Launch a 2011 Language Access Campaign to inform Rhode Island residents with limited English proficiency of their rights and responsibilities for accessing interpreters and translated information in healthcare settings (CLAS Initiative).

Provide translated “My Health Booklets” for refugee populations being resettled in Rhode Island to help the refugees become familiar with the public health and primary care systems (Refugee Health Program).

Screen and facilitate discussions of the Unnatural Causes documentary that teaches the public about the social determinants of health.

Publish bi-annual Minority Health Fact Sheets as well as Cost of Health Disparities Briefs.

Provide additional educational materials and data analyses for consumers, providers, and policy makers, as needed.

Host up to four Health Equity Dialogues per year to raise awareness about health disparities and the impact of social and environmental determinants of health on racial and ethnic minority health status (Minority Health Promotion Program).

Promote and monitor progress toward state and national targets for healthy people in healthy communities (Healthy Rhode Island 2020 Initiative).

Ensure that newly arrived refugees initiate a relationship with a primary care provider to receive a health assessment, lab work, catch-up vaccinations, and appropriate referrals and follow-up care (Refugee Health Program).

Co-locate a mental health clinician within the Refugee Clinic at Hasbro Children's Hospital to perform child mental health assessments and provide needed referrals (Refugee Health Program).

Work with hospitals, private providers, and other healthcare delivery organizations to establish policies and operational systems that assure access to interpreters and translated health information for persons with limited English proficiency (CLAS Initiative).

Establish internal procedures and contracting requirements to help the Department of Health and its contracted agents adhere to language access mandates (CLAS Initiative).

Work with housing and lead programs to ensure that new refugees are placed into safe housing (Refugee Health Program).

Support training, certification, and reimbursement to grow the Community Health Worker workforce in Rhode Island.
The Health Impact Pyramid describes the effect of population-based public health interventions and provides a framework to improve health. Figure Source: American Journal of Public Health, Vol 100, No. 4, April 2010; adapted from the Thomas Frieden, MD, MPH presentation at the Weight of the Nation conference, Washington, D.C., July 27, 2009.
To increase access to effective education and counseling, work across the state to increase the numbers, effectiveness, and utilization of community health workers, including those employed in rural areas.

Recruit and retain primary care providers in health professional shortage areas across the state (including in non-metro areas) through the National Health Service Corps, 3RNET, NOSORH, NRHA, and the New England Rural Health Roundtable.

Develop and deliver core competency training to existing and prospective community health workers.

Promote the patient-centered medical home model in sites serving vulnerable populations.

Work to establish policies and assistance programs to make all primary care practices patient-centered medical homes.

Conduct policy activity to support statewide efforts to require additional investment of commercial insurance revenue into primary care systems building.

Work to recognize, grow, and remunerate the community health worker workforce as a way to promote employment, fair wages, career laddering opportunities, and self-determination among vulnerable populations without formal higher education.

Work with non-metro communities to improve local healthcare systems.

Through rural health mini-grants for community assessment, help communities examine barriers to care and capacity issues and use this information to develop recommendations for system improvements.

Through systems building grants, support action plan development and strategy implementation to address social and environmental determinants of health. Strategies include action steps to promote the patient-centered medical home model.
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HEALTH DISPARITIES AND ACCESS TO CARE TEAM
HEALTHY COMMUNITIES INITIATIVE

1. **EDUCATION AND COUNSELING**
   - Help community-based project teams to develop Community Action Plans that include health education or counseling strategies related to chronic disease management.
   - Continue to support community-based projects through initial implementation.

2. **CLINICAL INTERVENTIONS**
   - Include strategies in Community Action Plans to increase access to primary care, including preventive services and screening.
   - Continue to support community-based projects through initial implementation.

3. **LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS**
   - As community-based project teams identify local factors that promote or impede healthy choices, help them develop and implement policy, systems, and environmental change to reduce the burden of chronic disease and related health disparities. (For example, strategies could include working with corner stores to offer more affordable produce and reduce the sales of less nutritious foods.)

4. **CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT**
   - Help community-based project teams identify change strategies that impact social and environmental determinants of health and incorporate them into Community Action Plans. (For example, strategies could include increasing the numbers and competence of community health workers in Olneyville and establishing community organizations that empower local residents to effectively advocate for their community’s health.)

