

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: RI

APPLICATION YEAR: 2005

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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.

### **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**

For copies of the Rhode Island Department of Health's signed assurances and certifications please forward requests to:

Cheryl LeClair  
Rhode Island Department of Health  
Division of Family Health  
3 Capitol Hill - Room 302  
Providence, RI 02908

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Please also refer to Attachment.

### **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; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

#### ***/2005/ Public Input***

***The DFH solicited feedback from variety of key stakeholders and families on the preventive health needs of its target population and on MCH programs and services through a variety of forums throughout FY2004. Over the past year, these forums have included the DFH's Successful Start initiative, AAP CATCH projects, school health discussions, COZ health surveys, Ready to Learn Providence focus groups, individual consumer input (including PRAMS), other DFH programs and a formal public hearing held on June 28, 2004. The public hearing was publicized through an extensive electronic mailing to community agencies and other key stakeholders and through a formal legal notice in the state's single statewide newspaper, the Providence Journal. Common themes among these sources have emerged and the following represents a summary of the issues and ideas that were raised this year for the FY2005 plan (See Attachment)/2005/.***

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

The state of Rhode Island is a small (1,055 square miles), coastal area of just over one million residents (1,048,319). 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 (82%) descendants of European immigrants, plus some long established African American families and members of the small Narragansett Native American Indian 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 Italians and Irish in the late 19th century to Asians and Latinos in the late 20th century -- have come to Rhode Island in search of a better life. Currently, an estimated one in eight Rhode Islanders is foreign-born, making the state home to the highest number of immigrants per capita in the country.

Eighty-six percent (86%) of Rhode Island's population resides in urban areas, which ranks the state seventh "most urban" and second most densely populated state in the nation after New Jersey, with 1,003 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. With over 400 miles of coastline and a wealth of historical resources, Rhode Island is an attractive place to work and live. Rhode Island's economy is built on three major industries: health services, tourism, and manufacturing.

As with other urban centers in the northeast, Rhode Island remains an important hub of government, health care, education, and entertainment activity, but faces the many challenges that its increasingly diverse and aging infrastructure present. Although two-thirds of the state is relatively "rural" in character, most of its population is concentrated in the urban, northeastern part of the state, around Providence. Providence is a major metropolitan community in which more than 173,000 residents live. An additional 437,349 residents live in the ten "suburban" urban communities surrounding Providence.

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 Rhode Island, especially for low-income residents.

The sole public health authority in the state is the Rhode Island Department of Health (HEALTH), which makes it legally responsible for the provision of core public health activities on both the state and local levels. Unlike many other states, HEALTH contracts with community-based organizations and professionals to provide nearly all direct preventive and public health services. HEALTH has no public health clinics. The absence of local health authorities means that health care providers in the state look to HEALTH for policy guidance and other forms of assistance.

#### Population Characteristics

About one fifth of the state's population (204,380) is women of childbearing age (15-44 years). Like other areas in the nation, Rhode Island has an aging population. According to the 2000 Census, the median age for female residents in Rhode Island is now 38 years. However, the median age for females varies by race and ethnicity. The median age for White female residents is 40.1 years. In contrast, the median age for female residents belonging to a racial or ethnic minority group is as follows: Hispanics (24.6 years), Blacks (27.6 years), Asians (26.8 years), and Native American (28.4

years).

Each year, about 12,500 new babies are born in Rhode Island and, currently, about one quarter of the state's population is made up of children under 18 years old (247,822). A major finding from the 2000 Census was the overall increase in the number of children under age 18 in Rhode Island and nationally. In Rhode Island, the child population increased 9.8% in the 1990s. The largest increase (20%) in any age category was in the number of children in early adolescence (ages 10-14). In contrast, the number of children under age 5 living in the state dropped nearly 5%.

Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. 73% of Rhode Island's children are White, 5% are African American, 3% are Asian, 1% is Native American, 1% is some other race, and 3% are more than one race. 14% are of Hispanic/Latino ethnicity. Due to both increased immigration and increased birth rates, it is expected that between 1997 and 2005 the number of Hispanic children in Rhode Island will increase by 52% and the number of Asian children by 75%.

