



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

**State Narrative for  
Rhode Island**

**Application for 2009  
Annual Report for 2007**



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## **I. General Requirements**

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

The Letter of Transmittal is to be provided as an attachment to this section.  
***An attachment is included in this section.***

### **B. Face Sheet**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

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

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

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

Assurances and certifications can be obtained by contacting:

Becky Bessette, MS, RD  
Division of Family Health  
Rhode Island Department of Health  
3 Capitol Hill, Room 302  
Providence, RI, 02908  
Phone: (401) 222-4604  
Email: [Becky.Bessette@health.ri.gov](mailto:Becky.Bessette@health.ri.gov)

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

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

### **E. Public Input**

Input from parents, agencies and providers on maternal and child health needs collected from November 2007 through June 2008 by HEALTH staff. This information drives the development of our 2009 RI Maternal & Child Health Plan. Input was collected by mail, group sessions at agency and advisory meetings, conferences, Survey Monkey and at the Title V public hearing on June 23, 2008 and notices posted on HEALTH's website and widely disseminated through list serves. An estimated 320 individuals participated. Eight high priorities were addressed. Participants were also asked to identify other priority family health issues including ***/2009/ those that involved other state Departments /2009//***.

#### ***Title V FY 09 Public Input Themes***

***Improve maternal health, including pregnancy outcomes-especially premature births and /2009/ reduce health disparities. Comments included how Title V might assist Rlers cut***

***from Rite Care, and insurance for contraceptives and abortions. //2009//***

Promote healthy lifestyles and healthy weights for school-aged children ***/2009/ and includes health food choices at schools and safe places for children to participate in outdoor activities. //2009//***

Support safe and healthy environments for children and families ***//2009// and support transportation for services and medical appointments. //2009//***

Build a closely connected system of services for families raising children and youth with special needs ***/2009/***

***Ensure community services for children and youth with special healthcare needs, including expanding PPEP into non-traditional settings. //2009//***

Ensure access to medical homes for all families including school-aged youth and young adults

Ensure a system that adequately addresses early childhood development ***/2009/ including requiring educational licensing for child care providers and insurers should support dev screening. //2009//***

Engage and empower parents as health advocates for their families. ***/2009/ Provide literacy services and re-establish EI parent advisory groups. //2009//***

Address social, emotional and behavioral health needs of children and young adults ***/2009/ support more Head Start programs, provide mental health services in schools and increase mental health resources in RI and health plan coverage. //2009//***

***An attachment is included in this section.***

## **II. Needs Assessment**

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

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

RI has opted to submit an entire Needs Assessment for FY '09.

### III. State Overview

#### A. Overview

In order to develop and implement priorities for Rhode Island's Title V MCH Program, it is first necessary to understand the health needs of the state's entire population and the general health care delivery environment. Other issues, such as the geographical and cultural characteristics of a state and its localities (including their governmental structures) and economic and educational characteristics, also impact the health and human services needs of a population.

Equally important is an understanding of the key policy issues currently being debated in Rhode Island's public arenas. Current agenda items include tax relief, health care, jobs and economic development, education, affordable housing, and welfare reform. However, the state's safety net infrastructure has been damaged by cuts made in response to the fact that Rhode Island is now in an economic recession. In addition, the Rhode Island Supreme Court overturned a string of decisions made by Superior Court Judge Michael Silverstein and a verdict by a six-person jury that found that three of the nation's major paint companies created a public nuisance by making and selling lead-based paints many years ago.

However, demographic data indicate that, by 2010, Rhode Island will be older, have fewer workers in their prime productive years, and be less self-sufficient, and more reliant on government assistance, requiring continued taxpayer investment in entitlement programs and fundamental public services. At the same time, the majority of state's voters believe that taxes are higher in Rhode Island than in other states and that the state is not doing enough to keep taxes low and is not spending taxpayer money wisely.

#### Geographical & Cultural Characteristics

The state of Rhode Island is a small, coastal area (1,214 square miles) with just over one million residents (1,067,610). The entire state measures just 48 miles, from north to south, and 37 miles, from east to west. Historically, most Rhode Islanders have been White descendants of European immigrants, plus some long established African American families and members of the small Narragansett Native American Tribe.

With the establishment of the first water-powered cotton mill in the nation in Pawtucket in 1793, Rhode Island became the birthplace of the industrial revolution in the United States. Since then, waves of immigrants -- from the Italians, Irish, French/French Canadians, and Portuguese in the late 19th century to the Asians and Latinos in the late 20th century -- have come to Rhode Island in search of a better life.

/ 2009/Currently, 12.6% of Rhode Islanders are foreign-born, which ranks the state the 13th highest in the nation in this respect. Of the total foreign-born population in Rhode Island, 30.4% entered the state prior to 1980, 21.8% between 1980 and 1989, 24.7% between 1990 and 1999, and 23.1% in 2000 or later.

The largest share of the foreign-born population in Rhode Island is from Latin America (40.4%), followed by Europe (26.2%), Asia (15.3%), Africa (12.2%), and Northern America (5.5%). The top three countries of birth for Rhode Island's foreign-born residents are Portugal (14.1%), The Dominican Republic (13.5%), and Guatemala (9.3%). In 2005, 43.8% of the state's foreign-born residents were citizens.

The foreign-born make up 1.7% of young children in the state, 5.0% of youth, and 15.0% of working-age adults. Among people at least five years old living in Rhode Island in 2005, 20.4% spoke a language other than English at home. Of those speaking a language other than English at home, 48.7% spoke Spanish and 51.3% spoke some other language //2009//.

***The three largest ancestral groups in Rhode Island are Italian, Irish, and French-Canadian. Rhode Island has a higher percentage of Italian Americans and a higher percentage of persons of Portuguese ancestry, including Cape Verdeans, than any other state in the nation. Mainly due to large Irish, Italian, and French-Canadian immigration and, to a lesser***

**extent, Portuguese, Puerto Rican, and Cape Verdean communities, Rhode Island has the highest percentage (63.6%) of Roman Catholics in the nation. Catholics are evenly spread throughout the state.**

**/2009/In 2006, there were 405,627 households in Rhode Island. The average household size was 2.5 people. Families make up 64.7% of the households in Rhode Island. This figure includes married-couple families (47%) and other families (17.7%). Rhode Island has the 7th lowest percentage of married-couple families living with their own children in the nation//2009//.**

Rhode Island is the seventh "most urban" and second most densely populated state in the nation after New Jersey, with 1,130 residents per square mile. In this small state - cities, suburbs, and "rural" areas are separated in some places by only a few miles of road. Even the most "remote" parts of the state are less than an hour's drive from the state's capitol city of Providence. However, with over 400 miles of coastline and a wealth of historical resources, Rhode Island is an attractive place to work and live.

As with other urban centers in the Northeast, Rhode Island remains an important hub of government, health care, education, and entertainment activity, but faces challenges presented by its increasingly diverse and aging character. / 2009/Although Rhode Island ranks high in percentage of forested land (60%), 75% of its population resides in a 40 mile long urban/suburban corridor along the shores of Narragansett Bay and in the valleys of the Blackstone and Pawtuxet Rivers. This corridor, which includes Providence, contains nearly all of the state's public infrastructure, major transportation routes, and institutional and cultural centers. Providence, the second largest city in New England after Boston, is a major metropolitan community in which an estimated 170,435 residents live.

Providence is one of Rhode Island's six (6) designated "core" communities, defined as being a city or town in which more than 15% of the children live in poverty. Rhode Island's other core communities include Pawtucket, Central Falls, Newport, Woonsocket, and West Warwick. Thirty-four (34.2%) percent of the state's population resides in these six core communities, where 37.3% of children under six (6) years and 33.9% of children under eighteen (18) years live below poverty // 2009//.

Rhode Island's population grew by 44,855 to 1,048,319 between 1990 and 2000, which represents a 4.5% increase. This growth was attributable to an increase in the state's minority population. The state lost nearly 38,000 Non-Hispanic Whites during the 1990s, as an elderly generation of mostly White residents died and as young professionals crossed state lines in search of better jobs. At the same time, the state gained about 82,500 racial and ethnic minorities, slightly more than half of them Hispanics. In 1990, one in ten Rhode Islanders belonged to a racial or ethnic minority group. In 2000, this ratio increased to nearly one in five. Forty-three percent (43%) of Rhode Island's population growth during the 1990s involved individuals with limited English proficiency. The national rate was 14%. Immigration grew substantially in Rhode Island (and in the nation) during the 1990s. In 2006, Rhode Island was home to 134,390 foreign-born residents. In addition, the U.S. Department of Homeland Security estimates that there are about 16,000 undocumented individuals living in Rhode Island. Since 2000, the net number of immigrants moving to Rhode Island from other countries has averaged 3,656 people per year. The largest percentages of immigrants to Rhode Island in 2005 were from the Dominican Republic (19%), Guatemala (6.4%), Cape Verde (6.3%), Columbia (6%), Liberia (5.4%), Portugal (4.5%), and China (4.1%). Together, these groups make up more than half (51.7%) of all individuals who immigrated to Rhode Island in 2005. For the first time in history, Rhode Island has communities (Providence and Central Falls) where minorities outnumber non-Hispanic Whites.

**/2009/According to the U.S. Census, the racial/ethnic distribution of Rhode Island's population in 2006 consisted of Whites (82.6%), Blacks (5.1%), Asians (2.8%), Native Americans (0.4%), Native Hawaiian or Pacific Islander (0.02%), those who identified**

*themselves as being some other race (6.9%) and those who identified themselves as being two or more races (2.2%) // 2009//. From 1990 to 2000, Rhode Island's non-Hispanic White population declined by 4%. During the same period, the state's Black population increased by 21%, Asians by 31% and Native Americans by 26%.*

*Blacks represent the largest racial minority group (and the second largest minority group) in the state. Rhode Island's Black population became increasingly diverse during the 1990s as a result of increased immigration from Haiti, Cape Verde, Liberia, and Nigeria. Rhode Island's Liberian population, conservatively estimated at 15,000, constitutes the largest per capitol Liberian population in the United States. In addition, 10% of the Black population in the state is Latino, a large majority of which came from the Dominican Republic.*

*The state's Asian population grew by 31% during the 1990s. Most Southeast Asians immigrated to Rhode Island from the war-torn countries of Vietnam, Cambodia, and Thailand during the 1970s and 1980s. From 1975-1979, well-educated professionals escaped from Cambodia and after a brief stay in Thai refugee camps, were resettled in the United States (including in Rhode Island) and Canada. From 1979-1985, Cambodians continued to resettle, and larger numbers of rural agrarian families arrived in the United States, including Rhode Island. According to the 2000 U.S. Census, Rhode Island's Cambodian refugee population is the 7th largest in the United States.*

*The Native American population grew by 26% during the 1990s, consisting primarily of members of the Narragansett Indian Tribe. Native Americans live in Providence, Narragansett, North Kingstown, and Charlestown. The Narragansett Reservation near Charlestown currently is about 2,500 acres in size and has a population of about 2,500 residents, however, the actual number of Native Americans living in Rhode Island remains very small (5,389). The Narragansett's are governed under the traditional leadership of a Chief Sachem with a nine-member sovereign Tribal Council.*

*However, more striking than any other trend was the surge in the number of Latinos in the state. Latinos saw their numbers double in Rhode Island in the 1990s from 45,572 to 90,820, a pace double that found in Massachusetts. In 2005, Latinos made up 10.9% (112,722) of the state's population (an increase of 24% since 2000). 36% of Rhode Island's Latinos are children. The majority of Latinos in Rhode Island (63.9%) come from Puerto Rico (28%), the Dominican Republic (19.7%), Guatemala (9.9%), and Columbia (6.3%).*

*/ 2009/ In 2006, Twenty-one percent (21.3%) of the state's population (227,401) was women of childbearing age (15-44 years). Like other areas in the nation, Rhode Island has an aging population. According to the 2006 Census, the median age for female residents in Rhode Island is now 39.5 years. However, the median age for females varies by race and ethnicity. The median age for White, non-Hispanic females is 42.8 years. In contrast, the median age for female residents belonging to a racial or ethnic minority group is as follows: Hispanics (26.5 years), Blacks (28.5 years), Asians (28.1 years), some other race (28.6 years), and two or more races (20.2 years). Women in Rhode Island are slightly younger than they were in 2005.*

*Over the past eight years, Rhode Island has averaged about 12,700 births per year. In 2006, 22.2% of the state's population was made up of children under 18 years old, similar to the state's child population in 2005. As with women, children in Rhode Island are older in 2005 than they were in 2000. Twenty-six percent (26.0%) were under age five, 26.4% were ages 5-9, 29.2% were ages 10-14, and 18.4% were ages 15-17. Between 2002 and 2006, 43% of infants in Rhode Island were born to mothers with a high-school diploma or less. Forty percent (40%) were born to fathers with a high-school diploma or less.*

*In 2006 in Rhode Island, sixty-one percent (61%) of Rhode Island's children live in a*

*married couple household, 30% live in a single-parent family, and 8% live with relatives, including grandparents. One percent (3,230) live with a family in which the child is not related to the head of household, such as children in foster care, and an additional 1,077 (less than 1%) children lived in non-family households. Between 2000 and 2006, the number of children living in single parent households increased 6%. The number of children living with one grandparent or other relatives increased 10%, and the number of children living in a two-parent household decreased 8%.*

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

*Of Rhode Island's immigrant children, 42% are from Mexico, Central, or South America; 29% from the Caribbean; 11% are from Europe; 11% are from Africa; and 6% are from Asia. Minority and immigrant children and their families are highly concentrated in the six core cities in Rhode Island. More than half (58%) of children living in the state's core cities are minority children. More than three-quarters (78%) of all minority children live in these six communities. Rhode Island has the highest percentage of Hispanic children living in poverty (79%) and fourth largest percentage of black children (71%) living in neighborhoods in which more than 18% of persons are in poverty in the nation.*

*According to the US Census, after gaining small numbers of people from other states from 2001 to 2003, Rhode Island began experiencing decreases in its population in 2004, with an estimated net loss of 2,114 people. In 2005, the estimate was a net loss of 11,618, and in 2006, a net loss of 12,566. Rhode Island was one of only four states to see its population decrease in the US Census Bureau's annual estimates in 2006. The decline in Rhode Island's population is being driven by the migration of young, college-educated people looking for better job opportunities and more affordable housing in other states //2009.*

#### **State & Local Government Structure**

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

*//2009/ for months during CY2008, the biggest issue before the state's legislature was how to close and estimated \$425 million budget deficit for the fiscal year that begins July 1, 2008. In late June of 2008, the legislature passed a \$6.89 billion state budget that, on paper, fixes that financial problem. The new budget closed the \$425 million gap mostly through cuts in hundreds of state programs and agencies, and through small increases in revenue. It does not increase sales or income taxes.*

*The largest projected savings include \$90 million in state personnel costs and \$67 million in Medicaid reductions. Additional savings came through legislation passed in recent months that was not among the 41 sections of the budget approved last week. More than half the shortfall - \$222 million -- would be made up through a wide variety of other savings, including cuts to the Rhode Island Housing Corporation and the Neighborhood Opportunities Program (\$28.5 million), cuts to the state's three public colleges (\$17*

*million), cuts to college scholarships (\$2.6 million), limiting the number of children in state custody removed from their homes (\$2.5 million), cuts to Head Start (\$2.3 million), and raises to required health care contributions from Rlte Care recipients between 133%-150% of poverty (\$2.2 million).*

*An estimated 1,000 low-income adults will lose Rlte Care health care coverage October 1, 2008. Around 250 poor children will lose spots in Head Start. Additionally, the state budget changes eligibility for cash assistance from 5 consecutive years to two (with a lifetime maximum of four years). Because of a 12-month grace period, most people won't lose their cash assistance until July 2009. Those eligible for the Rlde Program, which provides free transportation to the disabled and certain senior citizens who cannot use regular bus service -- will now have to pay \$4 per round trip.*

*These cuts are in addition to cuts made to balance the state budget ending on June 30, 2008. These cuts included removing 2,800 immigrant children from Rlte Care effective June 1, 2008. Of these 2,800 children, just under half are illegal immigrants. Most will still get care from the medical practices, health centers, and hospitals where they have been patients, which are willing to treat at reduced rates or for free. Acknowledging this added burden, the legislature approved \$1.2 million in aid to the community health centers that serve the poor and uninsured, and an additional \$9 million to help hospitals wit uncompensated care.*

*With respect to health care, the sole public health authority in the state is the Rhode Island Department of Health (RIDH), which makes it legally responsible for the provision of core public health activities at both the state and local levels. The RIDH contracts with community-based organizations and professionals to provide nearly all direct preventive and public health services. The RIDH has no public health clinics. The absence of local health authorities means that health care providers in the state look to the RIDH for policy guidance and other forms of assistance. The state's Title V MCH Program is located in the RIDH.*

#### ***Economic Needs of the State's Population***

*In earlier generations, Rhode Island workers were well-paid and well-insured for health care through the presence of its strong manufacturing base. However, many manufacturing jobs were lost in recent decades, and in the 1990s, Rhode Island experienced its worst recession since the Great Depression, losing 11.6% of its total job base. By 1992, Rhode Island's unemployment rate, at 9.1%, was the 4th highest in the nation.*

*After weathering the financial storms that battered the state in the early 1990s, Rhode Island rode a wave of economic growth in mid-1990s that few could have envisioned. Taking advantage of a strong economy, the state was able to reduce taxes, increase state spending by double and triple the rate of inflation, and still realize \$100 million end of year surpluses. When the national economy faltered in 2001, most states were hit a lot harder than Rhode Island. In New England, deficits for FY2002 ranged from 2.7% of total expenditures in Rhode Island to 10.1% in Massachusetts. The restructuring of Rhode Island's economy during the 1990s has been proposed as one of the reasons for Rhode Island's resilience during this period.*

*/2009/ However, on April 28, 2008, Economy.com (which is owned by Moody's Investor Services) and the international consulting firm Global Insight informed state officials participating in Rhode Island's annual Revenue & Caseload Estimating Conference that Rhode Island stands alone as the only Northeastern state "in recession" and that the state's economy has not been "this bad" in two decades . It was noted that Rhode Island's employment figures, foreclosure rates, and personal income growth are worse than its*

***New England neighbors and national averages.***

***In fact, it was noted that the state is just one of nine states in recession -- the next closest is Ohio -- while Maine, Vermont, and Connecticut have "expanding" economies and Massachusetts and New Hampshire have "at risk" economies. Rhode Island was the only New England state to report negative employment growth between March 2007 and March 2008. The state's unemployment rate grew to 6.1% as Rhode Island lost 7,200 jobs in the third quarter of 2007 alone. Rhode Island's foreclosure rate was among the worst in the nation. Approximately 2.4% of all home loans were in foreclosure in the fourth quarter of last year, which was the 7th highest rate nationally.***

***In May of 2008, The New England Economic Partnership (NEEP) noted that Rhode Island has the weakest economy in the region at the moment and is anticipated to perform poorly in 2008, with no improvement seen until the 3rd quarter of 2009. In the first three months of 2008 more jobs were lost than created, with the greatest losses reported in manufacturing, retail trade, professional and business services and financial services. In addition, the US Bureau of Economic Analysis ranked Rhode Island 47th in the percentage growth of personal income from 2006 to 2007.***

***Furthermore, as house prices decline, more than half of Rhode Islander's homeowners could lose in excess of \$7,000 of their property value. This devaluation could reduce the combined state and local tax base by \$1.7 billion, which would have a significant negative effect on the budgets of the state's cities and town and, therefore, schools. Lastly, Rhode Island is expected to have the lowest Gross State Product growth in New England, 2.1%, which is below the US annual average. Due to these factors -- loss of jobs, poor personal income growth, the plummeting housing market, and insufficient GSP growth -- Rhode Island's economy is not flourishing.***

***Although the state's real estate market has slowed down due to the recession, the lack of affordable housing is still a pressing problem in Rhode Island. A 2005 report by the National Low Income Housing Coalition found that Rhode Island faced a shortage of 11,000 housing units for residents earning 30 percent or less of the statewide median income, or \$19,397 a year. Rhode Island ranks among the 10 least-affordable states in the country. Unfortunately, the state's affordable housing programs have been cut. The state's Neighborhood Opportunities Program ---- the seven-year-old fund that helps finance affordable housing for those who make less than \$30,000 a year ----was allotted \$5 million of their \$7.5-million budget for FY2009. An additional \$26 million was cut from Rhode Island Housing Corporation's budget for FY2009***

***RI also has the highest mortgage delinquency rate in New England. The share of mortgages in RI that were 90 days or more delinquent during the first quarter was 4.31%, more than double the 2.1% during the first quarter of last year. Additionally, Rhode Island foreclosure rates have been rising since the end of 2005. In 2008, according to Rhode Island Housing Corporation data, of the nearly 3,000 properties in Rhode Island advertised for foreclosure during the 12-month period that ended March 31, 2008, 79% were in the cities and inner suburbs: Providence, Cranston, Johnston, East Providence and Warwick. Providence, with 1,543 foreclosure initiations, accounted for 52% of the total. Suburban and rural areas, however, also experienced more foreclosures. In Burrillville, for example, 79 properties were advertised for foreclosure auction during the recent 12-month period. In Coventry, there were 56. Even the most affluent communities were not immune. Barrington recorded 16 foreclosure initiations during the period and there were 8 in East Greenwich//2009//.***

***In Rhode Island, where house prices have increased ahead of growth in wages, 17% of households spent more than half their income on housing in 2005. Rhode Island is now one of 13 states -- including Massachusetts, Connecticut, and New Hampshire -- where more than half***

of all low-income households spend more than half of their income on housing. The disconnect between incomes and housing costs in Rhode Island is expected to persist into the next decade, as low-wage service jobs are added to company payrolls. **/2009/Currently, a family with a household income of \$51,814 (the median household income in 2006) cannot afford a median-priced, single-family home in any community in the state.**

**The average price of gasoline in Rhode Island is at a record high. The average price of regular, self-serve gas is was \$4.099 a gallon as of June 10, 2008. The average price is now \$1.07 more than it was one year ago. In 1952 gas was 19.9 cents a gallon in Rhode Island. 49.4 cents per gallon gets added to the cost of motor fuel in state, federal and other taxes in Rhode Island. The state's tax bite per gallon is higher than that of Massachusetts, which adds 41.9 cents per gallon in combined taxes. Vermont, New Hampshire and Maine also have lower combined tax rates, while Connecticut's rate is higher, at 62.5 cents per gallon. A Morgan Stanley analyst's prediction is that by July 4, 2008 gas will cost about \$4.40 a gallon. The price of petroleum products and gasoline will continue to rise for the foreseeable future.**

**As a result of a meeting held in July of 2008, New England's governors decided to send letters to the White House, the presidential candidates, and US Senate and House leaders and their Congressional delegations asking for an increase in the Low-Income Home Energy Assistance Program in response to the doubling of home heating oil prices in the past year (which are now approaching \$5 per gallon in some areas). During the winter of 2005.2006, the region received about \$313 million through the program, but that only helped poorer families get less than halfway through the winter. Fully financing the program, given the rising energy costs and expanded need would cost nearly \$1 billion. The National Energy Assistance Directors Association, which represents state-run low-income energy assistance programs, said the national average cost to heat a home with oil this winter will be \$2,593, up from \$1,962 last winter. Families in cold-weather Northeast states will be hit even harder.**

**In Rhode Island, heating oil in Rhode Island jumped 13 cents a gallon to \$4.629, a new record high, according to the Energy Office. Electricity consumer price is up 5.4% from 2007 and 34% from 2003, where the natural gas consumer price is down 1% from last year, but up 33% from 2003. The number of shutoffs in 2007 set an all-time record. Utility companies turned off service to a total of 30,144 households, according to state regulators, the highest number ever recorded. Without a solution, the number of shutoffs is expected to be even greater this coming year.**

**According to the U.S. Department of Labor, Rhode Island had the highest unemployment rate in New England (6.1%), followed by Connecticut (4.7%), Maine (4.7%), Vermont (4.5%), Massachusetts (4.1%), and New Hampshire (3.8%). The national average is 5.1%. In the last 12 months through March 2008 the state has gone from 494,900 non-farm jobs to 484,800 - - the lowest number of jobs since July 2003 -- creating a loss of 10,100 jobs. The biggest single sector for job losses is manufacturing (down 2,700 jobs). Rhode Island was the only New England state to report negative employment growth between March 2007 and March 2008.**

**Personal income growth in Rhode Island increased by 4.8%, but fell short of the national average of 6.2%. The average after-tax income for the bottom 20% of Rhode Island families was \$18,974, while the average after-tax income for the top 20% was \$143,211, according to figures for 2004-2006. With that \$143,211 average for its top 20%, Rhode Island ranked sixth in the nation. The bottom 20% of Rhode Islanders saw their average income drop from \$19,966 to \$18,974 over the past two decades. While Rhode Island ranked second in the growth of its income gap, it ended up ranked 12th in the nation in the size of its income gap. Massachusetts ranked fourth and Connecticut was seventh. The growth in the income gap is likely even greater than reported because the study did not**

**include income from capital gains, which go mostly to the top earners. Furthermore, due to the extreme budget cuts, most people's personal incomes are not likely to increase//2009//.**

#### **Educational Needs of the State's Population**

**//2009/ The high school graduation rate in Rhode Island's in 2007 was 89%. The rate in the core urban communities was 74% during this same year. In 2007, the high school graduation rate varied by race/ethnicity. The rate among White students was 91%; among Black students, it was 86%; and among Latino students, it was 82%.**

**Although only 5% of all public school students in Rhode Island were English language learners during the 2007 school year, 24% of all Central Falls public school students, 16% of all Providence public school students, and 11% of all Pawtucket public school students were English language learners during this same period // 2009//. The primary language for 73% of Rhode Island's English language learner students was Spanish, followed by Portuguese (6%), Cape Verdean (3%), and, all other languages combined (17%).**

**//2009/ Although Rhode Island's high school attainment rate is showing incremental improvement, it remains a problem in Rhode Island. For every 100 ninth graders, 72 complete high school, 40 enroll in college, and only 23 complete an Associate's degree within three years or a Bachelor's degree within six years. In Rhode Island, there are about 9,000 teens aged 16-19 who are not in school, not in the military, and not working -- 7% of this age cohort. As high school dropouts get older, their employment options are slim. Only 38% of working age Rhode Islanders without a high school education hold a full-time job //2009//.**

In 2000, 78% of Rhode Island adults had a high school diploma. The proportion of residents age 25 and older with at least a high school diploma is the smallest among the six New England states, and the proportion with at least a four-year college degree is the second worst - ahead of only Maine. **//2009/ In 2006, Beacon Hill Institute gave Rhode Island a competitiveness ranking of 36th worst of 50 states on its "percent of population aged 25 years and above that graduated from high school" sub-index //2009//.** Currently, almost 44% of workers in the state have a high school degree or less.

According to the Rhode Island Economic Policy Council (RIPEC), an advisory panel made up of leaders in government, education, and business, the average level of education in the state is declining at the same time that the skills required by employers are rapidly increasing. Of Rhode Island's one million residents, 142,000 adults lack a high school diploma and 35,500 have limited English language skills. By 2010, the share of the workforce that has not graduated from high school is expected to increase in Rhode Island, while the percentage of workers who have graduated from college, including those with a graduate degree, will drop, according to data from the National Center for Public Policy and Higher Education.

According to the Nellie Mae Foundation, the percentage of young workers in Rhode Island holding a bachelor's degree or higher will drop by 3%-4% by 2020 since Blacks and Hispanics (the fastest growing demographic groups in the state) have not been making the gains necessary to compensate for the exodus of Whites. Further, nearly half of all new college enrollments in Rhode Island originate from out of state (more than any other New England state) and many of these students choose to leave the state when they graduate.

**//2009/ With respect to public education for children through grade 12, Rhode Island has put in place an accountability system that measures the performance of schools. In 2007, 171 elementary and middle schools (68%) were classified as "high performing", 52 schools (21%) were classified as "moderately performing", and 27 schools (11%) were classified as making insufficient progress". Fifty percent (40%) of the 93 schools in the state's core communities were categorized as making "insufficient progress" // 2009//.**

#### **Social Service Needs of the State's Population**

**Economic forces and the educational needs of a community, coupled with the**

**demographic and cultural characteristics of the population, impact the social service needs of individuals and families. In 2005, 12% of Rhode Island's population lived in poverty. Although this percentage is comparable with the percentage for the nation as a whole (13%), it is higher than every other state in New England.**

**/2009/ In 2006, the proportion of children under age 18 as a proportion of the population in poverty in Rhode Island was 15.1% which was lower than the nation (18.3%). Rhode Island ranked 17th in the nation and 5th in New England, whereas only 9% of White children in Rhode Island live in poverty, 36% of Black children, 36% of Hispanic children, and 14% of Asian children live in poverty // 2009//.**

**The Family Independence Program (FIP) is the state's welfare reform program, as set forth in the Rhode Island Family Independence Act of 1996. FIP seeks to help low-income families by providing the supports (including subsidized health insurance, childcare, and work-readiness activities) that families need in order to obtain and keep a job. /2009/Between 1996 and 2007, there was a 46% decline in the state's FIP caseload, from 18,428 cases to 9,993 cases.**

**As of December 2007, there were 6,242 adults and 17,808 children under the age of 18 enrolled in FIP.**

**Three-quarters (74%) of all FIP beneficiaries were children under the age of 18. More than 2 in 5 (44%) children enrolled in FIP were under the age of six. In Rhode Island, 77% of the families enrolled in FIP have one or two children //2009//.**

**Rhode Island, under the childcare law (Starting Right), is the only state that has a legal entitlement to a childcare subsidy for income-eligible working families. /2009/ Until 2007, Working families with incomes up to 225% of the federal poverty level were entitled to a childcare subsidy for their children up to age fifteen. Co-payments were required for families with incomes over the federal poverty level. /2009/ In 2007, eligibility for child-care subsidies was reduced from 225% of the FPL to 180% and the age eligibility was rolled back to age 12. Rates to providers have been frozen since 2004 at the 2002 market rate level. These changes resulted in the removal of 1,743 children from Starting Right in 2007. In 2007, the number of children receiving subsidies dropped to 9,008.**

**Currently, Rhode Island is the 5th least affordable state in a United States for a 4-year old in a child-care center. In Rhode Island, the average cost of full-time child-care for a preschooler consumes 45% of the median single parent family income and 10% of the median two-parent family income. Using the federal affordability guideline that families should spend no more than 10% of their gross income on child care, a Rhode Island family would need to make at least \$87,000 a year to afford the average cost of child-care for a 3-year old at a licensed center (\$8,736) //2009//.**

**Unfortunately, the shortage of affordable apartments and increasing energy costs in the state is causing an increasing number of Rhode Islanders to seek shelter in the state's emergency shelter system. For the fifth year in a row, Rhode Island's emergency shelter system provided record nights of refuge to more people in 2006 (6,889 individuals) than the previous year. The number of families seeking shelter has increased 50% since 2000/2001. Eighteen percent (18%) of the 5,511 adults who entered the shelter system in 2006 entered as adults with families. Twenty-percent (20%) of the 6,889 individuals who entered the shelter system were children (1,378).**

**/2009/ During 2007, 317 women and 361 children spent a total of 20,123 bed nights in a domestic violence shelter in Rhode Island. In 2006, police officers reported that children saw their parent being abused in 1,230 incidents resulting in arrest, and heard their parent being abused in 1,341 incidents resulting in arrest. In 2006, children were present in 246 of the 2,017 (12%) incidents reported by police officers that did not result in an arrest. It is estimated that 41% of family violence incidents are never reported to the police.**

***In 2007, there were 2396 indicated investigations of child abuse and neglect involving 3,271 children. Seventy- nine percent (79%) of these cases were indicated for neglect, 9% for physical abuse, 6% for sexual abuse, 1% for medical neglect, <1% for emotional abuse, and the remaining 4% for other types of abuse. Between 1997 and 2006, 28 children died as a result of injuries due to abuse by a parent or caretaker. During 2005, there were 34 children hospitalized with a diagnosis of child abuse or neglect, up from 22 in 2004 and 28 in 2003 // 2009//.***

#### ***Health Care Needs of the State's Population***

***Rhode Island enjoys the second highest prenatal care rate (90.9%), the 4th lowest obesity rate (17%), the third lowest child death rate (15 per 100,000 children), the second lowest teen death rate (31 per 100,000 teens), the fifth lowest firearms death rate 5.1 per 100,000 population), the sixth lowest per capita rate of suicides (0.078 per 1,000 population) in the nation.***

***Unfortunately, it also has the third highest rate of cancer incidence (510.5 per 100,000 population) and the third highest homicide rate for victims aged 18-24 years (34.1%). Among people at least five years old in 2005, 16% reported a disability. The likelihood of having a disability varied by age -- from 9% of people 5-20 years old, to 13% of people aged 21-64 years old, and to 39% of those 65 years and older.***

***//2009/ Although details are not known, Rhode Island is proceeding to file a waiver for comprehensive Medicaid reform, which would set aside many traditional Medicaid requirements for up to five years, with the promise of substantial savings to help deal with the state's "structural deficit". Since much of the current MCH system is built on Rlte Care plan services, and on several flavors of targeted case management, many advocates and partners are worried about the "global waiver" plan, as we heard in many public forums. Nonetheless, we have also participated in the expansions of EPSDT standards to include oral health, developmental and autism screening, and other provisions of Bright Futures 3.0, and so there are also positive developments for Medicaid (and therefore commercial) coverage for kids, too) With great uncertainties about both national (CMS, Congressional) and state Medicaid directions...as well as the impending changes in our new Office of Health and Human Services, it will be vital to keep up MCH data and input channels (KIDSNET, PRAMS, TWOS, etc) to monitor and manage impacts on vulnerable kids and families. //2009//***

Economic trends, and the educational and social services needs of a community, coupled with the demographic and cultural characteristics of the population, impact the health care needs of individuals and families. In 1979, 74.4% of working Rhode Islanders had employment-based health insurance. By 2003, only 57.1% of workers received coverage through private employers.

In 2005, 352,000 Rhode Islanders were commercially insured, down from 380,000 in 2004 (a 7.3% decrease in 2005 compared to 2004) and 403,000 in 2003 (a 12.6% decrease over the two year period). The three largest health plans cover 91% of the states' commercially insured population. Blue Cross & Blue Shield of Rhode Island (BCBSRI) has a market share of 65% and United Health Care of New England (UHPNE) has 17%. Blue Cross of Massachusetts has a market share of 10% and the remainder of the market (8%) consists of a host of smaller plans, none of which have more than 10,000 members.

The state's Medicaid managed care program, Rlte Care, has had a profound impact on the state's health care system. Three carriers participate in Rlte Care. Neighborhood Health Plans of Rhode Island (NHPRI) has a market share of 59% and UHPNE controls 29%. The remainder of the market (12%) consists of BCBSRI through its Blue Chip Program. The majority of NHPRI's clients access services through the state's community health center network, while UHCNE and

BCBSRI clients access services through private providers or hospital-based clinics.

Rlte Care provides coverage to children up to age 19 in families with incomes up to 250% of poverty. Rlte Care also covers parents of eligible children in families with income up to 185% of poverty. Rlte Care also expanded eligibility to include pregnant women up to 350% of poverty and childcare providers who serve low-income children. / 2009/ As of December 31, 2007, 70% (77,054) of the Rlte Care members who qualified based on family income were children under age 19. There were 39,186 low-income parents enrolled in Rlte Care as of December 31, 2007. Of these parents, 16% (6,242) received Rlte Care because they were enrolled in the Family Independence Program (FIP) // 2009//.

In April of 2001, the Rhode Island Department of Human Services (RIDHS) launched the Rlte Share initiative as a way to control increasing costs associated with Rlte Care and to strengthen the employer-sponsored health insurance infrastructure in the state. Rlte Share requires Rlte Care applicants with access to employer-sponsored insurance to participate in their employer's insurance plan. Rlte Share pays the employee's share of the cost for enrolling in an approved employer-sponsored family or individual health insurance plan. Eligibility guidelines are the same as for Rlte Care. Rlte Share provides the full range of Rlte Care benefits to families by covering Rlte Care services not included in the employer's health insurance plan. ***/2009/ There were 5,365 individuals enrolled in Rlte Share as of December 31, 2006 //2009//.***

Despite the creation of the state's Medicaid managed care program, 10.2% of Rhode Island's population was uninsured for health care in 2003, partly due to deteriorating commercial coverage and unemployment. Latino (26%) and Black (10.7%) Rhode Islanders are more likely to be uninsured than White Rhode Islanders (7.7%). Although Rhode Island still remains among the top states with the lowest proportion of uninsured individuals, the proportion of uninsured individuals increased 65% from 2000 to 2003. In 2004, 5.8% of children under age 18 in Rhode Island were uninsured, compared to 11.5% of children nationally. The rate of uninsured children in Rhode Island has declined by 47% over the past ten years.

Rhode Islanders with the highest un-insurance rates are young adults ages 18-34 years (18.5%), adult males ages 16-64 years (12.8%), adults living in families without children (12.6%), adults with family annual incomes less than \$25,000 (23.1%), and unemployed adults (30.4%). However, the rise in un-insurance in 2003 compared to the previous year is seen primarily among young adults (a 10.1% increase), women (a 15.5% increase), families with children (a 5.8% increase), middle-income households (a 34% increase), and the employed (a 9.2% increase). Uninsured Rhode Islanders access services through the state's CHC network and through hospital emergency rooms.

Rhode Island's emergency room current utilization rates exceed the United States and Northeast averages by 4% and 9%, respectively. Based on these rates and the projected population, emergency room visits in Rhode Island will total 460,000, nearly 30,000 more emergency room visits as compared to 2000. As expected, young working age individuals (18-44 years), including the uninsured, comprise the largest population (44%) of these visits. In the absence of a state-supported hospital, all of the hospitals in the state are legally mandated to treat the uninsured.

With respect to mental and behavioral health needs of the state's population, the rate of non-federal acute hospital discharges with a principal diagnosis of a mental disorder, including substance abuse (MD/SA), was substantially higher in Rhode Island (11.9 per 1,000 population) than nationally (7.7) in 2004. The total number of discharges with a principal or secondary diagnosis of MD/SA comprised more than one-quarter (27.7%) of all discharges (excluding newborns) from these facilities. This data indicates that hospitalizations of persons with a diagnosis of MD/SA comprise a large proportion of the inpatient care provided in Rhode Island's hospitals. The majority of such patients have an MD/SA diagnosis secondary to a principal diagnosis of a physical illness or injury.

National Survey on Drug Abuse & Mental Health data (2004) seems to support that Rhode Islanders experience higher rates of substance abuse and serious psychological distress compared to other New England states. Rhode Island has the highest percentages of past year any illicit drug dependence or abuse (3.49%), past year cocaine use (3.52%), past year alcohol dependence or abuse (9.59%), and past year serious psychological distress (12.18%). It also had the highest percentages of individuals needing but not receiving treatment for illicit drug dependence or abuse (3.06%) or alcohol dependence and abuse (8.91%). Rhode Island also has the highest percentage of alcohol related traffic fatalities (50%), the second highest percentage of heavy drinkers (7.3%), the third highest percentage of binge drinkers (18.2%) in the nation.

In Rhode Island, private insurance rates for behavioral health services were reduced in the 1990s, and although rates for some services have been increased, many behavioral health services have yet to be adequately reimbursed. Public services have generally not been adequately funded to meet the needs presenting to the system.

Publicly funded mental health services for children in Rhode Island are provided by the state Department of Children, Youth, and Families (DCYF) through contracts with community-based organizations or through Rite Care. Mental health care for adults is provided by the state Department of Mental Health, Retardation, & Hospitals (MHRH) directly or through Rite Care. Low-income, uninsured individuals are dependent upon the state's community mental health system for services.

With respect to the mental health needs of the state's maternal population, 38.6% of Rhode Island's adult female population reported that they had poor mental health between 1 and 30 days in the past 30 days in 2004, which ranked Rhode Island the second highest state in New England in this respect, following Vermont. With respect to children's mental health needs, it is estimated that one in five US children ages 9-17 has a diagnosable mental or addictive disorder (in Rhode Island, about 26,500 children).

In 2006, the National Alliance on Mental Illness (NAMI) gave Rhode Island an overall grade of "C" with respect to its progress toward ensuring a proven, cost-effective mental health system, based on information from four information sources and scored from 39 specific criteria representing four categories: Infrastructure, Information Access, Services, and Recovery Supports. According to NAMI, Rhode Island's urgent mental health needs include: private sector provider rates and supply, alternatives to hospitalization, and Spanish language workforce development.

Dental insurance is not available to many working families in Rhode Island. Fewer than half (48%) of Rhode Island employers offer dental insurance to their full-time employees, and 14% offer it to their part-time employees. Despite this, the percentage of Rhode Islanders who had a dental visit within the past year was 78.5% in 2004, which ranked Rhode Island 4th highest among the 50 states. State law requires schools to provide dental screenings for all newly enrolled students, annually for children in grades K through 5, and at least once between grades 7-10.

In 2006, Medicaid reimbursement rates were raised for dental providers participating in the Rite Smiles Program. As a result, the number of dentists accepting qualifying children with Medical Assistance has more than tripled. Nearly half (49%) of children who were enrolled in Rite Care, Rite Share, or Medicaid fee-for-service during 2006 received a dental service during the year. This represents a 20% since 2003.

Fourteen percent (14%) of Rhode Island children under age 18 are estimated to have special health care needs. Currently, 23% of all households in Rhode Island have a child with at least one special health care need. A higher percentage of children in low-income families in Rhode Island have special health care needs compared to those in the United States, with 16% of Rhode Island children in families with incomes less than 200% of the federal poverty level reporting special health care needs, compared with 14% nationally.

Rhode Island is required under Part C of the federal Individuals with Disabilities Education Act (IDEA) to provide appropriate Early Intervention services to all children from birth to age three who are developmentally delayed or have been diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay. Recent changes to the federal legislation requires states to refer children who have been involved in a substantiated case of child abuse or neglect and children who have been affected by illegal substance abuse to EI for an eligibility assessment. In addition, Rhode Island's eligibility criteria include children who are at-risk of experiencing a substantial delay if early intervention services are not provided through a multiple established conditions category (very few states choose to provide services to at-risk children).

***//2009/ In 2007, the state's Early Intervention centers served 3,338 children aged birth to three, an 8.8% increase over the previous year. This is 9% of 37,775 Rhode Island children under age three. Of the Rhode Island children enrolled in Early Intervention in 2007, the majority (70%) was eligible under the developmental delay category. Twenty percent (20%) was eligible based on a single established condition and 8% was eligible based on multiple established conditions. Children living in Rhode Island's core cities were almost twice as likely to participate in Early intervention based on multiple established conditions (10.4%) than children in the remainder of the state (6.1%) //2009//.***

In Rhode Island, local school systems are responsible for identifying and evaluating students ages 3-21 who they have a reason to believe are students with disabilities and therefore might require special education and related services through IDEA. Between school year 1990/1991 and school year 2005/2006, the percentage of students enrolled in special education increased by 49% in Rhode Island. In school year 2004/2005 (the most recent year national data were tabulated), Rhode Island had the highest percentage (20%) of public school students identified as disabled and receiving special education services under IDEA in the nation.

***//2009/ In school year 2006/2007, 27,345 students were enrolled in special education. Forty-three (43%) percent of the children had a learning disability, 19% had a speech impairment, 17% had a health impairment, 11% had emotional disturbances, 4% were mentally retarded, 4% had autism, and 3% had other disabilities//2009//.*** In school year 2005/2006, Rhode Island met its test preparation targets on the New England Common Assessment Program for students with disabilities at all grade levels.

Children who meet certain disability criteria are eligible for Medicaid and/or cash assistance through the federal Supplemental Security Income (SSI) Program. In 2006, there were 5,175 Rhode Island children under age 21 receiving Medical Assistance benefits because of their enrollment in SSI. In Rhode Island, the Katie Beckett eligibility provision provides Medical Assistance coverage to certain children who have serious disabling conditions, in order to enable them to be cared for at home instead of an institution. In 2005, there were 1,562 Rhode Island children under age 21 enrolled in Medical Assistance because of eligibility through the Katie Beckett provision.

#### State Title V Priorities

The Rhode Island Department of Health is strongly committed to "doing public health better", which involves looking at what we do now, deciding what is most important, and how we can improve it, and then implementing change and evaluating our success. The Department's priorities include: reducing health disparities, combating the epidemic of obesity, and pursuing electronic health information opportunities. Through its current and planned programming and collaborations, the Department's Division of Community, Family Health and Equity (DCFHE) supports these department-wide priorities. In addition, the DCFHE is focused on nine strategic MCH priorities that support the Department's priorities.