5. **SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH**
**EQUITY PYRAMID**

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**HEALTHY HOMES AND ENVIRONMENT TEAM**

**INDOOR AIR QUALITY: ASBESTOS AND RADON PROGRAMS**

1. **EDUCATION AND COUNSELING**
   - Provide consumer, technical, and regulatory information via the Department website, information line, and pamphlets.
   - Support the inclusion of testing and hazard notification in real estate disclosure.
   - Conduct special outreach for radon month.

2. **CLINICAL INTERVENTIONS**
   - Develop and maintain a data system for address, inspection, and complaint data.
   - Review training for licensed professionals.
   - Conduct grant writing, strategic planning, and other program support activities.
   - Review asbestos abatement plans.

3. **LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS**
   - Provide radon test kits to weatherization and other housing programs.

4. **CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT**
   - Provide asbestos test kits to weatherization and other housing programs.
   - Conduct special outreach for radon month.

5. **SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH**
   - Perform compliance inspections and enforcement activities for asbestos and radon abatement.
   - Respond to complaints about improper asbestos removal.
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**HEALTHY HOMES AND ENVIRONMENT TEAM**

**CHILDHOOD LEAD POISONING PREVENTION PROGRAM**

**1. EDUCATION AND COUNSELING**
- Provide consumer, technical, and regulatory information via the Department website, information line, and pamphlets.
- Support the inclusion of testing and hazard notification in real estate disclosure.
- Issue alerts for lead-containing materials.

**2. CLINICAL INTERVENTIONS**
- Provide case management for cases of childhood lead poisoning.
- Evaluate and promote lead screening.

**3. LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS**
- Develop and maintain a data system for medical, address, inspection, and complaint data.
- Review training for licensed professionals.
- Conduct grant writing, strategic planning, and other program support activities.

**4. CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT**
- Ensure lead-safe housing is part of community development programs.
- Perform compliance inspections and enforcement activities for lead abatement.

**5. SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH**
- Respond to complaints about improper lead renovations.
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**EQUITY PYRAMID**

**HEALTHY HOMES AND ENVIRONMENT TEAM**

**HEALTHY HOMES AND OTHER ENVIRONMENTAL PROGRAMS**

1. **EDUCATION AND COUNSELING**
   - Provide consumer, technical, and regulatory information via the Department website, information line, and pamphlets.
   - Support the inclusion of testing and hazard notification in real estate disclosure.
   - Issue advisories about air quality, toxic algae, mercury, and other environmental health hazards.

2. **CLINICAL INTERVENTIONS**
   - Support emergency department requirements for carbon monoxide exposure equipment.
   - Require carbon monoxide poisoning reporting.
   - Develop indicators of healthy housing that incorporate data on the quality of housing, neighborhoods, and the health of residents.

3. **LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS**
   - Provide training for building officials.
   - Conduct grant writing, strategic planning, and other program support activities.
   - Maintain the Healthy Housing Collaborative.

4. **CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT**
   - Develop a housing locator for lead-safe and smoke-free housing.

5. **SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH**
   - Provide technical assistance for mold remediation.
   - Promote tools for schools and other activities that improve school environments.
CHRONIC CARE AND DISEASE MANAGEMENT TEAM

ASTHMA CONTROL PROGRAM

1. **EDUCATION AND COUNSELING**
   - Educate community health center providers on best practices to improve quality of care to asthma patients (RI Chronic Care Collaborative, or RICCC).

2. **CLINICAL INTERVENTIONS**
   - Implement RICCC asthma best practices (Community health center providers).
   - Establish a web-based referral system, Breathe Easy at Home (BEAH), to refer patients for a home inspection for asthma triggers by the city's housing inspector (city inspectors).
   - Provide outpatient education on disease management to patients (Certified Asthma Educators).
   - Conduct home visits for pediatric asthma patients who enter the emergency department due to asthma (Home Asthma Response Program, or HARP).

3. **LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS**
   - Address the environmental health of homes to improve asthma outcomes (RICCC, HARP, BEAH, Healthy Housing Collaborative).

4. **CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT**

5. **SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH**

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**DIVISION OF COMMUNITY, FAMILY HEALTH, AND EQUITY**

**CHRONIC CARE AND DISEASE MANAGEMENT TEAM**

**COMPREHENSIVE CANCER CONTROL & COLORECTAL SCREENING**

1. **EDUCATION & COUNSELING**
   - Educate health professionals and the general public at local and statewide events about cancer prevention, screening, treatment, survivorship, and palliative care (Partnership to Reduce Cancer in RI).
   - Train colorectal cancer screening patient navigators in community health centers.
   - Train physicians at seven RI Chronic Care Collaborative sites to track, refer, and report on patients for colorectal cancer screening through a registry.
   - Train a dermatology group on screening for early signs of skin cancer and making appropriate referrals.