/2004/ In 2000, 17%, or 40,117, Rhode Island children were living in poverty //2004//. This is an increase from the 1990 Census figure when 14% of the state's children lived in poverty. In addition, Rhode Island has one of the highest rates of single-parent families in the nation, and the highest rate in New England. /2004/ In Rhode Island, the percentage of births to unmarried mothers has increased from 26% in 1990 to 36% in 2000. Rhode Island is ranked 11th in the country for the highest rates of births to unmarried mothers //2004//.

Thirty percent (30%) of children in Rhode Island (67,978) and 47.8% of children living in the state's core cities (38,706) live in a single-parent family. Eighty-three percent (83%) of children living below poverty in Rhode Island live with a single mother. White children and Asian children are far more likely to live in married-couple families than are Black and Hispanic children. Almost 61% (60.6%) of Black children and 52.9% of Hispanic children in the state-live in single-parent families.

During the 1990s, the state gained about 82,500 racial and ethnic minorities, slightly more than half of them Hispanics. **/2005/ Forty-three percent of Rhode Island's population growth involved individuals with limited English proficiency. The national rate was 14% //2005//.** Federal immigration statistics show that the largest groups of immigrants to Rhode Island in the 1990s were from the Dominican Republic, Columbia and Guatemala. There is also a significant number of Puerto Ricans living in Rhode Island. For the first time in history, Rhode Island has communities (Providence and Central Falls) where minorities outnumber non-Hispanic Whites.

According to the U.S. Census, the racial/ethnic distribution of Rhode Island's population in 2000 consists of Non-Hispanic Whites (82%), Black (4.5%), Asians (2.3%), Native Americans (0.5%) and those who identified themselves as being more than one race (2.7%). In the past ten years, 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 and they have been established in Rhode Island for many years. During the 1990s, the state's black population grew by 21%, to about 46,908 people. Rhode Island's black population became increasingly diverse during the 1990s as a result of increased immigration from Haiti, Cape Verde, Liberia, and Nigeria. Over 11% of Blacks in the state are Latino, a large majority of whom came from the Dominican Republic. Nearly 99% of Blacks in the state live in urban areas, mainly Providence, Woonsocket, Pawtucket, Newport, or East Providence.

Asians grew by 31% during the 1990s and Cambodians, Hmong, Laotians, Thai, and Vietnamese represent 44% of the state's Asian grouping. 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 1975-1985,

well-educated Cambodians continued to resettle, and larger numbers of rural agrarian families arrived in the United States, including Rhode Island. About 93% of Asians in Rhode Island live in the older, urban communities of Providence, Woonsocket, and Cranston.

Native Americans grew by 26% during the 1990s and they consist primarily of members of the Narragansett Indian Tribe. Most Native Americans live in Providence, Narragansett, North Kingstown, and Charlestown. The Narragansett Reservation near Charlestown currently has about 2,500 acres, on which about 2,500 people reside. The actual number of Native Americans living in Rhode Island remains very small (5,241). The Narragansetts 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 Hispanics in the state. Hispanics saw their numbers double in Rhode Island in the 1990s from 45,572 to 90,820, a pace double that of Massachusetts'. /2004/ Of this number (90,820), 35,000 are children //2004//. Hispanics now make up more than 9% of the state's population. Most of Rhode Island's Hispanic growth occurred in Providence, Pawtucket, and Central Falls. Hispanic students now make up about 47% of the school population in Providence and the city's municipal workforce is increasingly made up of people of Hispanic decent.

Although there are small groups of Hispanics living in just about every community in the state, four out of five are concentrated in the older, urban communities of Providence, Pawtucket, Central Falls, Woonsocket, and Cranston.

Immigration grew substantially in Rhode Island (and in the nation) during the 1990s. Much of the growth was due to the passage of the federal Immigration Act of 1990, which began to take effect in 1992. As a result, immigration has become an important source of population growth in Rhode Island. For the period 1990-1994, about 6,000 individuals immigrated to Rhode Island. In 1999, Rhode Island was home to 87,559 foreign-born residents. Of these, 6,798 were under 18 years of age, 3% of all children in the state. Many of these people are Hispanic.

The majority of Hispanics in Rhode Island come from Puerto Rico, the Dominican Republic, and Columbia. In addition, Rhode Island has a significant number of undocumented individuals. The U.S. Immigration and Naturalization Services (INS) estimates that there are 6,000 to 9,900 undocumented individuals living in Rhode Island. This figure represents about one-half to one percent of the state's total population.