The DCFHE has primary responsibility for assessing the health and developmental needs of young families and children in the state, for planning effective measures to address those needs, for evaluating programs and policies affecting the health and development of women, children, and families in the state and for implementing effective measures to address those needs. During each Title V MCH needs assessment year, the DCFHE identifies new priorities informed by data collection and surveillance, family and community input, and interagency collaboration. Community input is gathered through community meetings, a public hearing, and parent surveys. The DCFHE analyzes vital statistics, newborn screening, KIDSNET, and many other sources of information on critical family health issues. */2009/ In FY2008, the DCFHE developed the following priorities for action under Title V:*

- *Improve Maternal health, including pregnancy outcomes-especially premature births and reduce health disparities;*
- *Promote Healthy Lifestyles and Healthy Weights for All Rhode Islanders;*
- *Support Safe and Healthy Environments for Children and Families;*
- *Support community services for children and youth with special healthcare needs;*
- *Ensure a Medical Home for All Rhode Island Families;*
- *Ensure a system that adequately addresses early childhood development;*
- *Engage, Empower, Support, and Inform Families;*
- *Address Social, Emotional and Behavioral health needs of the MCH population;*

*Through ongoing partnerships with community advocates, providers, and the families we serve, the DCFHE is committed to realizing these priorities and ensuring that all families in our state have the opportunity to raise safe and healthy children in safe and healthy communities. //2009//*

## **B. Agency Capacity**

### **B. Agency Capacity**

Chapter 23-13 of the RI General Laws (1937, 1999) designates the RI Department of Health (HEALTH) as the state agency responsible for administering the provisions of Title V of the federal Social Security Act in RI relative to MCH services. As the recipient of the state's federal

Title V MCH block grant funds, HEALTH's Division of Community, Family Health & Equity (DCFHE) plays an important role in addressing the MCH needs of children (including CYSHCN) and their families in RI. Like the federal MCH Program, the DCFHE believes that preventive measures directed at children and their families have the greatest potential for positive health achievements. Assuring optimal growth and development, detecting health problems early, and instilling an appreciation for positive, healthy behaviors all have payoffs, not only during childhood, but in adulthood as well.

***/2009/ In 2008, the RI Department of Health underwent a significant reorganization. The intent was to promote synergy among programs dedicated to:***

- Health Disparities and Access to Care,***
- Healthy Homes and Environments,***
- Chronic Care and Disease Management,***
- Health Promotion and Wellness,***
- Preventive Services and Community Practices.***

***Attached is a narrative to provide further information regarding the new Division of Community, Family Health and Equity.***

***The impact on maternal and child health is significant. As flexible and categorical resources become scarcer, public health has to rethink and carefully prioritize its work. Once departmental, divisional, team and program priorities are identified and aligned, those cross cutting issues that connect once divergent initiatives, can now be more clearly identified. Limited resources can be leveraged to better address the public health needs of communities.***

***RI maternal and child health programs have a long history of this integrated approach. WIC services link with lead screening; Kidsnet crosses multiple prevention health services program. There are numerous examples. The new Division of Community, Family Health and Equity will allow MCH programs to more closely align and collaborate new partners such as Diabetes Control, Initiative for Healthy Weight, Tobacco Control, Injury Prevention, Minority Health, Asthma, HIV / Viral Hepatitis and Healthy Homes (to name a few).***

***Division long-term trends and areas of concern were identified as outlined below:***

- Racial, ethnic and poverty driven health disparities continue to be documented. Increased cost of living (especially housing costs) is impacting many.***
- Shifting the focus from the individual to the community recognizes that community-level changes foster and sustain individual behavior change to reduce disability and death.***
- The diversity of RI's population continues to expand. -- The continued immigration and refugee influx means an ever- expanding cultural and language backdrop. Hispanic/Latino population is the fastest growing minority group.***
- Fewer people have health insurance and / or access to health care. Immigration status, program eligibility, family income and costs of health insurance are all contributing to this continued drop in insurance rates. The growing cost of health care acts as a deterrent to accessing needed services.***
- New parents struggle with issues related to low income, safety, and lack of extended family support, hindering their efforts to be effective parents. The emphasis is on those parents with multiple vulnerabilities and/or challenges, including those associated with children with special health care needs, and involve identifying and***

**addressing risks before conception, during pregnancy, and in the infant/preschool years.**

***These will link with the MCH needs assessment to form the basis of our work in this application. //2009//***

The DCFHE utilizes its federal MCH funds to assess, evaluate, promote, and improve health care and social systems in order to assure the essential receipt of services by children and their families in RI's communities and to foster culturally appropriate systems of care that encourage family involvement in decision making. Although most of the services needed by RI's children and families are well beyond the capacity of the DCFHE to provide, the DCFHE is committed to identifying what services are needed and ensuring that children and families access needed services through the development of new and/or enhanced systems of care in partnership with federal, state, and local government agencies, private organizations, and families. Guided by its Title V priorities, the DCFHE is committed to ensuring that all Rlers (especially the most vulnerable) have access to a full array of comprehensive, quality, health care services designed to help them reach their full physical, mental, and emotional potential.

/2007/ Please refer to the attachment for a summary of DCFHE programs and their capacity to provide:

- 1) Preventive and primary care services for pregnant women, mothers, and infants
- 2) Preventive and primary care services for children
- 3) Services for CYSHCN

#### Children and Youth with Special Health Care Needs

The Office of Special Health Care Needs (OSHCN) located in the Health Disparities and Access to Care Team of the DCFHE ensures that systems of care are built for families raising CYSHCN so they receive affordable health and related services that meet their needs. As RI's designated Title V Maternal and Child Health Office of Children with Special Health Care Needs, the OSHCN is mandated to "provide and promote family-centered, community-based, coordinated care for children with special health care needs, and facilitate the development of community-based systems of services for such children and their families." //2007//

RI is a 1914 A state (i.e. all children participating in the Supplemental Security Income program receive Medicaid benefits which includes rehabilitative services). /2007/ The DCFHE convenes the SSI, participate in the Rhodes to Independence Medicaid Infrastructure Steering Committee and the Family Voices Leadership Team to ensure a safety net for children eligible for SSI and their families. The Team includes representatives from the state departments of Health, Education, Human Services, Children, Youth and Families and other organizations such as the RI Parent Information Network, RI Family Voices, and Hasbro Children's Hospital.

The DCFHE and its OSHCN promotes family-centered, community-based, coordinated care (including care coordination) for CYSHCN and facilitates the development of community-based systems of services for CYSHCN and their families. Much of the Division's work in these areas focuses on infrastructure building activities. The DCFHE is in a unique position to advocate with families raising CYSHCN to coordinate statewide services and to provide leadership for the special needs service delivery system, especially as it relates to access to and quality of pediatric specialty services, educating children with special needs, child welfare prevention, and mental/behavioral health. DCFHE invests in the special needs infrastructure through parent support and empowerment opportunities and the provision of quality assurance through a special needs leadership council. These investments ensure that the service system is community based, family-centered, and accessible to all families. Also, family and consumer driven quality assurance promotes ongoing improvement in the health care system, which benefits all RI families. Please refer to the attachment for detailed information on DCFHE programs serving CYSHCN and their families. //2007//

## Assuring Culturally Competent Care

The DCFHE is also committed to ensuring that services are culturally competent. RI has one of the highest percentages of foreign-born residents in the nation and much of its recent population growth can be attributed to its minority residents. The DCFHE supports many community-based initiatives throughout RI, including in the core cities, where a large number of ethnic and racial minorities reside. An important function of the Health Disparities and Access to Care Team is to tailor health promotion messages and programs to minorities while engaging minority & disability leaders in policy discussions and quality assurance initiatives. Information and educational materials are written at a sixth grade reading level and most materials are available in English and Spanish, with a limited selection available in other languages based on program needs. In addition, the DCFHE Communication Unit continues to work to increase the Division's reach in RI's Latino community. Over the last ten years, DCFHE staff has become increasingly diverse. The majority of parent consultants employed through the DCFHE are from diverse backgrounds. Training on cultural competence is a critical component of the Division's success.

Reducing racial and ethnic disparities is a priority for both HEALTH and the DCFHE. The DCFHE leads the Department's prevention and the elimination of health disparities efforts. The department has been working with programs, vendors, partners, and hospitals in adopting the National Standards for the Provision of Culturally and Linguistically Appropriate Services in Health Care Settings (CLAS) standards. The DCFHE supports the delivery of culturally competent care through data analysis and dissemination specific to racial and ethnic groups. DCFHE data sets, including the Pregnancy Risk Assessment Monitoring System (PRAMS), birth defects, and others report data on specific racial/ethnic subgroups to inform program planning and policy development. The Child Care Support Network funds a component of the network to provide services in Spanish to child care providers. In addition, the DCFHE provides services to and continually solicits input from minority groups by partnering with agencies and organizations serving racial, ethnic, and linguistically diverse populations.

### State Statutes Relevant to Title V

/2008/ The enabling legislation for the childhood immunization program was expanded to encompass an adult influenza vaccination program. It requires HEALTH to purchase and manage the distribution of adult influenza vaccine starting with the FY07-08 influenza season. //2008//

Other state statutes that impact the Division's work include:

RIGL 16-21-7 (1938, 2007) requires local schools to have a school health program that is approved by HEALTH and RIDE.

RIGL 23-5-20.5 (2002) establishes standards for the maintenance of pre-1978 rental property in RI and provides property owners with access to liability coverage for lead poisoning.

RIGL 23-1-18 (1966, 1993) authorizes HEALTH to require the reporting of immunization status for the purpose of establishing and maintaining a childhood immunization registry for children under the age of 18 years.

/2008/ RIGL 23-1-44, 23-1-45, 23-1-46 (2006) required HEALTH to purchase and distribute adult influenza vaccine. //2008//

RIGL 23-1-49 (1985, 1997) authorizes HEALTH to establish and maintain registries for traumatic brain and spinal cord injuries.

RIGL 23-13-3 (2003) creates a birth defects surveillance registry.

RIGL 23-13-13 (1979) requires all newborns to be screened for hearing impairments.

RIGL 23-13-14 (1987, 2001) requires all newborns to be screened for metabolic, endocrine, and hemoglobinopathy disorders.

RIGL 23-13-16.1 (1988) requires hospitals to submit statistics relating to the annual rate of caesarian sections, primary and repeat, to HEALTH.

RIGL 23-13-17 (1987 & 1996) designates HEALTH as the state agency for administering the provisions of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program.

RIGL 23-13-20 (1988) authorizes HEALTH to establish a family life and sex education program to assist in the establishment of community networks in the maternal and child health planning areas with high rates of teenage pregnancy.

RIGL 23-13-21 (1988) authorizes HEALTH to establish a payer-of-last-resort program to cover the costs of outpatient family planning counseling and comprehensive reproductive health services for men and women who are uninsured and ineligible for Medicaid in RI.

RIGL 23-24.6 (1991) authorizes HEALTH to establish a comprehensive statewide program to reduce the prevalence of childhood lead poisoning in the state.

RIGL 40-19.1 (1997) requires HEALTH, the RI Department of Human Services (DHS), the RI Department of Children, Youth, & Families (DCYF), and the RI Department of Education (RIDE) to develop a comprehensive statewide plan to prevent and reduce the incidence of unwanted pregnancies among adolescents in RI.

These and other state statutes that indirectly impact DCFHE activities are included as an attachment.

#### Collaboration With Other State Agencies & Private Organizations

***/2009/ The WIC Program collaborates with the Department of Environmental Management in relationship to authorizing local farmers' markets. Veggin' Out classes encourage tasting and teaches preparation of fresh produce, this aids in helping families to make good meal choices for their families.***

***Breastfeeding Support: The WIC Breastfeeding Coordinator is a member the Statewide Breastfeeding Coalition, which has had an impact on breastfeeding support both in the community and at the legislative level. WIC collaborates with W&I hospital to support breastfeeding in the NICU. //2009//***

*/2007/ The DCFHE works closely with other state agencies, community providers of health services, and constituent groups to promote the healthy development of women, infants, and children, including CYSHCN. //2007//*

*/2008/ The Office of Early Childhood and Development collaborates at the state and community level. At the state level, the Office works with the Advisory committee on Child Care and Development, managed by the Department of Human Services (DHS), but representing all state agencies, ensures that all activities mandated by the state are implanted with the input of other state departments as well as the community.*

The Successful Start Advisory Board is comprised of approximately 20 community members as well as some state representatives. This committee is responsible for helping to implement RI's early childhood comprehensive systems plan. It provides a forum of community experts in which

progress in implementing the plan is evaluated, changes to the plan are recommended and new opportunities are identified. //2008//

/2008/ RI Department of Human Services (DHS): HEALTH has a formal Medicaid agreement with DHS for Early Periodic Screening, Diagnosis and Treatment (EPSDT) services. It also has a memorandum of agreement with DHS to share data related to KIDSNET. /2007/ Exchange of Medicaid data with KIDSNET will be explored under the State System Development Initiative //2008//. HEALTH has an agreement with DHS to provide funds to support the Early Intervention Child Find mandate. //2007// Staff from the HEALTH provide consultation and professional expertise to DHS in the areas of assessment, assurance, and policy development through formalized workgroups and program specific discussions. //2008//

//2008//The DCFHE collaborates extensively with DHS to create a statewide infrastructure for addressing the problem of childhood lead poisoning among children with Medicaid in RI. DHS supports four regional certified lead safe centers, which provide lead poisoned children with Medicaid with comprehensive case management services and coordinated linkage to other services and supports. As part of this effort, DHS covers replacement windows as a medically necessary service for lead poisoned children through Medicaid. /2008/ The DCFHE also has a formal memorandum of understanding with DHS to share data related to calculating lead screening rates among the Medicaid population. //2008// The DCFHE convened a Healthy Housing Collaborative, a statewide collaborative of agencies and individuals, designed to initiate genuine partnerships to help move communities towards a more comprehensive approach to healthy housing practices. The DCFHE offers a 'clinical day' training to student nurses at 4 state colleges to educate future home visitors about environmental hazards found in the home. //2008//

/2007/ The DCFHE also works collaboratively with DHS in the administration of the state's care coordination system for CYSHCN (CEDARR), the provision of services through the Early Intervention program, statewide access to screening and assessment for children with complex special health care needs, and the administration of parent engagement and support activities in clinical practices (through the Pediatric Practice Enhancement Project). The DHS and the OSHCN collaborate on family engagement programs, parent leadership and stakeholder initiatives. The DCFHE and DHS also jointly manage and fund the Child Care Support Network. DHS is a full partner in the implementation of Successful Start, RI's Early Childhood Comprehensive Systems initiative. //2007//

RI Department of Education: The DCFHE has a cooperative agreement with the RI School for the Deaf for the purposes of enhancing early hearing detection and intervention (EHDI) and systemically assessing, developing, and implementing strategies for tracking children beyond age five by including school hearing screening information and results in KIDSNET. /2007/ The DCFHE is also working with RIDE in an effort to share school health data with HEALTH in a manner allowed under federal education privacy laws. RIDE is also a key partner in the implementation of RI's Early Childhood Comprehensive Systems Plan. . RIDE also partners in the implementation of the PPEP program and assists families in understanding their rights in the special education system. RIDE and OSHCN partner on autism initiatives including the screening, diagnosis and education of children and youth with autism spectrum disorders.

RI Department of Children, Youth & Families: The DCFHE is collaborating around data sharing via KIDSNET to better coordinate preventive health care for children in foster care. The DCFHE Family Outreach Program (FOP) is also working with DCYF in the implementation of new regulations regarding screening young children with substantiated cases of child abuse/neglect for Early Intervention eligibility. FOP nurse home visitors perform screening and serve as a liaison between DCYF and Early Intervention providers. DCYF is a full partner in the implementation of RI's Early Childhood Comprehensive Systems Plan. OSHCN partners with DCYF and DHS on the design and implementation of the children's behavioral health system in RI. OSHCN convenes and sponsors opportunities for family involvement and stakeholder participation in the

children's behavioral healthcare system and the recently awarded Family Care and Coordinating Partnership (FCCP). The OSHCN participates on the Children's Trust Fund, which administers the state's primary and secondary prevention of abuse and neglect.

Children's Neurodevelopment Center at Hasbro Children's Hospital (CNDC): The CNDC provides specialty and sub-specialty services to medically complex CYSHCN from birth to 21 years of age, including infants identified through newborn screening and is a DHS certified CEDARR Family Center. Via a cooperative agreement DCFHE supports and works closely with the CNDC on issues relating to quality of care, identification of services, access to reimbursement and family centered practices. Two parent consultants are assigned to work with the CNDC on these issues. The CNDC has access to KIDSNET to assure proper preventive services and coordination of care to children being seen at the CNDC and is in the process of managing the information technology for the PPEP through their electronic medical record.

RI Hearing Screening Assessment Program (RIHAP): RIHAP at Women & Infants Hospital provides support and follow-up for children with hearing impairments identified through the newborn screening process. The DCFHE participates on RIHAP's Hearing Screening & Follow-Up Committee. //2007/ In addition, the DCFHE recently completed a Resource Guide for Families of Children Who Are Deaf or Hard of Hearing. //2007// //2008/ Algorithms for medical homes and families to explain what to expect following newborn hearing screening have been produced. //2008//

RI Transition Council: The DCFHE continues to participate on the RI Transition Council, which was established by state statute to coordinate the activities of state agencies and school districts for youth with disabilities transitioning from school to adult life. The OSHCN is responsible for the development of an adolescent healthcare toolkit that is being used by the members of the Transition Council and their organizations, specifically, school-nurse teachers, transition coordinators, RIDE administrators, Local Education Authorities' Special Education administrators and Vocational Rehabilitation Counselors.

Child Maltreatment Surveillance Project: DCFHE staff met with representatives from the Child Advocate's Office, the Medical Examiners' Office, the Attorney General's Office, DCYF, Brown University, and Hasbro Children's Hospital staff regularly to review mortality and morbidity incidents in RI. A group of researchers and physicians reviewed hospital discharge data (including emergency room data) of all fatal cases of children under 21 years of age who had one or more of 30 ICD-9 codes related to possible child maltreatment to look for "missed opportunities". In early 2008, the CDC published a chart book and provider reference guide in which RI's contributions to the document are well-noted.

RI Family Voices: The DCFHE works closely with leadership from the RI Chapter of Family Voices. The Director of Family Voices meets regularly with the DCFHE Medical Director and Chief of the OSHCN. The Director of Family Voices is a member of the SSI Team and assist in the administration of the PPEP. RI Family Voices is one of a few state Family Voices chapters to implement a Family-to-Family Health Information Center, funded under Medicaid and MCHB. Family Voices and the DFH have formed the Family Voices Leadership Team comprised of leadership from state agencies, community organizations, and service providers to address barriers to a coordinated CYSHCN service delivery system.

//2008/ School and Home Day Care Provider Initiatives: The Immunization Program (IP) provides training and technical assistance to schools and all home child care providers (English and Spanish-speaking) licensed by the Department of Children, Youth and Families regarding rules and regulations for childhood immunizations. The program collaborates with the Department of Education and provides in ensuring that children entering schools are up-to-date on required vaccines. //2008//

Perinatal Hepatitis Prevention Program: The program goal is to identify pregnant women infected

with hepatitis B virus (HBV) and hepatitis C virus (HCV) and prevent or identify transmission of the virus to the infant. The program works with RI's birthing hospitals and prenatal providers to ensure routine screening for HBV virus in all pregnant women, and screening for HCV virus in pregnant women with one or more high risk factors. The program offers comprehensive case management services in partnership with the VNA, to women infected with HBV or HCV during the perinatal period. Tracking of infants born to positive women includes ongoing education and outreach to pediatric providers to ensure infants receive recommended immunoprophylaxis and referrals for medical management

RI Parent Information Network (RIPIN): RIPIN, a statewide, non-profit agency, provides information, training, support, and advocacy to parents seeking help for their children in RI. RIPIN provides training and administers the DCFHE Parent Consultant Program. In addition, the toll-free Family Health Information Line refers parents who express interest in child development, school readiness, literacy, discipline, violence prevention, disabilities, special education, transitions, and health-related issues to RIPIN and other appropriate community-based resources. //2007/ RIPIN also provides training and support to Pediatric Practice Enhancement Project (PPEP) parent consultants. Parent consultants are also placed in the following DCFHE programs: Immunization, Birth Defects, and Adolescent Transition.

RI Chapter of the March of Dimes (MOD): The DCFHE collaborates with the MOD on several major initiatives. The first focuses on ensuring that women (especially low-income women) in RI have access to folic acid information and supplements prior to becoming pregnant or early in pregnancy in order to prevent birth defects. Another initiative is working to reduce prematurity in RI. //2007/ A third initiative places family support in the state's only neonatal specialty care nursery, the NICU at Women & Infants Hospital and blends the expertise of a Parent Consultant and a MOD parent support professional to provide family support, education to families and staff, and referrals. DCFHE is working collaboratively with MOD to implement the expanded newborn screening panel to meet the recommendations of the American College of Medical Genetics. //2007//. //2008/: The DCFHE, in partnership with the MOD and Women and Infants Hospital, established a statewide Prematurity Task Force to identify and prioritize recommendations to reduce premature births in RI. In November 2007, the top ten Task Force recommendations were presented at the MOD Prematurity Summit. During FY07, the Task Force has continued to work on implementing the recommendations. //2008//

Interagency Coordinating Council on Environmental Lead (ICCEL): The ICCEL, created as a part of the new Lead Hazard Mitigation Law passed in June of 2002, and is chaired by the Director of Health, with members that include DHS, the RI Department of Environmental Management (DEM), the Office of the Attorney General, the RI League of Cities and Towns, and the RI Housing Resources Commission. The ICCEL oversees the implementation of the Lead Hazard Mitigation Law and reports to the Governor on an annual basis.

Brain Injury Association of RI: The Traumatic Brain & Spinal Cord Injury (TBSCI) Program maintains a registry of individuals with traumatic brain and spinal cord injuries for the purpose of helping children and adults with TBSCI access appropriate services, including SSI and rehabilitative services. The program sends individuals with TBSCI a follow-up letter informing them of the Brain Injury Association of RI as a potential resource. **//2009/ With the passage of Rules & Regulations Pertaining to Traumatic Brain and Spinal Cord Injuries in July 2007, the OSHCN has seen a 500% increase in the reporting and linkage of victims and valuable information. //2009//**

//2008/ RI Department of Environmental Management: The DCFHE collaborates with DEM's Division of Agriculture in the promotion, support and monitoring of the WIC Farmers Market Nutrition Program.

RI Food Stamp Advisory Committee: This DHS sponsored committee engages community partners, including DCFHE, in monitoring the success of outreach and service provision of the

Food Stamp Program in RI. //2008//

#### State Support for Communities

/2008/ DCFHE supports breastfeeding training of WIC nutritionists, WIC Peer Counselors and community educators, by offering training as Certified Lactation Consultants (CLC) and International Board Certified lactation Consultants (IBCLC). This provides standardized appropriate information to those supporting breastfeeding women in the community. //2008//

Ready to Learn Providence (R2LP): The DCFHE continues to support the Providence Plan's community-driven strategic planning initiative to increase utilization of MCH services (including CYSHCN services) among young families living in the city of Providence. R2LP, through federal Early Learning Opportunities Act funding, continues to implement activities relating to improving the quality of child care through expanding and better connecting providers to professional development, expanding the capacity and cultural competency of existing early childhood learning programs, and institutionalizing a kindergarten transition initiative designed to better prepare children for learning at school entry. Linking children, including CYSHCN, to needed health related services through a medical home represents an important part of R2LP activities. Parents participate in all phases of R2LP activities.

/2007/ The DCFHE is currently participating in the several other community initiatives, including Warwick FOCUS, the Pawtucket/Central Falls CATCH, and Woonsocket CATCH. The DCFHE and the RI Initiative for Healthy Weight have issued a request for proposals to fund several of these community coalitions to develop plans to address childhood obesity. //2007// /2008/ The DCFHE, in partnership with the Providence Plan and East Bay Community Action Program, applied and was selected to be one of seven teams to participate in the 2006-2007 City MatCH DaTA Institute: Data to Action for Effective MCH Leadership. The RI team's project focuses on childhood obesity in Newport, RI and is working to collect data from a variety of sources including: pediatric providers, schools, WIC, Head Start and community service agencies. The DaTA Institute is identifying community indicators for assessment, evaluation, planning and advocacy. //2008// DCFHE is working with the Woonsocket CATCH and Northern RI Area Health Education Center on an adolescent medical home pilot project DCFHE

/2008/ Child Care Support Network supports healthy child care environments through contracts to local community agencies. These agencies have staff that conduct technical assistance to child care providers to help them promote children's mental health and healthy development. The project also helps ensure that efforts around the state to promote children's health y development are coordinated //2008//

Successful Start: The Successful Start Early Childhood Comprehensive Systems initiative engaged in a two-year, statewide planning effort to assess capacity, quality, and integration issues surrounding five core components of the state's existing early childhood system. The five core components include medical homes, social and emotional development, child care, parenting education, and family support for all children, including CYSHCN. Beginning in Fall 2005, the plan developed for Successful Start will go into implementation. Parent involvement will be a key to success in the implementation phase. /2007/ Last Fall, Successful Start published its Early Childhood Systems Plan. Many key elements of the plan are underway, including support for local communities and neighborhoods to integrate developmental screening into medical homes, offer multidisciplinary training in infant and early childhood mental health, and build capacity for child care health and mental health consultation. //2007//

#### Coordination With Health Components Of Community-Based Systems

***/2009/ The WIC Program is co-located within Local Community Health Centers and***

**Hospitals: WIC's co-location in the community healthcare settings provides direct referrals to WIC that increases access to services. Also, referrals from the WIC program also increases access to medical care, dental care, social services as well an array of services these agencies provide. //2009//**

/2008/ The Office of Early Childhood Health and Development coordinates with a number of existing systems relevant to children's health care. Watch Me Grow RI, the Family Outreach Program, and the Child Care Support Network all coordinate with SCHIP, Early Intervention, the system of Community Mental Health Centers, and the Child Care Subsidy system. The Newborn Screening program coordinates with the birthing hospitals, the State Laboratory, and the RI Hospital. //2008// The Lead Poisoning Prevention Program also coordinates with Medicaid, the states system of Lead Centers and the two lead clinics in the state which provide medical treatment for significantly lead poisoned children. //2008//

Thrive formerly Health Schools! Health Kids! There are many opportunities to address the critical health issues of school-age children, including obesity, oral health, chronic conditions, tobacco use, mental and behavioral health concerns, school environmental concerns, and access to health care. The DCFHE has a Cooperative Agreement with RIDE for implementation of the Coordinated School Health Program which addresses eight components of infrastructure for healthy schools and is also responsible for coordinating the internal work of HEALTH related to the health of school-age children, including CYSHCN. //2008//

The Initiative for Healthy Youth in partnership with the RI Public Health Institute and with a small planning grant from the RI Foundation, is conducting a feasibility study for a mental/behavioral health resource center for RI schools. This project is in response to schools' ongoing challenges coping with mental/behavioral health issues that are barriers to school success and their expressed need for support. Bradley Hospital is interested in participating with us in developing a model center and has included language in its certificate of need application that commits Bradley to working with us on this issue.

Family Outreach Program (FOP): Via HEALTH contracts, 3 VNA agencies conduct home visits to almost one-third families with newborns who have specific risk profiles created from information collected at birthing hospitals. They provide general parenting information, conduct home assessments, and educate parents about infant care, and link families to appropriate resources. Other community partners (ie, pediatricians / Early Intervention) can also make referrals to the FOP for specific concerns in which case the program will make home visits to children who are beyond the newborn period and link these families with services. //2008// Home visitors also serve as the follow-up staff for the Newborn Screening, Lead Poisoning Prevention, and Immunization Programs. /2007/ FOP is an active contributor to the Child Find system for the Early Intervention program.//2007// **/2009/ The DCFHE is exploring the feasibility of implementing an intensive home visiting model as well as prenatal home visiting through FOP. //2009//** /2008/ FOP collects housing related information during the initial home visit. This data will be used to promote access and availability to healthy housing, This includes data from home visitors from the 4 lead centers in RI. //2008//

Watch Me Grow RI is a program that provides support to pediatric primary care providers and child care providers to implement developmental screening within community based settings. WMGRI also provides technical assistance around understanding community services and how to refer/link to these services. As a result of the AAP recommendation around autism specific screening in addition to standardized developmental screening, WMGRI and the OSHCN provides technical assistance on standardized measures of development.

Coordination of Health Services with Other Services at the Community Level

**/2009/ WIC Education: During a WIC Certification appointment clients are assessed for any needs of clients on an individual basis. Appropriate referrals are made (i.e. Family**

**Resource counselors, smoking cessation, housing, fuel assistance, food pantries, etc).**  
**//2009//**

/2008/ Family Outreach Program coordinates with the system of pediatric primary care to accept referrals, coordinate information exchange and make referrals to many diverse community programs.

The Newborn Screening Program coordinates with community based and hospital based programs, which address the needs of families with children who have specific disabilities and disorders. //2008// The Newborn Screening Program provides universal newborn screening and follow-up for a growing list of metabolic, endocrine, and blood disorders. The program also provides hearing screening and developmental risk assessments for newborns. Implementation of a newborn developmental risk module, integrated with a new electronic birth certificate system, began in May 2003. Consumer input into genetics and newborn screening policy development was obtained through outreach, focus groups, surveys, and other means. The DCFHE worked closely with local hospitals to implement the integrated electronic developmental risk assessment/birth certificate system in RI. /2007/ The DCFHE is currently working with hospitals, specialty clinics, and pediatric providers to implement an expanded panel of conditions for newborn screening. //2007//

OSHCN and parent consultants worked with parents to develop "medical passports" for families with CYSHCN, which contain information about services for CYSHCN and their families in RI. The DCFHE will also continue to work with the New England Regional Genetics Group (NERGG) for technical assistance in implementing HEALTH's statewide genetics plan. The genetics plan focuses on access to genetics services, including genetics counseling. **/2009/ In early 2008 a parent consultant was added to RI's genetic team. //2009//**

The Birth Defects Program is working to ensure that children with birth defects have a medical home and that families have access to preventive services. The DCFHE designed a template for birth defects, a data book, and newsletter.. /2007/ The DCFHE has worked closely with its Birth Defects Advisory Council to design and pilot a checklist of services for specific conditions that families and health care providers will complete. //2007//

**/2009/ The Birth Defects Program parent consultant has been coordinating focus groups with families of children with birth defects to learn about their experiences with the health care system, identifying any barriers to or gaps in services and developing strategies to elicit parent input in data collection; working closely with community agencies /families to determine the need for educational materials; helping to monitor the program to ensure that all children with birth defects have a medical home. A parent consultant works with the Advisory Committee to develop/implement statewide birth defects prevention strategies //2009//**

/2008/: During FY07, the Birth Defects Program began exploring the possibility of working with the Pediatric Practice Enhancement Program (PPEP) and the RI Parent Information Network to obtain service and referral information for children with birth defects. PPEP parent consultants based in pediatric offices and clinics could obtain this information from families and medical records. The Birth Defects Program also worked closely with hospitals and clinics to enhance and expand case ascertainment and planned the 2nd annual Birth Defects Grand Rounds and Forum on fetal alcohol syndrome. Community organizations that serve children with birth defects were invited to set up informational tables at the forum. //2008//

/2008/ The Childhood Lead Poisoning Program refers children who are significantly lead poisoned to a network of lead centers who deliver direct services in the form of non-medical case management and provide family support and referrals. The DCFHE recently lowered the blood lead level used to determine eligibility for referral in an effort to promote primary prevention of lead poisoning and has a Memorandum of Understanding with lead centers to send referrals and

work collaboratively in the monitoring, evaluation, and quality assurance of the case management of lead poisoned children. DCFHE supports a clinic offers lead screening testing free of charge for children who are uninsured in one of the major pediatric hospitals in Providence. //2008//

***An attachment is included in this section.***

### **C. Organizational Structure**

***/2009/ The DCFHE is a major component of HEALTH, which is a department located under the umbrella of the Executive Office of Health and Human Services (EOHHS). EOHHS is a cabinet agency that directly reports to the Governor. EOHHS is comprised of the Department of Children, Youth and Families; the Department of Elderly Affairs; the Department of Health; the Department of Human Services; and the Department of Mental Health, Retardation and Hospitals. Together, these agencies provide direct assistance and support services to more than 248,000 individuals and families at a cost of over \$2.7 billion per year.***

***The DCFHE is organized into the Office of the Executive Director and 7 Teams:***

- Data and Evaluation Team***
- Health Disparities and Access to Care Team***
- Helathy Homes and Environment Team***
- Chronic Care and Disease Management Team,***
- Health Promotion and Wellness Team***
- Perinatal and Early Childhood Health Team***
- Preventive Services and Community Practices Team***

***The Office of the Executive Director focuses on overall division cross-cutting public health resources, administration and coordination of division activities and includes:***

***“ The Data and Evaluation Unit develops, supports and analyzes data for needs assessment; policy and program management; and reporting and quality assurance and includes KIDSNET, the Birth Defects Registry and Pregnancy Risk Monitoring System, PRAMS.***

***“ The Administrative Unit manages and monitors Community, Family Health and Equity resources and investments.***

***“ The Health Policy, Management and Program Administration Unit is responsible for analyzing national and state policy to assess potential impacts, and recommend positions/ responses/ resource allocation and enhances integration.***

***Chronic Care and Disease Management Team is composed of the following areas:***

***Diabetes Prevention and Control Program which addresses the burden of diabetes in the state by targeting controlling diabetes and preventing diabetes-related complications.***

***Asthma Control Program addresses the prevalence and burden of asthma among people of all ages living in Rhode Island and focuses on quality clinical asthma care, quality asthma patient education, and environmental health to address patients' ability to control their asthma.***

***Colorectal Cancer Screening Program improves colorectal cancer screening rates among all Rhode Islanders aged 50 and older, African American Rhode Islander's aged 40 and older and ensure access to screening among underserved populations.***

***Comprehensive Cancer Control (CCC) works to eliminate health disparities in cancer***

*services and programs in Rhode Island and create a workforce knowledgeable in cancer in underserved communities.*

*Women's Cancer Screening Program provides breast and cervical screening, diagnostic services, and treatment for women 40-64, QA, TA to providers on women's cancer screening issues, public education & outreach to increase the number of women screened in the target groups.*

*Arthritis Program works to raise awareness about arthritis in Rhode Island..*

*Office of HIV/AIDS & Viral Hepatitis addresses the major areas of reportable infectious communicable diseases pertaining to HIV infection (including pediatric cases) and AIDS, Hepatitis B & C control and outbreak control. The Program works closely with the immunization staff within the division on pediatric cases of Hepatitis B & C.*

*Health Disparities and Access to Care Team is composed of the following areas:*

*Office of Minority Health works to eliminate racial and ethnic health disparities and assure that racial and ethnic minority populations have equal access to high quality health services and works through the Minority Health Promotion Program, Refugee Health Program, and Healthy Rhode Island 2010 Initiative.*

*Office of Women's Health serves as the focal point for coordinating statewide improve and eliminate disparities in the health status of all Rhode Island women.*

*Office of Special Health Care Needs ensures family-centered, community based, systems of services for children and youth with special healthcare needs through infrastructure building, training / TA, and collaboration with families, other state agencies, health plans, and community agencies and linkages other state agencies such as the Department of Education, the Department of Human Services, Department of Elderly Affairs, Department of Mental Health and Retardation, and Department of Children, Youth, and Families to serve people with disabilities in their care.*

*Disability and Health Program promotes health and wellness for people with disabilities and prevents secondary health conditions and maintains the Traumatic Brain Injury database, and assures successful transition of adolescents with disabilities to the adult health care system. It manages the Emergency Preparedness for People with Disabilities and Adolescent Healthcare Transition projects.*

*Pediatric Specialty Services provides an integrated system of care for children with special healthcare needs and maintains quality assurance in this system through educating, supporting and empowering families raising children with special healthcare needs. Family-to-Family Network is a family-led, organized effort to link families raising children with special needs with support families who have lived through similar circumstances. It manages the Pediatric Practice Enhancement Project (links pediatric primary and specialty practices with community-based resources) and the Autism Response Program (track the incidents of ASD and implement best practice in the areas of screening, evaluation and the treatment of children with an ASD and available resources).*

*Office of Primary Care promotes access to high quality, comprehensive primary care to all state residents, regardless of their ability to pay. Particular emphasis is placed on expanding access for the traditionally medically underserved -- racial and ethnic minorities, low income and uninsured individuals. It manages the Primary Care Services Resource Coordination and Development Grant and the NHSC Student Experiences and Rotations in Community Health.*

*Office of Rural Health works on access to care in rural RI areas including lack of an*

**adequate number of providers, geographic barriers and lack of transportation.**

**Health Promotion & Wellness Team is composed of the following areas:**

**Tobacco Control Program uses prevention and cessation program and includes a tobacco control initiative funded in part by the US Centers for Disease Control and Prevention (CDC).**

**Initiative for Healthy Weight (IHW) supports schools, communities, health care providers, early childhood organizations, and worksites to assess their environments and develop policies and strategies supportive of increased physical activity, healthy eating and healthy weight. It works closely with the Coordinated School Health Program to ensure that school children and parents learn about and have access to physical activity and healthy foods in schools, and the WIC program to reduce obesity and overweight among low-income women with young children. Additional focus is placed on the implementation of physical education content standards and assessments in the state through awareness raising and training activities, working with the state Association for Health, Physical Education, Recreation and Dance.**

**Safe RI / Injury Prevention Program addresses unsafe behaviors, such as violence, self-harm, failure to wear seat belts and use bicycle helmets, and unsafe environments, such as homes without smoke detectors or homes where smoking is permitted, contribute to injury in Rhode Island. The injury prevention component, Safe Rhode Island concentrates on initiatives to increase safe behavior and a safe environment for Rhode Islanders, with special emphasis on motor vehicle crashes, elder falls, and suicide prevention. Worksite Wellness Program works with the Worksite Wellness Council of RI to provide assistance to worksites in the state to develop wellness programs that include weight management, physical activity, nutrition, and tobacco use cessation.**

**Initiative for Healthy Youth includes a CDC funded initiative called "thrive," to build an infrastructure for Coordinated School Health Programs in partnership with the Department of Elementary and Secondary Education to integrate school health into the state education reform agenda and district and school reform plans, especially in communities of color and youth at risk. ThRIve works to improve nutrition, increase physical activity, decrease use of tobacco products, create "healthy school food environments," and improve HIV/AIDS education through partnerships with schools, families, and communities. Activities include programs that prepare and support men to be role models for boys, policies and programs to support healthy father/children relationships, [www.ParentLinkRI.org](http://www.ParentLinkRI.org), a web site for parents that provides information on parenting classes, workshops, activities and services for youth and families, and monthly parenting tips, and multiple strategies to support youth as action researchers and innovators to inform policy and programming around health issues affecting youth.**

**Healthy Homes and Environment Team is composed of the following areas:**

**Childhood Lead Poisoning Prevention and Healthy Homes is to eliminate childhood lead poisoning in Rhode Island's youngest children, and to reduce other environmental threats in the home. This is accomplished by formulating lead screening policy, increasing lead screening rates, assuring timely follow-up for lead poisoned children and their families, educating parents and professionals about the dangers of lead poisoning, and developing strategies with housing entities to assure a healthy environment for children.**

**Environmental Health Risk Assessment identifies and assesses environmental risks to public health in Rhode Island.**

**Environmental Lead works to protect the public, specifically children under the age of six,**

*from lead in the environment.*

*Indoor Air Quality protects Rhode Islanders from unnecessary exposures to airborne asbestos fibers and radon, and works with schools and building owners on issues relating to indoor air quality.*

*Occupational Consultation conducts health and safety evaluations at Rhode Island workplaces and provide technical assistance and follow-up training to ensure that hazards are addressed.*

*Perinatal and Early Childhood Health (PECH) Team is composed of:*

*Early Childhood Health - Strong families and healthy communities provide the foundation for children's healthy development. Community-based early childhood services are part of the critical network of supports for families. An effective early childhood system addresses the needs of all children, while providing more intensive services for infants and children most at risk. Early detection of metabolic and genetic risks prevents death, disability and mental retardation. The activities are noted below:*

*Newborn Screening Program -- is a multi-focused screening program for newborn infants comprised of Newborn Metabolic and Genetic Screening, The Rhode Island Hearing Assessment, and Newborn Developmental Risk Screening.*

*Family Outreach Program - is the state's home visiting program for pregnant women and families with young children who are at risk for poor developmental outcomes. Home visitors also provide follow-up for the Newborn Screening, Early Intervention, Lead Poisoning, Immunization and Special Healthcare Needs programs, and work closely with community physicians and service providers.*

*The Child Care Support Network -- provides Health and Mental Health Consultation services to child care providers, children and families in community settings to promote healthy child care environments, and reduce rates of illness in child care settings, reduce the number of children excluded from child care programs due to behavior problems, enhance the ability of child care providers to promote healthy social emotional development, and help child care providers recognize children who need additional services at the earliest possible opportunity.*

*Watch Me Grow RI -- provides technical assistance to implement a developmental screening for children birth to three in pediatric primary care offices and child care settings. This program provides a critical link between primary care offices and other community programs where children spend time.*

*Successful Start - facilitates the implementation of recommendations for system improvements relevant to early childhood services and programs in Rhode Island. Recommendations for system improvement bring together elements of the early childhood system in Rhode Island that have previously been fragmented to maximize resources and to better coordinate services for families with young children.*

*The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental foods, nutrition education and information, referral and coordination services to these women and children and acts as adjunct to good health care during critical periods of growth and development to prevent the occurrence of health problems and improve health status. It includes the Farmer's Market Nutrition Program that enables WIC clients to purchase locally grown fresh fruits and vegetables at farmer's markets along with nutrition education about fruits and vegetables and the positive effects of these food on health and obesity prevention..*

### ***Breastfeeding Support and Promotion***

***Breastfeeding Peer Counselor Mother to Mother Program -- a Peer Counseling Program to promote breastfeeding to WIC participants and provide support to breastfeeding WIC mothers.***

***The Tender Lactation Care (TLC) Program -- a breastfeeding support program that provides post-partum breastfeeding assistance to WIC mothers who deliver at Women and Infants Hospital.***

***Reproductive Health - Promotes the reproductive health of youth and adults and provides individuals with the information and means to exercise personal choice in determining the number and spacing of their children.***

***Title X Family Planning Program - provides access to comprehensive family planning and preventive services. Services include birth control, abstinence messages for school-age adolescents, diagnosis and treatment of sexually transmitted diseases, and basic reproductive health care, with priority given to low-income women and men.***

***Women's Health Screening and Referral Program - provides no-cost pregnancy tests, and a risk assessment to all women requesting services at Title X clinics. Providers refer women to appropriate health care (prenatal or family planning) and available risk reduction and psychosocial services to reduce identified risks and to follow-up on client care.***

***Preventive Services and Community Practices Team is composed of:***

***Immunization Program works to prevent and control vaccine preventable disease in Rhode Island by increasing the number of fully immunized residents thru vaccine distribution, quality assurance, public and provider education, information dissemination, surveillance and community collaboration.***

***The Childhood Immunization Program serves children birth-18 years of age thru universal vaccine purchase and distribution for all children, quality improvement, and an integrated program/practice management information system [KIDSNET] and supports supports initiatives for special populations, such as Vaccinate Before You Graduate and Perinatal Hepatitis Prevention***

***The Adult Immunization Program manages the purchasing and distribution of influenza vaccine to providers for insured adults aged 19 and older.***

***The Office of Oral Health seeks to improve the oral health of Rhode Islanders by: (1) providing oral health/public health leadership developing, implementing, and evaluating state plans/prevention programs; and collaborating with partners to build and sustain community capacity.***

***An organization chart is attached to this narrative. //2009//***

***An attachment is included in this section.***

## **D. Other MCH Capacity**

### D. Other MCH Capacity

***/2009/ There are 101 Full-Time Equivalents (FTEs) who work in the DCFHE as state employees. This number includes staff that provide planning, evaluation, and data analysis. In addition, the Division's staffing configuration includes 30 consultant; 24 ADIL consultants, four university contractors, 3 private contractors, one temporary employees, five parent consultants and 2 assignees from the Center for Disease Control and Prevention. //2009//***

Parent consultants are culturally diverse and are assigned to DCFHE programs based on the program's need for parent participation and the parent consultant's experience with the program. Parent consultants are assigned to the WIC Program, the Immunization Program, the Birth Defects Program, and the OCSHCN. /2008/ Many of the parent consultants are parents of CSHCN and all are consumers of DCFHE programs or have been in the last three years. Parent consultants are full partners in policymaking, outreach, and program quality assurance and evaluation. //2008//

***/2009/ In addition to these parent consultants, the DCFHE also manages the Pediatric Practice Enhancement Project (PPEP), has placed 24 parent consultants in pediatric practices serving high volumes of CSHCN throughout the state. There are 12 pediatric primary sites, 10 specialty care sites and 2 sites outside the medical community. The pediatric primary care sites include hospital-based primary care clinics, health centers, private physician offices, and private physician group practice in geographic location throughout the state serving ethnically, culturally, linguistically, and geographically diverse populations. Specialty care sites include multi-disciplinary evaluation, intensive clinical, disability specific, special intervention and dental. The additional 2 non-medical sites includes a correction department and social service agency. //2009//***

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

#### Executive Director's Office

***/2009/ Ana Novais, MPA, is the Executive Director of the Division of Community, Family Health and Equity and provides leadership for the Division and its programming. Ms. Novais provides leadership and planning to eliminate health disparities, assure healthy child development, to reduce/prevent/control chronic disease and disabilities, as well as HIV/AIDS and Viral Hepatitis, and how the built environment affects health. //2009//***

William Hollinshead, MD, MPH is the DCFHE Medical Director and provides leadership for the Division's efforts related to maternal and child health and its programming. He has been active in the leadership of the Association of Maternal & Child Health Programs (AMCHP), the National Academy of State Health Policy, and numerous other organizations. Dr. Hollinshead's recent interests include uses of public health information for leadership and consumer decisions, integrated local family health and development programs for young families, population tracking systems for children, and training of professionals for comprehensive primary care, especially in a managed care environment.