2. **CLINICAL INTERVENTIONS**
   - Help patients overcome barriers in the cancer screening process (Colorectal cancer screening patient navigators in community health centers).
   - Assist cancer committees at all American College of Surgeons certified cancer centers on improving and maintaining National Committee for Quality Assurance status.
   - Provide five free colonoscopies for each community health center site (Screening Colonoscopies for Underserved Persons (SCUP) physicians).
   - Provide skin screenings and referrals for potential skin cancers at events (Partnership to Reduce Cancer in RI).
   - Collaborate with the Oral Health Program on head and neck cancer prevention through a variety of activities (e.g., working with the Rhode Island Dental Hygienists’ Association to assure cancer screening at all dental visits; increasing human papillomavirus (HPV) immunization among young adults).

3. **LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS**
   - Provide HPV vaccinations to underserved young adults, targeting African Americans and Hispanics (Partnership to Reduce Cancer in RI Prevention Workgroup).

4. **CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT**
   - Assure compliance with palliative care beds at hospitals.
   - Support adding HPV immunization to the school immunization record.
   - Collaborate with the Tobacco Control Program on environmental improvements such as smoke-free public housing.
   - Support insurance reimbursement to mass immunizers outside the medical home for college students and disparate adult populations.
   - Support city ordinances to ban the sale of “two-for-” one cigarette package specials.
   - Support adding grades 9–11 to the Vaccinate Before You Graduate Program.
   - Support Culturally and Linguistically Appropriate Services (CLAS) standards training for registration clerks at hospitals.

5. **SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH**
   - Encourage cancer survivors to use their personal experiences and cancer literacy skills to engage their communities in cancer prevention and early detection activities, such as smoking prevention and cessation, healthy eating and exercise, and screenings for breast, cervical, colon, prostate, skin, and oral cancers.
**EQUITY PYRAMID**

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**CHRONIC CARE AND DISEASE MANAGEMENT TEAM**  
**DIABETES PREVENTION AND CONTROL PROGRAM**

1. **EDUCATION AND COUNSELING**  
   - Educate community health center providers on best practices to improve quality of care for diabetes patients (RI Chronic Care Collaborative, or RICCC).
   - Train certified diabetes outpatient educators (dietitians, nurses, and pharmacists) on patient education for diabetes disease management.
   - Organize group patient visits that bring a nurse, dietitian, and pharmacist to the healthcare provider's office for a focused diabetes session (TEAMWorks Program).

2. **CLINICAL INTERVENTIONS**  
   - Organize group patient visits that bring a nurse, dietitian, and pharmacist to the healthcare provider's office for a focused diabetes session (TEAMWorks Program).
   - Provide outpatient education on disease management to diabetes patients (Trained dietitians, nurses, and pharmacists).
   - Conduct a demonstration project to promote diabetes screening during pregnancy and program referral for women with gestational diabetes.
   - Use RICCC diabetes best practices (Community health center providers).

3. **LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS**

4. **CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT**  
   - Conduct policy activity to promote the sugar-sweetened beverage tax.
   - Collaborate with Diabetes Council members to improve communities’ physical environments.

5. **SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH**
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Educate community health center providers on best practices to improve quality of care for cardiovascular disease (CVD) patients (RI Chronic Care Collaborative, or RICCC).

Train certified diabetes outpatient educators (dietitians, nurses, and pharmacists) on patient education for CVD management.

Encourage communities to receive a designation as a HeartSafe Community by training a certain number of citizens and/or law enforcement agencies in CPR or CPR/AED (RI HeartSafe Community Program).

Conduct media campaigns (FAST, Go Red/Heart Health Month) and a PSA (Waiting) to educate the public on how to recognize heart attack symptoms and when to call 911.

Educate health professionals and the general public on best practices related to heart disease and stroke prevention (Events such as the Annual Summit and RICCC Outcomes Congress; communication channels such as the Department website and Partnership newsletter).

Use RICCC CVD best practices (Community health center providers).

Provide outpatient education on disease management to CVD patients (Trained dietitians, nurses, and pharmacists).

Establish primary stroke centers in acute care hospitals in RI to ensure the rapid triage, diagnostic evaluation, and treatment of patients suffering an acute stroke (Stroke Prevention and Treatment Act Legislation).