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 entirely attributable to minorities. 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 32,500 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, nearly one in five did.

Rhode Island will continue to become more ethnically and racially diverse during this century. The state's racial and ethnic minority populations are undergoing a very rapid growth rate, especially in the state's urban, core communities. According to Census 2000 projections, African Americans in Rhode Island will increase by 38%, Asians by 55% and Hispanics by 65%. Between 1995 and 2005, the number of White, Non-Hispanic children is expected to decrease by 7%, while the number of Black, Hispanic, Asian, and Native American children will increase by 43%.

In Rhode Island, the health disparities experienced by the poor and racial and ethnic minorities have been well documented. In general, Rhode Island's racial and ethnic minorities are more likely to be poor, uninsured for health care, unemployed, and have limited access to quality, affordable housing. Racial and ethnic health disparities in Rhode Island are discussed in more detail in the need assessment section of this application.

In earlier generations, Rhode Island workers were well-paid and well-insured for health care through the presence of a 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 in the 1930s, losing 11.6% of its total job base and seeing 10% unemployment rates. 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-the-year surpluses. Since 1996, the state increased support for public schools by 47.1%, expanded medical insurance programs for needy Rhode Islanders by 206.7%, and strengthened capital spending by 262.9%. /2004/ In the early 2000s, the state's (and the nation's) economic cycle reversed again. Although many economists believe that the national recession has ended, the ensuing recovery continues to struggle to regain its footing and, as a result, the national recovery was likely to be "jobless", through at least the first half of 2003.

On a comparative basis, Rhode Island's economy has fared well and Rhode Island's economic performance has outpaced those of Connecticut, Massachusetts, and the nation as a whole. The restructuring of the state's economy during the 1990s has been given as one of the reasons for its resilience. The war with Iraq and its aftermath remains the biggest threat to the state's economy at this time, primarily through reverberations from its impact on the national economy. On the positive side, consumer confidence appears to be rising and oil prices have been falling with the war in Iraq winding down.

***/2005/The growth in the Governor's FY2005 budget (3.7%) is slightly less than projected personal income growth (3.9%). In addition, the budget proposal does not include any increases in either the personal income or sales tax. The budget proposal would close a projected \$190 million deficit with \$168.9 million in revenue enhancements, including \$56.8 million in tax and fee increases. The budget proposal is also balanced with some difficult fiscal choices. For example, some entitlement programs are modified, direct school aid is reduced by 1.2% (\$7.9 million), and state employees are asked to pay a portion of their health insurance.***

***The budget projects a deficit of \$68.5 million in FY2006, which represents a significant improvement from the \$190 million budget gap the Governor addressed in his FY2005 budget. The deficit is projected to increase to \$177.8 million in FY2009 -- an amount that would exceed 5% of estimated revenue in that fiscal year. Successful implementation of the Governor's Fiscal Fitness Program could help alleviate the state's structural budget gap. The Fiscal Fitness Program will contribute \$32.7 million to balancing the FY2005 budget -- nearly \$19 million (60%) would come from revenue enhancements and a health cost-sharing agreement with state employees.***

***The governor created the Fiscal Fitness Program in 2003 for the purpose of developing specific ways to improve the efficiency, economy, and effectiveness of state government operations. The Fiscal Fitness Team made 140 recommendations that when fully implemented are projected to improve the state's bottom line by \$180 million annually. After adjusting for federal savings, the annual bottom line benefit to Rhode Island taxpayers would be \$161 million annually. Twenty-one of the 140 recommendations are valued at over \$2.5 million. These proposals account for \$138.6 million, or over three-quarters of all savings and revenue enhancements. Over 20% of the savings, or \$38.9 million, would result from proposals to modify the state employee health insurance program//2005//.***

Although many economists predict that the current recession has ended, they are also predicting a slow recovery. ***/2005/ Rhode Island's unemployment rate in March of 2004 was 5.6%, which is identical to the national and regional rates. Between 1983 and 2000, Rhode Island lost 93,000***

**jobs for adults with a high school diploma and gained 89,000 for adults with at least some college education. This shift in labor demand will continue to have a huge impact on wages as well as implications for moving families out of poverty //2005//.**

Secure parental employment is a strong determinant of whether or not children will be poor. /2004/ In Rhode Island in 2000, there were about 75,000 children with no parent working full time, year round. This is almost a third (31%) of all Rhode Island children, slightly higher than the national rate of 28% //2004//. The level of secure parental employment varies by race and ethnicity in Rhode Island. /2004/ In 2000, 69% of Black, Non-Hispanic children and 72% of Hispanic children had a parent working full-time, full-year in contrast with 85% of White, Non-Hispanic children //2004//.