Peter Simon, MD, MPH is the DCFHE Deputy Director. He is responsible for establishing medical policy for all DCFHE programs. In addition, he provides technical assistance on areas of prevention services for women, infants, children, and adolescents to other divisions within HEALTH (i.e. sexually transmitted diseases, laboratory screening for inborn errors of metabolism and hemoglobinopathies, school health, injury control) and to other state agencies.

***/2009/ Becky Bessette, MS, RD is the Chief of Policy and Management for the DCFHE. In***

***this capacity, Ms. Bessette is responsible for strategic planning related to maternal and child health, management oversight of the HIV and WIC Programs, personnel planning, and providing support to the Executive Director. Her activities include setting program direction and Title V resource allocation to meet DCFHE priorities. //2009//***

Marliot Uzcategui, BS, is the DCFHE Chief Administrator. In this capacity, Ms. Uzcategui is responsible for managing DCFHE budget, resources and investments (purchases and contracts). Ms. Uzcategui monitors and manages federal grants, state and private funding, and other federal and state requirements. She also provides managerial assistance to DCFHE programs.

***/2009/ Carol Hall-Walker, Chief Program Administrator, is responsible for the Communications Unit. In this capacity, Ms. Hall-Walker develops and supports communication and public engagement efforts in partnership with DCFHE programs, ensures that clear and consistent messages are communicated through all campaigns, provides consultation on communication issues in support of Division goals, and links to HEALTH's Center for Communications.***

***Ms. Hall-Walker also manages the Health Disease and Stroke Grant and the Prevention Grant. //2009//***

Data & Evaluation Team

***/2009/ Sam Viner-Brown, MS, has been selected to lead the Department's Center for Health Data and Analysis. She continues to act as the Team lead for Data and Evaluation. In this capacity, Ms. Viner-Brown is responsible for developing, supporting, collecting, and analyzing data for needs assessment, policy development, program management, quality improvement, and reporting purposes in collaboration with national, state, and local partners. //2009//***

*/2008/ The KIDSNET program has been moved to the Data and Evaluation Unit, under the leadership and management of Sam Viner-Brown. Ellen Amore, MS, serves as the KIDSNET Office's chief. //2008//*

Perinatal & Early Childhood Health Team

***/2009/ A new Perinatal & Early Childhood Health Team has been established and is lead by Blythe Berger, ScD. This team includes the Office of Early Childhood, the WIC Program, and Reproductive Health.***

***The Office of Early Childhood includes Successful Start Early Childhood Systems initiative, the Newborn Screening Program, the Family Outreach Program, the Child Care Support Network and the "Watch Me Grown" Program. //2009//***

*/2008/ Ann Barone, LDN is the acting Chief of the Office of WIC. In this capacity, Ms. Barone is responsible for the overall administration of the WIC Program, which includes nutrition, farmers market, and breastfeeding initiatives, education and outreach, food delivery, financial management, and management information systems. //2008//*

***/2009/ Reproductive Health manager Cheryl LeClair, MSW, is responsible for Title X Family Planning and the Women's Risk Screening and Referral Program. //2009//***

Chronic Care & Disease Management Team

***/2009/ Under the direction of Dona Goldman, RM, MPH, this Team is responsible for the Diabetes Control Program, Asthma Control Program, Arthritis, Cancer Control Program and the Office of HIV / ADIS & Viral Hepatitis.***

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

**Carrie Bridges, MPH, is the team lead for this unit and responsible for the management and administration of the Office of Minority Health, Office of Special Health Care Needs, Office of Primary Care and Rural Health and the Office of Women's Health.**

**Deb Garneau, MA is the Chief of the Office of Special Health Care Needs. In this capacity, Ms. Garneau is responsible for the management and administration of the Disability & Health Program, the Pediatric Practice Enhancement Project (PPEP), and Pediatric Specialty Services.**

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

**/2009/ Jan Shedd, MEd, is the Team Lead of the Health Promotion & Wellness Team. In this capacity, Ms. Shedd is responsible for the management and administration of the Tobacco Control Program, the Initiative for Healthy Weight, Safe RI / Injury and Violence Prevention Program, Worksite Wellness and the Initiative for Healthy Youth.**

**Rosemary Reilly-Chammat, EdD is the manager of the Initiative for Healthy Youth including School-Based Health Center (SBHC) Program, Men 2B Program, Healthy Schools! Healthy Kids!, and Youth Development initiatives.**

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

**A new Services and Community Practices Team Office of Immunizations has been established and encompasses the Childhood Immunization Program, the Adult Immunization Program and Oral Health. Patricia Raymond, MPH, RN has been named as the new Team lead for this unit.**

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

**Under the direction of Robert Vanderslice, PhD, this Team is responsible for the Healthy Housing and Communities Program and the OSHA Consultation Program. Magaly Angeloni, MBA, is the manager of the Health Homes and Communities Program that includes lead poisoning prevention. //2009//**

### **E. State Agency Coordination**

**/2007/ Affecting positive change in maternal, child, and family health requires a common vision and collective effort. The DCFHE enjoys strong working relationships with other state departments and community-based agencies and organizations that enhance its efforts to promote and protect the health of MCH populations. //2007//**

#### **State Agency Partnerships**

The DCFHE actively collaborates with other state agencies on a variety of levels. The DCFHE is the largest division of HEALTH, which reports directly to the Governor. RI General Law 42-72-5 (1991) created a Children's Cabinet to "address all issues, especially those that cross departmental lines, and relate to children's needs and services". HEALTH is a full participant in the many workgroups and special projects of the Children's Cabinet. As in the past, "Family Health in Rhode Island" will be on the Children's Cabinet agenda as part of the a comprehensive

conversation with all stakeholders before, during, and after the filing of the FY2009 Title V plan. In 2007 the Children's Cabinet adopted the priorities of Successful Start, the state's Early Childhood Comprehensive Systems Plan, and charged DCFHE staff to create recommendations for the Children's Cabinet to reconfigure early childhood systems and services. /2007/ HEALTH also formally collaborates with other state agencies through the Executive Office of Health and Human Services. //2007//

There are five other state agencies that provide various services to the state's MCH populations, including CSHCN. These five agencies include the RI Department of Human Services (DHS), RI Department of Mental Health, Retardation & Hospitals (MHRH), RI Department of Children, Youth & Families (DCYF), RI Department of Corrections (DOC), and RI Department of Education (RIDE).

The DCFHE has a number of formal interagency agreements with DHS related to Medicaid. Existing Medicaid agreements with DHS include Early Periodic Screening, Diagnosis & Treatment (EPSDT) and the Family Resource Counselor (FRC) Program. /2007/ FRCs, located in community health centers and hospitals, outreach to pregnant women, children, and families to assist them in enrolling the state's Medicaid/SCHIP program. /2009/ . ***In FY2008, the DFH, in partnership with DHS, DCYF and community providers, piloted a model of developmental services designed to increase the numbers of young children receiving comprehensive screening for a range of developmental and behavioral problems and referral to appropriate intervention and treatment services.*** //2009// The DCFHE and DHS also have a data sharing agreement, which provides a framework for the two agencies to evaluate programs and services. //2007// In FY2008, the DCFHE will begin discussions around data exchange between KIDSNET and Medicaid as part of the State Systems Development Initiative (SSDI) grant. /2009/ ***DCFHE developed an MOU with DHS for the payment of influenza vaccine for adult Medicaid beneficiaries.***//2009//

***/2009/ Although details are not known, Rhode Island is proceeding to file a waiver for comprehensive Medicaid reform, which would set aside many traditional Medicaid requirements for up to five years, with the promise of substantial savings to help deal with the state's "structural deficit". It will be vital to keep up MCH data and input channels (KIDSNET, PRAMS, TWOS, etc) to monitor and manage impacts on vulnerable kids and families.***  
//2009//

DCFHE staff works closely with DHS to create a statewide infrastructure for addressing childhood lead poisoning among Medicaid-eligible children. DHS supports three regional Lead Safe Centers, which provide lead poisoned children with comprehensive case management services and coordinated linkage to other services and supports. DHS also partially funds the Child Care Support Network (CCSN), which provides health and mental health consultation to child care providers and children in child care. The DCFHE participates on the DHS RItE Care Consumer Advisory Committee. The DCFHE sends monthly reports of newborns with Medicaid covered deliveries to Medicaid to facilitate prompt enrollment in RItE Care./2007/

DCFHE staff works closely with DHS on implementing the state's care coordination system for CSHCN (CEDARR), the state's parent consultant program, and the Family Voices Leadership Team (which is dedicated to removing system barriers to CSHCN and their families). DCFHE staff also participates with the DHS Office of Child Support Services on the RI Fatherhood Coalition. DCFHE staff also coordinate with the DHS Kids Connect program which provides additional staffing so that children with special health care needs can participate in child care with typically developing peers//2007//

The DCFHE works with RIDE to ensure an integrated educational system that serves CSHCN transitioning to adulthood. and also to ensure children receive regular developmental screening ages 3-5. In addition, the DCFHE jointly managed the coordinated school health program "Thrive"

initiative under a cooperative agreement with RIDE. Thrive is a collaborative process that involves parents, legislators, schools, health care providers, community organizations, and state departments. The DCFHE is working with RIDE and the RI School for the Deaf to coordinate and maintain follow-up for infants identified with hearing loss, to conduct two research studies related to hearing loss, and to develop systems related to school-based hearing screening and follow-up. //2007/

In FY2006, the DCFHE began partnering with DCYF on the implementation of the new Child Abuse Prevention and Treatment Act (CAPTA) regulations pertaining to young children who have been victims of abuse/neglect. DCYF now employs a Family Outreach Program home visitor to facilitate access to Early Intervention services for children under the age of three. //2007// In FY2007, DCYF and KIDSNET began exchanging data to help assure children in DCYF care receive appropriate preventive services and to direct communication to the legal guardians.2009/ In 2007, the Immunization Program (IP) established a partnership with DCYF to ensure that children in daycare and preschool settings are up-to-date on their immunizations. The IP's parent consultant conducts quarterly immunization education trainings for DCYF workers as well as in-home daycare workers to educate staff about the immunization requirements for entry into daycare and preschool. //2009//

***//2009/ In FY2008, the DCFHE continued to partner with the Housing Resources Commission (HRC) under an Memorandum of Understanding to obtain necessary information for the mutual benefit of HEALTH and HRC by engaging in a collaborative effort to identify effective environmental health interventions at a statewide level across housing and health programs in the state. The partnership benefits families by coordinating efforts to provide healthy, safe, and affordable housing to all Rhode Islanders.//2009//***

//2007/ The DCFHE also has a strong working relationship with the RI Department of Environmental Management (DEM) on two projects. First, the Lead Program works with DEM to assure that public complaints about illegal exterior lead-based paint removal are addressed. Second, DEM assists the WIC Program in operating the Farmers Market Nutrition Program. DEM serves as a liaison to farmers and organized farmers' markets to ensure that sales of locally grown produce to program participants are in compliance with rules and regulations.

In addition to formal agreements, staff from the DCFHE provide consultation and professional expertise to the DHS, RIDE, DCYF, and MHRH in the areas of assessment, assurance, and policy development through formalized workgroups and program specific discussions.

#### Legislative Initiatives

DCFHE staff participate on the Governor's Council on Mental Health, the Permanent Legislative Commission on Child Care, and the RI Transition Council (for youth with disabilities transitioning to adulthood). The DCFHE has also participated on numerous other shorter-term legislative initiatives, including recent ones focusing on Early Intervention, childhood lead poisoning, and childhood obesity. //2007/ DCFHE staff are also members of the Governor's Commission on Disabilities and the Governor's Interagency Coordinating Council for Early Intervention. As part of Thrive, the DCFHE partnered with RIDE and community agencies to inform activity on legislation focusing on improving nutrition and increasing physical education in schools. //2007// DCFHE staff participate in a legislative work group on vision screening.

#### Coordination with Other HEALTH Programs/

2009/ With respect to internal collaboration, the DCFHE works closely with other HEALTH programs on an ongoing basis. ***//2009/ Most notably, is the recent merger between the Division of Family Health and the Division of Community Health and Equity . With respect to internal collaboration, the Title V-funded programs in DCFHE work closely with other***

***division and department programs on an ongoing basis This has enabled better collaboration around oral health, obesity prevention, STD prevention, and control and chronic disease and environmental issues. The Team lead of the new division (Community, Family Health and Equity) DCFHE Data and Evaluation Unit co-chairs an Interdepartmental Surveillance and Statistics Group with the DDCP and HEALTH's Center for Health Data Analysis and Center for Epidemiology to facilitate data/information/best practices sharing within HEALTH. //2009// /2007/*** DCFHE currently collaborates across programs within the division on the Initiative for Healthy Weight, the Child and Adolescent Violence Prevention Advisory Committee, the Can We Talk initiative, and the Early Childhood Oral Health Coalition. The lead poisoning program collaborate with the asthma program and is assessing the feasibility of training lead center staff to incorporate asthma education and other healthy homes initiatives when visiting the homes of children with elevated blood lead levels. The Immunization Program collaborates with the Viral Hepatitis Program working to provide necessary vaccinations for at-risk adolescents and adults. The DCFHE also works closely with the Office of Minority Health (OMH). The OMH has organized training for DCFHE staff on culturally competency and the provision of linguistically accessible services.

The DCFHE also participates as a member of the Department's Center for Public Health Communication, which sets policy and procedures for strategic and effective communication. //2007// In FY2008, KIDSNET made immunization information available to the DDPC for disease outbreak investigations. The DCFHE also has ongoing partnerships with HEALTH's Division of Environmental and Health Service Regulation (EHSR) provides comprehensive site reviews of licensed health care facilities, including hospitals and community-based health centers. In addition, the DCFHE works closely with the Office of Vital Records to coordinate data collection at maternity hospitals and to integrate birth certificate data with KIDSNET and newborn screening systems. KIDSNET works with the Refugee Health Program to help track immunization and lead screening in refugee children. The Childhood lead poisoning prevention program collaborates with Refugee Health to ensure that refugees from 0 to 16 years of age receive lead screenings and timely follow-up.

/2007/ The DCFHE participates on the state's Child Death Review Team which is coordinated by HEALTH's Medical Examiner's Office. HEALTH's Division of Laboratories works with the Lead Program to analyze lead screening specimens and collect data. In addition, the Lead Program coordinates efforts with HEALTH's Refugee Health Program to ensure that refugees are screened for lead. In addition to regular coordination around programmatic data management, KIDSNET holds quarterly stakeholder meetings that include representatives from all HEALTH programs participating in KIDSNET. A workgroup looking at access to school health data by several HEALTH programs including dental, school-based health centers, hearing, diabetes, chronic disease, and others is facilitated by KIDSNET. //2007//

#### Collaboration with Private Organizations & Associations

The Division's partnerships with private, community-based organizations and associations are extensive. The following represents a summary of several of its major relationships.

**Private Provider Community:** Both the Medical Director and the Deputy Medical Director are active in professional provider organizations. DCFHE staff has worked closely with the RI Chapter of the American Academy of Pediatrics (RIAAP), the RI Chapter of Family Practitioners, and the RI Chapter of the American Academy of Obstetricians and Gynecologists on a number of DCFHE initiatives, including the Women's Health Screening & Referral Program (WHSRP) and KIDSNET, and Watch Me Grow RI, a program that supports standardized developmental screening. DCFHE works closely with the Physicians' Committee for Breastfeeding in RI, which recently introduced and passed legislation promoting breastfeeding in the workplace. /2007/ In FY2005, the DCFHE collaborated with private physicians and various professional associations to develop and disseminate school emergency preparedness protocols. In addition, KIDSNET currently has user agreements with and collects immunization data from all but 18 primary care practices in the

state. KIDSNET is working with the RIAAP outreach to and enroll the remaining sites. Also in 2005, the DCFHE and the RIAAP began working to increase the number of young children who receive standardized developmental screening in medical homes and community settings. //2007// All primary care providers have signed user agreement and the last remaining sites are scheduled to begin sending data and using KIDSNET in FY2008. **//2009/ DCFHE staff also provide technical assistance to Rhode Island CATCH projects funded by the AAP.DCFHE will continue to support a CATCH project in Woonsocket focused on adolescent medical homes and a former CATCH project Washington County working to increase rates of prenatal care during the first trimester. //2009//**

Community Health Centers: A significant proportion of DCFHE investments support activities in community health centers, including Family Resource Counselors (FRCs), WIC, Family Planning, PPEP Parent Consultants, WHSRP, Tobacco Cessation and SBHCs. The DCFHE works directly with individual community health centers on an ongoing basis. The DCFHE also works with the RI Health Center Association on larger policy issues impacting community health services delivery.

Hospitals: The DCFHE has strong partnerships with several hospitals in RI. DCFHE provides funding to the Children's Neurodevelopment Center (CNDC) at Hasbro Children's Hospital. Memorial Hospital is a Title X family planning site. The DCFHE supports FRCs in St. Joseph Hospital, Memorial Hospital, Women & Infants' Hospital, and Hasbro Children's Hospital. The Newborn Screening Program works closely with Women & Infants' Hospital //2007/ and other birthing hospitals in RI around training and quality assurance. The Newborn Screening Program also works closely with metabolic, cystic fibrosis, and hemoglobinopathy clinics at Rhode Island Hospital for diagnosis, treatment, and follow-up. //2007// Newport Hospital is collaborating with the DCFHE and other partners on the Newport County Healthy Communities initiative. The DCFHE supports lead and immunization clinics for uninsured children at Rhode Island Hospital and St. Joseph Hospital. The Birth Defects Program has been working closely with Women & Infants', Kent County, and Hasbro Children's Hospital to improve case ascertainment. Representatives from these hospitals provide information, consultation, and guidance; several are members of the Birth Defects Advisory Council. //2007/ The Immunization program continues to provide all birthing hospitals in the state with a supply of Hepatitis B vaccine so that newborns receive the birth dose prior to discharge. In FY2005, PPEP Parent Consultants were placed at Hasbro Children's Hospital, Memorial Hospital, and Women & Infants' Hospital. In 2006, the DCFHE began working with Bradley Hospital (the state's psychiatric hospital for children and adolescents) on a mental health resource guide. //2007//

**//2009/ Insurers: In FY09, DCFHE will work with the largest Medicaid insurer in the state to evaluate the PPEP Parent Consultant Program. PPEP Parent Consultants help families of children with children with special health care needs receive appropriate primary care and attain/maintain health insurance. The evaluation of the PPEP Parent Consultant Program will help develop payment mechanisms to sustain the program. //2009//**

Visiting Nurse Associations (VNAs): The DCFHE has strong partnerships with several VNAs through the Family Outreach Program (FOP). FOP home visitors provide home assessments, connection to community services, and help with child development and parenting for almost one-third of all families with newborns each year. In addition, one VNA is a Title X family planning site. Another VNA provides newborn developmental risk assessment statewide, newborn blood spot screening follow-up and hepatitis B follow-up through contracts with the DCFHE. VNAs also participate on the Birth Defects Advisory Council.

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

Healthy Mothers/Healthy Babies Coalition: The DCFHE participates in this statewide coalition dedicated to improving birth outcomes. Associated with the Rhode Island Chapter of the March of Dimes, members include state departments, community agencies, and providers. Healthy Mothers/Healthy Babies participates on the PRAMS Steering Committee.

Rhode Island Kids Count: This children's policy organization provides information on child wellbeing and stimulates state dialogue on children's issues. Each year, the agency publishes a factbook, which provides detailed community-by-community pictures of the condition of children in RI. The DCFHE a significant proportion of data utilized in the factbook, including data on lead poisoning, WIC, CSHCN, breastfeeding, prenatal care, low birth weight infants, infant mortality, and births to teens. Kids Count is also a member of the Birth Defects Advisory Council /2007/ and PRAMS Steering Committee. RI Kids Count is also a key partner in Successful Start and is contracted to assist in statewide early childhood policy development. //2007//

Covering Kids Rhode Island: Funded by a Robert Wood Johnson grant, the purpose of Covering Kids RI is to increase children's access to Medicaid. Covering Kids accomplishes this goal by helping local communities develop and implement strategies to enroll potentially eligible children and their families into Medicaid (including Rlte Care/Rlte Share). The DCFHE works closely with Covering Kids through the FRC Program and community systems development initiatives, including Ready to Learn Providence (R2LP) and Newport County CATCH.

Childhood Lead Action Project: This non-profit agency is the only advocacy agency in RI solely dedicated to addressing the problem of childhood lead poisoning. The agency is a member of the Childhood Lead Poisoning Prevention Advisory Committee.

Rhode Island Public Health Institute (RIPHI): The RIPHI was formed to organize and activate private sector professionals interested in the advancement of public health in RI. DCFHE personnel participate in RIPHA conferences and workshops. The RIPHI is working with the Division's Heart Disease and Stroke Program on community assessment.

Youth In Action (YIA): The DCFHE is partnering with the youth-led, community-based organization YIA to provide family planning outreach, education, and referral services to culturally diverse young men living in the Southside of Providence. Young men in need of clinical family planning services are referred to a Title X site.

Rhode Island Breastfeeding Coalition (RIBC): RIBC is a coalition of community organizations and groups dedicated to supporting and promoting breastfeeding in RI. Members include lactation consultants from local birthing hospitals, physicians, and other health care professionals. The RIBC organizes statewide breastfeeding events such as "World Breastfeeding Month".

/2008/ Rhode Island Food Dealers Association: This professional association acts as the liaison between the WIC Program and WIC vendors throughout the state. Members include large and medium stores, issues discussed include WIC processes, data and customer service issues relating to the WIC program. //2008//

***/2009/ Childhood Lead Action Project: This non-profit agency is the only advocacy agency in RI solely dedicated to addressing the problem of childhood lead poisoning. The agency is a member of the Childhood Lead Poisoning Prevention Advisory Healthy Homes Collaborative Committee.***

***Local Colleges- Schools of Nursing: The Childhood Lead Poisoning Prevention program (CLPPP) offers training to nursing students from local colleges to attend lectures and a site visit to a home for a hands on walk through of the environmental hazards that can be identified in a home and how to address those issues.***

***Certified Lead Centers: Partners with the CLPPP to identify areas for collaboration and***

**monitor compliance with certification standards to ensure all children with elevated blood lead levels receive quality case management services.**

**The DFH convened the Healthy Homes Collaborative which is a partnership of community health, environmental health, state and city planners, and other stakeholders working to develop a plan to create and maintain healthy housing in all communities. The collaborative consults and informs about the lead and asthma program's policies, updates, changes, quality assurance, and other primary and secondary prevention efforts related to the elimination of lead poisoning and reducing the incidence of childhood asthma. //2009//**

Childhood Immunization Action Coalition: The coalition consists of DCFHE staff, community-based agencies, civic organizations, medical care providers (including community health centers), schools, Head Starts, hospitals, and health insurance plans. The purpose of the coalition is to share strategies and develop plans for improving utilization rates.

Rhode Island School Nurse Teachers' Association: The DCFHE partners with this group to provide input and feedback for the annual school nurse teachers' conference. This conference is an educational opportunity for school nurses from all public and private schools./2007/

Family Leadership & Support Programs: The DCFHE actively collaborates with a number of family leadership and parent support agencies and programs. //2007// The DCFHE works closely with leadership from the RI Family Voices and participates in the Family Voices Leadership team. The DCFHE also contracts with the RI Parent Information Network (RIPIN) to provide training and technical assistance to the Parent Consultant Program. /2007/

Higher Education: HEALTH and the DCFHE have active relationships with many of the state's colleges and universities. Many DCFHE programs have hosted student interns, and currently interns work in the Lead Program and the Data and Evaluation Unit. In addition, HEALTH is working to develop formal agreements with area institutions of higher education to facilitate HEALTH staff training and collaborative research and grant writing. In partnership with Rhode Island College, the Lead Program offers training to nursing students about environmental threats in the home. The DCFHE is also working with the RI Area Health Education Center (housed at Brown University) to develop and offer multidisciplinary training on early childhood mental health and with the Northern RI AHEC on a model for adolescent medical home in the Woonsocket area.

Ocean State Adult Immunization Coalition -- HEALTH entered into a formal contract with OSAIC to provide support and consultation in regards to adult immunization services/2009/ ***Mental Health: The DCFHE has partnerships with Bradley Hospital and the Providence Center, both of whom provide mental health services to young children and their families. These partnerships provide mental health consultation in child care settings and other community based settings. //2009//***

#### Coordination with Other Federal Grant Programs

DCFHE programs receive funding from several federal grant programs. These programs include: Family Planning (Title X), WIC (USDA), Newborn Hearing Screening (CDC), PRAMS (CDC), Immunization (CDC), Lead Program (CDC), Disability & Health (CDC), and Child Care Support Network (ACF). DCFHE programming is also supported through several HRSA grants including: Universal Newborn Hearing Screening, President's New Freedom Initiative Integrated Community Systems for CSHCN, State Systems Development Initiative, State Early Childhood Comprehensive Systems, and Healthy Tomorrows Partnership for Children.

The DCFHE ensures that resources are coordinated and maximized through integrated program planning conducted by senior staff. Wherever possible, funding streams are combined to

maximize the impact of resources. For example, health and mental health consultation to child care centers (through CCSN) is supported by the Child Care Development Fund, State Early Childhood Comprehensive Systems grant, Healthy Tomorrows grant, and Title V. In addition, DCFHE cross-functional units (e.g. Data and Evaluation, Communications) provide support to federally funded DCFHE programs. For example, the Data and Evaluation Unit provides significant analytical assistance to WIC, the Title X Family Planning Program, and the Disability & Health Program.

The DCFHE also collaborates with other state and community-based agencies receiving federal funds. For example, DCFHE staff is participating in a partnership with RIDE to implement a new CDC funded RIDE initiative to create an integrated data system that will enhance the state's capacity to plan and implement appropriate services addressing prevention of substance abuse, violence, and other related behaviors. //2007//

#### Advisory Committees

The DCFHE has established advisory committees and workgroups for many of its programs that include professional and consumer representation. Current DCFHE advisory and workgroups include the Childhood Immunization Action Coalition, Immunization Physician Advisory Committee, Disability & Health Advisory Council, Women's Health Screening & Referral Program (WHSRP) Advisory Committee, , Family Resource Counselor (FRC) Network, CCSN Advisory Board, Successful Start Steering Committee, WIC Vendor Advisory Council, Childhood Lead Poisoning Prevention Advisory Committee, Birth Defects Advisory Council, PRAMS Steering Committee, Traumatic Brain Injury Advisory Committee, and newborn screening advisory committees. /2007/ Newly developed committees supported by the DCFHE include the RI Prematurity Task Force, Healthy Homes Collaborative, Autism Spectrum Disorder Advisory Board, Childhood Obesity Action Teams, and the Coordinated School Health Program Leadership Team. An attachment is provided which details the Division of Community, Family Health and Equity's participation on internal and interagency committees, councils, and workgroups working to improve the health of women, children, and families in Rhode Island. //2007//

**An attachment is included in this section.**

## F. Health Systems Capacity Indicators

### Introduction

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	89.9	88.0	79.9	79.1	81.0
Numerator	576	564	512	490	502
Denominator	64080	64080	64080	61961	61961
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2007**

Denominator from the 2006 US Census Estimates.  
Data reflect children aged 0 - 4.

**Notes - 2006**

Denominator from the 2006 US Census Estimates.  
Data reflect children aged 0 - 4.

**Notes - 2005**

Rhode Island's Population Projections for 2005 was used.  
Data reflect children aged 0 - 4.

**Narrative:**

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

Narrative:

In Rhode Island, the asthma hospitalization rate appears to have stabilized in FY2004 after increasing significantly during the previous four years. In FY2000, it was 60.3; in FY2001, it was 65.3; in FY2002, it was 84.6; in FY2003, it was 98.8 (provisional); and in FY2004, it was 98.0 (provisional). These increases reflect national trends. About 50% of the children who are hospitalized for asthma in Rhode Island live in one the state's culturally diverse, older, urban, "core" communities. /2007/ The rate of asthma hospitalization for children under age five was 88.5 in FY2005 (provisional). This rate has remained steady over the past four years. //2007//

HEALTH, in collaboration with the American Lung Association of Rhode Island (ALARI) and other community partners in the Asthma Control Coalition of Rhode Island, are working to implement a comprehensive 5-year statewide plan for asthma control (2002-2007). The plan will include comprehensive community-based strategies for managing pediatric asthma and will include a focus on reducing health disparities.

/2007/ Asthma is the number one chronic health condition in children in Rhode Island, the third-ranked cause of hospitalization in children under age 15, and the leading cause of school absences resulting from chronic illness. In FY2005, DCFHE staff continued to work with HEALTH's Asthma Control Program, the Community Asthma Programs at Hasbro Children's Hospital, and ALARI in implementing the pediatric elements of the state's asthma control plan. The DCFHE also convenes the newly developed Healthy Homes Collaborative, a partnership of community health, environmental health, state and city planners, and other stakeholders working to develop a plan create and maintain healthy housing in all communities. //2007// /2008/ In January 2007, The Healthy Homes Collaborative released "Healthy Housing: Why RI should invest in the vision" which can be found at <http://www.health.ri.gov/lead/HealthyHousingVisionRI2007.pdf>. This document intends to provide a brief overview of the vast literature indicating the impact that unhealthy housing has on health outcomes to give Rhode Islanders a base of knowledge of why the state is working on these issues. . In 2008, the DCFHE continues to work with stakeholders to connect agencies working on health and housing issues and encouraging them to share knowledge and collaborate. //2008//

/2007/ The DCFHE provides technical assistance and support to the Newport County Healthy Communities Initiative, which is working with the Newport Housing Authority to launch a project titled Healthy Residents, Healthy Homes. The project's goals are to ensure that every housing authority unit is environmentally sound and asthma- friendly and to connect residents of the housing authority with medical homes and specialty support services for asthma.

In addition, the DCFHE supports the work of a Parent Consultant in the Community Asthma Programs at Hasbro Children's Hospital. The Parent Consultant's primary responsibilities are to

outreach to families of children with asthma to enroll them in asthma education classes, provided on-site at the hospital and in community settings. Priority populations for asthma education include children who have been discharged from the hospital or the emergency department and racially/ethnically diverse children living in urban environments. Participation in the Community Asthma Program's asthma education classes has been shown to reduce utilization of the emergency department and inpatient services and to facilitate increased use of appropriate outpatient preventative care and disease management services. There is also a parent consultant at the Healthy Homes, Healthy Residents initiative at the Newport Housing Authority. The parent consultant is a key member of the resident response team that also includes a property manager, housing administrator and emergency responders

//2008/ Beginning in FY2007, Family Outreach Program home/environmental assessments were modified to be more comprehensive, encompassing healthy homes, asthma, and lead. The DCFHE continues to collect data from the environmental assessments and will analyze this information in 2008. The 4 Lead Centers in the state are also collecting a subset of the comprehensive data and this information will be included in the analysis. //2008//  
DCFHE

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	91.4	93.2	93.8	91.0	89.7
Numerator	10652	11889	12274	11717	11968
Denominator	11650	12752	13081	12878	13342
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

Data are provided by RI Department of Human Services the Center for Child and Family Health.

**Notes - 2006**

Data are provided by RI Department of Human Services the Center for Child and Family Health.

**Notes - 2005**

Data are provided by RI Department of Human Services the Center for Child and Family Health.

**Narrative:**

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

**Narrative:**

In Rhode Island in 2000, this percentage was 91.7%; in 2001, it was 92.6%; in 2002, it was 88.4%; in 2003, it was 91.4%; and in 2004, it was 93.2%. The 2003 and 2004 rates are up a bit from the previous year's rate (2002), but still within normal limits of annual variations. It is important to point out that there were considerably more infants in 2003 and 2004 than in

previous years due to increased births and increased enrollment in RIte Care. /2007/ In 2005, approximately 94% of infants enrolled in Medicaid received a well-child visit.

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

The DCFHE works collaboratively with DHS and other partners to ensure children receive timely, quality preventive health care in the context of a medical home. The Family Outreach Program provides home visits to vulnerable newborns and their families. Home visitors link families to primary care providers and through parent education, stress the importance of well child visits in promoting healthy development. The Childhood Lead Poisoning Prevention Program works to ensure that all young children in RI receive lead screening as part of preventive well-child visits. Other DCFHE programs, including WIC and the Child Care Support Network, include messages about the benefits of preventive health care in their communications with parents and other caregivers. The DCFHE is also working with the RI Chapter of the American Academy of Pediatrics, DHS, and other partners to improve the content of well-child visits through increased rates of standardized developmental and behavioral health screening of infants and young children. In 2007 the DCFHE with Successful Start launched Watch Me Grow RI, a program to support pediatric primary care providers to implement standardized developmental screening. The project provides tools and technical assistance to practices interested in implementing the screening. //2007// /2008/ KIDSNET sends monthly reports of newborns to Medicaid for Medicaid covered deliveries so that eligibility can be established early and prevent delayed access to preventive services. KIDSNET collects data on newborn developmental, bloodspot and hearing screening. In 2007 the DCFHE with Successful Start launched Watch Me Grow RI, a program to support pediatric primary care providers to implement standardized developmental screening. In 2008 Watch Me Grow has expanded, with 9 pediatric practices and 18 child care centers participating //2007// /2008/ KIDSNET sends monthly reports of newborns to Medicaid for Medicaid covered deliveries so that eligibility can be established early and prevent delayed access to preventive services. KIDSNET collects data on newborn developmental, bloodspot and hearing screening. //2008// **/2009/ KIDSNET is working with Medicaid under the SSDI grant to develop a data sharing plan that will likely include updating KIDSNET with Medicaid participation to facilitate accurate tracking of preventive screening and services that are in KIDSNET received by children on Medicaid/2009//.**

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	NaN	100.0	100.0	100.0	100.0
Numerator	0	1	1	1	1
Denominator	0	1	1	1	1
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

In Rhode Island, children in SCHIP are aged 8-18. Infants and children less than 8 years old are enrolled in our Medicaid Managed Program [RiteCare]. This Health Systems Capacity Indicator does not apply to Rhode Island.

**Notes - 2006**

In Rhode Island, children in SCHIP are aged 8-18. Infants and children less than 8 years old are enrolled in our Medicaid Managed Program [RiteCare]. This Health Systems Capacity Indicator does not apply to Rhode Island.

**Notes - 2005**

In Rhode Island, children in SCHIP are aged 8-18. Infants and children less than 8 years old are enrolled in our Medicaid Managed Program [RiteCare]. This Health Systems Capacity Indicator does not apply to Rhode Island.

**Narrative:**

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

Narrative:

Not applicable, since SCHIP enrollees in Rhode Island are eight years old and older.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	88.0	83.7	81.4	76.0	76.3
Numerator	9937	9431	9311	8915	8970
Denominator	11291	11266	11441	11733	11763
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2007**

Data reflects calendar year.

**Notes - 2006**

Data reflects calendar year.

**Notes - 2005**

Data reflects calendar year.

Starting with 2003, totals include all births to Rhode Island residents aged 15 -44 regardless of location of birth.

The TVIS system does not allow revision of data prior to 2003.

**Narrative:**

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

**Narrative:**

In Rhode Island, this percentage went down in 2004 as compared to previous years. In 2000, it was 87.2%; in 2001, it was 87.3%; in 2002, it was 86.8%; in 2003, it was 87.9% (provisional); and in 2004, it was 83.9% (provisional). //2007/ In 2005, approximately 85% (provisional) of women giving birth had observed to expected prenatal visits greater than or equal to 80% on the Kotelchuck Index.

Rhode Island continues to lead the country in women's access to prenatal care. Pregnant women with incomes up to 350% of the Federal Poverty Level are eligible for Rlte Care, which provides a comprehensive pregnancy benefit package. The DCFHE works to increase access to prenatal care through the Family Resource Counselor (FRC) Program, the Women's Health Screening & Referral Program (WHSRP) The FRC program supports culturally and linguistically diverse Family Resource Counselors in community health centers and hospitals throughout the state. The primary role of the FRC is to outreach to and enroll uninsured pregnant women, children, and families in Rlte Care. FRCs ensure that pregnant women who enroll in Rlte Care are connected to prenatal services. WHSRP provides comprehensive health risk screening to women receiving pregnancy tests at Family Planning Program clinics. The health screen is designed to help women identify risks that could harm their baby or themselves during a pregnancy. Agencies help connect women to the services they need early in pregnancy, or before a pregnancy, to improve the health of the mother and her baby. An evaluation of the Family Outreach program was completed in FY2006, which included recommendations for program improvement to expand outreach and services to pregnant women with specific risk factors. There is currently no way to fund this. //2007//

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	86.5	85.9	85.1	82.9	84.1
Numerator	89628	91638	91144	90731	88641
Denominator	103628	106638	107144	109411	105365
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

Data is are estimated.

Source of data: Department of Human Services and reported in 2008 Rhode Island Kids Count Factbook.

Data is reporting children under the age of 19 receiving Medical Assistance.

**Notes - 2006**

Data is are estimated.

Source of data: Department of Human Services and reported in 2007 Rhode Island Kids Count Factbook.

Data is reporting children under the age of 19 receiving Medical Assistance.

**Notes - 2005**

Data is are estimated.

Source of data: Department of Human Services and reported in 2006 Rhode Island Kids Count Factbook.

Data is reporting children under the age of 19 receiving Medical Assistance.

**Narrative:**

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

Narrative:

/2007/ Approximately 85% of children eligible for Medicaid/SCHIP in Rhode Island accessed the program in 2005.

Rhode Island is committed to ensuring that all children have access to insurance and quality health care. The state supports outreach to eligible populations through a variety of mechanisms, including a toll-free RlTe Care information line at DHS and promotional activities carried out by each of the three RlTe Care managed care health plans (television advertisements, billboards, etc.). The DCFHE manages several programs designed to facilitate access to RlTe Care by eligible children and families. The FRC Program provides outreach and assistance with enrollment to children and families in community health centers and hospitals throughout the state. Other programs, including WIC, CCSN, and the Family Outreach Program, refer families who are uninsured or underinsured to FRCs in the community and directly to Medicaid.

Rhode Island is reassessing its approach to adolescent access to care. Rhode Island has been supporting eight school-based health centers in high-need urban communities and monitoring school-based health centers' efforts to improve billing practices including pursuit of reimbursements from RlTe Care/Medicaid. At the same time, the DCFHE is also providing technical assistance to several local CATCH projects and community coalitions. These groups are working at the local level to build the capacity of medical homes, including developing models for adolescent medical homes, and to link children and families to needed health and human services. As state funding for school based health centers decreases, strategies to define, implement, and sustain models for adolescent medical home is a promising way to provide access to care for adolescents across the State. The DCFHE is exploring opportunities to provide a sustainable infrastructure for on-site support and referrals to help schools identify and address mental and behavioral health issues through the establishment of a Mental Behavioral Health Care Resource Center for RI schools in partnership with the RI Public Health Institute. . Finally, the DCFHE is a key partner in Covering Kids Rhode Island, a coalition of partners working

statewide and in local project communities to ensure that all children and adults eligible for RIte Care or RIte Share are enrolled and retain their coverage. //2007//

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	54.1	56.1	58.7	62.0	67.5
Numerator	12152	11358	12033	12392	13043
Denominator	22451	20262	20484	19976	19309
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

Data are provided by RI Department of Human Services the Center for Child and Family Health.

**Notes - 2006**

Data are provided by RI Department of Human Services the Center for Child and Family Health.

**Notes - 2005**

Data are provided by RI Department of Human Services the Center for Child and Family Health.

**Narrative:**

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

Narrative:

In Rhode Island, this percentage appears to be going up slightly over the past four years. In 2000, it was 48.9%; in 2001, it was 55.9%; in 2002, it was 54.6%; in 2003, it was 54.1%; and in 2004 it was 56.1%. As the RI Department of Human Services (DHS) continues to work to improve the existing state infrastructure for providing dental services for Medicaid eligible populations, it is expected that this percentage will increase over time. /2007/ This indicator's upward trend continued in 2005, with approximately 59% of Medicaid children age six through nine receiving dental care in 2005.

The DCFHE supports HEALTH's Oral Health Program (housed in the Division of Community Health & Equity). The Oral Health Program is working to improve basic oral health services, monitor the oral health status of the population, and implement prevention programs in the areas of: early childhood caries, oral and pharyngeal cancers, oro-facial injuries, and professional workforce enhancement and recruitment. The DCFHE participates on the Oral Health Program's Early Childhood Oral Health Coalition, a public/private partnership that seeks to improve oral health and reduce disparities for young children and their families by increasing awareness of the unmet oral health needs of preschool children, increasing oral health promotion/disease prevention resources for professionals working with young children, and promoting integration of oral health with primary care providers. In FY2008, the DCFHE, through CCSN, will begin offering

health consultation to child care centers and family child care homes. Dental health, including prevention and access to care, will be a component of the health consultation. In addition, CCSN has worked with the Oral Health Program to provide child care providers with curricula and materials to implement oral health education programs within child care centers.

State supported SBHCs provide dental services to children and youth in a variety of ways though State funding for SBHCs is decreasing. DCFHE will work with community health center operators to ensure that students have access to dental services through the community health center site.

KIDSNET is leading efforts to work with the RI Department of Education to get parental permission for HEALTH to access school health records. If implemented, this will improve the ability to collect data related to this indicator. //2007//

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	9.1	8.1	7.9	100.0	100.0
Numerator	293	295	296	1	1
Denominator	3236	3654	3768	1	1
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

The Rhode Island Department of Health does not paid for any rehabilitation services through the CSHCN Program for three primary reasons.

- 1) The Early Intervention Program [EI] transferred to the Department of Human Services in 2005.
- 2) Late in 2005, Rhode Island eliminated carve-out funding of services for children and youth with complex special needs, and requested insurers to reimburse for these services.
- 3) SSI recipients are enrolled in Medicaid which funds rehabilitation services.

Please note that this health system capacity indicator does not apply to Rhode Island.

**Notes - 2006**

The Rhode Island Department of Health has not in the past year paid for any rehabilitation services through the CSHCN Program for three primary reasons.

First, the Early Intervention Program [EI] transferred to the Department of Human Services and a private insurance mandate passed in 2005.

Second, the State in late 2005 eliminated carve-out funding of services for children and youth with complex special needs, and requested insurers to reimburse for these services.

Third, SSI recipients are enrolled in Medicaid which funds rehabilitation services.

Please note that this health system capacity indicator does not apply to Rhode Island.

**Notes - 2005**

2005: Data are estimated.