Collaborate with the National Salt Reduction Initiative, a partnership led by the New York City Health Department that works with food manufacturers and the restaurant industry to lower the salt levels in commonly-consumed products.

Advocate for the Tobacco Control Program’s Tobacco Excise Tax Bill and Bill regarding Other Tobacco Products.

Collaborate with the Initiative for a Healthy Weight Smart Meal Program, which educates restaurants and the public about healthier food choices.

Collaborate with the Initiative for a Healthy Weight to support Menu-Labeling Legislation, which would provide consumers with important information about the caloric content of food they order in restaurants.
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Conduct peer-led group workshops, for people 18+ years old with chronic diseases, providing participants with skills to change behaviors to better manage their chronic diseases.

Conduct outreach and media campaigns to increase awareness of workshops among the community and healthcare providers.

Integrate efforts with the Chronic Condition Workforce Collaborative to increase awareness and understanding of the program among public health-supportive workers.

Develop a workforce of peer leaders and Master Trainers, paid with stipends.

Empower workshop participants to direct healthcare decisions.
EQUITY PYRAMID

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DIVISION OF COMMUNITY, FAMILY HEALTH, AND EQUITY

CHRONIC CARE AND DISEASE MANAGEMENT TEAM

WOMEN'S CANCER SCREENING PROGRAM

1. EDUCATION AND COUNSELING
   - Partner with community-based agencies to educate all women on the importance of breast and cervical cancer screening.
   - Contract with Women & Infants Hospital to conduct outreach and recruitment with neighborhood workplaces, businesses, places of worship, and community-based organizations.
   - Contract with each Federally-Qualified Health Center to recruit established health center clients, make appointments, and do related work.

2. CLINICAL INTERVENTIONS
   - Encourage clinicians to discuss the importance of breast and cervical cancer screening with clients and to refer uninsured clients to the Women's Cancer Screening Program (WCSP).
   - Refer patients diagnosed with cancer to support services.
   - Help eligible clients enroll in Medicaid.
   - Use patient navigators, social workers, and social agencies to assist clients, as needed.

3. LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS
   - Provide access to breast and cervical cancer screening, diagnosis, and treatment services for eligible clients through provider contracts statewide.
   - Collect and analyze data on screening and diagnostic services to evaluate timeliness and quality of services provided to clients, and address results with providers who do not meet standards of care.

4. CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT
   - Support the federal Breast and Cervical Cancer Mortality Prevention Act of 1990, which authorizes the Centers for Disease Control and Prevention to provide breast and cervical cancer screening services to underserved women.
   - Support the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, which allows states to provide medical assistance through Medicaid to eligible women diagnosed with breast or cervical cancer.
   - Support the state Breast Cancer Act 2000, which provides mammography for women age 40-49 through the WCSP, mandates reimbursement for breast screening, covers the cost of prosthetic devices and/or reconstructive surgery incident to mastectomies within 18 months of surgery, and accredits facilities and technologists to perform mammography.

5. SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH
   - Interact on an ongoing basis with traditional and non-traditional partners within schools, neighborhoods, workplaces, businesses, places of worship, government agencies, and healthcare settings.
   - Work with Newport Hospital to ensure the availability and accessibility of expanded mammography services by uninsured, underinsured, and racial/ethnic minority populations and to annually report the amount of free care provided.
   - Work with the Lifespan Minority Outreach Program to promote WCSP services to all uninsured women who visit the emergency room at Miriam Hospital.
   - Coordinate hospital-based screening events that provide free breast screening to low-income, uninsured clients and link women with primary care providers.
DIVISION OF COMMUNITY, FAMILY HEALTH, AND EQUITY

EQUITY PYRAMID

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HEALTH PROMOTION AND WELLNESS TEAM

TOBACCO CONTROL PROGRAM

1 EDUCATION AND COUNSELING

- Hold community meetings in Newport, Pawtucket, Providence, and North Kingstown (Tobacco Control Network).
- Promote and communicate systematically about cessation coverage for Medicaid recipients (Promote Quitting).

2 CLINICAL INTERVENTIONS

- Fund and oversee telephonic counseling services (Promote Quitting).
- Fund and manage Quitline telephone counseling services (Cessation).

3 LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS

- Fund free nicotine replacement therapy and counseling to un/underinsured people statewide (Promote Quitting).
- Institutionalize QuitWorks cessation services in healthcare facilities (Cessation).
- Conduct policy activity to inform the streamlined implementation of Medicaid cessation services (Cessation).