In addition to good jobs for parents, safe, quality, affordable housing is also a basic issue for family health, and a challenge in Rhode Island. Children living in substandard housing are more at risk for injuries, lead poisoning, asthma, and malnutrition. /2004/ Research shows that there are strong links between substandard housing and educational disadvantages. Eighty percent of the state's housing stock predates 1978, when lead paint was banned //2004//. It is estimated that 9,900 of Rhode Island's rental units have physical defects. Eighty percent of these units are located in Rhode Island's urban communities.

Rhode Island is one of the least affordable housing markets in the nation (only Virginia and New York are worse). /2004/ In 2002, the average rent for a two-bedroom apartment in Rhode Island was \$863 per month, up from \$765 per month in 2001. **//2005/ The cost of renting a two-bedroom apartment increased to \$1,032 in 2003. To be able to afford this rent, a worker would have to earn \$19.85 per hour for 40 hours per week. This is nearly three times the state's new minimum wage of \$6.75 per hour //2005//.** There are 17,000 Rhode Islanders on waiting lists for subsidized or public housing and the waits range from 9 months to 9 years depending on the area of the state.

**//2005/ The shortage of affordable apartments and the dwindling availability of subsidized housing have caused many Rhode Islanders to double-up, resulting in overcrowded and unstable living conditions. Almost half of all families (43%) with children in the Rhode Island shelter system had been doubled-up with family members or friends just before moving to a shelter //2005//.** Homeless children are more likely to get sick, have poor nutrition, develop mental health problems, have academic problems, and experience violence than children who are not homeless are. /2004/ Nearly 80% of the families that used shelters in Rhode Island were headed by single women. Seventy percent of these families had incomes between \$5,000 and \$15,000 per year //2004//.

**//2005/ In 2003, families represented 40% of the population receiving emergency shelter. More than two out of three families (68%) entering the emergency shelter system in Rhode Island were headed by a single parent, and 91% of families with children had incomes below \$15,000 per year. Between 7/1/02 and 6/30/03, 1,450 children under 18 received shelter from Rhode Island's emergency shelter system. Nearly half, 697 (48%) were age 5 or under, 542 (37%) were ages 6-12, and 211 (15%) were ages 13-17. Youth between the ages of 13 and 17 are only admitted if accompanied by a parent or other adult //2005//.**

The widespread recognition that child care is a fundamental need has resulted in statewide efforts to assure a safe and nurturing learning environment in other settings as well (i.e. infant and pre-school child care, Head Start, school-age child care, and full-day kindergarten). /2004/ In Rhode Island in 2000, 62% of children under age six (45,820) had all parents in the work force, which is higher than the national average of 59% //2004//. **//2005/ Between 1990 and 2000 in Rhode Island, the number of children living in low-income working families (full time work and income below 200% of the poverty level) increased 18% from 28,000 children to 33,000 children. This is 15% of all children, lower than the national average of 19% //2005//.** Rhode Island, under a 1998 childcare law (Starting Right), is the only state that has a legal entitlement to a childcare subsidy for income-eligible families. Working families with incomes up to 225% of the federal poverty level are entitled to a childcare subsidy for their children up to age sixteen. Co-payments are required for families with

incomes over the federal poverty level.

Success in school is the objective and the measure of much family health work, and the highest priority of families as well. In Rhode Island, there has been intense debate about public education and schools, with new laws, new funding, and new measures for evaluation and accountability. School facilities are deteriorating and sometimes environmentally unhealthy. Schools are also responding to new challenges with school-based health, mental health, nutrition, and other services.

With respect to public education for children through grade 12, Rhode Island recently put in place an accountability system that measures the performance of students on statewide tests in every school in the areas of math, reading, writing, and health. Schools in which 50% or more of the students achieve the state standards in reading, writing, and math are classified as high-performing; schools in which 33% or more of the students score significantly below standards or do not take the test are classified as low-performing; and schools that fall in between the two categories are considered to be moderately performing.