**Narrative:**

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

**Narrative:**

This percentage continues to decrease as more CSHCN (including SSI beneficiaries less than 16 years old receiving rehabilitative services) are transitioned to services provided through Medicaid. In 2000, it was 20.1%; in 2001, it was 15.6%; in 2002, it was 10.2%; in 2003, it was 9.1%; and in FY2004, it was 8.1% (provisional). /2007/ The percentage decreased to 7.9 in 2005.

Rhode Island is a 1914A state and all children on SSI are enrolled in Medicaid. Medicaid benefits are extensive and include rehabilitative services. The CSHCN Program is transitioning away from providing direct services. It is the goal of CSHCN Program to build resources in the community and sustain the provision of services for children with complex medical needs to other systems of care. It is the state's intention for the objective in this performance measure to decrease. //2007//

**Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)***

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	8.7	7.4	8

**Narrative:**

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

INDICATOR #05

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

**Narrative:**

Using birth certificate data, the percent of low birth weight infants (< 2,500 grams) for Medicaid, non-Medicaid, and all MCH populations in the state in 2003 was higher for the Medicaid population (9.6%) than it was for the non-Medicaid population (8.0%). /2007/ In 2004, the percent of low birth weight infants dropped in both Medicaid and non-Medicaid populations, however a disparity remains between recipients of Medicaid (8.8%) and those insured by other means

(7.5%).

The DCFHE is working to reduce the number of low birth weight infants born in RI, targeting specific interventions to high-risk populations. The FRC Program assists low-income, vulnerable women in accessing health coverage through RIte Care. The program also ensures that pregnant women are connected with an ongoing source of prenatal care (generally a community health center or hospital clinic). As of July 1, 2007, the FRC Program will be fully funded and administered through the Department of Human Services. The WHSRP also targets at-risk populations utilizing services at Title X Family Planning Clinics. Women who receive positive pregnancy tests through the clinics are referred to medical and community services. The WIC Program provides nutritious foods, education, and support to low-income pregnant women (the majority of whom are enrolled in RIte Care) to promote healthy pregnancies and healthy births. Finally, the DCFHE, in partnership with the RI March of Dimes, directs the RI Prematurity Task Force. //2007//

**Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births**

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	payment source from birth certificate	6.9	4.3	6

**Notes - 2009**

Nine infant deaths were missing insurance status.

**Narrative:**

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

INDICATOR #05

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

Narrative:

Using birth certificate data, the percentages of infant deaths per 1,000 live births in 2003 was higher for Medicaid populations at 9.0% as compared to non-Medicaid populations (4.7%). /2007/ RI's infant mortality rates appear to fluctuate significantly due to the small number of infant deaths each year. In 2004, there were 20 less infant deaths (provisional) than in 2003. The rates for Medicaid, non-Medicaid, and all populations were 4.9, 5.3, and 5.3, respectively. Over the past decade, RI's infant mortality rate (for all populations) has remained stable.

A multitude of factors are associated with infant mortality, including poor health of the mother, inadequate prenatal care, birth defects, and a host of socioeconomic factors (e.g. low-income, low levels of education). The Pregnancy Risk Assessment Monitoring System (PRAMS) is working to improve the health of mothers and infants by reducing poor pregnancy outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS uses a confidential survey to identify and monitor select maternal behaviors and experiences before, during, and after pregnancy. PRAMS over-samples births in the core cities of Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket. These cities are home to

large numbers of women and families insured through Medicaid. Information gathered through the survey gives an overall picture of mothers and babies in RI. PRAMS data is used to: increase understanding of maternal behaviors and experiences and their relationship to adverse pregnancy outcomes; identify groups of women and infants at high risk for health problems; monitor changes in health status indicators such as unintended pregnancy, prenatal care, breastfeeding, smoking, drinking, and infant health; measure progress towards local, state, and national goals for improving the health of mothers and infants; develop new, and modify existing, maternal and child health programs; help health professionals incorporate new research findings into standards of practice; and influence public health policy. The DCFHE also manages efforts to identify newborns at-risk for serious disease or disability and provide necessary follow-up care. The Rhode Island Birth Defects Program identifies newborns with birth defects, ensures that these children receive services and treatment on a timely basis, and monitors trends over time. The Newborn Screening Program currently tests infants at birth for 29 genetic, and sometimes life-threatening, conditions. Family Outreach Program nurses provide immediate, family-centered follow-up for any newborn testing positive for one of these conditions. In addition to screening for genetic conditions, newborns are also screening for developmental risks. Families of newborns screening positive for risk are offered home visits through the Family Outreach Program. //2007//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	75.8	92.4	84.5

**Narrative:**

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

INDICATOR #05

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

Narrative:

Using birth certificate data, the percent of infants born to pregnant women receiving care in the first trimester in 2003 was lower for Medicaid populations (83.5%) as compared to Non-Medicaid populations (95%). /2007/ There has been little change in this indicator since last year. In 2004, percentages for Medicaid, non-Medicaid, and all populations were 84.1%, 95.7%, and 89.6%, respectively. However, it is important to note that over the past decade (1995-2004), the percentage of women on Medicaid who began prenatal care in the first trimester increased from 77% to 84%.

The DCFHE supports numerous activities targeted at ensuring women access prenatal care early in their pregnancy, including the FRC Program and the WHSRP. As of July 1, 2007, the FRC

Program will be fully funded and administered through the Department of Human Services. In FY2005, the WHSRP revised its screening tool to more accurately identify and address risk factors in women who seek a no-cost pregnancy test. This tool, used in community health center settings, ensures that women are referred to prenatal care, if pregnant, or family planning if they do not want a pregnancy. In the coming years, the WHSRP will be expanded into private practices. //2007//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	66.6	83.8	76

**Narrative:**

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

INDICATOR #05

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

Narrative:

Using birth certificate data, the percentage of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% of the Kotelchuck Index) in 2003 was lower for Medicaid populations (81.5%) as compared to Non-Medicaid populations (91.3%). /2007/ In 2004, performance on this indicator declined slightly for the Medicaid population. The percentages for Medicaid, non-Medicaid, and all populations were 76.8%, 89.2%, and 83.7%.

The DCFHE supports numerous activities targeted at ensuring women access appropriate prenatal care, including the FRC Program and the WHSRP. As of July 1, 2007, the FRC Program will be fully funded and administered through the Department of Human Services. In FY2005, the WHSRP revised its screening tool to more accurately identify and address risk factors in women who seek a no-cost pregnancy test. This tool, used in community health center settings, ensures that women are referred to prenatal care, if pregnant, or family planning if they do not want a pregnancy. In the coming years, the WHSRP will be expanded into private practices. //2007//

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

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Infants (0 to 1)	2007	250
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)		

**Notes - 2009**

Infants < 250% percent of poverty for Medicaid.

**Notes - 2009**

SCHIP does not include infants. Infants are covered by Rlte Care.

**Narrative:**

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

**INDICATOR #06**

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

Infants (0 to 1)

**Narrative:**

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

*/2007/ Eligibility for Medicaid and SCHIP have not changed. Rhode Island continues to enjoy one of the lowest rates of un-insurance among children in the country. In 2005, a total of 91,144 children under the age of 19 were enrolled in Medicaid. In FY2005, 37% of the RI population under the age of 17 was enrolled in Medicaid, as compared to 32% in FY2004.*

The DCFHE supports access to Medicaid and SCHIP through the FRC Program. FRCs perform outreach to uninsured and underinsured pregnant women, children, and families and provide assistance in completing applications for Rlte Care. In addition, numerous DCFHE programs, including WIC, CCSN, and the Family Outreach Program, refer families who are uninsured or underinsured to FRCs in the community and directly to Medicaid. As of July 1, 2007, the FRC Program will be fully funded and administered through the Department of Human Services. All WIC applicants are screened for health insurance, and referred as needed to Medicaid. *//2008//*  
***/2009/ In 2008, Rlte Care enrollment among WIC participant infants (0-12 months) was 82.5% up from 82.3% in 2007 and 79.1% in 2005). //2009//***

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

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>

Medicaid Children (Age range 1 to 18) (Age range to ) (Age range to )	2007	250
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 8 to 18) (Age range to ) (Age range to )	2007	250

**Notes - 2009**

Children aged 8 - 18 qualify for SCHIP if poverty level from 100 - 250%.

**Narrative:**

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

**INDICATOR #06**

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

**INDICATOR #06**

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

**Narrative:**

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

//2007/ Eligibility for Medicaid and SCHIP have not changed. Rhode Island continues to enjoy one of the lowest rates of un-insurance among children in the country. In 2005, a total of 91,144 children under the age of 19 were enrolled in Medicaid. In FY2005, 37% of the RI population under the age of 17 was enrolled in Medicaid, as compared to 32% in FY2004.

The DCFHE supports access to Medicaid and SCHIP through the FRC Program. FRCs perform outreach to uninsured and underinsured pregnant women, children, and families and provide assistance in completing applications for Rite Care. In addition, numerous DCFHE programs, including WIC, CCSN, and the Family Outreach Program refer families who are uninsured or underinsured to FRCs in the community and directly to Medicaid. As of July 1, 2007, the FRC Program will be fully funded and administered through the Department of Human Services. All WIC applicants are screened for health insurance, and referred as needed to Medicaid. //2007//  
//2008/ In 2008, Rite Care enrollment among WIC participant children (1-5 years) was 85.29% (up from 84.3% in 2007 and 83.8% in 2005). //2009//

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

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
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Pregnant Women	2007	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2007	250

**Notes - 2009**

Pregnant women aged 8 - 18 qualify if 185 - 250%.

**Narrative:**

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

**INDICATOR #06**

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

**INDICATOR #06**

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

**Narrative:**

Pregnant/postpartum women qualify for Medicaid if their income is <185% of FPL. Pregnant/postpartum women qualify for SCHIP if their income is between 185-250% of FPL. Parents of Medicaid or SCHIP-eligible children with incomes between 100% and 185% of FPL are eligible for SCHIP. Families with incomes >150% of FPL are subject to a family partial premium. The premium threshold increases to 185% for families consisting of only pregnant women and infant(s). /2007/ In Rhode Island, there is also state funded program for pregnant women with income between 251% and 350% of FPL. Under this program, which requires a premium, the state funds the cost of labor and delivery only.

The DCFHE supports pregnant women's access to Medicaid and SCHIP through the WHSRP and the FRC Program. As of July 1, 2007, the FRC Program will be fully funded and administered through the Department of Human Services. The WHSRP targets at-risk populations utilizing services of Title X Family Planning clinics. The program identifies health risks among women and connects women to medical and community services, including Rlte Care. FRCs perform outreach to uninsured and underinsured pregnant women, children, and families and provide assistance in completing applications for Rlte Care. In addition, numerous DCFHE programs, including WIC and the Family Outreach Program, refer pregnant women who are uninsured or underinsured to FRCs in the community and directly to Medicaid. All WIC applicants are screened for health insurance, and referred as needed to Medicaid. //2007// /2009/ **In 2008, Rlte Care enrollment among WIC participants who were pregnant was at 70.32% (down from 71.7% in 2007 and 63.4% in 2005). //2009//**

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

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
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<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

**Notes - 2009**

**Narrative:**

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

Narrative:

/2007/ The DCFHE links birth and infant death data from vital records on an annual basis. Birth data are also linked to WIC eligibility and newborn screening files. KIDSNET allows the DCFHE to also link birth data with newborn developmental risk screening, newborn hearing, immunization, lead screening, early intervention, and home visiting data. //2007//

The DCFHE has the ability to obtain data for program planning and policy purposes in a timely manner from the following registries/surveys: hospital discharge data for at least 90% of in-state discharges, PRAMS, and Birth Defects Surveillance (the latter two are managed by the DCFHE). It does not have the ability to obtain annual data linking birth certificates and Medicaid eligibility or paid claims files, electronically or otherwise, at this time. /2007/ In 2005, a memorandum of agreement was signed with DHS to explore data exchange, including Medicaid eligibility data. //2007// /2008/ State System Development Initiative (SSDI) will further explore data exchange with Medicaid and KIDSNET in 2007. //2008// //2009/ **SSDI is working with Medicaid to develop a data sharing plan that will likely include updating KIDSNET with Medicaid participation to facilitate accurate tracking of preventive screening and services that are in KIDSNET received by children on Medicaid//2009//.**

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

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	Yes
School Accountability for Learning and Teaching	3	No
Youth Tobacco Survey	3	No

**Notes - 2009**

**Narrative:**

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

Narrative:

HEALTH participates in the Youth Risk Behavior Survey (YRBS) and the DCFHE has direct access to the YRBS database for analysis. The state also participates in the School Accountability for Learning and Teaching (SALT) Survey which provides school building-level data; the state had participated in the Youth Tobacco Survey biannually since 2001, but discontinued participation in the YTS since 2005. In 2007, HEALTH added questions to the YRBS to enable more defined analysis on how risks including tobacco, affect sub-populations in schools. The DCFHE does not have direct access to either the SALT or Youth Tobacco Survey databases for analysis.

//2007/ The DCFHE is producing user-friendly data tools that combine and compare multiple data sources to identify determinants of youth risk behaviors such as tobacco use and identify disparate populations. //2007//

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

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

For FY2006, the DCFHE developed new priorities and State Performance Measures based on its comprehensive needs assessment and the community input received in FY2005. ***//2009/ These state performance measures (and their affiliated priorities) continue to be used for FY2009 and are as follows:***

***SPM #1. Percent of PRAMS respondents who report a diagnosis of depression before or during pregnancy***

***Addresses Priority #1: Improve maternal health, including pregnant outcomes- especially premature births and reduce health disparities through the reproductive lifespan***

***SPM #2. Percent of children aged 2-5 enrolled in the WIC Program with BMI's  $\geq$ 95th percentile***

***Addresses Priority #2: Promote healthy lifestyles and healthy weights for all Rhode Islanders***

***SPM #3. Percent of Rhode Island resident families with at-risk newborns that received a home visit from the Family Outreach Program within the newborn period ( $\leq$ 90 days)***

***Addresses Priority #7: Engage, empower, support and inform families***

***SPM #4. Percent of children aged less than 6 who live in the core cities and have blood lead levels at or above 10ug/dL***

***Addresses Priority #3: Support safe and healthy environments for children and families***

***SPM #5. Percent of children who received a behavioral health service among children who received any school-based health services***

***Addresses Priority #8: Address social, emotional and behavioral health needs of the MCH population***

***In FY2006, SPM #5 was revised and is now reported as SPM #10: Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.***

***Addresses Priority #8: Address social, emotional and behavioral health needs of the MCH population***

***SPM #6. (a) Ratio of the Black or African American prematurity rate to the White prematurity rate; (b) Percent of PRAMS respondents who report taking a multi-vitamin with folic acid prior to pregnancy***

***Addresses Priority #1: Improve pregnancy outcomes***

***//2007/ While the DCFHE uses both measures (a) and (b) above to assess performance related to State Priority #6, only measure (a) is discussed in detail in this annual report.***

***//2007//***

***SPM #7. Percent of children (who have had at least one immunization from a primary care***

*provider) with complete immunization series (4:3:1:3) and at least one lead screening by age 2*

*Addresses Priority #5: Ensure a medical home for all Rhode Island families*

*SPM #8. Percent of at-risk newborns who live in a neighborhood or community with MCH community systems building partnerships*

*Addresses Priority #6: Ensure a system that adequately addresses early childhood development.*

*SPM #9. Percent of licensed child care providers with on-site health consultants*

*Addresses Priority #6: Ensure a system that adequately addresses early childhood development.*

*DCFHE priorities and performance measures build upon families' strengths and assets. New research in public health promotion is beginning to document how building a population's strengths and social capital can promote positive outcomes and avoid or mitigate negative ones. In addition, asset-based community development activities throughout the country have also shown how empowerment, resiliency, and the ability of communities to build on their asset base can contribute to achieving desired changes.*

*The DCFHE will utilize the FY2009 Title V MCH application to discuss how its new priorities, National Performance Measures, new State Performance Measures, and program activities relate to the four levels of the MCH pyramid and all MCH population groups in detail. In this application (FY2009), the DCFHE will discuss and assess its performance with respect to addressing the state priorities, State Performance Measures, and National Performance Measures originally adopted and/or developed in 1999 (with minor modifications made in subsequent years).*

*DCFHE programs and activities impact both national and state performance measures and span all levels of the MCH pyramid. The DCFHE continues to support Direct Health Care Services through contracts with community providers, including the Children's Neurodevelopment Center at Hasbro Children's Hospital and Visiting Nurse Associations. Examples of DCFHE Enabling Services include home visiting, FRC, and WIC. The DCFHE manages numerous Population-Based Services including Newborn Screening and Immunization and supports public education on a variety of topics including breastfeeding, parenting, etc. Finally, significant resources are dedicated to various Infrastructure Building Services (e.g. local systems building, strategic planning, state systems development, and data analysis and reporting).*

*This year, the DCFHE began analyzing data on the new State Performance Measures. This data will serve as a baseline from which to measure the impact of DCFHE investments in the priority areas.*

*Annual report accomplishments, current activities, and planned FY2009 activities for each of the 18 NPMs and the SPMs are discussed in the following sections. //2009//*

## **B. State Priorities**

This section looks at the relationship between the state priorities and its State Performance Measures by the four levels of MCH services. This discussion pertains to the state priorities and performance measures originally developed (with minor modifications made in subsequent years) in 1999.

Direct Health Care Services

*//2009/ The DCFHE has identified two priority areas that relate to direct services: "Improve*

**maternal health, including pregnant outcomes-especially premature births and reduce health disparities", "Ensure access to medical homes for all RI Families including school and young adults". The corresponding State Performance Measures for these two priorities are: "Ratio of the Black or African American prematurity rate to the White prematurity rate" (SPM #6 a) and "Percent of RI resident families with at-risk newborns that received a home visit from the Family Outreach Program within the newborn period (<=90 days) (SPM#3).**

**Investments made in the Women's Health Screening and Referral Program, and the Family Planning Program focus on improving pre-conceptual health of uninsured / underinsured women. Some Family Outreach Program home visits are to provide direct health care services, while some visits are considered "enabling" services. //2009//**

#### Enabling Services

/2008/ The DCFHE has identified two priority areas that relate to enabling services: "Promote Healthy Lifestyles and Health Weights for All" and "Engage, Empower, Support and Inform Parents". The corresponding State Performance Measures for these priorities are "the percentage of infants who are underweight and the percentage of children who are underweight or overweight in the WIC Program" (SPM #8) and "the percentage of at risk newborns who receive a home visit from the Family Outreach Program during the early newborn period" (SPM #9). //2008//

Childhood obesity continues to be a significant health risk in Rhode Island. One in ten children enrolled in the WIC Program are overweight. In addition, not all those who are eligible for MCH services are enrolled. Although nearly half of the state's newborns are determined to be at-risk for developmental delays, some families refuse DCFHE home visiting services.

#### Population-Based Services

**/2009/ The DCFHE has identified two priority areas that relate to population-based services: "Support safe and healthy environments for children and families" and "Engage, empower, Support and Inform Parents". The corresponding State Performance Measures for these three priorities are: "the percentage of 9th graders who are expected to graduate from high school" (SPM #6); "the percentage of children less than 6 years old who live in the core cities and have lead levels at or above 10 ug/dl" (SPM #4); and "the percentage of at risk newborns who receive a home visit from the Family Outreach Program during the early newborn period" (SPM #9)**

**Although the proportion of children who have elevated lead levels is decreasing, still nearly one in ten children under the age of six has elevated lead levels. Quality education is linked to school success. High school dropouts are more likely to be unemployed, on public assistance, and earn less money than high school graduates. Families who participate in the Family Outreach Program are provided the needed tools to better access beneficial services. //2009//**

#### Infrastructure Building Services

**/2009/ The DCFHE has identified three priority areas that relate to infrastructure building services: "Ensure a system that adequately addresses early childhood development"; and "Ensure access to medical homes for all families, including school age and young adults". The corresponding State Performance Measures for these three priorities are: "Percent of licensed child care providers with on-site health consultants (SPM# 9) and "Percent of children...with complete immunization series...and at least one lead screening by age 2" (SPM #7); //2008//**

**Studies have shown that quality child care programs are linked to school readiness. Children in these settings are cared for in environments that protect their health and safety. //2009//**

Activities that correspond to DCFHE priorities and State Performance Measures are included in Section IV (D) in this application.

#### National Performance Measures

The following discusses the relationship between the state's priority needs and the National Performance Measures by the four levels of the MCH pyramid. The service level assigned to each priority was determined by its performance measure. This discussion pertains to the state priorities that were originally developed (with minor modifications made in subsequent years) in 1999.

#### Direct Health Care Services

***/2009/ The DCFHE has identified two priority areas that relate to direct services: "Ensure a system that adequately addresses early childhood development" and "Ensure access to medical homes for all families...". //2009//***

The corresponding National Performance Measures that relate to these two priorities are as follows: the birth rate per 1,000 for teenagers aged 15 through 17 years (NPM #8); the rate per 1000,000 of suicide deaths among youth ages 15-19 (NPM #16); and the percentage of youth with CSHCN who received the services necessary to make transitions to all aspects of adult health (NPM #6).

#### Enabling Services

*/2008/ The DCFHE has identified two priority areas that relate to enabling services: "Promote healthy lifestyles and healthy weights for all" and "Engage, empower, support and inform parents". //2008//*

The corresponding National Performance Measures that relate to these two priorities are as follows: the percentage of mothers who breastfeed their infants at hospital discharge (NPM #11); the percentage of infants who are screened for conditions mandated by their state-sponsored newborn screening program and receive appropriate follow-up and referral (NPM #1); the percentage of CSHCN whose families have adequate private and/or public insurance to pay for the services they need (NPM #4); the percentage of newborns who have been screened for hearing prior to hospital discharge (NPM #12); the percent of children without health insurance (NPM #13); and the percentage of potentially eligible Medicaid children who have received a service paid for by Medicaid (NPM #14).

#### Population-Based Services

*/2008/ The DCFHE has identified two priority areas that relate to population-based services "Support safe and healthy environments for children and families" and "Engage, empower, Support and Inform Parents. //2008//*

The corresponding National Performance Measures that relate to these three priorities are as follows: the rate of deaths to children ages 14 years and younger caused by motor vehicle crashes per 100,000 (NPM # 10); the percentage of CSHCN ages 0-18 who receive coordinated, ongoing, comprehensive care within a medical home (NPM #3); the percentage of third grade children who have received protective sealants on at least one permanent molar tooth (NPM #9); the percentage of CSHCN ages 0-18 whose families partner in decision-making at all levels and are satisfied with the services they receive (NPM #2); and the percentage of CSHCN ages 0-18 whose families report that the community-based services systems are organized so that they can use them (NPM #5).

#### Infrastructure Building Services

***/2009/ The DCFHE has identified three priority areas that relate to infrastructure building services: "Ensure a system that adequately addresses early childhood development"***

***,"Ensure access to medical homes for all families..."and "Improve maternal health, including pregnancy outcomes..."//2009//***

The corresponding National Performance Measures that relate to these three priorities are as follows: the percentage of 19-25 month olds who have received full schedule of age-appropriate immunizations (NPM #7); the percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates (NPM #17); the percentage of infants born to pregnant women receiving prenatal care in the first trimester (NPM #18); and the percentage of very low birth weight infants among all live births (NPM #15)

Activities that correspond to DCFHE priorities and the National Performance Measures are included in Section IV (C) in this application.

State Priorities

***/2009/ New state priorities were developed in 2005 in conjunction with the five-year needs assessment. All nine state priorities address significant needs identified through data analysis and community input. The DCFHE has assessed internal capacities as well as external resources to meet these needs. State Performance Measures were developed for each of the new priorities. In addition, many of the state priorities directly relate to the National Performance Measures.***

***State Priority #1: Improve maternal health , including pregnancy outcomes -- especially premature births and reduce health disparities.***

***SPM #1: Percent of PRAMS respondents who report a diagnosis of depression before or during pregnancy***

***Women's health through the reproductive lifespan is critical for many reasons and has a significant impact on pregnancy outcomes. Women who are depressed, exposed to tobacco, or untreated for chronic disease are also at risk for poor birth outcomes, such as prematurity and low birth weight. Protecting and promoting women's health is a priority of the DCFHE.***

***State Priority #2: Promote healthy lifestyles and healthy weights for all Rhode Islanders***

***SPM #2: Percent of children aged 2-5 enrolled in the WIC Program with BMI's >=95th percentile***

***This priority is directly related to NPM #11 and #14.***

***Lack of physical activity, poor nutrition, early sexual activity, tobacco, alcohol, and other drug use are all risk factors that can damage the health and success of school-aged children. Preventing childhood obesity is a department-wide priority spearheaded by HEALTH's Initiative for Healthy Weight. HEALTH, the DCFHE, and community partners are working to develop and implement a comprehensive plan to promote healthy eating and active living among all Rhode Islanders, with a special emphasis on children and families.***

***State Priority #7: Engage, empower, support and inform families***

***SPM #3: Percent of Rhode Island resident families with at-risk newborns that received a home visit from the Family Outreach Program within the newborn period (<=90 days)***

***Parents and guardians are the primary caretakers and decision makers for children. Yet, parents often lack skills and information to find the services they need. In addition, the stress of parenthood can take a toll on families' overall health and wellbeing, especially when raising children with special needs and/or living with limited resources. The DCFHE, though the Parent Consultant Program, Successful Start, and other initiatives is working to develop a sustainable infrastructure to support high quality, culturally appropriate family education and support services.***

**State Priority #3: Support safe and healthy environments for children and families**  
**SPM #4: Percent of children aged less than 6 who live in the core cities and have blood lead levels at or above 10ug/dL**  
**This priority is directly related to NPM #10.**

**Place has an enormous impact on health outcomes, both at the individual and population-level. Environmental hazards can result in asthma, lead poisoning, and other negative health outcomes. At the population-level, poor environments translate into missed work days, poor school performance, and increased health care costs. To advance this priority, DCFHE has developed a Healthy Homes strategy to better address the multiple environmental risks facing families. The DCFHE is convening the Healthy Homes Collaborative to develop a statewide action plan to improve housing and neighborhood conditions for all families in RI..**

**State Priority #\*: Address social, emotional and behavioral health needs of the MCH population**  
**SPM #10: Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months**  
**This priority is directly related to NPM #16.**

**Currently, the state's children's mental health system lacks capacity in several areas, including access to quality preventative and step-down services and availability of qualified clinicians. The DCFHE is partnering with state and community agencies, including DCYF, Bradley Hospital, and many other partners to develop systems to detect behavioral health issues early, facilitate access to community and school-based services, and provide interdisciplinary training on targeted issues relating to children's mental health.**

**State Priority #1: Improve pregnancy outcomes**  
**SPM #6: Ratio of the Black or African American prematurity rate to the White prematurity rate**  
**This priority is directly related to NPM #15, #17, and #18.**

**Premature infants are more likely to have a number of health problems, including breathing and heart problems, anemia, jaundice, blindness, deafness, mental retardation, cerebral palsy, and infant death. While Rhode Island has high rates of prenatal care and low infant mortality, serious disparities exist in these areas, and the rates of premature births are increasing. The DCFHE, in partnership with the RI Chapter of the March of Dimes and Women and Infants Hospital, established a statewide Prematurity Task Force to identify opportunities and actions to reduce the rate of prematurity in RI.**

**State Priority #5: Ensure a medical home for all Rhode Island families**  
**SPM #7: Percent of children (who have had at least one immunization from a primary care provider) with complete immunization series (4:3:1:3) and at least one lead screening by age 2**  
**This priority is directly related to NPM #2, #3, #4, #5, #6, #7, and #13.**

**A medical home is more than a doctor's office; it's a team approach to comprehensive health care. Rhode Island is doing better than the nation in terms of ensuring access to a medical home for children, however challenges still remain. To advance this priority, the DCFHE will continue to expand the Pediatric Practice Enhancement project, provide support to local CATCH projects, and promote developmental screening in pediatric offices throughout the state.**

**State Priority #6: Enhance MCH programs**

**SPM #8: Percent of at-risk newborns who live in a neighborhood or community with MCH community systems building partnerships**

*Through ongoing partnerships with community advocates, providers, and families, the DCFHE is committed to making sure that all families in our state have the opportunity to raise safe and healthy children in safe and healthy communities. Community systems building partnerships develop and support MCH system assessment and strategic planning in high-need communities in RI. The DCFHE will continue to develop strategies to support local initiatives in conducting community assessments, implementing strategic plans, and increasing utilization of MCH services.*

**State Priority #6: Promote healthy human development in children, adolescents and families**

**SPM #9: Percent of licensed child care providers with on-site health consultants**  
*This priority is directly related to NPM #1, #8, #9, and #12.*

*Early childhood development begins with genetics and maternal nutrition, and continues with child care and after school care years later. During the first five years of life, a child's foundation is built. The DCFHE has taken the lead in Successful Start, RI's plan to address healthy development for all children in the preschool years. As part of this effort, in FY2007, DCFHE will begin offering child care health and mental health consultation to licensed child centers and family child care homes throughout the state.*

*A new state priority has emerged over the past year. State Priority #4: Community services for children & youth with special healthcare needs. The focus is collaborating with health care providers to better serve families with children with special health care needs. This includes the transition period when adolescents and young adult may move to new primary care providers. //2009//*

**C. National Performance Measures**

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	99.2	99.2	99.5	99.5	99.5
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	26	22	19	20	33
Denominator	26	22	19	20	33
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	99.6	99.6	99.6	99.6	99.6

**a. Last Year's Accomplishments**

The DCFHE continued to assure early screening, diagnosis, and intervention for all newborns. Specifically, the DCFHE provided universal newborn screening for twenty nine conditions including hearing impairment, and developmental risks and assured that newborns identified received appropriate follow-up care.

The Newborn Screening Program continued to track all babies in need of follow-up through to a passing screen or diagnosis and initiation of treatment. This includes maintaining contracts with the RI Hearing Assessment Program at Women and Infants' Hospital, VNA of Care New England for tracking and follow-up of blood spot results, and with Rhode Island Hospital for diagnosis and treatment of infants identified through bloodspot screening. The DCFHE continued to assure that newborns with developmental risks received appropriate follow-up care through the Family Outreach Program. In addition, culturally competent home visitors provided home visiting services to families who are difficult to reach.

A Continuous Quality Improvement (CQI) plan for bloodspot newborn screening continued. The CQI Plan included data and system level quality issues, and ongoing review by the Newborn Screening Advisory Committee of policies and procedures. The Newborn Screening Program continued to use KIDSNET to identify true missed specimens, delayed specimens, cancelled orders, and other important systems issues which were addressed at the hospital level. Condition-specific reporting guidelines for the RI system are in development and will document reporting and follow-up processes for program staff.

During FY07, PRAMS continued to survey approximately 2,000 women who recently gave birth to monitor the impact of the informing materials, including the impact of newborn screening informing materials and Spanish translations that previously did not exist.

Rhode Island-specific Newborn Hearing Screening process algorithms adopted from the American Academy of Pediatrics Early Hearing Detection and Intervention (EHDI) guidelines were re-printed and continue to be distributed to pediatric providers of infants needing follow-up from the newborn hearing screen. In addition, a family-friendly version was developed in English and Spanish and is now being distributed to parents of newborns needing follow-up

Upgrades were made to the newborn hearing screening database to permit bidirectional data exchange with KIDSNET of demographic information, hearing loss risk factors and audiology test results, to automatically generate follow-up correspondence in two languages, and to improve capacity to track and report newborn hearing screening and follow-up data. On-line audiology reporting and a newborn screening report for PCPs summarizing birth information and newborn screening results and needed follow-up were implemented in KIDSNET.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Universal newborn screening, diagnosis, and intervention for 29 conditions (including hearing impairment) and developmental risk			X	
2. Newborns identified through the newborn developmental screening process are referred to Family Outreach Program for home visiting services		X		
3. Mechanisms to ensure that hard-to-reach families with a risk positive newborns are reached through culturally competent home visitors		X		
4. Continue planning to pre-populate the newborn screening laboratory and hearing screening databases with electronic birth				X

certificate data				
5. Administer a CQI plan for bloodspot screening, which includes data and systems level quality issues				X
6. Distribute integrated prenatal, perinatal, and postnatal informing brochures for providers and families			X	
7. Disseminate of the RI Early Hearing Detection and Intervention Medical Home algorithm		X		
8. Survey women who recently gave birth through PRAMS, which includes questions related to newborn screening				X
9.				
10.				

**b. Current Activities**

The DCFHE assures early screening, diagnosis, and intervention for all newborns through universal newborn screening for 29 inherited conditions including hearing impairment, and developmental, tracking all babies in need of follow-up, including contracts with the RI Hearing Assessment Program at Women and Infants' Hospital, VNA of Care New England, and with Rhode Island Hospital.. Newborns with developmental risks receive appropriate follow-up care through the Family Outreach Program.

NBSP coordinates with the Newborn Screening Advisory Committee, Metabolic Center, Newborn Screening Follow-up Coordinator, Laboratory, and Cystic Fibrosis Center.

CQI uses KIDSNET to identify gaps in screening and links confirmed diagnosis with the Birth Defects Surveillance and Newborn Hearing Screening Programs. On-line diagnostic audiology reporting and bidirectional data exchange of hearing loss risk factors and audiology testing data via KIDSNET is implemented.

Informing brochures (prenatal, perinatal, postnatal) printed in English and Spanish includes bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET and are distributed via maternity hospitals, mail to parents of newborns, and to obstetric offices.

PRAMS continues to survey recent mothers to monitor the impact of the informing materials.

**c. Plan for the Coming Year**

The DCFHE will continue to assure early screening, diagnosis, and intervention for all newborns. The DCFHE will provide universal newborn screening for developmental risk and the 29 inherited conditions and hearing loss.

The NBSP will continue to track all babies in need of follow-up through to a passing screen or diagnosis and initiation of treatment thru contracts with the RI Hearing Assessment Program at Women and Infants' Hospital for newborn hearing screening including tracking, VNA of Care New England for tracking and follow-up of blood spot results, and with Rhode Island Hospital for diagnosis and treatment of infants identified through newborn bloodspot screening, and newborns identified with developmental risks receive appropriate follow-up care through the Family Outreach Program. Culturally competent home visitors will provide home visiting services to families who are difficult to reach.

The DCFHE will refine policies and procedures related to the expansion of the screening panel to 29 conditions as needed and assure that the annual cost of living adjustment for newborn screening passed in the regulations is successfully transferred into the Newborn Screening line item of the state budget for next fiscal year.

A CQI plan for newborn screening will continue. The Newborn Screening Program will continue to

use KIDSNET to identify true missed specimens and missed hearing screens, misplaced and delayed specimens, cancelled newborn screening orders, and other important systems issues to be addressed at the hospital level.

KIDSNET will continue to pre-populate the newborn hearing screening data system with demographic data collected through the electronic birth certificate system and to exchange diagnostic audiology and risk factor information with RITrack. Training and education of KIDSNET users about the availability of this data to help assure appropriate follow-up will be conducted. Planned data system upgrades include creation of several electronic reports(annual national EHDI data report, EHDI data feedback for community partners such as hospitals and audiologists, patient level reports for audiologists), training new user categories on KIDSNET (Pediatric Practice parent consultants, High Risk NICU Follow-up clinic), training audiologists on new system features, increasing access to information needed for care coordination and creating a secure mechanism to transfer electronic EHDI data among New England States with data sharing agreements.

Distribution of English and Spanish newborn services informing brochures at all maternity hospitals, through obstetric provider offices, and through direct mailing to parents will be continued and PRAMS will survey new mothers about their awareness of newborn screening.

The Rhode Island-specific Newborn Hearing Screening process algorithm will be mailed to the primary care provider of record following a confirmed diagnosis of hearing loss.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	68.6	68.6	68.6	70	70
Annual Indicator	68.6	68.6	68.6	68.6	61.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	61.4	61.4	61.4	63	63

**Notes - 2007**

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

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

**a. Last Year's Accomplishments**

The Successful Start Early Childhood Systems Plan contains several elements to ensure parent engagement in policy and programming decisions related to young children, including young children with special health care needs. Parents of CSHCN, including the Executive Director of RI Family Voices, are members of the Successful Start Steering Committee.

In addition, during FY07, the Birth Defects Program analyzed and disseminated information obtained from focus groups and interviews with families of children with birth defects regarding their satisfaction with services. The DCFHE through the Office of Special Healthcare Needs (OSHCN) makes resources available to parents of children with special healthcare needs and the professionals working with them. Since FY2005, the OSHCN has made available the RI Resource Guide for Families of Children with Autism Spectrum Disorders, RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, the Complete Care Notebook, and Family Voices Resource Guide. Last year the OSHCN collaborated with community partners to prepare the RI Resource Guide to Mental Behavioral Services & Supports, made the RI Resource Guide for Families of Children with Autism Spectrum Disorders available in Spanish and developed a toolkit for youth, parents and providers concerning adolescent healthcare transition.

The Pediatric Practice Enhancement Project (PPEP) was present in 20 pediatric primary and specialty practices to foster the communication and partnership between the parents and providers. Through the PPEP and Family Voices of RI, parent leaders have been cultivated and supported to lead policy initiatives, make systems improvements and champion principles of parent-professional partnerships. In FY2007, PPEP was expanded to include two youth with special healthcare needs who provided policy and leadership on transition issues.

The OSHCN supported the activities of the SSI Team by visiting each SSA Office in RI to train staff on local resources and deliver resource guides. The OSHCN and the SSA Offices finalized and distributed the health-care-at-a-glance document describing healthcare and insurance options for youth with special healthcare needs and their families.

Through the Family Voices Leadership Team, the OSHCN addressed identified systems barriers to a coordinated service delivery system.

The parent professional partnership conference focused on transitions, including transition from EI to Special Education and the transition from youth to adulthood.

The Child Care Support Network offered both health/mental health consultation to child care centers staff and families. Parents of CSHCN will continue to participate on CCSN's Advisory Board. The DCFHE partners with DHS to expand the KIDS CONNECT Program to new child care centers serving CSHCN.

The Data and Evaluation Unit tracked medical home indicators, determining an overall "medical home index" for children and families in RI. The Birth Defects Program surveys families of children with birth defects to satisfaction with services/systems of care.

According to data from the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 61.4% of families of CSHCN reported they are partners in decision making at all levels, and are satisfied with the services they receive. This represents a decline from the 2001 NS-CSHCN figure of 68.6%.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Ongoing dissemination of the Complete Care Notebook for Raising Children with Special Needs, RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, and RI Resource Guide for Families of Children with Autism Spectrum		X		
2. Provide ongoing support to the SSI Team				X
3. Place trained parent consultants in pediatric primary care and specialty care settings throughout the state to assist families in navigating the system of services for CSHCN		X		
4. Provide technical assistance and information for child care providers on how to better accommodate CSHCN and behavioral challenges in child care settings		X		
5. Support the participation of parents of CSHCN in advisory and planning committees				X
6. Convene a statewide CSHCN conference on medical homes for parents of CSHCN and agencies providing services to CHSCN				X
7. Interview families of children with birth defects to determine satisfaction with services and identify barriers to and/or gaps in services				X
8. Collect data on medical home indicators to assess family satisfaction and decision-making				X
9. Collect information on services and referrals provided to families of children with selected birth defects via PPEP parent consultants				X
10.				

**b. Current Activities**

Ensures families with CYSHCN engagement in planning, implementation, and evaluation; that families are full partners in the development of impacting policy; and seeks an increase in satisfaction among consumers, continue to participate on Child Care Support Network’s Advisory Board (offers health/mental health consultation to child care centers staff and families).

Assesses the need for resource guides and makes them available for families/professionals including guides for families of children and youth with mental health disorders, the RI Resource Guide for Families of Children with Autism Spectrum Disorders (in English and Spanish), the RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, the RI Complete Care Notebook, the Adolescent Healthcare Toolkit, and the RI Family Voices Resource Guide; and evaluate their impact.

Partners to expand the KIDS CONNECT Program to new child care centers serving CSHCN.

Trains local SSA staff on local resources, delivers resource guides and provides the health-care-at-a-glance document describing healthcare and insurance options for youth with special healthcare needs and their families.

Promotes family-centered care and parent consultant services at the through the Pediatric Practice Enhancement Project (PPEP) currently being evaluated for impact on utilization rates and healthcare costs of PPEP and non-PPEP children with special healthcare needs. Addresses barriers thru Family Voices Leadership.

**c. Plan for the Coming Year**

The DCFHE, through its OSHCN will continue to ensure that families with CYSHCN are engaged in program planning, implementation, and evaluation and that families are full partners in the development of policy affecting their lives and the lives of their children. In addition, the DCFHE will continue to seek an increase in satisfaction among consumers through qualitative and

quantitative evaluation of its programs and initiatives.

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

The OSHCN will continue to support the activities of the SSI Team by visiting each SSA Office in RI to train staff on local resources and deliver resource guides. The OSHCN and the SSA Offices will continue to distribute the health-care-at-a-glance document describing healthcare and insurance options for youth with special healthcare needs and their families.

The OSHCN will continue to promote family-centered care and parent consultant services at the through the Pediatric Practice Enhancement Project (PPEP). The PPEP will make available the results of the rigorous evaluation comparing the utilization rates and healthcare costs of PPEP and non-PPEP children with special healthcare needs in order to sustain the PPEP. The OSHCN will continue to provide technical assistance within the state and to other states regarding the engagement of consumers in all aspects of decision making. Through the Family Voices Leadership Team, the DCFHE will address identified systems barriers to a coordinated service delivery system.

The OSHCN will provide opportunities to demonstrate parent professional partnerships including an annual conference, policy meetings and ongoing committees.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	53.9	53.9	53.9	55.2	55.2
Annual Indicator	53.9	53.9	53.9	53.9	50.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	50.9	50.9	50.9	55.5	55.5

**Notes - 2007**

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

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

**a. Last Year's Accomplishments**

Also in FY2007, Successful Start continued implementation of its statewide Early Childhood Systems Plan. Several initiatives to build the capacity of medical homes are underway. In partnership with the RI Chapter of the American Academy of Pediatrics, a workgroup created a model of developmental screening and referral to services. This model was piloted in FY2007. The DCFHE worked to increase the number of CSHCN in RI who have a medical home by partnering with PPEP, DHS (on CEDARR, EPSDT, and Medicaid policy), Health Plans, the RI Chapter of the American Academy of Pediatrics, and the Society of Adolescent Medicine.

The PPEP -- medical home enhancement project -- expanded to include three additional primary care practices for premature infants, children with autism and children with asthma. The Family Voices Leadership Team addressed barriers identified through the PPEP to a coordinated service delivery system and partners with health plans to identify and reimburse medical home-type services. The DCFHE worked with RI health plans on appropriately reimbursing practices that provide a comprehensive medical home.

The OSHCN participated on the CEDARR Interdepartmental Team, convening RI's Leadership Roundtable on CSHCN addressing care coordination and additions to the Medicaid package, was engaged in RI's review of the EPSDT Schedule, supported existing medical home systems development in the communities of Newport, Washington County, Mt. Hope, and Pawtucket/Central Falls. The DCFHE provided assistance and support to the community of Woonsocket to become a CATCH community.

Family Outreach Program linked children at risk for developmental concerns to a medical home and provides education / support to families. PPEP parent consultants in the Neonatal Intensive Care Unit at Woman & Infants Hospital, the Ventilator Integration Program at Hasbro Children's Hospital and the Neonatal Follow-Up Program provided medical home services to infants and toddlers with complex medical conditions.

A workgroup convened to address adolescent needs for medical homes, performance measures for adolescent access to mental health services and development of adolescent medical homes. Successful Start is piloting a model of developmental screening and referral to services. Youth Consultants conducted research to develop a teen medical home model, indicators and utilization info. The Data and Evaluation Unit gathered data and determined the percent of RI children with medical homes.

Data from the 2005/2006 National Survey of CSHCN indicate that 50.9% of CSHCN received coordinated, ongoing and comprehensive care within a medical home. This represents a decline from the 2001 survey figure of 53.9%.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the Pediatric Practice Enhancement Project to new pediatric primary and specialty care offices serving CSHCN		X		
2. Continue efforts to build the infrastructure necessary to sustain the model of parent consultants in pediatric offices				X
3. Outreach to and enroll pediatric providers in KIDSNET to ensure that all children, including CSHCN, have a medical home				X

and are linked to appropriate support services				
4. Through the Family Outreach Program, continue to link children to medical homes and provide parent education and family support to vulnerable children and families		X		
5. Support systems development efforts that work to build medical home capacity in local communities				X
6. Finalize a model of early childhood developmental screening and services and pilot the model in selected communities in the state			X	
7. Continue work to assure that children with birth defects have a medical home and receive appropriate services			X	
8. Continue collaborative work with DHS, RI Family Voices, professional associations, and other stakeholders to build medical homes for CSHCN				X
9. Analyze indicators of a medical homes to determine the percentage of RI children who have a medical home				X
10. Demonstrate new models of adolescent medical homes aligned with existing investments.				X

**b. Current Activities**

DCFHE Works to increase the number of CSHCN in RI who have a medical home by partnering with PPEP, DHS (on CEDARR, EPSDT, and Medicaid policy), Health Plans, the RI Chapter of the American Academy of Pediatrics, and the Society of Adolescent Medicine.