4 CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT

- Conduct policy activity to inform laws and regulations governing the sale and promotion of emerging tobacco products (Community initiatives).
- Conduct policy activity to promote taxation parity between cigarette and other tobacco products (Prevent Youth Initiation).
- Conduct policy activity to require cessation coverage benefits from all health insurers (Promote Quitting).
- Conduct policy activity to ban sales of flavored other tobacco products in Providence (American Recovery and Reinvestment Act (ARRA) Providence).
- Conduct policy activity to maintain high cigarette tax rate (Eliminate Second-Hand Smoke).

5 SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH

- Engage community partners in civic support of funding of the Tobacco Control Program and policies to limit industry targeting of youth (Prevent Youth Initiation).
- Conduct policy activity to pass smoke-free policies in public housing (Eliminate Second-Hand Smoke).
- Conduct policy activity to maintain indoor smoke-free policy (Eliminate Second-Hand Smoke).
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Provide training and technical assistance for support staff who work with older adults (Elder Falls).

Implement the Your Voice, Your View Program, which provides workshops and brings high school students together to create anti-sexual violence PSAs (Sexual Violence).

Air the winning Your Voice, Your View prevention PSA on local cable stations (Sexual Violence).

Conduct a means (guns) restriction media campaign (Youth Suicide).

Train school and community-based organization staff in Question/Persuade/Refer (QPR) gatekeeper training (Youth Suicide).

Train high school-aged youth in signs of suicide (SOS) gatekeeper training and screening (Youth Suicide).

Increase screening with providers who work with older adults (Elder Falls).

Implement an internet-based Interactive Screening Program at local colleges and universities (Youth Suicide).

Conduct policy activity to influence the passage of a primary seat belt law (Motor Vehicle Injury and Death).
**HEALTH PROMOTION AND WELLNESS TEAM**

**INITIATIVE FOR A HEALTHY WEIGHT**

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<thead>
<tr>
<th>1</th>
<th>EDUCATION AND COUNSELING</th>
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<tbody>
<tr>
<td><strong>Conduct a Sugar Sweetened Beverage counter-marketing communications campaign (American Recovery and Reinvestment Act (ARRA) Physical Activity (PA)).</strong></td>
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<tr>
<td><strong>Conduct training to build the capacity of local community teams (community-based organizations and municipalities) to implement and support policies that improve access to physical activity and healthy foods (ARRA Healthy Places by Design (HPbD)).</strong></td>
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<th>2</th>
<th>CLINICAL INTERVENTIONS</th>
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<tr>
<td><strong>Inform policy activity around a sugar-sweetened beverage tax (ARRA PA).</strong></td>
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<tr>
<td><strong>Create recommendations from the Healthy Communities Plan to inform municipal Comprehensive Plans and regulations to support physical activity and access to healthy foods (ARRA HPbD).</strong></td>
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<tr>
<td><strong>Conduct policy activity to change child care physical activity and nutrition regulations.</strong></td>
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<td><strong>Facilitate coalitions to prioritize and coordinate activity around statewide prevention policies.</strong></td>
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<th>3</th>
<th>LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS</th>
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<tr>
<td><strong>Engage and empower communities to identify civic issues and mobilize for change (i.e., better quality of life).</strong></td>
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**PERINATAL AND EARLY CHILDHOOD HEALTH TEAM**

**ADOLESCENT HEALTH PROGRAM**

1. **EDUCATION AND COUNSELING**
   - Provide teen pregnancy prevention programs.

2. **CLINICAL INTERVENTIONS**
   - Support adolescent medical homes in Pawtucket and Woonsocket schools.

3. **LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS**
   - Conduct quality improvement site visits.

4. **CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT**
   - Partner with local leaders and apply for Community Access to Child Health (CATCH) grants to support adolescent medical homes.

5. **SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH**
   - Develop community-level systems to support adolescents.
   - Develop and promote a mental health toolkit.
   - Develop systems to support access to care.
   - Develop full-service community schools.
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**EDUCATION AND COUNSELING**
- Provide client-centered counseling focusing on obesity and physical activity (Local WIC Clinics).
- Conduct breastfeeding grand rounds.
- Educate and train retail stores.
- Educate and train local farmers and markets.

**CLINICAL INTERVENTIONS**
- Monitor WIC stores.
- Provide breastfeeding peer counseling by trained members of the community.
- Review training provider courses.