***//2005/ Rhode Island's accountability system shows that, in 2003, 29% of schools in Rhode Island were categorized as high performing, 33% as moderately performing, and 38% as in need of improvement. In the state's core communities, only 2% of schools were high performing and 79% were in need of improvement. In 2003, of 123 schools in need of improvement, only 21 (17%) were making progress. Seven of these were in the core cities //2005//.***

Spanish is the most commonly spoken language of Rhode Island's public school students who are English language learners, which is consistent with the increase in the Hispanic child population in Rhode Island. Nearly 4 out of 5 English language learners in the state attend school in the cities of Central Falls, Pawtucket, and Providence. ***//2005/ Central Falls serves the largest percentage of English language learners student population in Rhode Island at 30% of the total number of students. Providence (19%) and Pawtucket (12%) follow //2005//.***

***//2005/ Research shows that frequent moves can have a negative effect on school performance and behavior and may affect other areas of child well-being //2005//.*** The overall school mobility rate for Rhode Island was 17% for the 2001-2002 school year. There is significant variation across school districts, from a high of 40% in Central Falls to a low of 3% in Jamestown ***//2004//. //2005/ Between 1997 and 2001, 47% of children ages birth to five living in the state's core cites experienced one or more moves, compared to 26% of children ages birth to five living in the remainder of the state. Central Falls (25%), Providence (22%), and Woonsocket (21%) had the highest percentages of children under six years of age who moved more than once //2005//.***

Students in Rhode Island become adults in Rhode Island. ***//2004/ In 2000, 81.9% of Rhode Island adults had a high school diploma //2004//.*** The proportion of residents aged 25 and up 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 second to the smallest - ahead is only Maine. ***//2004/ The high school graduation rate for Hispanics, at 63%, was the lowest of any racial or ethnic group in RI in 1999-2000. Between 1997 and 2001, 15% of all births in Rhode Island (and 26% of all births in the state's core urban communities) were to mothers with less than a high school education //2004//.***

***//2005/Rhode Island has education levels nearly equal to U.S. averages but lags behind other New England states on almost all levels of educational attainment. Compared to the other New England states, Rhode Island has the highest percentage of residents without a high school diploma. Of these adults, 37% have less than a 9th grade education. In Rhode Island between 1998 and 2002, 12% of infants were born to fathers without a high school diploma and 15% were born to mothers without a high school diploma //2005//.***

A report issued recently by the Nellie Mae Foundation and Jobs For the Future, titled "Rising to the Challenge", estimated that 47% of Rhode Islanders can not read or do math well enough to perform

the duties expected of them in today's workforce. In Rhode Island, an estimated 368,000 adults need literacy instruction. However, only 5,592 adults were served last year. Of the 5,592 served, 35% were enrolled in basic courses, 27% in secondary level courses such as GED preparation, and 38% in English as-a-second-language courses. /2004/ Within the six New England states, Rhode Island provides the least amount of state and local dollars for adult education //2004//.

The Family Independence Program (FIP) is the state's welfare reform program, as set forth in the Rhode Island Family Independence Act of 1996. The 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. **/2005/ As of December 2003, there were 11,727 adults and 26,168 children in Rhode Island enrolled in FIP. Three out of four children receiving cash assistance through FIP are age 12 and under //2005//.**

If a family has no earned income, the maximum monthly FIP benefit for a family of three in Rhode Island is \$554 per month. The FIP monthly payment has not increased in 13 years. **/2005/ With an additional \$371 per month in food stamps, this amount is 73% of the federal poverty line //2005//.**

/2004/ Under the Rhode Island FIP, adults can receive cash assistance up to a lifetime limit of five years, unless they are working at least 30 hours a week or receive an exemption. **/2005/ As of December 1, 2003, there were 917 families enrolled in FIP who were unable to work due to illness or advanced age, and 2,128 who were exempt from work because they were in their third trimester of pregnancy or had children under age one //2005//.** Children are not subject to a time limit on cash assistance. Eligible teen parents under 18 must live at home or in a supervised setting and stay in school.