PPEP's evaluation plan is to determine the short / long term health outcomes and to access public and private insurance reimbursement. OSHCN and partners want to include PPEP in RI's Medicaid Reform efforts.

Collaborates with Family Voices Leadership Team (address the systems barriers to a coordinated service delivery system continue) CEDARR Interdepartmental Team and in convening RI's Leadership Roundtable on CSHCN (care coordination for CYSHCN and additions to the Medicaid package) and support the preventative and screening functions of the medical home through RI's revised EPSDT Schedule.

In FY 2008, the DCFHE Initiative for Healthy Youth Program, through a partnership with the Northern RI Area Health Education Center and the Woonsocket CATCH grant coalition, produced a model report on adolescent medical home, which will include a common definition, indicators, data, lessons learned, best practice models, tools for technical assistance and guidance, and recommendations.

**c. Plan for the Coming Year**

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

The OSHCN will continue to promote access to a medical home through the PPEP -- medical home enhancement project. The plan for the PPEP is to access public and private insurance reimbursement for purposes of sustainability and to continue program evaluation. The OSHCN will be partnering with RI's Area Health Education Centers on positioning the PPEP model within the healthcare reform and preparation arena and raising the awareness among RI's practitioners of medical home concepts and practices.

Through the Family Voices Leadership Team, strategies to address the systems barriers to a coordinated service delivery system will continue to be addressed. The Family Voices Leadership Team will continue to partner with health plans to identify and reimburse medical home-type services.

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

In FY 2009, the DCFHE Initiative for Healthy Youth will continue to work with the Northern RI Area Health Education Center and the Woonsocket CATCH grant coalition, to provide technical assistance and tools on adolescent medical home. DCFHE will identify two more communities to pilot the adolescent home model. DCFHE will seek additional support for professional development through the MCHB TA resource.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	68.9	68.9	68.9	70.2	70.2
Annual Indicator	68.9	68.9	68.9	68.9	68.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	68.2	68.2	68.1	70.2	70.2

**Notes - 2007**

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

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

**a. Last Year's Accomplishments**

In FY2006, the DCFHE continued to work to increase the percentage of CSHCN with adequate insurance to pay for the services they need. In FY2006, 37% of the RI population under the age of 17 was enrolled in Medicaid, including many CSHCN.

The Family Resource Counselor Program continued to screen and enroll eligible families into Medicaid (including RItE Care or RItE Share) and other health financing programs (including SSI and Katie Beckett). During 2007, culturally diverse FRCs were located in 20 community health center sites and four hospital clinics throughout the state. FRCs screened over 5,000 children for RItE Care eligibility and assisted in completing 4,900 RItE Care applications for children.

The Rhode Island Department of Human Services (DHS) transition CSHCN from fee-for-service Medicaid to managed care on a voluntary basis. The DCFHE worked with the DHS and Neighborhood Health Plan of RI to facilitate this process. In addition, the DCFHE, in partnership with the RI Health Center Association and Covering Kids RI, provided training to FRCs to support the particular needs of this population during the transition.

The Pediatric Practice Enhancement Project (PPEP) assisted 2100 families with CSHCN in 2007 on issues concerning insurance, education, and access to mental health services. Almost 25% of these families required direct assistance in accessing insurance. As RI implements federal citizenship documentation requirements, PPEP parent consultants were trained and authorized to verify citizenship documents.

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

The DCFHE supported the toll-free Family Health Information Line, which continued to refer families to appropriate resources, including Medicaid/RItE Care. The Family Health Information Line is a statewide resource for all families, including those with CSHCN, and is staffed by bi-lingual information specialists. Culturally appropriate informational materials for families were distributed through the centralized distribution center.

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

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist in efforts to transition CHSCN to Medicaid managed care and provide appropriate, comprehensive, and coordinated services through managed care mechanisms				X
2. Continue to support the Pediatric Practice Enhancement Project, which links families to Medical Assistance and includes a strong service coordination component to assist families of CSHCN in accessing services		X		
3. Support the Family Outreach Program in referring families with no or inadequate health insurance to Medical Assistance and in linking families to community-based health and social services		X		
4. Participate on the CEDARR Interdepartmental Team which oversees and monitors the state's care coordination system for CSHCN				X
5. Distribute and evaluate the Complete Care Notebook for		X		

Raising CSHCN and other CHSCN resource guides				
6. Participate on the Rhode Island Pediatric Council, the Rlte Care Consumer Advisory Committee, and other groups which advocate for appropriate and accessible services for CSHCN				X
7. Analyze data from the 2005/2006 National Survey of CSHCN				X
8.				
9.				
10.				

**b. Current Activities**

DCFHE works to increase the % of CSHCN, ages 0-18, whose families have adequate private and/or public insurance.

PPEP and Family Resource Counselors screens / enrolls eligible families into Medicaid (including Rlte Care or Rlte Share), SSI and Katie Beckett across the state. PPEP assists DHS in citizenship verification to prevent gaps in insurance coverage.

The Family Outreach Program refers vulnerable families with no or inadequate health insurance to appropriate services and programs. The toll-free Family Health Information Line links callers to health insurance ptions.

The Complete Care Notebook enable families to track expenses and determine adequacy of insurance. The DCFHE distributes and evaluate the use of condition-specific resource guides which detail financing options for families raising CSHCN.

Participates on the CEDARR Interdepartmental Team RI Pediatric Council, the Rlte Care Consumer Advisory Committee, the Family Voices Leadership Team, and the Neighborhood Health Plan.

As of June 1, 2008, undocumented children and their families were dropped from Rlte Care. Several children with complex special needs were among the undocumented children dropped from public insurance. The OSHCN works with community partners, advocacy organizations and local providers to continue access to care.

Data from the 2005/2006 National Survey of CSHCN indicates that 68.1% of families with CSHCN have adequate private and/or public insurance to pay for the services they need.

**c. Plan for the Coming Year**

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

The Family Resource Counselor Program will continue to screen and enroll eligible families into Medicaid (including Rlte Care or Rlte Share) and other health financing programs (including SSI and Katie Beckett). Culturally and linguistically diverse FRCs will continue to be located in 20 community health center sites and 4 hospital-based clinics throughout the state.

PPEP will continue to ensure that families with CSHCN, from birth to twenty-one years of age, are linked to adequate health financing programs, including Medicaid, SSI, and Katie Beckett. PPEP will continue to assist DHS in citizenship verification to prevent gaps in insurance coverage.

In FY2008, the Family Outreach Program will continue to refer vulnerable families with no or inadequate health insurance to appropriate services and programs. The toll-free Family Health Information Line will continue to provide information to callers about health insurance options, including Medicaid/Rlte Care.

The DCFHE will continue to participate on the CEDARR Interdepartmental Team. The Team will continue to be responsible for program monitoring and oversight, policy review and revision, and program development. CEDARR includes a strong care coordination component, which ensures that families with CSHCN are linked to financial resources for which they may be eligible.

The DCFHE will outreach to families on the use of the Complete Care Notebook to track expenses and determine adequacy of insurance. The DCFHE will continue to distribute and evaluate the use of condition-specific resource guides. These guides detail financing options for families raising CSHCN.

DCFHE staff will continue to participate on the Rhode Island Pediatric Council, the RIte Care Consumer Advisory Committee, the Family Voices Leadership Team, and the Neighborhood Health Plan CSHCN Advisory Board to ensure that health care for CSHCN is accessible, adequately financed, culturally competent, and family-centered.

The DCFHE will work with state and community partners to ensure adequate and appropriate services for undocumented CSHCN.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	78.8	78.8	78.8	80	80
Annual Indicator	78.8	78.8	78.8	78.8	87.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	87.6	87.6	87.6	80	80

**Notes - 2007**

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

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

**a. Last Year's Accomplishments**

In Rhode Island, as in other parts of the country, services for families can often be fragmented and hard to navigate. The DCFHE worked both at the state and community levels to create new procedures and pathways to enable CYSHCN and their families to more easily navigate existing health and social service systems. The OSHCN is committed to assisting families in navigating the special needs service delivery system as this was one of the goals of the PPEP and the development of several resource guides.

The DCFHE continued to build the Pediatric Practice Enhancement Project (PPEP), which assists families of CSHCN in accessing medical and community services. Services were expanded to several new sites. In addition, PPEP parent consultants participated in several quality assurance meetings with the CEDARR Interdepartmental Team and the CEDARR Family Centers in order to enhance collaboration, reduce duplication, and clarify roles. These meetings led to policy changes in the CEDARR Program regarding access and service provision.

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

The OSHCN continued dissemination of the Complete Care Notebook for Raising CSHCN. The Notebook was developed in response to requests from families for a portable organizer to record and file their child's important health information. The Notebook also includes a community and state resource guide. The Notebook was distributed to families through the Women & Infants Hospital NICU, Hasbro Children's Hospital Children's Neurodevelopment Center, and Early Intervention providers.

The DCFHE is home to Successful Start, RI's State Early Childhood Comprehensive Systems Initiative. The Successful Start Partnership is working to improve and coordinate the state's systems of early childhood services, with a special focus on systems serving CSHCN. In FY2006, Successful Start completed began implementation of the Successful Start Early Childhood Systems Plan. The plan incorporates numerous strategies to streamline services, facilitate relationship building between providers, and promote parent engagement and family-centered In FY2006, several communities began or continued systems building initiatives focused on the health care needs of children, including CSHCN. The DCFHE supported these initiatives by providing technical assistance on community organizing, executing a needs assessment, and developing a strategic plan. The DCFHE also provided community-level data to these groups as they worked to identify needs and resources to meet those needs. In FY2007, the DCFHE worked collaboratively with the Newport County Healthy Communities Initiative, the Washington County Coalition for Children, and Mt. Hope CATCH.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pilot a community-based model of developmental screening and services to ensure that children at-risk for delays and disabilities are identified and access appropriate intervention services			X	
2. Provide support and technical assistance to community systems development initiatives, including CATCH projects and child and family coalitions				X
3. Continue expansion of PPEP to additional sites to assist families of CSCHN in accessing community-based services and supports		X		
4. Distribute and evaluate the Complete Care Notebook for		X		

Raising Children with Special Needs and other resource guides for families of CSHCN				
5. Continue to administer and enhance KIDSNET's ability to house and appropriately share information that supports the provision of preventive health services and follow-up				X
6. Continue to obtain service and referral information from families of children with birth defects via the Birth Defects Program and PPEP parent consultants.				X
7. Provide oversight to and ensure the continuous quality improvement of the CEDARR program through the CEDARR Interdepartmental Team				X
8. Continue to support the Family Voices Leadership Team in its efforts to ensure a comprehensive coordinated service delivery system for CSHCN				X
9. Demonstrate new models of adolescent medical homes aligned with existing investments.				X
10.				

**b. Current Activities**

PPEP parent consultants (in 25 pediatric primary /specialty care practices) collect data on system barriers & assist families in accessing resources. These concerns are addressed by the Family Voices Leadership Team, state and community leaders.

Successful Start, and RI AAP are increasing the dev screening / services to young children via community-based dev screening / referral services in child care centers/medical home; received TA from the Commonwealth Fund .

Participates / provides TA to existing and emerging community systems development initiatives, (Woonsocket CATCH projects & Child Care Support Network-partners with Washington County Coalition in health/mental health consultation in child care settings).

Provides family resources including the Complete Care Notebook for Raising Children with Special Needs, the Resource Guide for Families of Children Who are Deaf or Heard of Hearing and the Resource Guide for Families of Children with Autism Spectrum Disorders (in English and Spanish), and RI Resources Guide for Families of Children with Mental / Behavioral Health Conditions.

The Birth Defects Program conducts family focus groups/ interviews re: their health care system experiences (barriers / gaps in services).

The Initiative for Healthy Youth Program, the Northern RI Area Health Education Center and the Woonsocket CATCH grant coalition are reporting on adolescent medical homes (common definition, data, best practice models, recommendations).

**c. Plan for the Coming Year**

According to the 2005/2006 National Survey of CSHCN, 87.6% of families of CSHCN reported that services are organized in ways they can be easily used. This represents an 11.2% increase from the 2001 figure of 78.8%.

The Birth Defects Program will work with PPEP parent consultants to assess service / referrals provision to families of children with birth defects and any related issues (e.g., barriers to and gaps in services). Will continue to support streamlining the service delivery system for CSHCN and its partnerships with state /community partners to ensure coordination between programs & services.

Successful Start will continue to support the developmental screening and services in several communities.

The Initiative for Healthy Youth will continue to work with the Northern RI Area Health Education Center and the Woonsocket CATCH grant coalition, to provide technical assistance and tools on adolescent medical home, identify two more communities to pilot the adolescent home model and seek additional support for professional development through the MCHB TA resource.

Will continue to participate in and provide technical assistance to existing and emerging community systems development initiatives, including CATCH projects and child and family coalitions throughout the state. The DCFHE will support the community of Woonsocket to become a CATCH community. In addition, the Child Care Support Network will continue partnering with the Washington County Coalition to offer health and mental health consultation in child care settings.

Will collaborate with DHS, Neighborhood Health Plan of RI, Family Voices RI, and the RI Parent Information Network to identify and alleviate the barriers of coordinating care for CYSHCN. Parent consultants will continue to assist medical homes in developing linkages with community resources and assist families in accessing those resources.

Will continue to print, distribute, and evaluate the Complete Care Notebook for Raising Children with Special Needs, the Resource Guide for Families of Children Who are Deaf or Heard of Hearing, the Resource Guide for Families of Children with Autism Spectrum Disorders (in English and Spanish), and the RI Resource Guide for Families of Children with Mental / Behavioral Health Conditions.

The Birth Defects Program will continue to work with PPEP parent consultants to assess what services and referrals have been provided to families of children with birth defects and any related issues (e.g., barriers to and gaps in services).

Will continue to participate in the implementation and continuous quality improvement of the CEDARR Initiative.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	5.8	5.8	5.8	6.4	6.4
Annual Indicator	5.8	5.8	5.8	5.8	37.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	37.6	37.6	37.6	38.4	38.4

**Notes - 2007**

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

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

**a. Last Year's Accomplishments**

The DCFHE worked to increase the percentage of CYSHCN successfully transitioning to adult health care, work, and independence.

Pediatric Practice Enhancement Project (PPEP) participating sites have been working on identifying YSHCN in need of transition support. In FY2007, the OSHCN held focus groups to develop and test the adolescent healthcare transition toolkit.

The OSHCN, in collaboration with the RI Chapter of the American Academy of Pediatrics, developed and administered a survey to all licensed practicing primary care pediatricians in Rhode Island in order to further understand the health care transition process from the perspective of physicians. The findings of the survey were analyzed to develop outreach, training, and education strategies for youth, families, and health care professionals.

The DCFHE worked with the adult and pediatric rehabilitation units at RI Hospital to facilitate a seamless transition to adult rehabilitative care. The DCFHE sponsored an interactive session at the 2007 Medical Home Partnership meeting in which national and local transition specialists brought awareness to issues concerning transition.

The OSHCN worked closely with DHS in the implementation and evaluation of the CEDARR Initiative and the transitioning of CSHCN from fee-for-service Medicaid to Medicaid managed care. The OSHCN ensured that YSHCN in Medicaid Managed Care were provided assistance in transitioning from pediatric to adult medicine.

The DCFHE continued to participate on the RI Transition Council that provides technical assistance to the state's regional transition centers and monitors the transition system.

In collaboration with RIDE, the DCFHE participated in a 3-year evaluation study of students who have graduated from high school to determine the effectiveness of CYSHCN services.

The DCFHE produced and disseminate an annual Disability Data Book on individuals with disabilities, including CYSHCN who are transitioning to adulthood.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the Children's Neurodevelopment Center and PPEP, both of which serve CSHCN transitioning to adult health care		X		

systems				
2. Continue to participate on the Rhodes To Independence Youth In Transition Subcommittee				X
3. Continue to participate on the Rhode Island Transition Council				X
4. Continue to efforts to improve the transition process through provider surveys and by fostering collaborations between pediatric and adult providers				X
5. Continue to use the Complete Care Notebook as a model of a medical summary that can flow from the pediatric to adult provider at the time of transition		X		
6. Provide support and assistance to DHS in administering the CEDARR Initiative				X
7. Provide support and assistance to DHS and Neighborhood Health Plan of RI in transitioning CSHCN to Medicaid managed care and providing appropriate services to this population				X
8. . Produce and disseminate publications including data on individuals with disabilities and CSHCN transitioning to adulthood			X	
9.				
10.				

**b. Current Activities**

HEALTH, the RI AAP, Rhodes to Independence and Healthy and Ready to Work are conducting a statewide needs assessment of health care providers re: the transition process and to ID their capacity to accept transitioning youth with disabilities and chronic health conditions); family / youth outreach and education (multiple resources for youth, parents) & healthcare provider resources (including the Portable Medical Summary & the Physicians Checklist.

The RI Partnership Conf focused on transitions & presented the parent and youth checklists (used to encourage independence / principles of self-determination). PPEP sites are implementing the adolescent healthcare toolkit and especially the Physician Toolkit. The Toolkit has been presented at several conferences/forums. A parent consultant assists in coordinating transition activities/materials development.

Continue working with the Adolescent Leadership Council of Hasbro Children's Hospital (TALC), and a youth advisory board & Brown University students/ RI teenagers to obtain advise on youth materials and policy direction.

Collaborating with DHS collaborate in the implementation/evaluation of the CEDARR Initiative and the transitioning of CSHCN from fee-for-service Medicaid to Medicaid managed care.

According to the NS-CSHCN, the % of youth with SHCN who received the services necessary to make appropriate transitions to adult health care, work and independence increased 9-fold from 4.1% in 2001 to 37.6% in 2005/2006. .

**c. Plan for the Coming Year**

The DCFHE will continue to work to increase the percentage of CSHCN successfully transitioning to adult health care, work, and independence.

The OSHCN will continue to contract with the Transition Council, PPEP, and TALC addressing and sponsoring activities concerning the health and wellness of young adults with disabilities and chronic conditions. The educational component of the health and wellness activities will explore responsibility, decision-making, healthy lifestyles, and reducing secondary conditions. The

physical activity component will involve activities such as volleyball, kayaking, bowling, and cycling.

The DCFHE will continue to make the adolescent healthcare toolkit available to youth, parents and physicians and provide technical assistance as indicated. The DCFHE will continue to participate on the Rhodes To Independence, Youth In Transition Subcommittee and the RI Transition Council.

The DCFHE will continue to work closely with DHS in the implementation and evaluation of the CEDARR Initiative and the transitioning of CYSHCN from fee-for-service Medicaid to Medicaid managed care.

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

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	85.5	87.7	86.5	86.5	80.5
Annual Indicator	85.2	86.7	83.1	82.2	84.4
Numerator	10829	11180	10968	10504	10710
Denominator	12710	12895	13199	12778	12690
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	84.5	84.5	84.9	85	85

**Notes - 2007**

Data for 2007 is estimated.

Data for this performance measure reflects the 4:3:1:3:3 series collected through the National Immunization Survey. Data will be updated when final survey results are available.

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

**Notes - 2006**

Data for 2006 is provisional.

Data for this performance measure reflects the 4:3:1:3:3 series collected through the National Immunization Survey. Data will be updated when final survey results are available.

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

## **Notes - 2005**

Data for this performance measure reflects the 4:3:1:3:3 series collected through the National Immunization Survey. Data will be updated when final survey results are available.

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

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

The DCFHE continued to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and the public to ensure that children in RI receive timely, age-appropriate immunizations. The DCFHE focused its improvement rates on populations new to the country and state. In addition, the DCFHE continued to offer injectable and intranasal influenza vaccine for appropriate use in children ages six months through 18 years.

In FY2007, the DCFHE continued its assessment of immunization rates of children receiving care through home child care providers.

The DCFHE distributed a newly designed immunization requirement manual to childcare centers, in-home day cares, Head Start agencies, and schools. The manual outlined mandatory vaccination requirements and offered tools and guidelines for assessing vaccination status of children in school settings. The DCFHE created provider and patient educational materials targeting culturally diverse populations on new childhood vaccines (meningococcal conjugate and pertussis booster). The DCFHE continued to evaluate and update the Immunization Program website.

The Immunization Program worked with the Education Coordinators at all of the state's birthing hospitals to distribute culturally appropriate Health and Safety Records in the hospital discharge packages. The DCFHE hosted its annual educational conference for school nurse teachers and its annual Immunize for Life event at the Warwick Mall.

KIDSNET continued to send families of all newborns congratulations cards, which include messages about the importance of immunizations. KIDSNET allows providers to independently generate reports on their patients' immunization status.

All Early Intervention sites were connected to KIDSNET and all WIC agencies have access to KIDSNET. KIDSNET works with managed care organizations in the state to exchange immunization information for the purpose of health plan performance (HEDIS) reporting. In addition, health plans have direct access to the KIDSNET system.

KIDSNET tracks immunizations for all children who receive state supplied vaccine. KIDSNET sends families of all newborns a congratulations card, which includes information about the importance of timely immunizations. Updates were made to the KIDSNET immunization algorithm to meet current immunization guidelines. The algorithm (available on the program's website) provides recommendations for when a vaccine is next due and when a series is complete. The Immunization Program continues to use KIDSNET to conduct practice based assessments.

The DCFHE continues to use newborn developmental risk assessment to capture maternal Hepatitis B information and newborn hepatitis B vaccination and treatment information, which is stored in KIDSNET. Infants with Hepatitis B positive mothers were referred to the Family Outreach Program for case management to ensure completion of the Hepatitis B vaccination series. In 2006 all of the 60 babies born to HbsAG-positive women received HBIG and HepB within 24 hours of birth.

Newborn developmental risk screening and KIDSNET continued to capture and store maternal Hepatitis B information. The Family Outreach Program provides follow-up and case management.

KIDSNET released a guide for HL7 immunization transactions to submit electronic immunization data to KIDSNET in standard format. The HL7 data exchange was successfully tested with one

community health center and one electronic medical record.

The WIC Program continued to assess the immunization status of children receiving WIC services based on DTaP. In addition, the Child Care Support Network continued to provide immunization informational materials to families accessing center and home-based child care services.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide all recommended vaccines for all children in Rhode Island, including influenza vaccine during influenza season, for all children ages 6 months through 18 years			X	
2. Provide free immunizations to uninsured and newly emigrated children	X			
3. Revise and distribute culturally and linguistically appropriate immunization materials to families, health care providers, child care providers, and schools throughout the state			X	
4. Continue to update the Immunization Program website to include specific sections for health care professionals, child care providers, school personnel, and culturally diverse families			X	
5. Host a biannual conference for school nurse teachers to provide up-to-date information on a variety of health care issues, including immunizations		X		
6. Host an annual immunization awareness event at the Warwick Mall			X	
7. KIDSNET will continue to track children's immunization status				X
8. Continue to enroll new pediatric and other providers of services to children and families in KIDSNET				X
9. Provide technical assistance, consultation, and resource materials to child care providers to ensure that all children in child care are up-to-date on their immunizations			X	
10.				

**b. Current Activities**

The DCFHE provides all ACIP recommended vaccines to providers, free immunizations to uninsured children, and education materials to providers / public ensuring children receive immunizations. TA/training continue for Vaccine for Children-certified providers via the school nurse teacher conference, provider breakfast and "Immunize for Life" event. Vaccine is directly delivered to provider offices. DCFHE is purchasing/ distributing adult influenza vaccine this year.

KIDSNET tracks the immunization status of children who receive state supplied vaccine. Providers may generate KIDSNET reports re: their patients' immunization status. KIDSNET monitors providers' system usage and reports quarterly. Managed care organizations / KIDSNET exchange immunization information to enhance MCO HEDIS reporting.

The Child Care Support Network offers health consultation to childcare centers/ family childcare homes. Nurses review child health records (including immunization status), provide staff training and preventative health/safety TA, distribute educational materials, and refer families to

community services and resources.

EI sites are being connected to KIDSNET. WIC sites view KIDSNET to access children's immunization status, and refer as needed. KIDSNET captures Newborn developmental risk screening and stores maternal Hepatitis B information. The Family Outreach Program provides follow-up and case management.

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

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

The DCFHE will continue to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and to the public to ensure that children in RI receive timely, age-appropriate immunizations. In addition, the DCFHE will continue to offer both injectable and intranasal influenza vaccine for appropriate use in children ages six months through 18 years.

The DCFHE continues to provide technical assistance and training for all Vaccine for Children-certified providers. The DCFHE will distribute patient and provider educational and resource materials and host its biannual school nurse teacher conference and its annual immunization event at the Warwick Mall.

In coordination with other DCFHE programs, a revised and updated birthing hospital educational packet will be made available to RI birthing hospitals.

The DCFHE will continue purchasing and distribution of adult influenza vaccine.

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

KIDSNET will continue to update the immunization algorithm and data quality reports so that all reports and displayed data reflect current guidelines. Reports regarding invalid doses will be moved to the web for easy accessibility to immunization providers. Ongoing improvements to the reports available for the immunization assessment team are also planned. KIDSNET will continue to expand HL7 interface with electronic medical records and develop web based on-line data entry. Exemptions to vaccinations may also be added to KIDSNET in FY2009.

IN FY2009, KIDSNET will monitor the use of the immunization report that pediatric providers participating in KIDSNET generate, and will continue to share the use of such reports in a monthly newsletter and on a quarterly basis at stakeholder meetings and as a performance measure. KIDSNET will continue to work with managed care plans to exchange immunization information for the purpose of health plan performance (HEDIS) reporting and allow health plans direct access to the KIDSNET system.

In FY2009, newborn developmental risk screening and KIDSNET will continue to capture and store maternal and newborn Hepatitis B information. The Family Outreach Program will provide follow-up and case management.

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

#### **Tracking Performance Measures**

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	21.3	21	20.5	18.3	19.3
Annual Indicator	19.6	18.3	18.3	18.1	18.0
Numerator	386	361	361	388	386
Denominator	19730	19730	19730	21390	21390
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	18.3	19	18.8	18.7	18.5

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

The DCFHE is committed to reducing teen birth rates and other risk behaviors through a three-pronged approach: 1) access to health care services, within the context of adolescent medical home including family planning, 2) youth development programming that prepares adults and institutions to meet the developmental needs of youth, and engages youth in building skills, attitudes, knowledge and experience that prepare them for the present and future, and 3) coordinated school health programs, including sexuality and family life education within the context of comprehensive health education.

In FY2007, the DCFHE supported nine Title X family planning clinics to provide reproductive health services. The Women's Health Screening & Referral Program (WHSRP) provided no cost pregnancy testing and comprehensive health risk assessment to teens in eight Title X clinics; those with a negative pregnancy test were linked to family planning services; those with a positive test were referred to the Adolescent Self-Sufficiency Program. Teens with identified health risks (i.e. smoking, nutrition, mental health services, intimate partner violence, etc.) were referred to appropriate follow-up services.

Youth In Action provided family planning outreach, education, and referral to racially and ethnically diverse young men in Providence. Young men in need of family planning services were referred to a Title X site. Consumers who called the Family Health Information Line were provided with "Ten Tips on Parenting Teens" and referrals. The DCFHE, in partnership with the RI Department of Education, continued to sustain the website [www.ParentLinkRI.org](http://www.ParentLinkRI.org) for parents of 9-17 year olds and providers, which provided monthly parenting tips. School based health centers (SBHCs) continued to provide preventive health and mental health services in racially and ethnically diverse communities. The Met (state run alternative) School SBHC provides birth control onsite with parental consent. Teens using other SBHCs who are in need of birth control are referred to a Title X site.

Consumers who called the Family Health Information Line were provided with "Ten Tips on Parenting Teens" and referrals. The DCFHE, in partnership with the RI Department of Education, continued to sustain the website [www.ParentLinkRI.org](http://www.ParentLinkRI.org) for parents of 9-17 year olds and providers, which provided monthly parenting tips.

Supported the Men2B Program in three urban communities, training men to be positive role models for boys. A pilot project at the men's prison was extended into FY2006. A pilot project at the men's prison was extended into FY2006. Through thrive!, the DCFHE is working to advance the development of a statewide infrastructure for coordinated school health programs that includes comprehensive sexuality education.

Participated on an interagency workgroup to use data to better understand teen birth trends. The

DCFHE continued to track births to teens and examine trends by demographic factors. In addition, the Youth Risk Behavior Survey (YRBS) and School Accountability for Learning and Teaching (SALT) have been used to look at risk behaviors. thrive! issue briefs on variety of topics, including sexual behavior, were updated with data from the YRBS and SALT surveys. The briefs were e distributed to school administrators to help inform discussions about a variety of health issues, including teenage pregnancy prevention.

Continued in a three-year contract with the Providence Plan to examine the health and educational outcomes of teen mothers and their children. The study is focused on the state's core cities, where the majority of teen births occur. The relationship of neighborhood indicators to teen pregnancy and child wellbeing will be examined. The study will also identify opportunities for the prevention of repeat pregnancies.

Participated, in an advisory capacity, in the newly formed RI Teen Pregnancy Coalition, which seeks to reduce teen births and repeat births and was involved in the December 2006 RI Kids Count Issue Brief on teen pregnancy and parenting in RI. The RI Prematurity Task Force is including improved comprehensive school sex education in its recommendations, a shared goal with the RI TPC.

Worked with a CATCH project to determine the extent to which area practices reflected the definition of adolescent medical home.

Hired 8 youth action researchers to conduct action research to determine reasons for the high pregnancy and STD rates among Providence youth.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide adolescents with access to confidential family planning services, pregnancy testing, and comprehensive health risk assessment	X			
2. Support the RI Prematurity Task Force implementation of recommendations				X
3. Participate on RI Children's Cabinet Youth Development Advisory Committee to build state capacity to meet the needs of adolescent's aged 9 to 25.				X
4. Participate on the statewide Teen Pregnancy Prevention Coalition and provide staff support to RI alliances for after-school programming and youth development				X
5. Define and measure medical home models for teens and young adults				X
6. Implement a Youth Consultant Program to strengthen the Division's capacity to involve youth in program development				X
7. Continue to support a website for parents of 9-17 year olds and professionals			X	
8. Continue to support and expand the Men2B Program		X		
9. Continue to administer the Thrive coordinated school health initiative				X
10. Continue to track teen pregnancies by demographic and other factors				X

**b. Current Activities**

Family planning services are provided to teens, the WHSRP provides free pregnancy testing/comprehensive health risk assessment; teens with neg pregnancy test are linked to family

planning services; teens with positive test are referred to the Adolescent Self-Sufficiency Program.

HEALTH's Task Force on Prematurity is exploring a Medicaid family planning waiver based on income, developing a medical home for preterm infants, developing strategies to assist schools meet/ maintain state comprehensive family life/ sexuality education standards, enhancing family-support programs for high risk teen families, and expanding preconception care opportunities.

Youth In Action provide family planning outreach, education/ referral services to young men in Providence.

Is an active member of the RI Teen Pregnancy Coalition (RI TPC).

Engaged minority youth in ethnographic research and recommendation setting around adolescent health policy/ practice. The results of their efforts were shared widely within HEALTH and our partners.

The [www.ParentLinkRI.org](http://www.ParentLinkRI.org) website provides monthly parenting tips.

Via contract, transitioning the Men2B Program to a sustainable statewide program. An evaluation of M2B including recommendations for sustainability is being produced.

Continue to track teen births (e.g., race/ethnicity, city/town of residence, etc.) and other factors, work with the Providence Plan to determine the health and educational outcomes of children born to teens and of the teen mothers.

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

In FY2009, the DCFHE will continue to provide teens with access to family planning services, pregnancy testing, and comprehensive health risk assessment. DCFHE will continue to implement and work to expand the WHSRP to assure that youth and young adults seeking pregnancy tests receive referrals to risk prevention services and family planning as appropriate.

The RIDH's Task Force on Prematurity will continue to formulate plans for implementing its ten recommendations. Recommendations related to teen pregnancies and births include: exploring the feasibility of a Medicaid family planning waiver based on income (the strengthen teen access to contraception), developing a coordinated medical home for preterm infants (the primary risk factor for rehospitalization is a teen parent), developing strategies to assist schools meet and maintain state comprehensive family life and sexuality education standards, enhancing family-support programs for high risk teen families to improve outcomes for teens and their children and prevent subsequent teen pregnancies, and expanding preconception care opportunities before and between pregnancies for all women, including teens.

Youth In Action will continue to provide family planning outreach, education, and referral to young men in Providence.

The DCFHE adolescent medical home workgroup will continue to work to identify new models of teen medical homes. The DCFHE will continue to work with the Northern RI AHEC and the Woonsocket CATCH grant Coalition. DCFHE will seek funds to support an Adolescent Medical Home issue brief and conference for FY 08 or 09.

The DFCHE will seek new opportunities to engage youth in action research in a variety of health risk areas.

The website [www.ParentLinkRI.org](http://www.ParentLinkRI.org) will continue to provide parents and providers with connection to programs and resources and will continue to be promoted as part of a coordinated communications strategy. The DFCHE will continue to support the Men 2B Program through its contract with the RI Mentoring Partnership. DFCHE is actively seeking partners who can manage ParentLinkRI and Men@B outside of State government.

DCFHE will continue to seek funding to support a pilot Plain Talk project in RI. intended to reduce teen birth rates and rates of sexually transmitted diseases.

DCFHE staff will continue to support RI alliances for after-school programs and youth development by participating on advisory committees and workgroups. Thrive! will continue to focus on strengthening the infrastructure to support coordinated school health programs.

The DCFHE will continue to track births to teens and examine trends by demographic factors. YRBS and SALT will continue to be used to look at risk behaviors, after-school activities, and time left unsupervised.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	51.5	51.7	51.9	54	34.3
Annual Indicator	48.5	31.4	32.7	33.2	36.3
Numerator	7094	4600	4780	4230	4625
Denominator	14628	14628	14628	12740	12740
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	36.3	36.3	36.3	36.9	37.2

**Notes - 2007**

The Basic Screening Survey (BSS) was conducted in the fall of 2007. The BSS was funded by the CDC and conducted in 35 States. The actual number of 3rd graders screened was 1303.

Denominator from US Census estimate for 2006.

**Notes - 2006**

Data are estimated.

Denominator from US Census estimate for 2006.

**Notes - 2005**

2005 Data are estimated.

As part of Rhode Island's State Systems Development Initiative (SSDI) grant, the Department of Health along with the Dental Program are interested in obtaining information from school records. This involves working with the Department of Education to obtain parental consent. Such permission is required under federal educational privacy laws (FERPA).

In addition, The Robert Wood Johnson Foundation provided \$737,308 for oral health projects. The grant was administered by The Rhode Island Foundation and organizations were invited to apply for funds to: increase the supply of dentists, dental hygienists and dental assistants by increasing the number of graduates from training programs in the state; increase the capacity of dental safety net providers that serve low-income or underserved children and adults; and expand the "Providence Smiles" model - a school-linked dental program - to the state's core cities.

Grants were awarded to 12 organizations for 15 projects throughout the state for an 18-month period.

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

In FY2007, the DCFHE continued to work with numerous state agency and community partners to improve children's access to oral health services and prevent dental caries in children.

Throughout FY2007, parents of young children receiving home visiting services through the Family Outreach Program continued to receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care.

The Healthy Child Care RI Initiative continued to support activities to ensure that parents of children in child care had access to culturally and linguistically appropriate informational materials about childhood dental caries and the importance of preventive dental care. The Child Care Support Network provided dental health curriculum materials to 15 child care centers.

Families receiving WIC services were provided with information about early childhood caries as well. All local WIC staff continued to be offered technical training on oral health topics. Education materials addressing oral health issues were developed by the WIC Program in conjunction with HEALTH's Oral Health Program and are currently used during counseling during WIC certification appointments. Through this grant, HEALTH promotes "common sense" oral health practices for young children by teaching parents and Head Start providers about early childhood tooth decay prevention. The "common sense" practices include drinking fluoridated water, daily brushing with fluoridated toothpaste, and annual visits to a dentist.

SBHCs in Providence, Woonsocket, Pawtucket, and Central Falls referred students to dental services provided by local community health centers.

The DCFHE continued to participate on HEALTH's Oral Health Coordinating Team, which is working to improve the oral health of school-age children, including CSHCN. HEALTH also participated in the work of the RI Oral Health Access Project. The project is working to increase access to primary and preventive dental services for children and families covered by Medicaid and for Rhode Islanders underserved for dental care.

During FY07, the DCFHE continued to survey mothers of two year-olds via the Toddler Wellness Over Survey (TWOS). The survey includes the following questions related to oral health: "Does your child have tooth decay or cavities?" "How often does your child fall asleep with a bottle or cup?" Data indicate that approximately 2% of two year-olds had tooth decay and 26% reported their child falls asleep with a bottle or cup.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the Family Outreach Program, which provides culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care		X		
2. Continue to provide families receiving WIC services with culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care		X		
3. Support school-based health centers in providing children and youth with direct access to and/or referrals to oral health services	X			
4. Provide technical assistance, consultation, and materials on children's oral health issues to child care providers and parents through the Child Care Support Network			X	
5. Support the activities of the Oral Health Program, including participation on the program's Early Childhood Oral Health Coalition				X
6. Conduct the TWOS survey to help assess the oral health status of two year-olds				X
7.				
8.				
9.				
10.				

**b. Current Activities**

The Family Outreach/ WIC programs provide culturally appropriate information about early childhood caries/prevention.

The state's seven SBHCs in middle and high schools providing teenagers with access and referral to preventive health services including oral health services, are in jeopardy due to loss of state funding. The future of SBHCs in RI uncertain.

The DCFHE supports HEALTH's Oral Health Program (in the Division of Community Health & Equity) that hosted the State Oral Health Summit to solicit feedback on the draft RI Oral Health Plan. Once finalized, the RI Oral Health Plan will be widely disseminated to policymakers and oral health stakeholders statewide.

TWOS data continue to be collected and analyzed.

**c. Plan for the Coming Year**

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

Parents of young children who receive home visiting services through the Family Outreach Program will continue to receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care.

Families receiving WIC services will continue to be provided with culturally and linguistically appropriate information about early childhood caries and the importance of preventive dental care. . In FY2008, the Coalition will finalize the early childhood oral health curriculum and

implement the curriculum in Head Start agencies and child care centers.

DFCHE-supported SBHCs will provide dental services to children and youth at their main health enter sites if the SBHCs they are operating can not be sustained..

In FY2008, the Child Care Support Network will begin to offer health consultation to child care centers and family child care homes throughout the state. Trained consultants (nurses) will conduct child health records review, provide staff training and technical assistance on issues related to preventative health and safety, distribute educational materials, and will work directly with families to provide referrals to community services and resources. Oral/dental health will be included in the range of physical and developmental health issues that the health consultants will address.

The DCFHE will continue to support the work of HEALTH's Oral Health Program. In FY2008, the Oral Health Program will finalize and disseminate the RI Oral Health Plan.

The DCFHE will continue to conduct the TWOS survey and analyze responses to the oral health questions.

The Family Outreach/ WIC programs provide culturally appropriate information about early childhood caries/prevention.

The state's seven SBHCs in middle and high schools providing teenagers with access and referral to preventive health services including oral health services, are in jeopardy due to loss of state funding. The future of SBHCs in RI uncertain.

The DCFHE supports HEALTH's Oral Health Program (in the Division of Community Health & Equity) that hosted the State Oral Health Summit to solicit feedback on the draft RI Oral Health Plan. Once finalized, the RI Oral Health Plan will be widely disseminated to policymakers and oral health stakeholders statewide.

TWOS data continue to be collected and analyzed.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	1	1.5	1.5	1.5	1.5
Annual Indicator	2.1				
Numerator	4				
Denominator	194965	186874	186874	181152	181152
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average			Yes	Yes	Yes

cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5

**Notes - 2007**

Data are for children aged 1 -14.  
Denominator is from the US 2006 estimated Census.

**Notes - 2006**

Data are for children aged 1 -14.  
Denominator is from the US 2006 estimated Census.

**Notes - 2005**

Data are for children aged 1 -14.  
  
Denominator is estimated using Statewide Planning numbers for 2005.

**a. Last Year's Accomplishments**

The number of deaths to children ages 14 years and younger caused by motor vehicle crashes in Rhode Island is very small. In 2006, motor vehicle accidents resulted in two child deaths.

In FY2007, the Family Outreach Program continued to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low-income families receiving home visits were referred to the RI Safe Kids Coalition, which provides free car seats to low-income families.

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

Deaths to children caused by motor vehicle crashes where the driver was impaired due to alcohol and/or drug intoxication is a public health concern in Rhode Island as well as the rest of the country. The Women's Health Screening & Referral Program (WHSRP) provides free pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in eight Title X family planning sites. As a part of the WHSRP, women are assessed for risks related to substance abuse and referred for appropriate substance abuse evaluation and/or treatment services. In 2005, 20.2% of the women who participated in the WHSRP reported that they used alcohol and/or drugs.

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

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

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>

1. Continue to support the Family Outreach Program to provide families with young children with culturally and linguistically appropriate information and education about automobile safety	X			
2. Refer families to the RI Safe Kids Coalition, which provides free car seats to low-income families		X		
3. Provide culturally and linguistically appropriate information and technical assistance to families with children in child care settings and child care providers about automobile safety through the Child Care Support Network			X	
4. Refers risk positive women who receive pregnancy tests to substance abuse assessment and/or treatment services through the Women's Health Screening & Referral Program	X			
5. Continue to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Family Outreach Program continues to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low-income families receiving home visits continue to be referred to the RI Safe Kids Coalition, which provides printed informational materials to the public and free car seats to low-income families.

The Child Care Support Network provides informational materials regarding the proper use of car seats, air bag safety, and the safest location in the car for children to families with children in child care and to child care providers.

The Women's Health Screening & Referral Program (WHSRP) continues to provide free pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in eight Title X family planning sites. Women with risks related to substance abuse are referred for appropriate substance abuse evaluation and/or treatment services.

The DFCHE will continue to track children's death caused by motor vehicles and examine trends by demographic factors and to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable

YRBS and SALT will continue to be used to look at risk behaviors including alcohol and other drug use, after-school activities, and time left unsupervised.

**c. Plan for the Coming Year**

The DCFHE will continue to work to reduce the number of deaths to children caused by motor vehicle crashes.

In FY2009, the Family Outreach Program will continue to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat).

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

proper use of car seats, air bag safety, and the safest location in the car for children to families with children in child care and to child care providers. In FY2009, the Child Care Support Network will continue offering health consultation to child care centers and family child care homes throughout the state. Health consultants will provide information and technical assistance on a variety of child health and safety topics, including automobile safety.

Deaths to children caused by motor vehicle crashes where the driver was impaired due to alcohol and/or drug intoxication is a public health concern in Rhode Island and in the nation. The Women's Health Screening & Referral Program (WHSRP) will continue to provide free pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in eight Title X family planning sites. As a part of WHSRP, women are assessed for risks related to substance abuse and referred for appropriate substance abuse evaluation and/or treatment services.

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

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				28.5	31.5
Annual Indicator		28.3	32.9	32.9	31.2
Numerator		3616	4175	4070	3858
Denominator		12778	12690	12370	12365
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	32.5	32.5	32.7	33	33

**Notes - 2007**

2007 data from United States National Immunization Survey, 2004 Births.

**Notes - 2006**

2006 data are estimated.

**Notes - 2005**

Data from National Immunization Data [NIS] for 2004.

Exclusive breastfeeding was defined in the 2004 study as ONLY breast milk - no solids, no water and no other liquids. Previously, exclusive breastfeeding included breast milk and water.

**a. Last Year's Accomplishments**

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

In FY2007, the WIC Program continued to support a lactation support program for WIC participants six days a week in a birthing hospital. Mothers who receive adequate lactation support after giving birth are more likely to continue breastfeeding after they leave the hospital. WIC also continued to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support to WIC participants at all WIC sites and at the state's largest birthing hospital. Peer counselor trainings were held every six months to minimize service interruptions. WIC also sponsored WIC staff to attend a Certified Lactation Counselor training to ensure skilled and consistent breastfeeding services.