**LONG-LASTING PROTECTIVE PUBLIC HEALTH INTERVENTIONS**
- Conduct quality improvement site visits.

**CHANGING THE CONTEXT—HEALTHY BEHAVIORS AS THE DEFAULT**
- Support laws requiring workplace support for breastfeeding.
- Promote the baby-friendly hospital initiative.
- Collaborate with Johnson & Wales University and local farmers to offer ‘Veggin’ Out cooking demonstrations at summer farmers’ markets.
- Implement WIC package changes that include low-fat milk and more fruits, vegetables, and whole grains.
- Allow WIC participants to buy foods using Electronic Benefits Transfer.

**SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH**
- Develop systems to support access to care.
- Place breastfeeding peer counselors in WIC agencies.
Support child care providers by offering mental health consultation, health consultation, and developmental screening services (Child Care Support Network).

Place mental health clinicians in primary care practices and child care centers to address the needs of children birth to 8 years old (RI Launch).

Increase developmental screening and referral services with healthcare and childcare providers.

Conduct quality improvement site visits.

Provide training and technical assistance to child care providers and healthcare providers on developmental screening and related topics (Watch Me Grow RI).

Develop and implement a developmental screening module within KIDSNET.

Use Rhode Island’s Early Childhood Systems Plan to ensure that all young children reach their full potential through a system of services that promotes healthy social-emotional development, quality early care and education, coordinated medical homes, and effective parent education and family support services (Successful Start).

Work with the Successful Start Steering Committee to identify and solve barriers within the system of early childhood services (RI Launch).

Develop systems to support access to care.

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Preventive Services and Community Practices Team
Office of Immunization

1. Education and Counseling
   - Provide immunization updates via an email list serve, the KIDSNET Update newsletter, and the Director's monthly "Health Connections" newsletter to vaccine providers.
   - Provide immunization education and outreach materials to providers and the public.
   - Conduct an annual influenza vaccination campaign.
   - Conduct quality assurance site visits to providers enrolled in the state-supplied vaccine program.
   - Conduct school immunization assessment (record review) visits in preschools and schools.
   - Conduct annual immunization trainings for child care workers and nursing students.
   - Conduct quarterly Immunization Coalition meetings.
   - Conduct a school nurse teacher conference every other year.
   - Conduct an immunization provider breakfast every other year.
   - Support perinatal hepatitis prevention and immunization education/outreach home visits.

2. Clinical Interventions
   - Control vaccine-preventable disease outbreaks.

3. Long-Lasting Protective Public Health Interventions
   - Provide school-based immunization (Vaccinate Before You Graduate program; K-12 flu vaccination clinics).
   - Vaccinate household and close contacts of women with chronic hepatitis B infection (Perinatal Hepatitis Prevention Program).
   - Support the St. Joseph Hospital Free Immunization Clinic.
   - Hold immunization clinics for child care providers (Child Care Worker Initiative).
   - Hold immunization clinics for healthcare workers (Healthcare Worker Immunization Initiative).

4. Changing the Context—Healthy Behaviors as the Default
   - Support regulations requiring immunizations for preschool, school, and college entry.
   - Support regulations requiring immunizations for healthcare workers.

5. Social and Environmental Determinants of Health
   - Promote universal vaccine policy in Rhode Island.
   - Provide access to vaccines for uninsured healthcare workers to expand the workforce.
   - Provide an immunization registry for monitoring vaccination coverage rates among Rhode Islanders.

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Provide community outreach and education on birth control methods, abstinence, fertility awareness, sexually transmitted infections (STIs), and HIV/AIDS.
Conduct family involvement and sexual coercion counseling.

Provide referrals to care (e.g., HIV treatment, sterilization, and breast and cervical cancer follow-up).
Provide STI treatment.
Provide a broad range of birth control methods.

Provide long-acting reversible contraceptives.
Conduct surveillance and quality assurance of HIV testing and other family planning services.
Provide breast and cervical cancer screening, pregnancy testing, routine HIV testing, Chlamydia and Gonorrhea testing (IPP project), and comprehensive annual exams.
Conduct preconception health assessments and referrals, including to social services.

Provide routine HIV testing and preconception care.
Integrate reproductive life planning into preconception care.

Support a state plan amendment that expands Medicaid for family planning services for those not currently eligible for Medicaid (including men, women, and teens) and that requires the provision of transportation.
Provide a funding formula specifically to address the needs of low-income and uninsured people, including a sliding fee scale that slides to zero dollars for uninsured people with an income below 100% of the federal poverty level seeking family planning services.
Provide services to incarcerated women in need of family planning services.
Provide better accessibility to family planning services by assuring sites are geographically-spread across the state.

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