Comprehensive Integrated Asthma Care System to provide comprehensive asthma services
- Colorectal Cancer Program received funds to purchase tablets for Patient Navigators at partner health systems.

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

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

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

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

The Association of State and Territorial Health Officials (ASTHO) featured a Health Equity Zone webinar.
• Secured CDC funding to support the Drug Overdose Prevention Program with five staff persons and community-prevention resources
• Partnered with the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals to lead the Governor’s Task Force on Overdose Prevention and Intervention and implement strategies included in *Rhode Island’s Strategic Plan on Addiction and Overdose – Four Strategies to Alter the Course of an Epidemic*.

• Secured five years of continuation funding for the Violence and Injury Prevention Program to address child abuse and neglect, traumatic brain injury, intimate partner/sexual violence, and motor vehicle crash injury and death
• Trained more than 1,000 middle and high school staff professionals in the Question, Persuade, Refer model of gatekeeper youth suicide prevention; and trained more than 500 middle and high school students in the evidence-based Signs of Suicide - Suicide Prevention Peer Gatekeeper Program
• Reduced Rhode Island’s adult cigarette smoking rate to 12% and the youth rate to 4.8%

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

Successfully completed Health Equity Zone Year 2 Initiatives and launched Year 3

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

• Worked with Public Housing Authorities (PHA) and residents to ban smoking in 23 of the 25 PHA buildings, thus reducing exposure to second-hand smoke in the home
• Provided funding and staff support to 10 Health Equity Zones and the Health Equity Learning Community
• Facilitated implementation of built-environment policies that support safety, physical activity, and access to healthy foods; and nutrition guidelines in public facilities, including schools
Collaborated with the Department of Corrections to coordinate public health education and services for incarcerated people

- Family Visitors and WIC staff are collaborating to achieve better outcomes.
- The Newborn Screening Program met newborn screening rates 100%.
- Family Visiting staff were accepted into National Home Visiting Community Associations Institute Project.
- Revised Family Visiting database; streamlined and added questions with equity lens.

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

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

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

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

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

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

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

- High immunization rates and highest immunization coverage rates for HPV
- Improved access and reduced barriers to flu vaccine for providers
- Implemented new vaccine assessment law for all payers
- Improved vaccine temperature monitoring in provider settings

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

- Improved/increased partnerships across adolescent health
- Worked with partners to complete the Adolescent Sexual Health Profile
- Hired State School Nurse Consultant
- Organized youth feedback sessions for the Personal Responsibility Education Program
- Conducted three-day Teen Outreach Program (TOP) training and certified 15 new TOP facilitators
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Health Information Line 401.222.5960 / RI Relay 711
www.health.ri.gov

Gina M. Raimondo
Governor

Eric Beane
Secretary, Executive Office of Health and Human Services

Nicole Alexander-Scott, MD, MPH
Director of Health