In FY2007, the DCFHE maintained partnerships with the RI Breastfeeding Coalition (RIBC) and the Physicians' Committee for Breastfeeding in RI (PCBRI) and collaborated with these groups to update and carry out the initiatives of the statewide breastfeeding promotion plan. The DCFHE actively promoted adoption of the Baby-Friendly Hospital Initiative, a global program developed to encourage and recognize hospitals that offer an optimal level of care for lactation. The DCFHE collaborated with RIBC, PCBRI, and health insurers to ensure the availability of electric breast pumps for low-income families. The DCFHE partnered with Rhode Island's Healthy Eating and Active Living (HEAL) Collaborative to promote obesity awareness and reduction and collaborated on implementing breastfeeding strategies for the obesity state plan.

During World Breastfeeding Week in FY2007, the DCFHE engaged state officials and the local media to recognize employers as Breastfeeding-Friendly Workplace Award in partnership with PCBRI. The WIC Program provided local WIC agencies with special funds to purchase sustainable breastfeeding promotion materials and to sponsor breastfeeding promotion events at their clinics.

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

KIDSNET continued to track the percent of mothers that breastfeed through Family Outreach Program and newborn developmental screening data. During FY2007, the DCFHE conducted both RI PRAMS and TWOS surveys which asks respondents about breastfeeding practices. PRAMS asks the mother whether she ever breastfed, whether she is still breastfeeding, and about barriers to breastfeeding. TWOS asks if the respondent ever breastfed and the duration she breastfed.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support a lactation support program for WIC participants in birthing hospitals	X			
2. Continue to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support to WIC participants in WIC sites and the state's largest birthing hospitals		X		
3. Sponsor WIC peer counselors and nutritionists to attend a Certified Lactation Counselor training.				X
4. Collaborate with key partners to update and implement the statewide breastfeeding promotion plan				X

5. Continue to enhance the statewide breastfeeding support infrastructure through partnerships with health insurers, visiting nurse agencies, birthing hospitals, and other community groups and agencies				X
6. Continue to disseminate culturally and linguistically appropriate breastfeeding informational materials targeting low-income families through WIC agencies and health care provider offices		X		
7. Update and distribute breastfeeding resources, including the breastfeeding website, Breastfeeding Resource Directory, and Breastfeeding Pocket Guide			X	
8. Continue to support the toll-free Family Health Information Line to refer breastfeeding callers to appropriate community resources			X	
9. Collect and track breastfeeding information through KIDSNET, the Family Outreach Program, PRAMS, and TWOS				X
10.				

**b. Current Activities**

WIC lactation support services are available 6 days a week in the state's largest birthing hospital. WIC supports a "mother-to-mother" peer counselor program at all WIC sites, Certified Lactation Counselor training for WIC peer counselors and nutritionists, and a planned statewide breast pump loan program. Peer counselor trainings are held at regular intervals. WIC collaborates with Parent Consultants to share resources and integrate breastfeeding peer counselor/ parent consultant services across programs.

DCFHE, RIBC, PCBRI, and the HEAL Collaborative are jointly implementing the statewide breastfeeding promotion plan. The DCFHE is actively promoting adoption of the Baby-Friendly Hospital Initiative, and collaborating with health insurers to define/deliver contractual breastfeeding benefits and helped pass legislation to allow women to breastfeed their children in any public place. The DCFHE partners with PCBRI to recognize Breastfeeding-Friendly Workplaces and with RIBC to promote World Breastfeeding Week.

The Family Health Information Line refers breastfeeding women/health care providers to resources. Consumer breastfeeding info is distributed to health care providers/families through hospitals, agencies, and private practices. The RI Breastfeeding Resource Directory and Breastfeeding Pocket Guide for Providers are made available to providers. A breastfeeding website is updated and maintained.

PRAMS survey data is collected and analyzed.

**c. Plan for the Coming Year**

DCFHE will continue to work to increase the percentage of mothers who breastfeed their infants at birth and at six months of age.

The WIC Program will continue to support visits by lactation consultants to WIC participants in the state's largest birthing hospital. WIC will also continue to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support to WIC participants at WIC sites and in the state's largest birthing hospital. Peer counselor trainings will continue to be held as needed to minimize gaps in staffing. WIC will continue to offer the Certified Lactation Counselor Certificate training to WIC peer counselors and WIC nutritionists who were not trained in previous years to ensure skilled and consistent breastfeeding services.

WIC will continue to co-sponsor educational talks and events for health care providers and will

continue to work on instituting and sustaining a statewide electric breast pump loan program.

The Child Care Support Network health consultants will provide child care providers with information about promoting breastfeeding for families and also assistance in how to help support mothers who want to breastfeed their child while he/she is in out of home child care.

DCFHE will continue to partner with RIBC, PCBRI, the HEAL Collaborative, and other community partners to update and implement the statewide breastfeeding promotion plan. The DCFHE will continue to collaborate with health insurers to enhance and deliver breastfeeding insurance benefits, to partner with PCBRI each year to recognize Breastfeeding-Friendly Workplaces, and to sponsor birthing hospitals to adopt the Baby-Friendly Hospital Initiative. The new public breastfeeding law will be actively promoted to employers.

DCFHE will continue to support World Breastfeeding Month activities and media promotion to encourage women to breastfeed their infants. The WIC Program will also continue to provide WIC agencies with special funds to purchase breastfeeding promotion materials and to sponsor World Breastfeeding Month events.

DCFHE will continue to support the toll-free Family Health Information Line to refer breastfeeding women and providers to appropriate community resources, and to distribute culturally and linguistically appropriate breastfeeding materials to health care providers and low-income families through hospitals, agencies, and private practices and will continue to update the breastfeeding website.

KIDSNET will continue to track the percentage of mothers that breastfeed their infants. The DCFHE will continue to collect information on intended feeding practices at the time of hospital discharge and conduct RI PRAMS and TWOS to obtain and analyze data on breastfeeding practices among recent mothers and mothers of two year olds.

The Child Care Support Network health consultants will provide child care providers with information about promoting breastfeeding for families and working mothers.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	99.3	99.3	99.5	99.5	96.5
Annual Indicator	99.6	99.6	99.4	96.0	97.3
Numerator	13705	13468	13336	12597	12783
Denominator	13763	13521	13416	13121	13139
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	97.3	97.3	96.6	96.8	96.8

**Notes - 2007**

Data for 2007 was provided by the Kidsnet Database and reflects total screened before DISCHARGE.

Denominator reflects births occurring in Rhode Island minus 52 infants that died within hours of birth.

**Notes - 2006**

Data for 2006 was provided by the Family Health's Kidsnet Database and reflects total screened before DISCHARGE. Data for 2001 through 2005 were provided by the Rhode Island Hearing Assessment Program [RIHAP] which was unable to select infants screened before discharge.

Denominator reflects births occurring in Rhode Island minus 58 infants that died within hours of birth.

**Notes - 2005**

Data reflect births occurring in Rhode Island and should be considered estimated. VLBW infants that died within days or infants that died within hours are excluded from the denominator. Data for 2001 through 2005 were provided by the Rhode Island Hearing Assessment Program [RIHAP].

**a. Last Year's Accomplishments**

The RI Hearing Assessment Program (RIHAP) ensures that all newborns receive hearing screening prior to hospital discharge. The DCFHE utilizes KIDSNET to track RIHAP screening information, which originates through the newborn screening process. Infants with confirmed hearing impairment are referred to the RI School for the Deaf Family Guidance Program and Early Intervention. Family Outreach Program home visitors also continue to track infants who are lost to follow-up by RIHAP.

The newborn hearing-screening database is pre-populated with birth information collected on a new, integrated newborn developmental risk assessment and birth certificate system then sent to KIDSNET. Two way data exchange between KIDSNET and RITrack allows RIHAP to match birth data to assure that all infants have a hearing screen with a result in KIDSNET. RIHAP and KIDSNET follows up when a child was missed or if the data was never entered into KIDSNET. Rhode Island-specific Newborn Hearing Screening process algorithms adopted from the American Academy of Pediatrics Early Hearing Detection and Intervention (EHDI) guidelines were mailed to primary care providers caring for infants. A system was put into place to mail the algorithm to providers when a newborn in their practice requires follow-up related to the newborn hearing screen.

Informing brochures continued to be distributed in English and Spanish at three time points (prenatal, perinatal, postnatal). The brochures include information on several programs including bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET. RI PRAMS continues to collect data on parental awareness that babies are tested in the hospital for hearing loss.

The Birth Defects Program continues to work with the Newborn Screening Program to ensure that a final diagnosis of hearing loss in an infant is recorded and reported to the Birth Defects Program.

Also in FY2007, the newborn hearing screening quality assurance committee continued to meet. Representatives from the Newborn Screening Program, the Family Guidance Program at the RI School for the Deaf, and Early Intervention meet quarterly to assure that every baby referred has had audiological evaluation and that every baby diagnosed with a hearing loss is enrolled in Family Guidance and Early Intervention (or the parents have chosen not to participate).

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensure universal newborn hearing screening prior to hospital discharge			X	
2. Ensure that infants identified with hearing impairment are referred to the RI School for the Deaf and Early Intervention		X		
3. Continue to support the Family Outreach Program to track infants lost to follow-up by the RI Hearing Assessment Program		X		
4. Utilize KIDSNET to track hearing screening information and refer newborns who do not have a hearing screening to the RI Hearing Assessment Program for follow-up				X
5. Continue efforts to connect all pediatric audiologists in the state to KIDSNET				X
6. Continue to work to ensure that a final diagnosis of hearing impairment is recorded and reported to the Birth Defects Program				X
7. Collect and analyze information on family awareness about newborn hearing screening through PRAMS				X
8. Distribute integrated culturally and linguistically appropriate brochures that include hearing screening			X	
9.				
10.				

**b. Current Activities**

All newborns receive hearing screening prior to hospital discharge. It's tracked in KIDSNET. Infants who are identified with hearing loss are referred to the RI School for the Deaf Family Guidance Program / EI. The Family Outreach Program home visitors track infants lost to follow-up by RIHAP. The Birth Defects Program works with the Newborn Screening Program and KIDSNET to ensure that a final diagnosis of hearing loss in an infant is recorded and reported to the DCFHE.

KIDSNET continues to send RIHAP electronic birth records to assure all newborns were screened and a hearing screening result is in KIDSNET. Audiologists are connected to KIDSNET, making newborn hearing screening results available to these professionals. Programming to allow for reporting of diagnostic audiology tests into KIDSNET near completion

The DCFHE continues to distribute integrated newborn screening brochures to families when the hearing screening is completed in the hospital. A system for distribution of similar brochures at the prenatal and postnatal time points was developed. The postnatal brochure discusses the importance of following up on recommendations received following newborn hearing screening All brochures are available in English and Spanish.

Education materials have been translated; HEALTH and RIHAP websites updated.

A Resource Guide for Families of Children who are Deaf or Hard of Hearing has been developed and is being translated into Spanish.

**c. Plan for the Coming Year**

RIHAP will continue to assure that all newborns receive hearing screening prior to hospital discharge. The DCFHE will utilize KIDSNET to track RIHAP screening information, which originates through the newborn screening process. Infants who are identified with hearing loss will continue to be referred to the RI School for the Deaf Family Guidance Program and to Early Intervention. Family Outreach Program home visitors will also continue to track infants who are lost to follow-up by RIHAP.

KIDSNET will continue to send RIHAP a report that indicates which children do not have a hearing screening result in KIDSNET. RIHAP will follow-up to identify whether the child was missed or if the data was never entered into KIDSNET. KIDSNET will continue efforts to train all pediatric audiologists to access newborn hearing screening results and Early Intervention information and to use on-line diagnostic reporting into KIDSNET once that feature is available.

The DCFHE will continue to distribute integrated newborn screening brochures to families at the prenatal, hospital, and postnatal time periods. This brochure discusses the importance of following up on recommendations received following newborn hearing screening and is available in English and Spanish.

A family version of the newborn hearing-screening algorithm will be distributed in English and Spanish to families of infants requiring follow-up after the newborn hearing screen. Upgrades to the HEALTH and RIHAP websites will be completed. The DCFHE will continue to distribute the Resource Guide for Families of Children who are Deaf or Hard of Hearing to assist families in navigating and accessing services.

The Birth Defects Program will continue to work with the Newborn Screening Program and KIDSNET to ensure that a final diagnosis of hearing loss in an infant is recorded and reported. In addition, RI PRAMS will continue to survey recent mothers regarding parental knowledge that babies are tested in the hospital for hearing loss. PRAMS will provide data to evaluate if introduction of the brochures or family algorithm is related to an increase in awareness, particularly among subpopulations such as Spanish-speakers.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	4.7	4.7	5.4	7.2	7.5
Annual Indicator	5.2	7.2	7.6	4.1	5.2
Numerator	12890	18180	19114	9735	12347
Denominator	247822	252500	251500	237451	237451
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	5.7	5.7	5.7	6	6

**Notes - 2007**

2007 Data are estimated.

Data is from US Census Bureau March Current Population Survey [CPS]:  
Table HIA-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided.

**Notes - 2006**

Data is from US Census Bureau March Current Population Survey [CPS]:  
Table HIA-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided.

**Notes - 2005**

Data is from US Census Bureau March Current Population Survey [CPS]:  
Table HIA-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided.

**a. Last Year's Accomplishments**

Rhode Island is committed to ensuring that all children have access to insurance and quality health care. In FY2006, the state continued to enjoy one of the lowest rates of un-insurance among children in the country.

The DCFHE continued to support culturally diverse Family Resource Counselors (FRCs) in 20 community health center sites and four outpatient hospital clinics. FRCs performed outreach to uninsured and underinsured pregnant women, children, and families and provided assistance in completing applications for Rlte Care/Medicaid. In 2006, FRCs screened over 5,500 children for Rlte Care eligibility and assisted in completing 5,100 Rlte Care applications for children.

Family Health Information Line Information Specialists and parent consultants working in the DCFHE continued to receive training about Rlte Care and assisted with outreach activities. Information Specialists continued to refer callers without health insurance to Rlte Care and to FRCs in the community for further assistance in completing applications. DCFHE parent consultants continued to provide information about Rlte Care in schools and child care centers and at health fairs and community agencies.

Numerous DCFHE programs refer families who are uninsured or underinsured to FRCs in the community and directly to Medicaid. In 2007, Rlte Care enrollment among WIC participants rose to 85% (up from 75.1% in 2000). The Pediatric Practice Enhancement Project (PPEP) assisted over 2200 families with CYSHCN in 2007 on issues concerning insurance, education, and access to mental health services; nearly 25% of these families required direct assistance in accessing health insurance. The School-Based Health Center (SBHC) Initiative supported SBHCs in eight schools that refer uninsured students to Rlte Care. The Family Outreach Program and the Child Care Support Network also referred uninsured or underinsured families with young children to Rlte DCFHE

In FY2007 the DCFHE implemented a child care health consultation model. Child care health consultants will work with licensed child care providers to ensure that all of the children in their care have access to health insurance and facilitate the enrollment of those who are eligible but not enrolled.

In FY2007 Family Outreach Program workers provided information to all families receiving a home visit about new Medicaid recertification requirements. FOP workers continued to work with the Department of Human Services to streamline the recertification process

The DCFHE also provided technical assistance to several local CATCH projects and community coalitions. These groups worked at the local level to build the capacity of medical homes and link children and families to needed health and human services. The DCFHE was also a key partner in Covering Kids Rhode Island, a coalition of partners working statewide and in local project communities to ensure that all children and adults eligible for RItE Care are enrolled and retain their coverage

During FY2007, RI PRAMS continued to survey women two to four months after delivery and asked about their baby's health insurance status. Data indicate that 4.2% of respondents did not have health insurance for their baby. Of those that did have health insurance for their baby, Medicaid or RItE Care covered 52.6%. The TWOS survey also includes questions regarding health insurance. In addition, the DCFHE analyzed data from the National Survey of Children's Health to determine insurance coverage among children in Rhode Island.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the toll-free, bilingual Family Health Information Line, which refers families without health insurance to RItE Care and/or Family Resource Counselors in their community			X	
2. Support culturally diverse parent consultants to provide information about RItE Care at health fairs and in schools, child care settings, community-based agencies, and other forums			X	
3. DCFHE programs, including WIC, the Family Outreach Program, school-based health centers, and others will refer uninsured children and families to RItE Care		X		
4. Provide technical assistance to CATCH projects and community coalitions that are working at the local level to build the capacity of medical homes and link children and families to needed health and human services				X
5. Continue to participate on committees and coalitions working to increase insurance coverage among Rhode Islanders				X
6. Collect and analyze data from PRAMS on the health insurance status of new mothers and their children				X
7. Collect and analyze data from TWOS on the health insurance status of mothers and their children				X
8. Administer the PPEP that provides direct assistance to families in accessing and retaining health insurance.			X	
9. Child care health consultants will assist child care providers to ensure that children in their care are linked with Rite Care		X		
10.				

**b. Current Activities**

FRCs are supported in 20 community health centers and four outpatient hospital clinics to identify/enroll eligible children and families into RItE Care.

Family Health Information Line Information Specialists and DCFHE parent consultants receive training re: RItE Care, and assist with outreach activities.

DCFHE programs refer families to FRCs/ RItE Care/Medicaid. PPEP refers families to RItE Care, SSI, and Katie Beckett. PPEP parent consultants (trained on community resources) partners with Neighborhood Health Plan of RI for targeted outreach to families who's RItE Care is due to expire,

are certified (thru RIDHS) to verify citizenship documentation and determine eligibility.

WIC, the Family Outreach Program, and the Child Care Support Network refer uninsured or underinsured families with young children to Rlte Care.

TA is provided to local CATCH projects/coalitions to build the med home capacity and link children/families to health services.

The DCFHE supports the Governor's Health Care Initiative via a workgroup focusing on medical homes/primary care, and supports Covering Kids Rhode Island (a coalition of partners working statewide and in local project communities to ensure that all children and adults eligible for Rlte Care are enrolled and retain their coverage).

Continue to survey mothers thru RI PRAMS and TWOS.

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

Continue to ensure that eligible families are enrolled in Rlte Care or other Medical Assistance programs while monitoring the impacts of implementing the Deficit Reduction Act in RI

Family Health Information Line Information Specialists will refer callers without health insurance to Rlte Care and refer them to FRCs for further assistance in completing applications. DCFHE parent consultants will provide information about Rlte Care in schools and child care centers and at health fairs and community-based organizations.

Numerous DCFHE programs will continue to refer families to FRCs in the community and directly to Rlte Care/Medicaid.

PPEP Parent Consultants will assist families in accessing health/social services, including health insurance and assist in the verification of citizenship requirements. WIC, the Family Outreach Program, and the Child Care Support Network will also refer uninsured or underinsured families with young children to Rlte Care.

Child care health consultants will work with licensed child care providers to ensure that all of the children in their care have access to health insurance

In FY2008, the DCFHE will continue to provide technical assistance to several existing CATCH projects and community coalitions, including one in the city of Woonsocket, RI with a focus on adolescent medical home

The DCFHE will continue to support the Governor's Health Care Initiative, which promises to reverse the continued erosion of employer-sponsored health insurance for small businesses in Rhode Island. In addition, the DCFHE will continue as an active member of Covering Kids Rhode Island.

DCFHE will work with state and community partners to ensure adequate and appropriate health services for undocumented children. Currently, undocumented children are eligible for state-funded Rlte Care coverage. However, effective January 1, 2007, any non-citizen child who applies for Rlte Care will be denied coverage.

RI PRAMS will continue to survey women and ask about their baby's health insurance status. TWOS will continue to survey mothers of two year olds and obtain information on children's health insurance.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				42.3	36.2
Annual Indicator			42.0	35.6	35.6
Numerator			4930	3826	4443
Denominator			11737	10753	12482
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	35.9	35.6	35.8	35.8	35.8

**Notes - 2007**

Data reflects children aged 24 to 59 months old. Rhode Island's WIC data system changed in June 2006. The new system retains the same child idnum which reduces duplicates.

**Notes - 2006**

Data reflects children aged 24 to 59 months old. Rhode Island's WIC data system changed in June 2006. The new system retains the same child idnum which reduces duplicates.

Unable to revise data for 2005. Data for 2005 should be:

Performance Indicator 35.8%  
Numerator 4207  
Denominator 11750

**Notes - 2005**

Data available for only 2004 and 2005. The average of the 2 years was 42.3%. The target for 2006 became 42.3%.

**a. Last Year's Accomplishments**

Preventing obesity is one of the five priorities of the Director of the RI Department of Health. The Department's activities related to obesity are spearheaded by the Initiative for Healthy Weight.

In FY2007, 5 action teams : Early Childhood, School-Age Children, Communities, Data and Evaluation, and Communications continued to implement action plans incorporated into the overall Initiative for Healthy Weight strategic plan.

In addition to working with the Initiative for Healthy Weight to support infrastructure building, the DCFHE also supported activities to prevent childhood obesity through the WIC Program. WIC continued planning of rollout of the Value Enhanced Nutrition Assessment (VENA). In 2008, State Agency Staff provided training to Local Agency staff on emotion based counseling and rapport building. USDA approved WIC's implementation plan for VENA that will nutrition and counseling services more client-centered and result in improved rates of sustained behavior change. WIC continued to provide WIC sites with technical assistance and training on accurate assessments regarding overweight children.

The Farmer's Market Nutrition Program continued to offer families vouchers to buy fresh fruits and vegetables each summer. In FY2007, WIC partnered with Johnson & Wales University to provide nutrition education around increasing fruit and vegetable intake at local farmer's markets.

WIC continued to provide nutrition information to community partners (hospitals, health centers, daycares, Early Intervention Programs) to provide consistent messages to parents and enhance communication among community partners.

The Breastfeeding Program conducted a range of activities to educate and promote breastfeeding and provided direct breastfeeding support to women enrolled in WIC.

During FY2007, Data and Evaluation Unit staff worked closely with the Division of Community Health and Equity's Initiative for Healthy Weight on issues related to data and surveillance, and analyzed WIC data to determine trends of obesity between 2-5 year-olds participating in WIC.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement the Initiative for Healthy Weight RI's state plan for promoting healthy eating and active living				X
2. Support statewide breastfeeding promotion initiatives			X	
3. Provide breastfeeding support and counseling to WIC clients	X			
4. Provide technical assistance and support to school district Health and Wellness Councils				X
5. . Provide funding and technical assistance to six communities to develop guidelines, environmental supports, and programs that promote healthy eating and active living				X
6. Support the WIC Program's adoption of Value Enhanced Nutrition Assessment to provide client-focused nutrition education in response to identified risks				X
7. Administer the Farmer's Market Nutrition Program to increase WIC clients' access to and consumption of locally-grown, fresh produce		X		
8. Continue to implement and develop the functionality of the WIC Program's RI Webs computer system				X
9. Continue outreach efforts to providers to improve access to WIC and consistency of nutrition education messages				X
10. Continue to analyze WIC Program data to determine the percentage of children who are overweight and obese and to determine risk factors of and trends for obesity				X

**b. Current Activities**

DCFHE supports hospitals in adopting the Baby-Friendly Hospital Initiative, lactation support and promotion activities. Direct support and counseling is provided to breastfeeding WIC clients.

The WIC WEBS is improving WIC services. WEBS calculates growth charts and risk factors associated with anthropometric data, significantly improving the accuracy of risk assessments for obesity.

The Farmer's Market Nutrition Program is currently underway for summer 2008 and partnering with Johnson & Wales University for nutrition education/ cooking demonstrations.

Data and Evaluation Unit staff work with the Division of Community Health and Equity's IHW on issues related to data and surveillance, and analyzes WIC data to determine trends of obesity between 2-5 year-olds participating in WIC.

**c. Plan for the Coming Year**

In FY2009, the DCFHE will continue to work to reduce childhood obesity by partnering with the Initiative for Healthy Weight on infrastructure building activities and by promoting good nutrition through the WIC and Breastfeeding programs. The Initiative for Healthy Weight submitted its state plan to the Centers for Disease Control and Prevention and was awarded an implementation grant. These additional resources are available to support obesity prevention in the state.

The DCFHE will continue to lead the state's breastfeeding promotion initiatives, including the Baby-Friendly Hospital Initiative and training of Family Outreach Program home visitors. Home visitors will begin to offer lactation visits. The DCFHE will also continue to provide support and counseling to breastfeeding WIC clients.

The DCFHE and RI Department of Education will continue to provide technical assistance to the school district Health and Wellness Councils.

In FY2008, HEALTH will provide grants to an additional four communities to develop guidelines, environmental supports, and programs that promote healthy eating and active living. Title V and Centers for Disease Control and Prevention funds will be used to support these projects.

WIC staff will continue to Provide additional training on VENA and will monitor counseling strategies in the clinics.

The RI WEBS system will be enhance to accommodate the new federal regulations in regards to VENA and food package implementation..

WIC will again partner with Johnson & Wales University for the nutrition education piece of the Farmer's Market Nutrition Program. WIC staff will be trained on how to educate WIC participants about increasing fruit and vegetable consumption. Johnson & Wales will partner with WIC on staff training.

The WIC Parent Consultant will continue to interview WIC participants regarding their perception of and experiences with WIC nutrition education services. This information will be shared with local WIC agencies to help them improve the nutrition education services they provide and identify staff training needs.

During FY2009, Data and Evaluation staff will continue to work closely with the Initiative for Healthy Weight on issues related to data and surveillance, and to analyze WIC data to determine trends of obesity between 2-5 year-olds participating in WIC.

The new Child Care Support Network Health Consultation model will coordinate with WIC and refer children in child care, and their families who would benefit from WIC

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				11.7	11.5
Annual Indicator		11.3	11.7	13.4	13.4
Numerator		1359	1382	1548	1548
Denominator		12024	11827	11520	11520
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	12.9	12.9	12.7	12.7	12.4

**Notes - 2007**

Data for 2007 are estimated..

Data for PRAMS 2007 will not be completed until July 2008 and the weighted data for 2007 will not be available to states until Fall of 2008.

**Notes - 2006**

Data for 2006 are estimated..

Data for PRAMS 2006 will not be completed until July 2007 and the weighted data for 2006 will not be available to states until Spring of 2008.

**Notes - 2005**

Source of data is the Rhode Island PRAMS program for 2003. Data are for Rhode Island resident births occurring in Rhode Island and unknown or blank responses are excluded.

The Annual Performance Objective for 2006 reflects the average of both 2002 and 2003 data.

**a. Last Year's Accomplishments**

Babies born to women who smoke while pregnant are at a higher risk for adverse birth outcomes, including low birth weight and prematurity. Over the past decade, rates of smoking during pregnancy have decreased dramatically, but disparities remain. Rates of smoking during the last three months of pregnancy vary significantly by age, educational level, marital status, race/ethnicity, household income, and health insurance.

The DCFHE RI Tobacco Control Program. conducts a variety of activities to prevent children from ever starting to use tobacco and helps smokers and users of smokeless tobacco quit. The Tobacco Control Program administers the toll-free telephone Quitline (1-800-Try-To-Stop), which directs smokers or those who care about smokers to the quitting program that will work best for them: an interactive website (trytostop.org), information materials, or telephone counseling.

In FY2007, the DCFHE supported Tobacco Control Program activities through participation on a tobacco use disparities workgroup and through integrated programming and messaging. In addition, the Family Health Information Line referred callers with questions about smoking to 1-800-Try-To-Stop.

Also in FY2007, the DCFHE continued to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy-testing services in nine federally funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy. Both pregnant and non-pregnant women who were screened and found to be smokers were provided with education about the hazards of smoking to their health and to that of their unborn child and were referred to smoking cessation programs.

During FY2007, the Data and Evaluation Unit continued to conduct PRAMS and determine the percentage of respondents who reported they had smoked during the last trimester of their pregnancy.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the RI Prematurity Task Force to identify opportunities and actions to reduce the rate of prematurity in Rhode Island				X
2. Continue efforts to strengthen the Division's current level of maternal health programming				X
3. Partner with the RI Tobacco Control Program through participation on intradepartmental workgroups and shared programming and messaging			X	
4. Continue to support the Women's Health Screening & Referral Program, which provides comprehensive health risk assessment and referral services to women in Title X sites	X			
5. Continue to conduct RI PRAMS and analyze data on women who smoke in the last three months of pregnancy				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

HEALTH was instrumental in the development of an insurance mandate that requires health insurers in Rhode Island to cover smoking cessation treatment, supports HEALTH's Tobacco Control Program, refers Family Health Information Line callers to 1-800-Try-To-Stop, and distributes tobacco prevention and cessation materials. Tobacco and other substance use is one of five priority areas of the Task Force on Prematurity. Recommendations include ensuring that women are informed about the danger of tobacco use on the unborn child and ensuring that there are adequate resources for pregnant women who smoke.

WIC continues to screen pregnant women re: smoking and refer to needed services.

The DCFHE continues to support the WHSRP at nine federally funded Title X family planning clinics. Through the WHSRP, pregnant/ non-pregnant women and smoke are provided with education about the hazards of smoking to their health and to that of their unborn child and are referred to smoking cessation programs. women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy. The WHSRP screening tool is being revised.

In FY2008, the Data and Evaluation Unit continued to conduct RI PRAMS and analyze data on women who smoke during pregnancy.

**c. Plan for the Coming Year**

The DCFHE will continue its efforts to reduce smoking during pregnancy, particularly among subpopulations of women with higher rates of smoking, including women with low levels of education, unmarried women, low-income women, and women from racially and ethnically diverse backgrounds.

The RIDH's Task Force on Prematurity will implement its ten recommendations. Recommendations include ensuring that women are informed about the danger of tobacco use on the unborn child and ensuring that there are adequate resources for pregnant women who smoke.

In FY2009, the DCFHE will continue to support the work of HEALTH's Tobacco Control Program through participation on intradepartmental workgroups and integrated programming and messaging. The DCFHE will distribute tobacco prevention and cessation materials through its programs and community partners. In addition, the Tobacco Control Program will provide training to DCFHE community partners on supporting clients in their efforts to quit smoking. Family Health Information Line Information Specialists will continue to refer callers to 1-800-Try-To-Stop.

DCFHE will continue to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in nine federally funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks will continue to be referred to prenatal care and other community-based supports early in pregnancy. Both pregnant and non-pregnant women who are screened and found to be smokers will be provided with education about the hazards of smoking to their health and to that of their unborn child and are referred to smoking cessation programs.

DCFHE will work with the RI Department of Human Services/Medicaid to obtain additional resources to expand Family Outreach home visiting services to pregnant women at-risk for poor birth outcomes, including women who smoke during pregnancy.

During FY2009, PRAMS data for 2007 will be analyzed once the weighted data have been received from the CDC. The Data and Evaluation Unit will continue to conduct RI PRAMS and analyze data on women who smoke during pregnancy.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	4	4	4	5.3	5
Annual Indicator	2.7	9.3			
Numerator	2	7			
Denominator	75445	75445	82818	81557	81557
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the			Yes	Yes	Yes

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	3.7	3.7	3.7	4	4

**Notes - 2007**

The US Census estimates for 2006 are used for 2006 and 2007. Data are provisional and todate, there are lt 5 events for the year and the average of the last 3 years [2005-2007]is lt 5 events.

**Notes - 2006**

Due to small numbers, this performance measure fluctuates from year to year.

**Notes - 2005**

Due to small numbers, this performance measure fluctuates from year to year.

**a. Last Year's Accomplishments**

During FY2007, the DCFHE continued to work to eliminate self-induced, preventable morbidity and mortality among youth ages 15-19 years. SBHCs provide teenagers with access to health/mental health services, referring to counselors onsite or to services in the community. This center continues to lose state funds every year, their future is uncertain.

The Women's Health Screening & Referral Program (WHSRP) provided no cost pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns were referred to appropriate mental health assessment and/or treatment services.

Consumers who called the Family Health Information Line were provided with "Ten Tips on Parenting Teens" and referrals to the Men2B and Can We Talk programs. Both of these programs address issues related to adolescent mental health.

In FY2007, the DCFHE and the RI Department of Education continued to sustain the www.ParentLinkRI.org website for parents of nine to 17 year olds. The site included programs, resources, referrals, and monthly parenting tips for parents and professionals working with adolescents and pre-adolescents.

The DCFHE also continued its support of the Men2B Role Model Support Capacity Program during FY2006. The DCFHE continued its cooperative agreement with the RI Department of Corrections to implement a pilot Men2B program in the Adult Correctional Institution for men who are transitioning out of prison and back to family and community.

The DCFHE managed the Centers for Disease Control and Prevention funded thrive, formerly Healthy Schools! Healthy Kids! initiative in partnership with the RI Department of Education. This partnership focused on strengthening the statewide infrastructure to address school guidance, counseling, and social services; school environment; and school climate to assure safe, caring, and nurturing schools.

DCFHE personnel continue to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable. Suicides are included in these reviews. Also in FY2007, the Data and Evaluation Unit analyzed Vital Statistics death file data to track the rate of suicides among teens.

HEALTH's Division of Community Health & Equity used CDC funding for a violence prevention project called ESCAPE, which resulted in a strategic plan around violence prevention and a state

report card on youth violence, including suicide.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fully implement the Youth Action Research to provide opportunities for youth to provide input into DCFHE programs and conduct research and make recommendations for youth violence and suicide prevention				X
2. Support the Women’s Health Screening & Referral Program to provide comprehensive health risk assessment to teens and refer teens in need of mental health services to appropriate resources	X			
3. Maintain and update the www.ParentLinkRI.org website to provide information on programs, resources, referrals, and monthly parenting tips for parents and professionals			X	
4. Actively participate on a suicide prevention task force and in the violence and suicide prevention project to mobilize support for violence and suicide prevention				X
5. Administer the “thrive” coordinated school health initiative to address issues related to school guidance, counseling, social services, and school climate				X
6. Participate on the Child Death Review Team, led by the state Medical Examiner, which reviews all child deaths in the state to determine if they were preventable				X
7. Analyze Vital Statistics and Youth Risk Behavior Survey data				X
8. Define and measure medical home models for teens and young adults				X
9.				
10.				

**b. Current Activities**

A Youth Action Research program engages minority youth in ethnographic research/recommendation re: adolescent health policy/practice. SBHCs provide teenagers with access to health/mental health services, referring to counselors onsite or to services in the community. This center continues to lose state funds every year, their future is uncertain.

Outreach to RI schools re: The www.ParentLinkRI.org website have begun, the Men2B Program (addressing issues related to adolescent mental health) continues. "thrive", (formerly Healthy Schools! Healthy Kids!) produced Issue briefs re: health topics have been updated again with data from current YRBSS, School Accountability for Learning and Teaching surveys.

The DCFHE is a member of a state suicide prevention task force, which has developed a framework and objectives for Rhode Islanders age 15 to 24, broadening its membership/scope to address priority needs.

DCFHE participates on the Child Death Review Team, and analyzes Vital Statistics death files/ YRBS data to track teen suicide rates, the % teens that have felt depressed, contemplated suicide, or attempted suicide.

DCFHE in partnership with the RI Public Health Institute is exploring the possibility of developing a RI Mental/Behavioral Health Resource Center for Schools at RI's Bradley Hospital (pedi mental health hospital) via a Certificate of Need review process.

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

The DCFHE will continue to work to eliminate self-induced, preventable morbidity and mortality among teens through its school age and youth programming and through partnerships with state and community-based agencies and youth.

The DCFHE will continue to support the Youth Action Research program, which engages minority youth aged 15 to 23 in ethnographic research and recommendation setting around adolescent health policy and practice. DCFHE will continue to explore strategies to engage youth action research to address issues related to poor health outcomes around sexual risk taking, substance use, violence, and mental/behavioral health.

The DCFHE will continue to try to support SBHCs and explore other avenues to ensure adolescent access to health care.

The WHSRP will continue to provide health risk assessment to teens at Title X clinics and refer teens in need of mental health services to appropriate resources.

In FY2008, the DCFHE will continue to implement ParentLinkRI, an online resource directory for parents of nine to 17 year-olds.

The DCFHE will transition the Men2B Program to RI Mentoring Partnership.

The DCFHE will continue to implement the violence prevention plan. The partnership will use the state report card on risk and protective factors for violence to highlight issues with shared risk and protective factors and to mobilize support for implementation of prevention activities. The DCFHE will also continue leading the state suicide prevention task force, which has expanded its membership and will seek funding to implement strategies for suicide prevention for Rhode Islanders 15 to 24 years old.

The DCFHE will continue to manage "thrive", formerly Healthy Schools! Healthy Kids! This partnership with the RI Department of Education will continue to address issues related to school guidance, counseling, social services, and school climate.

The DCFHE will continue to participate on the Child Death Review Team. The DCFHE will continue to analyze data from Vital Statistics death files and the Youth Risk Behavior Survey to track this performance measure and the related State Performance Measure.

The DCFHE adolescent medical home workgroup will continue to work to identify new models of teen medical homes, which include mental/behavioral health services. The DCFHE will continue to work with the Northern RI AHEC and the Woonsocket CATCH grant Coalition, including a Brown University MPH student intern, to conduct research, develop provider tools and provide TA. DCFHE will seek funds to support an Adolescent Medical Home issue brief and conference for FY 09.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	93.2	93.5	93.5	94.2	94.2
Annual Indicator	96.1	93.0	90.6	91.8	92.5
Numerator	219	173	173	168	198
Denominator	228	186	191	183	214
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	92.8	92.5	92.5	92.8	93

**Notes - 2007**

Data reflects VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for Rhode Island resident births occurring out-of-state.

**Notes - 2006**

Data reflects VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for RI resident births occurring out-of-state.

**Notes - 2005**

Data reflects VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for RI resident births occurring out-of-state.

**a. Last Year's Accomplishments**

The Neonatal Intensive Care Unit (NICU) at Women & Infants' Hospital in Providence, RI serves as the sole Level III NICU in Southeastern New England. The NICU provides care for newborn infants with significant medical problems. The majority of infants admitted to the NICU are low birth weight, premature infants. The NICU employs a complement of consultants in all of the pediatric subspecialties and experienced specialists in respiratory therapy, nutrition, infant development, social services, and case management.

The DCFHE is committed to ensuring that high-risk mothers deliver at Women & Infants' Hospital so that appropriate, comprehensive, and expert care can be provided as needed through the NICU. In 2007, approximately 92% of very low birth weight infants were delivered at Women & Infants' Hospital.

In FY2007, the DCFHE continued to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy-testing services in nine federally funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy.

In addition, the Family Outreach Program offered services on a limited basis to at-risk pregnant women and connected them to prenatal care and other community resources. In 2007, the program conducted 919 prenatal visits.

Also in FY2007, a pediatric developmental physician continued working as a consultant for the DCFHE at the Hasbro Children's Hospital Children's Neurodevelopment Center providing training to personnel at the Women & Infants' NICU to help ensure that high-risk infants were referred to the Early Intervention Program prior to discharge. In Rhode Island, very low birth weight is

considered to be a "single established condition", and as such, these babies are automatically eligible for Early Intervention services. Physician materials developed by the DCFHE for the Early Intervention Program were provided to NICU staff with information on the other risk factors that make a child eligible for Early Intervention.

In FY 2007, the DCFHE placed a Pediatric Practice Enhancement Project (PPEP) Parent Consultant in the Women and Infants' NICU. The parent consultant reviews with families the community resources available to them upon discharge and provides training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program. Physician materials developed by the DCFHE continue to provide NICU staff with information on the other risk factors that make a child eligible for Early Intervention services.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the RI Prematurity Task Force to implement recommendations to reduce the rate of prematurity in Rhode Island				X
2. Continue to support the Women's Health Screening & Referral Program, which provides comprehensive health risk assessment and referral services to women in Title X sites	X			
3. Continue efforts to expand the capacity of the Family Outreach Program to provide home-based education, support, and referrals to at-risk pregnant women		X		
4. Support a parent consultant at the Women & Infants' Hospital Neonatal Intensive Care Unit to assist parents in accessing community resources, including the Early Intervention Program		X		
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The RI Task Force on Prematurity Task Force will utilize 2008 to implement its recommendations re: poverty, previous preterm birth, family planning, teen pregnancy, and tobacco/substance use.

The WHSRP continues to provide no-cost pregnancy testing and comprehensive health risk assessment are referrals to women receiving pregnancy-testing services in nine federally funded Title X family planning clinics.

A Pediatric Practice Enhancement Project (PPEP) Parent Consultant is supported at the Women and Infants' NICU. The parent consultant reviews with families the community resources available to them upon discharge and provides training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program. Physician materials developed by the DCFHE continue to provide NICU staff with information on the other risk factors that make a child eligible for Early Intervention services.

**c. Plan for the Coming Year**

In FY2009, the DCFHE will continue efforts to ensure that high-risk mothers and newborns are provided the appropriate level of care to support their unique needs. The NICU at the Women & Infants' Hospital will continue to provide Level III subspecialty care to these women and their newborns.

The DCFHE will continue to staff the Prematurity Task Force. The RIDH's Task Force on Prematurity will implement its ten recommendations. Recommendations address access to appropriate care for all women.

In FY2009, the DCFHE will continue to support the Women's Health Screening and Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in nine federally-funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks will be referred to prenatal care and other community-based supports early in pregnancy.

The DCFHE will assist Rhode Island Kids Count to apply for funding to expand the scope of the Family Outreach Program to include a prenatal home visiting component with an Olds-like model of home visiting

The PPEP Parent Consultant working in the NICU will continue to provide assistance to families in accessing community resources and will provide training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program prior to discharge.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	91.5	91.8	90.2	89.4	85
Annual Indicator	90.8	89.6	89.8	84.5	82.1
Numerator	10989	10759	10541	10211	9909
Denominator	12107	12002	11744	12086	12064
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	82.5	84.5	85.2	85.2	85.2

**Notes - 2007**

Data for 2007 reflects calendar year and are provisional.

Starting in 2006, source for Month Prenatal Care Began, changed from mother's work sheet [self-reported] to OB chart provided hospital of birth.

Birth records with unknown or missing 'month of prenatal care' are excluded from the denominator.

**Notes - 2006**

Starting in 2006, source for Month Prenatal Care Began, changed from mother's work sheet [self-reported] to OB chart provided hospital of birth.

Birth records with unknown or missing 'month of prenatal care' are excluded from the denominator.

**Notes - 2005**

Data reflects calendar year.

Prior to 2003, data reflected Rhode Island resident births occurring in Rhode Island.

Due to system changes in Vital Records, out-of-state events are now entered in a timely manner. Therefore, starting with 2003, data reflects all Rhode Island resident births to date. Birth records with unknown or missing 'month of prenatal care' are excluded from the denominator.

**a. Last Year's Accomplishments**

Rhode Island continues to lead the country in women's access to prenatal care. Pregnant women with incomes up to 350% of the Federal Poverty Level are eligible for RItE Care. In FY2007, the DCFHE continued to support programming that ensures early access to care for pregnant women, with a special focus on at-risk populations.

The DCFHE continued to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in nine Title X family planning clinics. Pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy.

The Family Resource Counselor (FRC) Program continued to support culturally diverse FRCs in 20 community health center sites and four hospitals to assist pregnant women with RItE Care enrollment. The FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.

The DCFHE continued to support the toll-free Family Health Information Line. Bi-lingual Information Specialists answered questions and referred callers to appropriate community resources, including RItE Care and FRCs. Culturally and linguistically appropriate informational materials were distributed through the Division's centralized distribution center.

Also in FY2007, the DCFHE continued to analyze Newborn Developmental Risk Screening and birth certificate data to determine the adequacy of prenatal care. In addition, RI PRAMS continued to survey women two to four months post-delivery. The survey includes six questions regarding prenatal care, including: time of first prenatal visit, whether they received prenatal care as early in pregnancy as they wanted it, things that kept them from getting prenatal care as early as they wanted, where prenatal care was received, how prenatal care was paid for, and whether specific topics were discussed during the prenatal period.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support the Women's Health Screening & Referral Program to provide comprehensive health risk assessment and referral services to women in Title X sites	X			
2. Continue efforts to increase of the capacity of the Family Outreach Program to provide at-risk pregnant women with home-		X		

based education, support, and referral to services				
3. Continue to support the toll-free, bilingual Family Health Information Line to refer families without health insurance to Rlte Care and/or Family Resource Counselors in their community		X		
4. Continue to collect Newborn Developmental Risk Screening data to determine the adequacy of prenatal care			X	
5. Continue to survey new mothers on the adequacy of prenatal care through PRAMS				X
6. Support the RI Prematurity Task Force to implement recommendation to reduce the rate of prematurity in Rhode Island.				X
7. Continue to work with CATCH grant community partnership coalitions to increase the rate of entry into prenatal care in the first trimester				X
8.				
9.				
10.				