According to a recent study conducted by Brown University's Taubman Center for Public Policy in January of 2001, Rhode Island's FIP increased the income of recipients through employment, decreased state expenditures on cash assistance programs, and enhanced family cohesion and stability. The study found that Rhode Island emphasizes a "family first" (as opposed to a "work first" philosophy) with its absence of time limits for children, childcare subsidies up to age 16, and comprehensive health insurance coverage (RIte Care/RIte Start).

**/2005/ Since the implementation of welfare reform in 1997, caseloads have declined across the country, however, the rate has steadily slowed. Rhode Island experienced a more gradual caseload reduction than other states because of policies that allow more time for education and training before beginning work and higher income disregards. Since the start of the economic recession in March 2001, Rhode Island is one of the few states that continues to see caseloads decline //2005//.**

In addition to the state's health care program RIte Care (including RIte Start), the childcare program Starting Right, and the FIP welfare reform program, another important emerging statewide initiative is the Rhode Island Department of Human Services' (RIDHS's) planned Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Re-evaluation (CEDARR) initiative for children with special health care needs (CSHCN). Through this initiative, RIDHS will define a statewide set of services that will assure timely access to appropriate, high quality, coordinated services for CSHCN and their families. RIDHS will purchase services through certified providers and services will be provided through "centers for excellence" called CEDARR Family Centers. The services available through CEDARR Family Centers are expected to significantly enhance the range and quality of services available to CSHCN and their families in Rhode Island.

/2004/ In April of 2001, the first CEDARR Family Center opened and there are currently four CEDARR Family Centers in place and operating in Rhode Island //2004//. The centers provide family-directed coordinated services to help families navigate the services available for CSHCNs, including CSHCNs with developmental, behavioral, or emotional problems. The second phase of the CEDARR initiative will be the development of certified direct services to fill in the gaps in the existing service delivery

system. Identified gaps include therapeutic services in child and youth care, home-based therapeutic services, personal assistance services and supports (PASS) services, and pediatric home care for technology-dependent and other medically complex CSHCN. Once fully up and running, these services will be available through the CEDARR Family Centers.

/2004/ Despite recent expansions in the state's Medicaid managed care program, 6.2% of Rhode Island's population was uninsured for health care in 2000. This was the lowest rate in the nation. The proportion of working-age Rhode Islanders who are uninsured continues to drop in Rhode Island. In 1996, the percentage was 10.9% and in 1998 it was 10.2%. Younger Rhode Island adults ages 18-34 are more likely to be uninsured than older adults (14.1% versus 7.6% for those ages 35-49 and 5% for those ages 50-64). Seven percent (7%) of adults living with children were uninsured in 2000, while 11.6% of adults living without children were uninsured during this same year. The rate of uninsured adults living with children declined from 10.8% in 1996 to 7% in 2000.

After a three-year increase, uninsurance rates for working-age Rhode Islanders who earn less than \$25,000 a year declined by 20%, from 25.6% in 1998 to 21.1% in 2000. The likelihood of being insured is highly associated with employment status. The rate of uninsurance (7% in 2000) continues to be lowest for those who work for wages. Self-employed Rhode Islanders are three times more likely than Rhode Islanders who work for wages to be uninsured (21.8%). Unemployed Rhode Islanders continue to have the highest rate of uninsurance (30.6%).

Males are more likely to lack health insurance than females. The gap is widening and in 2000, males, at 12.8%, were twice as likely as females (6.2%) to be uninsured. The percentage of uninsured Whites has remained constant at about 9% for the past four years. The uninsured rate varies by race and ethnicity. The rate for Blacks is almost three times higher than the White rate at 22.2%. The Hispanic uninsurance rate has shown the fastest decline from 27.6% in 1996 to 5.8% in 2000.

As of 2001, 4.5% of children under age 19 in Rhode Island were uninsured, the lowest rate in the nation. Nationally, 13% of children were uninsured. The rate of uninsured children in Rhode Island has been reduced by more than half over the past six years. As of 2001, there were 11,000 uninsured children in Rhode Island. Of these an estimated 7,000 were eligible for Rlte Care but un-enrolled. Ninety-one percent (91%) of Rhode Island's uninsured children live in working families. Eighteen percent of uninsured children live in families with incomes less than 100% of poverty, 36% with incomes 100% - 174% of poverty, 9% with incomes 175% - 249% of poverty, and 36% with incomes greater than 250% of poverty //2004//.