**b. Current Activities**

The Women's Health Screening & Referral Program (WHSRP) provides no-cost pregnancy testing /comprehensive health risk assessment to women receiving services in nine Title X family planning clinics. Pregnant women with identified risks are referred to prenatal care/community-based supports early in pregnancy. A panel of women's health professionals made recommendations to the screening tool.

The FRC Program supports culturally diverse FRCs in 20 community health centers and four hospital clinics to identify/enroll pregnant women into Rlte Care/ provide referrals early in the pregnancy.

The toll-free Family Health Information Line continues. Bi-lingual information specialists provide answers/refer callers to resources. Culturally/linguistically appropriate informational materials are distributed.

The DCFHE continues to administer the PRAMS survey, and Newborn Developmental Risk Screening data are collected/analyzed re: the adequacy of prenatal care among pregnant women

The Washington County (CATCH) Coalition for Children is working with Westerly area obstetricians to identify obstacles and increase the rate of entry into prenatal care in the first trimester.

In 2008, the RI Task Force on Prematurity issued ten recommendations to decrease mortality and morbidity associated with preterm births. Implementation has started.

**c. Plan for the Coming Year**

In FY2009, the DCFHE will continue to support programming that ensures early access to care for pregnant women, with a special focus on at-risk populations.

The DCFHE will continue to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in nine Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy.

The DCFHE will work with Rhode Island Kids Count to apply for funding to implement an intensive home visiting model, which will increase the scope of the Family Outreach Program to include a prenatal home visiting component.

The DCFHE will continue to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answer questions and refer callers to appropriate community resources. Culturally and linguistically appropriate informational materials will be distributed through the Division's centralized distribution center.

Newborn Developmental Risk Screening data will be collected and analyzed to determine the adequacy of prenatal care. In addition, the DCFHE will continue to track rates of prenatal care using multiple sources, including PRAMS and vital records. The DCFHE will analyze 2007 weighted PRAMS data once the data are received from the Centers for Disease Control and Prevention.

DCFHE will continue to work with the Washington County (CATCH) Coalition for Children to increase the rate of entry into prenatal care in the first trimester.

The RIDH's Task Force on Prematurity will implement its ten recommendations. Recommendations include expanding preconception care opportunities before and between pregnancies for all women and assuring early entry into prenatal care.

## D. State Performance Measures

**State Performance Measure 1:** *Percent of PRAMS population who had a diagnosis of depression before or during pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				15.2	15.2
Annual Indicator		14.8	12.4	14.6	13.1
Numerator		221	1465	1653	1545
Denominator		1498	11802	11334	11754
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	13.7	13.7	13.2	13.2	13.2

### Notes - 2007

2007: Since collection of PRAMS surveys for 2007 is not yet completed, data are estimate.

### Notes - 2005

Unable to update data for 2004. Data for 2004 reflects unweighted data. else weighted data for 2004 is 14.6%.

### a. Last Year's Accomplishments

The DFH is committed to protecting and promoting the health of women across the reproductive lifespan. Research has shown that approximately one in five women experience perinatal depression and that these women are at a higher risk for poor birth outcomes. Identifying women with depression and facilitating access to services is a priority for the DFH. In addition, understanding characteristics and experiences of women suffering from depression informs program enhancements and policies, both within the DFH and among external partners.

In FY2007, the DFH continued to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in nine Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy. Both pregnant and non-pregnant women who were screened and found to be at risk for depression were provided with a referral for mental health follow-up. . The DFH began a process to revise the Care Questionnaire screening tool to reflect current knowledge and best practice and to better address social/emotional risk factors. Rhode Island's capacity to provide needed mental health services is limited, however.

As part of the Newborn Screening Program, all infants born in RI are screened for developmental risk factors at the birthing hospital (called Level I screening). Level I screening includes a risk criterion related to caregiver mental health. In FY2007, families of at-risk infants were offered home visits subsequent to hospital discharge through the Family Outreach Program.

The Family Outreach Program provides home-based outreach, education, referral, and follow-up for at-risk pregnant women and families with young children. The program employs registered nurses, social workers, and paraprofessionals. Services offered include child, family, and home assessments and linkages to resources and services in the community.

Implementation of the Successful Start Strategic Plan, a plan designed to create a more effective and coordinated system of early childhood services, began in 2006 The Plan contains several elements related to identifying maternal mental health concerns, including implementing an intensive home visiting program if funding is available, and working in pediatric primary care offices to identify maternal mental health concerns. In 2007 HEALTH staff began providing TA to physicians offices to screen women with young children for depression.

Based on the findings of the DFH maternal health assessment, in the spring of 2006, DFH partnered with Women and Infants' Hospital and the March of Dimes to create a Pre-maturity Task Force to review current research, policies and practice that influence pre-maturity and make recommendation to reduce rates of pre-maturity in RI. .

The DFH continues to survey recent mothers to determine the percentage of respondents who reported a diagnosis of depression before or during their pregnancy. During 2006, 11.6% of PRAMS respondents reported they had been diagnosed with depression before their pregnancy and 9.4% had been diagnosed with depression during their pregnancy. Approximately, two out of three (66.0%) respondents who were diagnosed with depression before their pregnancy were taking prescription medications for their depression before they became pregnant. Nearly half (49.8%) of the respondents who were diagnosed with depression during their pregnancy were taking prescription medications during their pregnancy; and nearly three quarters (72.4.0%) of these women were provided information about the risks and benefits of taking these medications during pregnancy. More than half of the respondents indicated they had received counseling for their depression before they became pregnant (55.4%) and during their pregnancy (55.1%).

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement strategies and recommendations to strengthening DCFHE maternal health programming to address the health needs of women of reproductive age				X
2. Continue to support the Women's Health Screening & Referral Program to provide comprehensive health risk assessment and referral services to women in Title X sites	X			

3. Continue to screen all newborns for developmental risk factors, including a history of caregiver mental health issues			X	
4. Provide high-risk pregnant women and families of young children with Family Outreach Program home-based outreach, education, referral, and follow-up services		X		
5. Expand elements of the Successful Start Early Childhood Systems Plan related to maternal mental health, including maternal depression screening and provider training				X
6. . Continue to conduct RI PRAMS to collect and analyze data on maternal depression				X
7. Implement recommendations of the RI Prematurity Task Force				X
8.				
9.				
10.				

**b. Current Activities**

The Women's Health Screening & Referral Program provides free pregnancy testing/comprehensive health risk assessment for women at Title X family planning clinics. Those with identified health risks were referred to prenatal care and other community-based supports early in pregnancy.

Home-based services are provided to at-risk pregnant women (on a limited basis) and families with young children. At birthing hospitals, newborns receive developmental risk screening; 1 risk criterion is related to caregiver mental health. Families of at-risk infants are offered home visits through the Family Outreach Program.

With community/ health care partners, Successful Start promotes maternal mental health thru a model of community-based developmental/behavioral screening of young children in medical homes/child care settings. It includes screening for maternal depression (implemented in primary care practices only).

Mothers continue to be surveyed to determine the % of respondents reporting a diagnosis of depression before or during their pregnancy and their associated risk factors.

The RI Prematurity Task Force has identified key partners /critical issues and is working on the implementation of its top 10 recommendations.

Strategies include educational materials for use with the Family Health Information Line and immigrant populations; expanded use of the WHSRP tool in private practices; alternative strategies to meet women's mental health needs and supports for women with disabilities.

**c. Plan for the Coming Year**

In FY2009, the DFH will continue its efforts to promote and protect the health of women across the reproductive lifespan.

The DFH will continue to support the WHSRP to provide pregnancy testing and health risk assessment to women receiving services in nine Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks will continue to be referred to prenatal care and other community-based supports early in pregnancy. Both pregnant and non-pregnant women who are screened and found to be at risk for depression will be referred for mental health follow-up.

The RI Prematurity Task Force will continue to work on implementing its top ten recommendations in FY 2007.

DFH will seek support in the way of grants and partnerships to implement priorities around maternal health including developing educational materials for use with the Family Health Information Line; developing educational tools for immigrant populations; exploring the feasibility of expanding use of the WHSRP tool in private practices; developing alternative strategies to meet the mental health needs of women; and developing supports for women with disabilities; and training health care providers in providing confidential services.

In FY2009, all newborns will continue to be screened for developmental risk factors at the birthing hospital. Level I screening includes a risk criterion related to caregiver mental health. This risk criteria will be updated to reflect the best research around determining maternal mental health. Families of at-risk infants will continue to be offered home visits through the Family Outreach Program.

The Family Outreach Program will provide home-based services to high-risk pregnant women (on a limited basis) and families with young children across the state with the current level of funding. Comprehensive child, family, and home assessments will be completed and families will be linked to resources and services in the community.

In FY2009, Successful Start will expand and evaluate elements of the Early Childhood Systems Plan related to promoting maternal mental health. In collaboration with the RI AAP and others, a model of community-based developmental screening and referral to services will be expanded beyond the pilot communities and evaluated in several communities

The DFH will continue to conduct PRAMS among recent mothers two to six months after delivery. Once weighted data for 2007 are received from the Centers for Disease Control and Prevention, data will be analyzed to determine the percent of respondents who reported a diagnosis of depression before or during their pregnancy.

**State Performance Measure 2:** *Percent of children aged 2-5 enrolled in the WIC Program with BMI's >=95th percentile*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				23.2	18.2
Annual Indicator		19.1	18.7	17.2	17.4
Numerator		2219	2195	1854	2167
Denominator		11640	11750	10753	12482
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	17.7	17.5	17.2	17.2	17

**Notes - 2007**

Data reflects children aged 24 to 59 months old. Rhode Island's WIC data system changed in June 2006. The new system retains the same child idnum which reduces duplicates

**Notes - 2006**

Data reflects children aged 24 to 59 months old. Rhode Island's WIC data system changed in June 2006. The new system retains the same child idnum which reduces duplicates

**a. Last Year's Accomplishments**

In 2007, 17.36% of children aged two to five enrolled in WIC had a Body Mass Index greater than the 95th percentile, this is compared to 2006 data at 17.24%. Preventing obesity among all Rhode Islanders continues to be one of the five priorities of the Director of the RI Department of Health. The Department's activities related to obesity are spearheaded by the Initiative for Healthy Weight, housed in the Division of Community Family Health & Equity. The DFH contributes much to this effort, including significant staff resources.

In 2007, 17.2%

In FY2006, the five action teams (Early Childhood, School-Age Children, Communities, Data and Evaluation, and Communications) met regularly to develop age-group specific statewide goals and objectives around childhood obesity. Each team prioritized their objectives and fine-tuned their actions plans, which were incorporated into the overall Initiative for Healthy Weight strategic plan.

In FY 2006 teams began implementation work to address needs in identified populations. The DFH/Department of Education partnership focused its coordinated school health program efforts on addressing childhood obesity in school settings. HEALTH drafted legislation for submission by the Governor that prohibited sweetened beverages and junk foods in schools. In addition, the DFH and other partners provided technical assistance to school district Health and Wellness Subcommittees. RI law mandates that each school district convene a Health and Wellness Subcommittee to develop strategic plans to address health issues, including obesity. HEALTH cosponsored training for 30 dieticians who have volunteered to serve on Subcommittees. Additionally, parents were identified at the Channel 10 Health Fair and were contacted to participate on subcommittees. The DFH and the RI Department of Education also developed draft guidance on incorporating wellness into district strategic plans.

In addition to working with the Initiative for Healthy Weight to support infrastructure building, the DFH also supported activities to prevent childhood obesity through the WIC Program. In FY2008, WIC continued with implementation planning for Value Enhanced Nutrition Assessment (VENA). A two day training was provided statewide to all local agency staff. . The WIC Program continued discussions regarding upcoming changes with respect to VENA with WIC staff. Tools to help staff assess the needs of the clients in WIC were fine tuned.. . The State WIC Program began using the Touching Hearts Touching Minds education materials developed in Mass. Through site visits, WIC staff has continued to provide feedback and training on how to accurately assess children and counsel parents/caretakers of overweight children. State WIC, in conjunction with the DOH communications department, finished developing and distributed several new education materials for WIC participants. These assisted them in counseling on the topic of obesity. These included new age-specific feeding and activity guides

WIC continues to support the Farmer's Market Nutrition Program to offer families vouchers to buy fresh fruits and vegetables each summer. In FY2007, WIC again partnered with Johnson & Wales University to provide nutrition education around increasing fruit and vegetable intake at local farmer's

In FY2006, RI Webs was implemented. This system has helped improve and enhance nutrition assessment procedures and data collection, significantly decreasing inaccurate risk assessments and improving assessments for obesity.

Also in FY2007, the Breastfeeding Program continued to conduct a range of activities to educate and promote breastfeeding and provided direct breastfeeding support to women enrolled in WIC.

#### **Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with the Initiative for Healthy Weight in developing and implementing RI's state plan for promoting healthy eating and active living				X
2. Support statewide breastfeeding promotion initiatives			X	
3. Provide breastfeeding support and counseling to WIC clients	X			
4. Provide technical assistance and support to school district Health and Wellness Subcommittees				X
5. Provide funding and technical assistance to six communities to develop guidelines, environmental supports, and programs that promote healthy eating and active living				X
6. Support the WIC Program's adoption of Value Enhanced Nutrition Assessment to provide client-focused nutrition education in response to identified risks				X
7. Administer the Farmer's Market Nutrition Program to increase WIC clients' access to and consumption of locally-grown, fresh produce		X		
8. Continue to implement and develop the functionality of the WIC Program's RI Webs computer system				X
9. Continue outreach efforts to providers to improve access to WIC and consistency of nutrition education messages				X
10. Continue to analyze WIC Program data to determine the percentage of children who are overweight and obese and to determine risk factors of and trends for obesity				X

**b. Current Activities**

Efforts to increase breastfeeding among new mothers continue including sponsoring hospitals that adopt the Baby-Friendly Hospital Initiative. Family Outreach Program nurses include certified lactation consultants. Direct support and counseling is provided to breastfeeding WIC clients.

WIC continues to train for VENA implementation, monitors/trains staff on accurate and appropriate assessments for overweight children.

RI WEBS helps expedite and improve WIC services via improved and enhanced nutrition assessment procedures and more accurate obesity risk assessments. Data quality is monitored and training provided to local agency staff as needed.

The Farmer's Market Nutrition Program continues. WIC again is partnering with Johnson & Wales University to enhance onsite nutrition education with cooking demonstrations.

WIC's parent consultant continues to work at the State WIC Office. The parent consultant plays an important role in outreaching to providers and other community organizations regarding WIC's childhood obesity prevention efforts. The parent consultant also interviews WIC participants at local agencies to assess their perception of the quality of nutrition services.

WIC participants are offered fresh fruits and vegetables at lower costs than the supermarkets, in Central Falls.

Health Metrics evaluated 11 sites and provided recommendations to Local Agencies and the State Office around Best Practices for meeting the needs of the community

**c. Plan for the Coming Year**

In FY2009, the DCFHE will continue to work to reduce childhood obesity by partnering with the Initiative for Healthy Weight on infrastructure building activities and by promoting good nutrition through the WIC and Breastfeeding programs. The Initiative for Healthy Weight is partnering with WIC through a CDC grant to improve childhood obesity services through WIC. This program will be developed through our Central Falls WIC site. Rhode Island WIC will be implementing some of the recommendations provide by Health Metrics.

The DFH will continue to lead the state's breastfeeding promotion initiatives, including the Baby-Friendly Hospital Initiative and training of Family Outreach Program home visitors. Home visitors will begin to offer lactation visits. The DFH will also continue to provide support and counseling to breastfeeding WIC clients.

The DFH and RI Department of Education will continue to provide technical assistance to the school district Health and Wellness Councils.

WIC staff will continue to update and submit a VENA implementation plan in late summer 2008 to FNS that will continue to clarify our states goals and timelines for nutrition education and training strategies for local WIC agency staff on VENA.

The RI Webs computer system will continue to be monitored and used more extensively as all levels of staff become comfortable and fully competent with its use. Updates to the RI WEBS system will be done to conform to the food package regulations.

WIC will again partner with Johnson & Wales University for the nutrition education piece of the Farmer's Market Nutrition Program. WIC staff will be trained on how to educate WIC participants about increasing fruit and vegetable consumption. Johnson & Wales will partner with WIC on staff training.

Consistent messages to families will continue to encourage more effective behavior change. The WIC Parent Consultant will continue to interview WIC participants regarding their perception of and experiences with WIC nutrition education services. This information will be shared with local WIC agencies to help them improve the nutrition education services they provide and identify staff training needs.

The Data and Evaluation Team will continue to analyze WIC Program data to determine the percentage of children who are overweight (85th to 95th percentile) and obese (at or above the 95th percentile) and associated risk factors.

**State Performance Measure 3:** *Percent of Rhode Island resident families with at-risk newborns that received a home visit from the Family Outreach Program within the newborn period (<=90 days)*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	53.5	54	54.5	55	55
Annual Indicator	53.0	58.5	56.4	56.1	45.3
Numerator	3588	3960	3894	3960	3308
Denominator	6768	6768	6902	7065	7300
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	47	49	51.2	52.7	52.7

**Notes - 2007**

The number of Rhode Island Resident newborns who received a home visit declined in 2007 because the primary contractor providing the services [VNA Care of NE], decided to close their pediatric service division. Only children with the most significant risk profiles received visits. The capacity of the Home Visiting Program remains to be determined in 2008 due to budget constraints.

**a. Last Year's Accomplishments**

Access to a broad range of health and family support services is critical to ensuring children grow into strong, healthy, productive adults. Children are at increased risk for poor development if their families experience risk factors such as inadequate income, isolation from family or friends, drug and/or alcohol abuse, mental illness, or domestic violence. Families facing multiple risk factors benefit from access to comprehensive services that build on family strengths while flexibly responding to their needs.

The Family Outreach Program is an assessment and referral program that targets children birth to age three who is at-risk for poor developmental outcomes. The program uses home visits to support families and their children by giving them the information and services they need to be as healthy as possible. Each year, nearly one-third of all families with newborns receive services from the program. The program is an integral component of the Early Intervention Program's "Child Find" outreach system.

The program works in conjunction with the state's universal screening program for newborns, which identifies babies with certain medical, social, or economic risk conditions. Social risk factors include: caregiver education less than 11th grade, low income, mother's age less than 19, caregiver history of a mental health condition, and many others. The databases for newborn developmental risk and home visiting are housed in KIDSNET. This creates a mechanism to track all newborns to ensure that they have been screened in the hospital.

A multidisciplinary team of nurses, social workers, and paraprofessionals provides family Outreach Program services. In FY2007, 54% (3,595 out of 7,322) of the families that were eligible and accepted home visits, Most received between two visits. Services included: instruction in basic newborn care, assessments of family needs and child development, and referrals to community resources. Home visitors also serve as the follow-up for newborn metabolic and hearing screening, the Early Intervention Program, Birth Defects Program, Childhood Lead Poisoning Prevention Program, and the Immunization Program. Health care and community service providers also refer families to the program. Families may also request a home visit.

Families with newborns identified as "risk-positive" based on newborn developmental screening results, or referred by a physician, were contacted by the Family Outreach Program and offered a home visit. In 200 % of the families who were offered home. The risk criteria were made more stringent due to fiscal constraints in FY2007 resulting in fewer visits than in  
If indicated, the program also provided additional services subsequent to the initial newborn visit, including a visit when the child was between six and eight months of age to assess development.

Also in FY2006, KIDSNET computer programming was modified to better track participation in the Family Outreach Program by risk factor.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to screen all newborns for medical, social, and			X	

economic risks through newborn developmental risk screening prior to discharge				
2. Continue to screen all newborns for medical, social, and economic risks through newborn developmental risk screening prior to discharge		X		
3. Family Outreach Program home visitors will continue to serve as the follow-up for newborn metabolic and hearing screening, Early Intervention, the Birth Defects Program, Lead Program, and the Immunization Program		X		
4. The Family Outreach Program will continue to coordinate with and accept referrals from health care providers, community service providers, and families				X
5. Support enhanced outreach to families with multiple risk factors to facilitate increased rates of program participation		X		
6. Generate and support electronic data exchange between home visiting agencies and KIDSNET to improve the timeliness, completeness, and reliability of home visiting data				X
7. The Family Outreach Program will continue to be an integral component of the Early Intervention Program's "Child Find" outreach system		X		
8. Continue partnership with the RI Department of Children, Youth & Families (CAPTA) to screen children under age three who have experienced abuse or neglect for Early Intervention eligibility		X		
9.				
10.				

**b. Current Activities**

The Family Outreach Program (FOP) provides home assessments, connection to community supports, and help with child development and parenting for families of newborns identified through universal newborn developmental risk screening.

FOP follows-up for newborn metabolic and hearing screening, the Early Intervention Program, Birth Defects Program, Childhood Lead Poisoning Prevention Program, and the Immunization Program. Health care/community service providers refer families to the FOP.

Families may self refer

The FOP collaborated with the RI Department of Children, Youth & Families to screen children under age three who have experienced abuse or neglect for Early Intervention eligibility.

KIDSNET has worked with the Family Outreach Program to develop a plan for home visiting reports that will monitor participation and support the home visiting agencies.

**c. Plan for the Coming Year**

In FY2009, the DFH will releast newly developed certification standards for the FOP program. New vendors may apply under these standards. This model will ensure that services are based in the community and allow for agencies to again bill Medicaid for home visits. In addition, efforts will be directed at identifying opportunities to improve the system of family support services in the state by expanding the capacity of evidence-based comprehensive support services for families most at risk.

The Family Outreach Program will provide home visiting risk and referral services to "risk-

positive" newborns identified through newborn developmental risk screening. It is expected that families participating in the program will receive an average of two to three visits.

In order to improve the timeliness, completeness, and reliability of home visiting data, the DFH will complete specifications for electronic data exchange between home visiting agencies and KIDSNET. The DFH will provide technical assistance to the agencies in developing the technical specifications for the required electronic forms and in integrating the specifications into their existing electronic systems. Family Outreach Program vendors will use this improved data function to conduct monitoring and quality assurance activities at the agency level.

Family Outreach Program home visitors will continue to serve as the follow-up for newborn metabolic and hearing screening, the Early Intervention Program, Birth Defects Program, Childhood Lead Poisoning Prevention Program, and the Immunization Program. Health care and community service providers may also continue to refer families to the program, and families may self-refer. Services will be provided to families with significant risk factors.

In FY2009, the program will be continuously evaluated to identify whether or not the program is meeting its goals, if the populations most in need are being served, and how the program impacts child and family outcomes. Measures of client satisfaction will be included in the evaluation.

KIDSNET will continue to provide database and data management services for developmental risk services and home visiting in FY2009. KIDSNET will also continue to generate electronic home visiting referrals based on developmental risk screening. Planned home visiting reports will be programmed in KIDSNET if resources are available.

**State Performance Measure 4:** *Percent of children aged less than 6 who live in the core cities and have blood lead levels at or above 10ug/dL*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	12.5	11	10.5	6	5
Annual Indicator	8.2	7.6	5.8	4.7	4.0
Numerator	1340	1226	916	746	611
Denominator	16334	16225	15664	15721	15224
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	4.5	4	3.7	3.7	3.7

**a. Last Year's Accomplishments**

Severe lead poisoning can lead to mental retardation, coma, seizures and death. Even low levels of exposure can impair central nervous system function causing delayed cognitive development, hearing problems, growth retardation, and metabolic disorders. In Rhode Island, lead poisoning rates are highest among children who reside in the state's six core cities.

Over the past decade, there has been a significant decrease in the number of children afflicted with lead poisoning. In 2007, 1.9% of children less than age six residing in RI had lead levels greater than or equal to 10mcg/dL. In addition, the percent of children living in the core cities with blood lead levels greater than or equal to 10 mcg/dL for the first time in their lives (incidence) decreased from 9.7% in 2000 to 2.1% in 2007. The percentage of children entering kindergarten

who ever had an elevated blood lead level of 10 mcg/dL or more continued to decline as well.

In FY2007, four certified Lead Centers (supported through Medicaid funding) continued to serve lead poisoned children and their families. In 2007, the Lead Centers received 94 referrals for significantly lead poisoned children (blood lead levels > 20ug/dL), as well as 76 referrals for children with first time blood lead levels between 15 and 19 mcg/dL. In 2007, 88% of the families with a significantly lead poisoned child accepted case management services through the Lead Centers.

Also in FY2007, the DFH continued its support of two hospital-based clinics to screen uninsured and underinsured children for lead poisoning. Lead safety remained a part of the Family Outreach Program home assessment protocols and home visitors began collecting additional information specific to the property they were visiting. The WIC Program continued to monitor lead screening among WIC-enrolled children with lead levels at or above 10 mcg/dL and continued to provide these children with nutrition counseling, education, and nutritious foods. . Lead Program staff re-trained WIC staff on reviewing and addressing lead issues with WIC staff. The Immunization Program continued to include lead screening questions in its annual Immunization School Survey.

Also in FY2007, the DFH continued to distribute lead educational materials and provide information to families and providers contacting the Health Information Line. DFH staff educated providers about lead issues and staffed community health fairs and workshops. The DFH sponsored activities during May for Lead Poisoning Prevention Month.

In FY2007, the DFH continued to survey recent mothers through PRAMS (Phase V), which included questions about the age of the respondents' housing and what they are currently doing to protect their families from lead poisoning (e.g.. washing windows, doorways, floors and dusty areas; blocking chipped or peeling paint; eating calcium and iron rich foods; washing hands frequently, etc.)

Approximately 70% of children born in 2001 through 2004 were screened for lead poisoning at least once by 18 months of age. These high screening rates may be attributed to pediatricians' access to KIDSNET. KIDSNET allows healthcare providers to monitor lead screening among their patients and generate reports of unscreened patients in their practice at any time. In 2007, 52.4% of KIDSNET practices used this report.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support the Healthy Housing Collaborative and work in partnership with other state agencies and community partners to promote healthy housing for all families in Rhode Island				X
2. Continue to support one outpatient hospital-based clinics to provide lead screening to uninsured and underinsured children under age six	X			
3. In partnership with the RI Department of Human Services/Medicaid, continue to support certified Lead Centers to provide services to significantly lead poisoned children and children with first time lead levels of 15-19 mcg/dL		X		
4. Continue to collaborate with the Environmental Lead Unit to offer comprehensive home environmental lead inspections to significantly lead poisoned children.				X
5. Utilize KIDSNET data to send postcards to families with			X	

children who have not been lead screened by 18 months of age				
6. Monitor usage of the "never screened" lead reports available to pediatric practices participating in KIDSNET				X
7. Continue to conduct lead poisoning awareness and prevention activities as a part of "Lead Poisoning Prevention Month"			X	
8. The Family Outreach Program will continue to include lead safety as part of the standard assessment protocol for all families receiving home visiting services		X		
9. CThe WIC Program will continue to monitor lead screening in WIC-enrolled children with lead levels at or above 10 mcg/dL and provide WIC clients with counseling, education, and nutritious foods		X		
10. Continue to survey mothers of infants about lead topics through PRAMS				X

**b. Current Activities**

The Childhood Lead Poisoning Prevention Program (CLPPP) continues to convene the Healthy Housing Collaborative to develop a plan to create/maintain healthy housing and offers an 8-hr Healthy Homes training program to community health nursing students.

CLPPP supports one hospital-based clinics to screen uninsured and underinsured children for lead poisoning.

Four lead centers provide services to lead poisoned children, as well as those with first time lead levels between 15 and 19 mcg/dL. Significantly lead poisoned children also receive an environmental lead inspection. In addition, DCFHE partners with one lead center to offer lead education and primary prevention strategies to children with lead levels below, but approaching 10mg/dL, the level of concern.

Through KIDSNET, providers can generate on-demand reports of unscreened patients for QA and follow-up. Reminders to families of unscreened 18-month year olds continue.

RI celebrates May as "Lead Poisoning Prevention Month" and held the first Healthy Housing Conference.

The Family Outreach Program assesses lead safety during all home visits. WIC monitors lead screening in WIC-enrolled children with lead levels at or above 10 mcg/dL.

Address info is being consolidated into a single statewide housing database. PRAMS surveys asking new mothers about lead poisoning prevention activities.

**c. Plan for the Coming Year**

In FY2009, the DCFHE will continue to monitor rates of lead poisoning among Rhode Island children.

The Lead Program will continue support the Healthy Housing Collaborative and continue implementation of a statewide action plan to create and maintain healthy housing in all communities across the state.

The Childhood Lead Poisoning Prevention Program will continue to support one hospital-based clinic to screen uninsured and underinsured children under age six for lead poisoning.

The DCFHE will refer significantly lead poisoned children for home inspections and for case management through the certified Lead Centers. Children with first time lead levels of 15-19 mcg/dL will receive a referral to a Lead Center for an educational home visit. Families of children with lead levels of 10-14 mcg/dL will receive culturally and linguistically appropriate printed lead

educational materials.

KIDSNET will continue to be used as a quality assurance tool to increase and measure progress in lead screening rates statewide. Letters to parents of all 18-month-old children who have not been screened will continue to be sent on a monthly basis. Providers participating in KIDSNET will continue to have access to running a "never screened" report of their patients. An additional online report will be programmed in KIDSNET for patients that have not had the 2 recommended lead screens.

The DCFHE will continue to conduct lead poisoning awareness and prevention activities, with an emphasis on primary prevention, which includes healthy homes initiatives. The DCFHE will continue to distribute educational materials and provide information to families and providers contacting the Health Information Line.

Also in FY2009, the Family Outreach and Lead Center home/environmental assessments will be evaluated by a graduate student intern. WIC will monitor lead screening in WIC-enrolled children with lead levels at or above 10 mcg/dL. The Immunization Program will include questions about lead screening on immunization forms utilized by schools and child care centers as a prerequisite for entry.

Child Care Support Network Health Consultants will educate and provide information to families and child care providers about the importance of lead screening and will conduct record reviews to ensure children in child care have been screened for lead.

The DCFHE will continue to conduct RI PRAMS during FY2009. Data for 2007 will be analyzed once weighted data are received from the Centers for Disease Control and Prevention in 2008

**State Performance Measure 6:** *Ratio of the Black or African American prematurity rate to the White prematurity rate*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				1.5	1.4
Annual Indicator	1.1	1.3	1.3	1.2	1.2
Numerator	2.8	12.2	13	12	12.2
Denominator	2.5	9.6	9.9	10.3	10.6
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	1.3	1.2	1.2	1.2	1.2

**a. Last Year's Accomplishments**

Preterm births are the leading cause of infant mortality in Rhode Island. Babies born prematurely are more likely to have complications such as breathing/lung problems, heart problems, anemia, jaundice, infections, etc. Among racial and ethnic groups, Black or African American women have the highest rate of preterm births.

The percentage of babies born prior to 37 weeks gestation or preterm has been rising in Rhode Island as in the nation.

Based on the findings of the DCFHE maternal health assessment, in the spring of 2006, DCFHE partnered with Women and Infants' Hospital and the March of Dimes to create a Pre-maturity Task Force to review current research, policies and practice that influence pre-maturity and make recommendation to reduce rates of pre-maturity in RI. .

In FY2007, the DCFHE continued to support the Women's Health Screening and Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in nine Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy. The DCFHE began a process to revise the Care Questionnaire screening tool to reflect current knowledge and best practice and to better address social/emotional risk factors.

The Family Outreach Program continued to provide home-based services to at-risk pregnant women, including assessment and referral to a range of prenatal services. In 2007, the program visited approximately 919 home visits to at-risk pregnant women.

Also in FY2007, the WIC Program conducted outreach and education to OB/GYN offices to enhance enrollment of eligible pregnant women in WIC early in their pregnancy (the first trimester). WIC provides nutritious foods, nutrition education, and referrals to health and other social services to its clients. WIC participation is linked to longer gestation periods, higher birth weights and lower infant mortality.

Race and gestational age data from the integrated newborn development risk assessment/electronic birth certificate were collected and stored in KIDSNET, facilitating monitoring over time and comparisons based on demographics, risk factors, and other information contained in KIDSNET.

Also in FY2007, the DCFHE analyzed birth certificate data to determine the rates of prematurity among Rhode Island residents by demographic factors including race/ethnicity, geographic areas, etc.

In FY2006, the DCFHE, in partnership with the RI Chapter of the March of Dimes and Women & Infants Hospital, established a statewide Prematurity Task Force. The goal of the Task Force is to identify opportunities and actions to reduce the rate of prematurity in Rhode Island. The taskforce reviewed data and identified four topic areas of focus: previous preterm birth, family planning, teen pregnancy, and tobacco/substance use.

During FY07, per the RI Prematurity Taskforce recommendations, DCFHE staff met with Vital Records staff to: 1) develop and add fertility questions to the RI birth certificate; and 2) add a gestational age methodology question to the Ob portion of the birth certificate worksheet.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In partnership with the March of Dimes and Women & Infants' Hospital, continue to support the Prematurity Task Force to implement recommendations.				X
2. Implement strategies for strengthening DCFHE maternal health programming to address the health needs of women of reproductive age and improve birth outcomes				X
3. Continue to support the Women's Health Screening & Referral Program to provide comprehensive health risk assessment and referral services to women receiving pregnancy tests in Title X sites	X			
4. Continue efforts to expand the Family Outreach Program's capacity to provide high-risk pregnant women with home-based outreach, education, referral, and follow-up services		X		
5. Continue to target OB/GYN providers for enhanced outreach		X		

to increase the number of pregnant women that enter WIC during their first trimester of pregnancy				
6. Collect and analyze race and gestational age data from the integrated newborn developmental risk assessment/electronic birth record				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Monitoring and analysis of prematurity rates by gestational age, plurality, and other maternal and infant characteristics continues.

The RI Prematurity Taskforce has developed briefs related to previous preterm birth, family planning, teen pregnancy, and tobacco/substance use and identified 23 recommendations to reduce Rhode Island's prematurity rate have been presented at the March of Dimes Prematurity Summit.

Questions concerning fertility drug treatment and procedures were added to the new RI birth certificate, which will be implemented during the summer/fall of 2008. It was determined that the adding gestational age to the birth certificate will require resources for computer programming and training and funding will need to be identified.

The Women's Health Screening & Referral Program (WHSRP) continues to provides free pregnancy testing/comprehensive health risk assessment in nine Title X family planning clinics. Those with identified health risks are referred to prenatal care/resources early in pregnancy.

Strategies re: maternal health have been developed including educational materials for use with the Family Health Information Line and immigrant populations; expanded use of the WHSRP tool in private practices; alternative strategies to meet women's mental health needs and supports for women with disabilities.

WIC continues to target OB/GYN providers for in-service training/outreach to enhance pregnant women's early access to WIC services.

**c. Plan for the Coming Year**

In FY2009, the DCFHE will continue efforts to improve pregnancy outcomes for all women and reduce disparities.

The DCFHE will continue to staff the Prematurity Taskforce, which will develop work plans for each of the recommendations identified.

The DCFHE will continue to support the WHSRP to provide pregnancy testing and health risk assessment to women receiving services in nine Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks will continue to be referred to prenatal care and other community-based supports early in pregnancy.

The RI Prematurity Task Force will continue to work on implementing its top ten recommendations in FY 2007.

DCFHE will seek support in the way of grants and partnerships to implement priorities around maternal health including developing educational materials for use with the Family Health

Information Line; developing educational tools for immigrant populations; exploring the feasibility of expanding use of the WHSRP tool in private practices; developing alternative strategies to meet the mental health needs of women; and developing supports for women with disabilities; and training health care providers in providing confidential services.

The WIC Program will continue to target OB/GYN providers for enhanced outreach to increase the number of pregnant women that enter WIC during their first trimester of pregnancy. WIC will continue to provide local agency coordinators with quarterly statistics on how their agency compares to statewide statistics of first trimester prenatal enrollment into WIC.

Race and gestational age data from the integrated newborn developmental risk assessment/electronic birth record will continue to be collected and stored in KIDSNET, facilitating monitoring over time and comparisons based on demographics, risk factors, and other information contained in KIDSNET.

**State Performance Measure 7:** *Percent of children (who have had at least one immunization from a primary care provider) with complete immunization series (4:3:1:3) and at least one lead screening by age 2*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				55.7	53.2
Annual Indicator			53.2	53.0	49.7
Numerator			6307	6150	5948
Denominator			11848	11608	11957
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	50.2	50.7	51.7	52.2	53.2

**Notes - 2007**

Medical Home Indicator Measure (Comprehensive)

All children with a most recent address of RI, who have had at least one immunization reported to KIDSNET by a Primary Care Provider are included in this measure. The numerator includes those who have had at least one lead test and completed the 4:3:1:3 (DTP, Polio, MMR, Hib) immunization series by their second birthday. This year's data includes children who were born in 2005 and turned 2 during 2007 and shows only 50% of children with both the immunization series and a lead test by the second birthday.

It is important to keep in mind that in order for a child to be considered complete for immunization, 11 separate immunizations had to be reported for each child by the second birthday. Failure to report just one of these 11 events means the child is incomplete for immunization. Nationally 40% of children in registries had incomplete immunization records, resulting in lower estimates of vaccine coverage when compared to the National Immunization Survey with provider verified results.

This measure underestimates actual coverage due to data gaps in KIDSNET. Children who have moved into RI and had their Lead test performed out of state may not have the test reported to KIDSNET. However, the largest gap in data can be attributed to missing immunizations. Immunization data may be missing because a provider has failed to report an individual visit, failed to report an immunization history of a new patient, or used an incorrect vaccine code.

Children may also be included who have moved out of state prior to finishing their immunization series.

#### **Notes - 2006**

##### Medical Home Indicator Measure (Comprehensive)

All children with a most recent address of RI, who have had at least one immunization reported to KIDSNET by a Primary Care Provider are included in this measure. The numerator includes those who have had at least one lead test and completed the 4:3:1:3 (DTP, Polio, MMR, Hib) immunization series by their second birthday. This year's data includes children who were born in 2004 and turned 2 during 2006 and shows only 53% of children with both the immunization series and a lead test by the second birthday.

It is important to keep in mind that in order for a child to be considered complete for immunization, 11 separate immunizations had to be reported for each child by the second birthday. Failure to report just one of these 11 events means the child is incomplete for immunization. Nationally 40% of children in registries had incomplete immunization records, resulting in lower estimates of vaccine coverage when compared to the National Immunization Survey with provider verified results.

This measure underestimates actual coverage due to data gaps in KIDSNET. Children who have moved into RI and had their Lead test performed out of state may not have the test reported to KIDSNET. However, the largest gap in data can be attributed to missing immunizations. Immunization data may be missing because a provider has failed to report an individual visit, failed to report an immunization history of a new patient, or used an incorrect vaccine code. Children may also be included who have moved out of state prior to finishing their immunization series.

#### **Notes - 2005**

##### Medical Home Indicator Measure (Comprehensive)

All children with a most recent address of RI, who have had at least one immunization reported to KIDSNET by a Primary Care Provider are included in this measure. The numerator includes those who have had at least one lead test and completed the 4:3:1:3 (DTP, Polio, MMR, Hib) immunization series by their second birthday. This year's data includes children who were born in 2003 and turned 2 during 2005 and shows only 53% of children with both the immunization series and a lead test by the second birthday.

9% of the children were missing both a lead test and at least 1 immunization. 4% were missing just a lead test and 43% were missing just immunization(s). It is important to keep in mind that in order for a child to be considered complete for immunization, 11 separate immunizations had to be reported for each child by the second birthday. Failure to report just one of these 11 events means the child is incomplete for immunization. Nationally 40% of children in registries had incomplete immunization records, resulting in lower estimates of vaccine coverage when compared to the National Immunization Survey with provider verified results.

This measure underestimates actual coverage due to data gaps in KIDSNET. Children who have moved into RI and had their Lead test performed out of state may not have the test reported to KIDSNET. However, the largest gap in data can be attributed to missing immunizations. Immunization data may be missing because a provider has failed to report an individual visit, failed to report an immunization history of a new patient, or used an incorrect vaccine code. Children may also be included who have moved out of state prior to finishing their immunization series.

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

In FY2007, efforts to assure that all children have a medical home and receive routine and preventive health care services continued.

The Immunization Program continues to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and the public. The program focusing its improvement rates on populations new to the country and state.

The Lead Program continues its efforts to ensure that all young children in RI receive a lead screening as part of pediatric well-child care. The program conducts lead poisoning awareness and prevention activities, including Lead Poisoning Prevention Month events. Through KIDSNET, reminders are sent to families of children turning one year old to remind them to request lead screening from their physician.

The Family Outreach Program continues to provide home-based education, support, and referral to families to ensure that children are connected to a medical home and other community resources.

In FY2007, the DCFHE continued to implement the Pediatric Practice Enhancement Project (PPEP), which places parent consultants in primary and specialty care settings to assist families in accessing family-centered and coordinated services. The DCFHE also provided technical assistance to several initiatives focused on building medical home capacity in local communities, including the Newport County Healthy Communities Initiative, Washington County Coalition for Children, and Mt. Hope CATCH.

In FY2006, the PPEP program was expanded to twenty provider sites. An analysis of PPEP was completed that included a review of claims data from one local health plan. The analysis found that children served by PPEP had decreased utilization of inpatient/intensive settings, increased utilization of home and community-based services, and that 57% had lower health care costs after becoming involved in PPEP.

The DCFHE continued to support medical home systems development in culturally diverse communities through technical assistance to the Newport County Healthy Communities Initiative, the Washington County Coalition for Children, Mt. Hope CATCH, and Pawtucket/Central Falls CATCH. These initiatives supported activities including: medical home training for providers, families, and social service agencies; RItE Care benefits training; dissemination of information on community resources; data development; and many other activities.

Also in FY2007, Successful Start continued implementation of its statewide Early Childhood Systems Plan. Several initiatives to build the capacity of medical homes are underway, including a project to integrate developmental screening of young children into medical homes and community settings.

The DCFHE continues to work to enroll all pediatric providers in KIDSNET to ensure that children are identified and linked to a medical home and appropriate support services. Individual level lead screening, primary care provider, and immunization information are housed in KIDSNET.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and the public to ensure that children in RI receive timely immunizations			X	
2. Continue to conduct lead poisoning awareness and prevention			X	

activities, including promoting lead screening as part of routine pediatric well-child care				
3. Provide technical assistance, consultation, and resource materials to child care providers to ensure that all children in child care are up-to-date on their immunizations and lead screenings and are linked to a medical home			X	
4. The Family Outreach Program will continue to ensure that at-risk families of newborns and young children are connected to a medical home and other community resources		X		
5. Support and expand the Pediatric Practice Enhancement Project, which places parent consultants in primary and specialty care settings to assist families in accessing family-centered and coordinated services		X		
6. Continue to provide support and assistance to existing and emerging CATCH projects and other medical home systems development initiatives in local communities				X
7. Support continued implementation of Successful Start medical home building activities, including developmental screening of young children in community-based settings				X
8. 8. Continue to work to enroll all pediatric providers in the state in KIDSNET to ensure that all children are identified and are linked to a medical home and appropriate support services				X
9. Continue analyze KIDSNET and other data sources related to medical homes to determine an overall index or percentage of RI children who have a medical home				X
10.				

**b. Current Activities**

All ACIP recommended vaccines are provided to providers, free immunizations to uninsured children, and education materials to providers / public. Children and new residents behind in immunizations are identified.

KIDSNET tracks immunization and lead screening status of children born after January 1, 1997. Providers may generate KIDSNET reports re: their patients' immunization / lead status. KIDSNET monitors providers' system usage and reports quarterly. Managed care organizations / KINSNET exchange information to enhance MCO reporting.

The Child Care Support Network, health consultation is provided to childcare centers/ family childcare homes. Nurses review child health records (including immunization / lead screening status), provide staff training and preventative health/safety TA, distribute educational materials, and refer families to community services and resources.

The Family Outreach Program providers follow-up to at-risk families.

PPEP parent consultants link families, pediatric practices, and community resources.

Medical home systems development continues through TA to community organizations and support of medical home training for providers, families, and social service agencies; RIte Care benefits training; dissemination of information on community resources including pediatric mental health services; data development and strategic planning; and many other activities.

**c. Plan for the Coming Year**

Through its programming and strategic partnerships with agencies, associations, and coalitions, the DCFHE will continue to increase the number of children that have a medical home and receive routine and preventive health care services that are delivered in a culturally-competent and family-centered way.

The Immunization Program will continue to provide all vaccines for all children at no cost, promote immunization awareness through distribution of patient and provider educational and resource materials, will identify children who are behind on immunizations, and will promote immunization among populations new to the country and state. Child Care Support Network Health Consultants will educate and provide information to families and child care providers about the importance of timely immunizations and conduct record reviews to ensure children in child care are up-to-date on their immunizations.

The Family Outreach Program will continue to ensure that at-risk families of newborns and young children are connected to a medical home and other community resources.

The DCFHE will continue to support existing medical home systems development initiatives in local communities and continue to support PPEP parent consultants in creating linkages between families, pediatric practices, and community resources. PPEP parents will be trained to use KIDSNET to work with parents and medical homes assuring appropriate immunization and lead screening.

The Initiative for Healthy Youth will continue to work with the Northern RI Area Health Education Center and the Woonsocket CATCH grant coalition, to provide technical assistance and tools on adolescent medical home. DCFHE will identify two more communities to pilot the adolescent home model. DCFHE will seek additional support for professional development through the MCHB TA resource.

Successful Start will expand a model of developmental screening and referral to services. Screening tools and onsite assistance will be provided to pediatric offices and child care centers. If a grant application to SAMSHA is successful, The project will offer multidisciplinary training on medical home topics and will provide opportunities for relationship building between service sectors to facilitate coordinated referrals and services for families.

The Data and Evaluation Unit will continue to gather data related to medical homes and will determine an overall index or percentage of RI children who have a medical home.

**State Performance Measure 8:** *Percent of at-risk newborns who live in a neighborhood or community with MCH community systems building partnerships*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				35.5	35.5
Annual Indicator	34.2	35.4	34.4	35.0	36.4
Numerator	2316	2434	2395	2486	2685
Denominator	6768	6877	6965	7112	7379
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	36.4	36.4	36.8	37.2	37.2

**Notes - 2007**

2007 data are estimated.

**a. Last Year's Accomplishments**

Community systems building partnerships help communities assess the status of children, families, and neighborhoods and implement strategies to improve the health of their communities. The DCFHE provides assistance to communities to develop and support maternal and child health system assessment and strategic planning in high need communities in Rhode Island. The American Academy of Pediatrics and its local chapter and Area Health Education Centers (AHECs) are key partners in this work, providing financial support to CATCH projects.

In FY2006, the DCFHE provided technical assistance to the Newport County Healthy Communities Initiative (formerly the Newport County CATCH), the Mt. Hope CATCH, Pawtucket/Central Falls and Woonsocket CATCH and Washington County Coalition for Children (the coalition was a key partner in the Washington County CATCH project).

These systems development initiatives continued to support community assessment and planning activities designed to increase utilization of maternal and child health services and improve medical homes. Initiative activities included: medical home training for medical providers, parents, and social service providers; Rite Care benefits training for medical providers and parents; development of local referral networks to improve care coordination; transportation advocacy; dissemination of information on care coordination resources; development of a network of health outreach workers; development of a plan to improve mental health resources for children; on-going community needs assessment; development of ways to utilize existing data on families without medical homes (i.e. local emergency room records); and project evaluation.

CATCH projects and community coalitions share their experiences in developing infrastructure to support a coherent and integrated system of care for children, including CSHCN, with other communities throughout the state and offer technical assistance. Parents participate in all phases of CATCH activities.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide training and technical assistance to support maternal and child health system assessment and strategic planning in local communities				X
2. Continue to work with The Providence Plan to develop and implement a data utilization training curriculum and technical assistance plan				X
3. Support participation of Family Outreach Program home visitors in community networks and coalitions				X
4. Continue to collect newborn risk information through universal newborn developmental risk assessment			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Newport County Healthy Communities Initiative, Washington County Coalition for Children, Mt. Hope CATCH, Woonsocket CATCH, and Pawtucket Central Falls CATCH support community assessment and planning activities designed to increase utilization of MCH services and improve

medical homes. Initiative activities include: medical home training for medical providers, parents, and social service providers; Rite Care benefits training for medical providers and parents; promotion of best practices around caring for adolescents; development and implementation of local referral networks to improve care coordination; transportation advocacy; dissemination of information on care coordination resources; development of a network of health outreach workers; implementation of a plan to improve mental health resources for children; development of ways to utilize existing data on families without medical homes (i.e. local emergency room records); ongoing community needs assessment; increasing community awareness of behavioral health, incorporating parent consultant system navigation into the medical homes (through PPEP) and project evaluation.

Several coalitions partner with the RI Area Health Education Centers (AHEC) to sustain and expand their work.

The Providence Plan provides TA and training to CATCH initiatives.

All Family Outreach Program are community based and participate in local networks with other agencies that provide home visits, social service agencies, local child welfare offi

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

In FY2009, the DCFHE will continue to provide assistance to communities to develop and support maternal and child health system assessment and strategic planning.

The Newport County Healthy Communities Initiative, Washington County Coalition for Children, Mt. Hope CATCH, Pawtucket/Central Falls CATCH, and a newly established group in the city of Woonsocket, RI will support community assessment and planning activities designed to increase utilization of MCH services, including Rite Care. Initiative activities will include: medical home training for medical providers, parents, and social service providers; development and implementation of local referral networks to improve care coordination; dissemination of information on care coordination resources; implementation of a plan to improve mental health resources for children; promotion of best practices around caring for adolescents; development of ways to utilize existing data on families without medical homes (i.e. local emergency room records); ongoing community needs assessment; and project evaluation. In addition, CATCH projects and community coalitions will increase their health education efforts directed at parents around specific topics, including asthma, diabetes, and obesity. Collaboration with RI AHEC and PPEP will continue.

Through the contract with The Providence Plan, the DCFHE will support communities in sharing their experiences in developing infrastructure to support integrated systems of care for children, including CSHCN, with other communities throughout the state. In addition, The Providence Plan will provide training and technical assistance to existing sites around conducting community assessments, developing and implementing strategic plans, and evaluating project success. The Providence Plan will also support new communities to apply for CATCH funding. The Providence Plan will continue to work with the DCFHE to develop a set of indicators to measure the impact of investment in community-based systems development initiatives.

All Family Outreach Program vendors will continue to be community based and participate in local networks. Through involvement at the community level Family Outreach Program staff will educate communities about the program and develop strategies to outreach to families who are difficult to locate.

Also in FY2008, information on newborn risk factors will continue to be collected through universal newborn developmental risk assessment and stored in KIDSNET. DCFHE staff will begin to explore opportunities to connect KIDSNET to the Department of Health's Geographic

Information System to allow for geo-coding of address information.

**State Performance Measure 9:** *Percent of licensed child care providers with on-site health consultants*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				30	35
Annual Indicator				0.3	0.4
Numerator				148	162
Denominator				423	426
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	40	45	50	55	55

**Notes - 2007**

Results are from a phone survey conducted of licensed child care providers.

**Notes - 2006**

Data are estimated.

This state performance measure continues to serve as a placeholder. In FY 2006 the state released a Request for Proposals to implement a statewide model of health consultation to child care providers. Imbedded within this model was a state child care health consultant. This position is responsible for collecting the data relevant to this performance measure. Due to the poor quality of applications received, no contract was awarded and the RFP has just been re-released in June of 2006. By January of 2007 the information to show status on this performance measure will be available.

**Notes - 2005**

Similar to other states, Rhode Island has regulations in place regarding child care health consultation. Current regulations require that child care centers serving infants under 18 months of age have a nurse onsite for a minimum of three hours per day. Centers serving children over 18 months of age are required to have "readily available" the consultant services of a licensed physician or registered nurse. However, on-site services are not required. There are no regulations pertaining to health consultation for family child care homes. In addition, some child care programs (e.g. Head Start) utilize the services of a nurse/health consultant even though they are not mandated to do so.

At this time, the exact number of licensed child care providers with on-site health consultants is unknown. Currently, this state performance measure serves as a placeholder. The state Title V agencies in federal Region I have agreed to develop an indicator that reflects the assets of their early childhood health and development systems. The region has chosen to focus on their collective assets regarding child care health consultants (CCHCs). CCHCs improve the general health and safety of children in child care and promote the development of children in other domains (e.g., social-emotional development, cognitive development, etc.). Rhode Island will work with Title V agencies in Region 1 to examine what strategies can be employed to measure the prevalence of CCHCs, their contributions to child health and development, and their role in the early childhood service system.

**a. Last Year's Accomplishments**

Strong families and healthy communities provide the foundation for children's healthy development. Community-based early childhood services are part of the critical network of

supports for families. An effective early childhood system addresses the needs of all children, while providing more intensive services for infants and children most at risk.

The state Title V agencies in federal Region I developed an asset-based measure of their individual early childhood health and development systems -- the percent of licensed child care providers with onsite health consultants. Child care health consultants improve the general health and safety of children in child care and promote children's development. At this time, a region wide means to accurately measure the use of health consultants is under development.

Region 1 has a long history of working to develop improve state's abilities to support child care health consultation. As part of the Healthy Child Care America initiative, the Region 1 states formed Healthy Child Care New England in 2000. The collaborative is focused on creating and maintaining a coordinated child care health consultant training program for all six New England state. The Chief of the Office of Early Childhood Health and Development participates on the New England Collaborative. .

In 2006 a request for proposals for Child Care Health consultation was published. Due to insufficient applications the Request for Proposals was reissued and awarded in FY 2007. During this time the DCFHE provided child care health consultation through its Division of Family Health Nurses. Training on caring for children with special health care needs and behavioral challenges, healthy and supportive environments, and caring for infants and toddlers was provided. 2 part time child care health consultants now provide consultation to 5 child care centers as part of a new pilot program.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue implementation of the Successful Start Early Childhood Systems Plan				X
2. Fully implement child care health and mental health consultation to support the healthy development of children in child care			X	
3. Continue partnering with Healthy Child Care New England to offer training opportunities for child care health consultants and continue efforts to integrate child care health consultation into states' Early Childhood Comprehensive Systems projects				X
4. Pursue funding to sustain				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Mental health consultation is provided to 6 child care centers and 70 family child care homes. An assessment of RI child care health/mental health consultation highlighted the importance child care environments that support children's physical, cognitive, and social-emotional development, promote communication and coordination with children's medical homes, and are connected to community-based health, developmental, behavioral, and other social services and resources

The partnership with Healthy Child Care New England continues. It plans region-wide training, refine existing training efforts, incorporate the Healthy Child Care America work with states' Early Childhood Comprehensive Systems projects, and explore avenues to sustain work. The Child Care Health Consultants now work with HCCNE

The partnership with Health Child Care New England continues. It plans region-wide training, refine existing training efforts, incorporate the Healthy Child Care America work with states' Early Childhood Comprehensive Systems projects, and explore avenues to sustain work.

**c. Plan for the Coming Year**

In FY2009, the DCFHE will continue efforts to promote healthy human development across the lifespan. The Successful Start initiative will continue to implement the Successful Start Early Childhood systems plan to ensure a coordinated and effective system of early childhood services that promotes school readiness. Child care health and mental health consultation will be expanded in FY2008 based on funding availability.

The Child Care Support Network, with funding from the RI Department of Human Services, Title V, Successful Start, and the Healthy Tomorrows Partnership for Children program will develop a network of well-trained child care health and mental health consultants. Consultants will provide program-level child care health and mental health consultation for child care centers and family child care homes that is based on best practices and current research in the fields of early childhood health, behavioral health, development, and education.

Well-trained child care health and mental health consultants will continue to work collaboratively with child care providers to increase providers' knowledge, skills, and abilities in providing optimal care for young children. Consultants will assist providers in creating physical and relationship-based environments that promote children's health and wellbeing.

Specific responsibilities of health consultants will include reviewing child health records to ensure completeness (including immunization record, evidence of recent physical examination, and documentation of the child's medical home), review of the child care program's health and safety policies and procedures (e.g. head lice, medication administration, excusing a child due to illness), modeling positive classroom techniques to support children with special needs, consultation with parents, and referrals to community services and resources, including Medicaid.

Also in FY2009, the DCFHE will continue working with the Healthy Child Care New England collaborative to share resources, offer training opportunities for child care health consultants, and investigate ways to measure the use of child care health consultants. The collaborative will continue work to integrate child care health consultation into states' Early Childhood Comprehensive Systems projects.

**State Performance Measure 10:** *Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
---------------------------------------	------	------	------	------	------

Annual Performance Objective				25.7	25.5
Annual Indicator	24.3	25.7	25.7	25.7	23.6
Numerator	11252	11188	12896	13390	11442
Denominator	46316	43505	50241	52100	48482
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	24.2	24.2	24.8	24.8	24.8

**Notes - 2007**

Weighted data from YRBS for 2007 entered in this cell.

**Notes - 2006**

Data for 2006 is estimated.

The Youth Risk Behavior Survey [YRBS] is conducted every other year. The survey was conducted in 2001, 2003 and 2005.

**Notes - 2005**

Weighted data from YRBS for 2005 entered in this cell.

**a. Last Year's Accomplishments**

Identifying and meeting the emotional and behavioral health needs of children is critical for their success. Adequate capacity to address child and family mental health needs remains a statewide concern. During FY2007 the DCFHE supported activities to promote the mental/behavioral health of the MCH population, including school age youth.

In FY2007, eight school-based health centers (SBHCs) continued to provide teenagers with access to comprehensive preventive health and mental health services. Teens in need of mental health services were referred to counselors onsite at the school or referred for appropriate community-based mental health evaluation and/or treatment.

The Women's Health Screening & Referral Program (WHSRP) continues to provide pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns are referred to appropriate mental health assessment and/or treatment services.

Consumers who called the Family Health Information Line were provided with "Ten Tips on Parenting Teens" and referrals to the Men2B and Can We Talk programs. Both of these programs address issues related to adolescent mental health. In FY2005 the DCFHE and the RI Department of Education continued to sustain the [www.ParentLinkRI.org](http://www.ParentLinkRI.org) website for parents of nine to 17 year olds. The website includes programs, resources, referrals and monthly parenting tips for parents and professionals working with adolescents and pre-adolescents.

The DCFHE also continued its support of the Men2B Role Model Support Capacity Program during FY2007. The program stresses the importance of caring adults in the lives of adolescent boys and includes a component, which addresses the impact of physical and emotional abuse. The DCFHE continued its cooperative agreement with the RI Department of Corrections to implement a pilot Men2B program in the Adult Correctional Institution for men who are transitioning out of prison and back to family and community. It also entered into a contractual arrangement with the RI Mentoring Partnership to provide Men2B training to men who are entering into formal mentoring relationships with boys. DCFHE began transition planning to move administration of Men2B to RI Mentoring Partnership.

DCFHE is exploring the possibility of developing a RI Mental/Behavioral Health Resource Center for Schools at RI's Bradley Hospital (pediatric mental health hospital) via a Certificate of Need review process. The RI Public Health Institute was funded by the RI Foundation to conduct strategic planning around the development of a mental/behavioral health resource center for schools in

partnership with DCFHE..

DCFHE will consider other models of care to support wellness activities and continue to explore partnerships to assure access to care for adolescents.

The DCFHE manages the Centers for Disease Control & Prevention funded Thrive (formerly Healthy Schools! Healthy Kids! coordinated school health initiative in partnership with the RI Department of Education. This partnership has focused on strengthening the statewide infrastructure to address school guidance; counseling and social services; school environment; and school climate to assure safe, caring, and nurturing schools.

HEALTH entered into a contractual agreement with RIDE to distribute funds to school districts to practice drilling for emergency events and to continue to build relationships with local emergency responders.

Also in FY2007, the DCFHE reviewed 2005 Youth Risk Behavior Survey data to determine the percentage of respondents who felt sad or hopeless almost every day for two weeks or more in a row. Data briefs were produced to help schools link state data with local school data on mental health and other youth risk behavior topics. Youth Risk Behavior Survey data was added to HEALTH's Web Query System, which facilitated further analysis.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to develop the Youth Action Research Program to provide opportunities for youth to provide input into DCFHE programs and conduct research and make recommendations for adolescent health programming				X
2. Support new models of care to support wellness activities in schools through partnerships and innovative funding strategies.	X			
3. Continue to support the Women's Health Screening & Referral Program to provide comprehensive health risk assessment to teens and refer teens in need of mental health services to appropriate resources	X			
4. Maintain and update the www.ParentLinkRI.org website to provide information on programs, resources, referrals, and monthly parenting tips for parents and professionals			X	
5. Actively participate on a suicide prevention task force to mobilize support for violence and suicide prevention				X
6. Analyze 2007 Youth Risk Behavior Survey data and plan for the 2009 survey				X
7. Work with the Transition Council on self-determination and youth empowerment activities for youth with disabilities, chronic conditions and special needs.		X		X
8.				
9.				
10.				

**b. Current Activities**

A disability indicator was included in the 2007 YRBS survey; OSHCN, the RI Transition Council and RIDE's Office of Diverse Learners are disseminating these results and looking to address the mental / behavioral health needs of youth with disabilities. OSHCN, the Rhodes to Independence

and the Transition Council are cataloging youth leadership development and youth programs of self-determination (Kids As Self-Advocates (KASA) and Dare to Dream).

Minority youth conducted ethnographic research/recommendation re: adolescent health policy/practice. This research was disseminated / discussed internally with select external stakeholders..

SBHCs provide teenagers with access to health/mental health services, referring to counselors onsite or to services in the community.

The Women's Health Screening & Referral Program (WHSRP) continues to provide pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns are referred to appropriate mental health assessment and/or treatment services.

The [www.ParentLinkRI.org](http://www.ParentLinkRI.org) website is being maintained and promoted.

DCFHE and its RIDE "thrive" partner are exploring

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

The DCFHE will seek continued support of Youth Action Researchers to conduct action research on adolescent health issues, including mental behavioral health, violence, suicide, substance use, and sex and will incorporate recommendations into its prioritizing and goal setting processes.

DCFHE will continue to pursue models of care to support wellness activities in schools through partnerships and innovative funding strategies.

The WHSRP will continue to provide pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns will be referred to appropriate mental health assessment and/or treatment services.

In FY2009, the DCFHE will continue to implement [ParentLinkRI.org](http://ParentLinkRI.org), an online resource directory for parents of nine to 17 year-olds. If grant funding is secured, the DCFHE hopes to transition the website to a new entity that will serve as the mental/behavioral health resource center for schools

The DCFHE will continue to support the Men2B Program to prepare men to be confident and effective role models for boys and to build community capacity to meet the developmental need of boys for safe caring adult relationships through its contractual relationship with the RI Mentoring Partnership.

The DCFHE will continue work on a violence prevention project. The partnership will use a previously created state report card on risk and protective factors for violence to highlight issues with shared risk and protective factors and to mobilize support for implementation of prevention activities.

The DCFHE will continue to participate on a suicide prevention task force, which will seek funding to implement strategies for suicide prevention for Rhode Islanders 15 to 24 years old.

The DCFHE will continue to work with HEALTH's Center for Health Data and Analysis to analyze 2007 Youth Risk Behavior Survey data and to produce data tools for state and local level stakeholders. .

If DCFHE and its partner, the RI Public Health Institute, will continue to pursue development of a mental/behavioral health resource center for RI schools, DCFHE and RIPHI will utilize a feasibility

study and stakeholder driven strategic plan du to inform the development of this Center.

The DCFHE will work with HEALTH's Center for Health Data and Analysis to analyze and disseminate data from the 2007 Youth Risk Behavior Survey.

**State Performance Measure 11: Percent of families of CSHCN served by the Pediatric Practice Enhancement Project (PPEP).**

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator			1.8	3.1	5.3
Numerator			740	1292	2200
Denominator			41783	41783	41783
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	6	6.4	6.7	6.9	7.1

**a. Last Year's Accomplishments**

This is a new performance measure for 2009

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the training of new PPEP parent consultants				X
2. Collect data to enhance the evaluation of PPEP				X
3. Work with insurers to secure sustainable funding for PPEP.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The RI Department of Health (RIDOH) Office of Special Health Care Needs (OSHCN) is sustaining twenty -- four (24) pediatric primary and specialty care sites located throughout the state of Rhode Island. The PPEP database will be moved from the RIDOH and housed in the Lifespan network to allow for electronic submission of data from the sites. The RI Department of Health OSHCN is developing and utilizing PPEP data reports to identify system barriers to be address by state and community leadership through the Family Voices Leadership Team

The RI DOH Data and Evaluation Team is developing an evaluation tool to enable PPEP to substantiate the cost benefits and insurer reimbursement.

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

During 2009, the RI Department of Health (RIDOH) Office of Special Health Care Needs (OSHCN) will continue to sustain the twenty -- four (24) pediatric primary and specialty care sites located throughout the state of Rhode Island. The PPEP database will be moved from the RIDOH and housed in the Lifespan network to allow for electronic submission of data from the sites. The RI Department of Health OSHCN will continue to develop and utilize PPEP data reports to identify system barriers to be address by state and community leadership through the Family Voices Leadership Team

The sustainability of the project which remains the most significant challenge as the PPEP is funded through grant dollars and some practice buy-in, will be addressed through an evaluation process conducted though late 2008 with the State's largest Medicaid Managed Care insurer. Utilizing an evaluation tool developed by the RI DOH Data and Evaluation Unit, PPEP outcome data will be analyzed to substantiate the cost benefits and insurer reimbursement.

## **E. Health Status Indicators**

Health Status Indicators

/2007/

The Division of Community, Family Health and Equity (DCFHE) represents the Rhode Island Department of Health as the state's maternal and child health agency responsible for the health of children and women of maternal age. DCFHE programming is data-driven, and as such, the Division and its individual programs use performance measures and indicators of maternal and child wellbeing in identifying population needs, developing programming, and evaluating impact. Use of the Health Status Indicators (HSI) for these purposes is discussed below.

HSI #01A: The percent of live births weighing less than 2,500 grams

HSI #01B: The percent of live singleton births weighing less than 2,500 grams

HSI #02A: The percent of live births weighing less than 1,500 grams

HSI #02B: The percent of live singleton births weighing less than 1,500 grams

As part of a needs assessment process, the DCFHE's Data and Evaluation Team tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the state.

/2008/ Successful Start is using this data to develop recommendations for the Children's Cabinet about targeting resources to areas of highest need

The Home Visiting program uses this data to identify children who will be offered home visits due to low birth weights //2008//

HSI #03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger

HSI #03B: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger

HSI #03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years

HSI #04A: The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger

HSI #04B: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger

HSI #04C: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years

The DFCHE is responsible for the health of school age children including injuries in school age children and young adults. DFCHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Data and Evaluation Team tracks, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). This information is shared within DFCHE and community partners through publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

HSI #05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia

HSI #05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia

The DFCHE is responsible for the health of school age children, adolescent health, the state's school-based health center initiative, and administration of the state's Title X family planning program. Data on reported cases of chlamydia, an often silent and dangerous sexually transmitted disease, is critical to identify needs of subpopulations and to develop effective planning and prevention interventions. The RI Department of Health Laboratory and its Sexually Transmitted Disease program track cases and report to the DFCHE data by demographic factors (e.g. age, race, ethnicity, city/town residence, community health centers, etc.) for needs assessment purposes. The DFCHE Title X family planning program tracks chlamydia tests, reported on its Family Planning Records forms. Information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

HSI #06A & B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race, and ethnicity

As part of a needs assessment process, the DFCHE's Data and Evaluation Team tracks, on an annual basis, subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. For example, teen birth rates are highest in Hispanic populations, which also have high rates of poverty. Teen pregnancy prevention efforts, therefore, are focused on the Hispanic community. Data are drawn from Vital Records, Department of Administration Statewide Planning, U.S. Bureau of the Census, and other population estimate sources. This information is used to calculate rates of various maternal and child health indicators. The information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data is monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, date of birth, race, and ethnicity are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. Age, and when possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. Using KIDSNET data, Newborn Screening programs (metabolic and hearing) report information on screening and follow-up rates and outcomes by race, ethnicity, and age to federal partners. Newborn Screening programs also use PRAMS data broken down by race/ethnicity to identify subpopulations that should be targeted for newborn screening awareness. This data will be monitored in the future to determine the effectiveness of parental informing strategies.

The WIC Program uses this data in the preparation of the WIC state plan, including ranking the relative need of communities. In addition, WIC uses this data to determine the effectiveness of outreach activities.

***//2009/ The Office of Immunization uses this data to assist in monitoring vaccination coverage rates among children and adolescents, identify disparities and disseminate information to key stakeholders. //2009//***

The Immunization Program uses this data to identify immunization need and disparities, unique educational needs of target populations, and translation needs/requirements of educational materials. The program also uses this data to outreach to key external partners and assess immunization coverage rates.

***//2008/ Programs that promote healthy child care use this data to target service delivery in areas of high need and appropriately direct services that are specifically designed to meet the needs of various cultural groups. //2008//***

HSI #07A & B: Live births to women (of all ages) enumerated by maternal age, race and ethnicity

As part of a needs assessment process, the DFCHE's Data and Evaluation Team tracks, on an annual basis, live births to women (of all ages) enumerated by maternal age, race, and ethnicity. These data are used to calculate fertility rates among women of all ages. They are also used to calculate overall pregnancy rates and teen pregnancy rates. Data are drawn from Vital Records. This information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored

over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

All live births, maternal date of birth, race, and ethnicity are collected in the integrated electronic birth certificate/developmental risk screening system (VR2000) and stored in KIDSNET.

The WIC Program uses birth data in the preparation of the WIC state plan, including ranking the relative need of communities across the state.

HSI #08A & B: Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity

As part of a needs assessment process, the DCFHE's Data and Evaluation Team tracks, on an annual basis, deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities to populations most in need. The DCFHE tracks data by cause of death, age, and geographical areas and looks at insurance status and other variables. Data are drawn from Vital Records. The Data and Evaluation Team works with programs to identify causes of death and to identify effective prevention strategies. The Team participates on a child death review team focused on preventable deaths among all children and adolescents. Information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Deaths to infants that occur prior to discharge from a maternity hospital are collected in the integrated electronic birth certificate/developmental risk assessment system (VR2000) along with date of birth and race/ethnicity data and stored in KIDSNET. KIDSNET also works with Vital Records and other processes to record infant and child death in KIDSNET.

HSI #09A & B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity

As part of a needs assessment process, the DCFHE tracks subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. The DCFHE's Data and Evaluation Team tracks, on an annual basis, infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various state programs enumerated by race and ethnicity. Data is drawn from program reports, the U.S. Bureau of the Census, and Vital Records. . Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Race/ethnicity data are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. KIDSNET includes program-level data for children born on or after January 1, 1997 for the following programs: Early Intervention, Family Outreach (home visiting), Immunization, Lead Poisoning Prevention, and Newborn Screening (metabolic, hearing, and developmental risk). KIDSNET generates program data enumerated by race and ethnicity for program use.

The WIC Program also uses data captured in HSI #09A and 09B in the preparation of the WIC state plan, including ranking the relative need of communities. The program also uses this data to

assess the effectiveness of WIC outreach activities.

***/2009/ The Office of Immunization uses this data to: support federally funded Vaccine for Children (VFC) activities, identify immunization need and disparities, identify unique educational needs of target populations, determine translation needs/requirements for educational materials, outreach to key external partners, and evaluate program success by comparing data to the number of eligible children. //2009//***

The Immunization Program uses this data to: support Vaccine for Children activities, identify immunization need and disparities, identify unique educational needs of target populations, understand translation needs/requirements for educational materials, outreach to key external partners, and evaluate program success by comparing data to the number of eligible children.

*/2008/ Successful Start is using this data to develop recommendations for the Children's Cabinet about targeting resources to areas of highest need. The data will help policy makers help determine existing services, the degree to which they meet population needs and what additional services are needed to provide comprehensive prevention efforts. //2008//*

HSI #10: Geographic living area for all resident children aged 0 through 19 years

As part of a needs assessment process, the DCFHE's Data and Evaluation Team tracks, on an annual basis, the geographic living area for all resident children aged 0 through 19 years in order to conduct cross-tabulations by geographic area to target prevention activities in areas most in need. For example, teen birth rates are highest in the core MCH planning cities, which have high rates of minority populations, poverty, and school failure. Teen pregnancy prevention efforts, therefore, are focused on those communities. Data is drawn from Vital Statistics Records and U.S. Bureau of the Census data. The RI Department of Health has implemented a geographical information system for use by all staff. Databases are gradually being geo-coded for mapping purposes. Information is shared with community partners through program reports and the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data is used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Address at the time of birth is collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When possible, address information is also collected in KIDSNET when new records are opened on children not born in Rhode Island. Address information is updated by KIDSNET users such as home visitors, the lead program, primary care providers, and others aware of address changes. KIDSNET data can be analyzed at the zip code, region, or city/town level. This data can then be shared with home visiting agencies and local coalitions working to address public health issues within communities. Geographic data has also been used to inform policymakers and planners working on disaster plans such as pandemic flu. KIDSNET will be exploring geographical information system capacity that will allow geo-coding and a more refined geographic analysis.

The WIC Program uses geographic data on children in preparation of the WIC state plan, including ranking the relative need of communities. The program also uses this data to assess the effectiveness of outreach activities.

***/2009/ The Office of Immunization uses this data to assist in monitoring vaccination coverage rates in cities and towns, identify immunization need and disparities, and identify unique educational/outreach needs of targeted populations. //2009//***

The Immunization Program uses this data to identify immunization need and disparities, identify

unique educational/outreach needs of targeted populations, and evaluate adequate access to medical care by geographic region.

HSI #11: Percent of the State population at various levels of the federal poverty level

HSI #12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level

As part of a needs assessment process, the DCFHE's Data and Evaluation Team tracks, on an annual basis, the percent of the population (state and child) at various levels of the federal poverty level in order to conduct cross-tabulations by poverty to target prevention activities in areas most in need. Poverty is a risk factor for nearly every poor health outcome and therefore must be addressed as part of strategic planning to improve health and wellbeing of maternal and child populations. For example, poverty is a risk factor for teen pregnancy and school failure. Teen pregnancy prevention efforts, therefore, must incorporate strategies to give youth hope for the future and skills to meet the demands of a 21st century workforce. Data is drawn from the U.S. Bureau of the Census and other survey and program data. This information is shared with community partners through program reports and the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data is used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, the WIC Program uses poverty-level data in preparation of the WIC state plan, including ranking the relative need of communities. The program also uses this data to assess the effectiveness of outreach activities.

The Immunization Program uses poverty-level data in determining eligibility for the federally funded Vaccine for Children (VFC) Program, advocating for consistent funding for this program, and quantifying the need for services.

*/2007/ The Immunization Program uses poverty-level data in determining eligibility for the Vaccine for Children Program, advocating for consistent funding for this program, and quantifying the need for services. //2007//*

*/2008/ Both programs designed to make out of home child care environments healthier and safer and programs targeted toward providing home visits to families with newborns use this data to focus efforts on areas of highest need. //2008//*

## **F. Other Program Activities**

2007/ DCFHE initiatives and activities that were not fully discussed within the context of the National and State Performance Measures are described below. //2007//

### **Toll-Free Family Health Information Line**

The DCFHE supports a statewide toll-free telephone resource for all families in Rhode Island, called the Family Health Information Line. Bi-lingual information specialists answer families' questions in English and in Spanish about DCFHE programs, as well as a wide variety of health topics. Staff refer callers to appropriate community resources. Callers to the Family Health Information Line include consumers, health care providers, school personnel, and community-based agencies. Culturally and linguistically appropriate informational materials are disseminated

through the DCFHE's centralized distribution center.

***//2009/ The Family Health Information Line received a total of 12,066 calls during the period 6/1/07-6/30/08. 58% were transferred to other programs within the Department of Health. 11.5% of the calls were related to WIC; 15.7% to immunizations; 3.74% to lead poisoning; 1.3% to mold and mildew; 0.0% to bio-terrorism; 0.36% to family planning; 0.04% to adolescent health; 0.12% to PRAMS; 0.56% to disabilities; 3.32% to KIDSNET; 0.09% to West Nile Virus; and 0.5% to child care.***

***84.8% of the callers were consumers, 11.3 % were health care providers, .9 were child care providers, .8% were social service providers, 1.5% were school personnel, .4% were WIC vendors, and 0.02% were legislators.***

***93.9% of the callers were English-speaking, 5.9% were Spanish-speaking, and 0.2% were Portuguese-speaking.***

***33.4% heard of the hotline via printed materials, 16.8% from the telephone book / information, 13.2% through the newspaper and 8.9% through another state agency. //2009//***

KIDSNET & the Rhode Island Health Information Exchange

***//2009/ Rhode Island's Health Information Exchange (HIE) continues to develop a system for providing secure access to patient health information from a variety of local public and private information systems to authorized users. In phase one, once patients are enrolled, health care providers would have access to pharmacy and laboratory-related data. The project will: create a database which uniquely identifies patients across health care settings and indicates where a patient has information stored, allow data from various sources to be viewed in an integrated and uniform manner, allow data from various sources to be integrated into electronic health records and allow this data to be shared, allow consumer control over who can access their data, provide decision support to providers (e.g. immunization algorithm), and create the ability to utilize the data for public health purposes, including evaluation, surveillance, and research.***

***KIDSNET is actively participating in this project as a Data Sharing Partner. Through the KIDSNET communications channels, pediatric providers are informed about the HIE project. //2009//*** The KIDSNET database already aggregates data on a number of childhood preventive services for all children born after January 1, 1997. KIDSNET will also participate in the group's data standards committee to facilitate the use of data standards in RI's healthcare transactions.

## **G. Technical Assistance**

***//2009/Technical Assistance FY2009:***

### ***1. Identification, Tracking, and Resource Provision to Children with Autism***

***The RI Autism Spectrum Disorder (ASD) Evaluation & Treatment Act requires DCFHE take the lead in combating problems associated with ASD. The question for the technical assistance is how should DCFHE approach a mandate to track and screen for ASD when it doesn't offer/fund direct services for ASD? what the DCFHE's influence should be, and How can DCFHE can affect the policies and programming for families raising children with ASD?. This request addresses the following CSHCN-related performance measures: NPM #3 and NPM #5.***

### ***2. Development of a Medical Home Index***

*One of Rhode Island's key priorities for maternal and child health is to assure that all Rhode Island families have a medical home. In 2004, a Medical Home Workgroup identified a set of indicators for each of the seven components of medical home (based on the American Academy of Pediatrics definition). The indicators utilize quantitative and qualitative data and rely on multiple sources of data including national, state, and local surveys, program data, and KIDSNET. We have begun to collect the data, but need technical assistance to create an overall index of medical home. Research conducted in the Northern RI Area Health Education Center will be used to inform this process. This request addresses NPM #3, NPM #6, and SPM #7.*

### **3. Development of Youth Input**

*The Office for Family, Youth and School success needs ongoing TA to develop and improve its model program for youth engagement providing meaningful input into priorities and planning for adolescent health. The first "class" of Youth Action Researchers completed action research around a health related issue, resulting in recommendations from youth around policy, programming and implementation. Throughout this process, Youth Infusion has provided TA via site visits, e-mails, and postal mail/ phone conferencing. It's been valuable in youth training curricula, staff training, tools/evaluation dev, and advice on sustainability and infrastructure development. DFCHE would like to continue this TA to develop other action research models. A site visit from Youth Infusion to obtain contextual assessment of the youth action research program model and outcomes, and provide staff training will allow HEALTH staff and partners to continue to work more effectively with youth and youth to work more effectively with HEALTH staff.*

*This request addresses NPM #8, NPM#13, NPM#16, SPM #6, SPM #7, and SPM #9.*

### **4. Community Partnership Projects**

*Community Partnership Projects requires technical assistance to support local partners to acquire knowledge and skills around improving community-based MCH systems. TA support from national experts on the impact of social and environmental influences on health will allow CPP to better serve the needs of conference attendees.*

*This request addresses NPMs # 3, #7, #8, #13, #14, #16, #18 and SPMs #2, #7, #8, #10*

**5. Successful Start, Rhode Island's State Early Childhood Comprehensive Systems (SECCS) Initiative, is working to coordinate and improve services in four critical areas of early childhood health and development: Early Care & Education, Medical Homes, Social-Emotional Development, and Parent Education & Family Support. The project is requesting technical assistance in implementing our goals and objectives relating to Parent Education and Family Support. Of the four critical areas of focus, It's difficult to dev a plan to coordinate/ improve services. The field of parent education and family support is broad, not owned by any one agency; there is no formal infrastructure to support capacity building, coordination, or quality imp. Through this request for technical assistance, the DCFHE hopes to bring in external experts in this field to assist it in working through these challenges. This request addresses the following performance measures: NPM #1, NPM #2, NPM #5, NPM 3#, NPM #7, NPM #9, NPM #10, NPM #11, NPM #12, NPM #15, NPM #18, SPM #4, SPM #5, SPM #8, and SPM #10.**

**6. The Office of Immunization needs technical assistance in working with key partners to address new influenza vaccination recommendations to expand vaccination efforts to all children 6 months-18 years of age, people with chronic medical conditions, pregnant women, healthcare workers, and individuals caring for or working in a setting with young**

***children. TA would assist in the development of a comprehensive plan to target all audiences with messages supporting the importance of flu vaccination to protect self, loved ones and community. This request addresses the following performance measures: NPM #7,SPM #7//2009//***

## **V. Budget Narrative**

### **A. Expenditures**

Budget Narrative - FY2009

Expenditures - FY2007

#### Federal Grant Monitoring Procedures

The Division of Community Family Health and Equity (DCFHE) maintains budget documentation for block grant funding/expenditures for reporting consistent with Section 505(a) and section 506(a)(1) for auditing. All federal grants are monitored both within the Division and by HEALTH's Office of Management Services (OMS). The DCFHE Chief Programs Operations meets bi-weekly with DCFHE office and program chiefs to review spending, performance, and quality assurance issues for each federal grant. The OMS reviews each federal grant monthly for cost and data reporting issues. Any non-compliance, such as delays in progress reports or personnel hiring or lack of billing, requires an immediate response by the DCFHE Chief Programs Operations. Federal financial status reports (FSRs) are due within three months of the close of a federal grant. HEALTH consistently submits FSRs correctly and on-time.

#### HEALTH Policies for Contracting & Purchasing

Any purchase made with federal or state dollars requires prior approval. In addition, all purchases must be approved by the DCFHE Chief Programs Operations. Once approved, the request to purchase form must be signed by OMS staff and then approved by the state Office of Purchasing. There are detailed policies for allowable and non-allowable purchases. These policies include restrictions on types of purchases, like gifts and food, as well as travel guidelines. There are procedures in place for the State of Rhode Island to assure that competition exists between all providers for federal and state dollars. State departments are allowed to make some purchases without the approval of the Office of Purchasing under certain detailed guidelines. The DCFHE has established an inventory management plan that includes rules for the purchasing of major equipment, monitoring equipment purchased with state dollars, and a plan for surplusing obsolete materials.

There are detailed procedures for establishing and monitoring contracts and grants at HEALTH. HEALTH staff cannot enter into a contract with a provider without following certain steps. There are two mechanisms for awarding funds at HEALTH: 1) through a competitive request for proposals (RFP) process and 2) through a grant based on need, legislative requirements, or through a formula funding mechanism. There are detailed requirements for RFPs including appropriate language in the proposals, submission of offers, appeals, public review, and use of minority businesses. An RFP template must be followed for all RFPs and the document is reviewed by the DFH and the OMS before dissemination. The RFP process also requires a formal review of procedures used to select vendors, including an independent session with Office of Purchasing staff. A grant may be awarded to a Rhode Island-based non-profit agency for an identified need, if the agency is solely capable of addressing the need or if there is a legislative requirement to award funds to a particular agency or if HEALTH is awarding funds to all capable agencies through a funding formula. Once approval is received to enter into a grant, DFH staff must then follow procedures for establishing contracts.

Procedures for contract management includes the establishment and modification of contracts, which is the responsibility of the OMS, while the monitoring of contract compliance is a DFH responsibility. The DCFHE Chief of Policy and Management and Key Administrator meet with DCFHE Team leads and program managers to review contract compliance and other administrative issues bi-weekly. Contract monitoring includes approval and signatures for appropriate charges to each contract and contract performance and progress. The DCFHE has

routinely held back payments or terminated contracts for issues related performance and progress. DFH program managers must review the appropriateness of all charges against a contract. Any variation in billing from the established contract must be requested in writing before reimbursements are made. DCFHE program managers are also responsible for the day-to-day oversights of contracts, monitoring performance, quality assurance, and billing procedures. The program managers regularly conduct performance reviews and customer satisfaction surveys for programs receiving state and federal funds.

#### Audits & Controls

Audits from both the state Office of the Auditor General and the state Bureau of Audits are conducted at HEALTH annually. The DCFHE has frequently been audited - the WIC Program is audited annually and the Immunization Program and Family Planning were both audited in the recent past. HEALTH's OMS conducts audits of DFH contracts regularly and monitors payments. In addition to external audits, the DCFHE routinely audits all of its sub-contracted agencies and requires formal audits to be sent to the DCFHE annually.

HEALTH's division managers must submit an annual financial audit review to monitor controls on contracts, personnel, budget, and other administrative policies. These financial audits are reviewed by the state's Financial Officer for compliance with existing state policies.

#### EXPENDITURES

##### Form #3

Expenditures for FY2007 decreased from the amount budgeted due to a higher carryforward than expected and the loss of state funds (MCH, Home Visits, School Based Health Clinics, Child Development Center and WIC Farmers Market). FY2007 carryforward was higher than expected due to the implementation of a new state financial system, which significantly delayed the contracting, and purchasing processes. Most of the expenditures for FY2007 were for Infants and Children (1-22) due to the increase in vaccines purchases. The division relies on this prior year balance to fund new initiatives and unplanned expenditures.

##### Form #4

Investments in Pregnant Women, Infants, Children and CSHCN are lower than budgeted due to loss of state funds (MCH, Home Visits, School Based Health Clinics, Child Development Center and WIC Farmers Market). Administrative cost increased slightly due to personnel cost increases.

##### Form #5

Investments for FY2007 moved away from Direct Services to Enabling, Population-Based and Infrastructure Services.

## **B. Budget**

Title V expenditures for FY2007 were 48.48% to preventive services for children, 30.39% to children with special health care needs and 3.36% for administrative functions. In FY2009, the Division proposes to spend the estimated RI allocation of \$1,860,000.00 in addition to a carry forward of \$471,103 from FY2008 (for a total of \$2,331,103)

Our Office of Children with Special Health Care Needs has addressed the needs of vulnerable young children and adolescent, investing in parent involvement and system building during FY07 and FY08. We continue to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments. The Division's 2009 budget allocates \$2,331,103, of which 31.12% (\$725,551) will be expended on children with special care needs, 39.82% (\$928,138) will be expended on preventive services for children and 5.75% (\$133,955) in administrative functions.

The Division's budget for FY2009 presents an increase of \$38,954,748, due to the recent merger of former Divisions of Family Health and Community Health and Equity. The new Division of Community Family Health and Equity's budget is \$76,102,031 (including state Medicaid matching funds which were not included in form 2). \$8,476,335 allocated from state resources excluding program income and private funds. The Division's total budget for FY2009 presents an increase of 4,800,300.00 in State funds and a decrease of \$1,128,400 in funds destined to vaccines purchases (Child and Adult Immunization restricted receipts).

Our Maternal and Child Health investment for FY2007 was \$37,750,368.00 including \$2,929,653.00 of state funds, excluding program income and private funds.

The maintenance of effort amount for FY2007 and for proposed FY2009 exceeds the FY89 level of effort of \$1,875,000. Our commitment to Kids Net, Parent Consultants, Newborn Screening, and Adolescent Health are some of the ways that RI commits state funds to maintain its match with HRSA, Title V. Rhode Island defines administrative costs as those costs associated with disbursing funds from a central office (e.g., budgeting, oversight) that fall within the purview of administration. This is consistent with a legal opinion on the subject obtained by the Association of Maternal and Child Health Programs.

Rhode Island proposes to expend approximately \$8,867,270 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposed to expend \$14,265,753 on population based services an increase from prior years reflecting our investment in Childhood Immunization, Adult Immunization as well as newborn screening.

The Division plans to allocate its FY2009 award to meet the goals outlined in the annual plan by purchasing services from and contracting with other state agencies and community-based providers using standard purchasing procedures including RFPs, and sole/single source provider justifications. Every contract is managed by a program chief or manager, as well as monitored by fiscal staff. Payment for services outlined in the contract is reviewed and approved by the contract officer and the division Chief Program Operations prior to reimbursement.

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.