The state's Medicaid managed care program; Rlte Care has had a profound impact on the state's health care system. The comprehensiveness of services offered under Rlte Care has made it a national model. Rhode Island increased eligibility for Rlte Care, through the federal Children's Health Insurance Program (CHIP), to include coverage children up to age 19 in families with incomes of up to 250% of poverty. Rhode Island has made significant progress in reducing the number of uninsured children in the state by enrolling eligible children in Rlte Care.

Rlte Care covers undocumented children up to age 19 in income-eligible families and the parents of eligible children in families with income up to 185% of Rlte Care was also expanded eligibility to include pregnant women up to 350% and child care providers who serve low-income children. Initially (in 1995), about 75,000 adults and children were covered by Rlte Care. By July 2000, Rlte Care increased the number of previously uninsured enrollees from to 108,000, up from 101,000 just two months before. /2004/ Enrollment seems to have leveled off and as of December of 2002, 117,507 individuals are enrolled in Rite Care. Nearly two-thirds of these individuals are children under the age of 19 years (76,151). In 1995, the number of children enrolled in Rlte Care was 43,413 //2004//.

***/2005/ As of December 31, 2003, nearly two-thirds (76,152) of the Rlte Care members who qualify based on income were children under age 19. There were 43,427 low-income parents enrolled in Rlte Care as of December 31, 2003. Of these parents, 11,727 (27%) received Rlte Care because they were enrolled in FIP. As of 2002, there were 14,000 uninsured children***

***under age 19 in Rhode Island. Of these, an estimated 9,000 were eligible for Rlte Care but un-enrolled. Sixty-four percent of Rhode Island's uninsured children live in working families //2005//.***

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 (i.e. the employee must have a Rlte Care eligible family member in order to enroll in Rlte Share). 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. As of April of 2002, 866 individuals were enrolled in Rlte Share. As of April 1, 2003, 3,950 individuals were enrolled in Rlte Share. ***//2005/ During 2003, Rlte Share included 1,824 adults and 3,182 children //2005//.***

Beginning in January of 2002, families participating in Rlte Care or Rlte Share with incomes above 150% of poverty began to pay a monthly premium, ranging from \$61.00 to \$92.00, depending on family income. If two months go by with no payments made, families are dis-enrolled from health insurance and are ineligible for Rlte Care or Rlte Share for a period of four months. Pregnant women and children under one year of age are not dis-enrolled for failure to pay the premium.

*//2004/* In February of 2002, RIDHS issued a follow-up survey and found that of the 4,805 premium bills that Rlte Care sent out on December 15, 2001, 63% of the members had paid by January 15, 2002. A later subsequent analysis of 1,853 families who were first sanctioned in 2002 showed that 1,101 (59.4%) of those families returned to Rlte Care coverage and an additional 82 (4.4%) met other criteria under Medical Assistance regulations that allowed specific family members to continue coverage. The remaining 670 families (36.1%) of those receiving a first sanction did not return to coverage.

In the past few months, RIDHS received a waiver to enroll 7,800 children with special health care needs into Rlte Care and RIDHS is currently in the process of planning for the transition of this population into Medicaid managed care. More than half of these children (59%) qualify for Medicaid due to Supplemental Security Income (SSI) eligibility, 13% qualify under the Katie Beckett provision, and the remainder (28%) are Medicaid-eligible by virtue of their qualification under Rhode Island's adoption subsidy program. It is believed that these children can benefit from improved access to care and service coordination afforded through Rlte Care and that service improvements will help prevent unnecessary hospital admissions and facilitate timely discharge to the home with appropriate community supports. Particular attention will be made to coordinating with CEDARR, Early Intervention, and Special Education as well as those in development, such as therapeutic services in child and youth care and PASS.

The majority of Rhode Islanders (559,625) are commercially insured. There are basically three major commercial health insurance plans in Rhode Island, Blue Cross & Blue Shield of Rhode Island (including its HMO subsidiary Blue Chip), United Health Care of New England, and Blue Cross of Massachusetts, which together cover 92% of the state's commercially insured population. Health insurance is more expensive in Rhode Island than elsewhere and for the first time since 1998, monthly premiums in the state (\$193) exceeded both the regional (\$185) and the national (\$150) rates.

Rhode Island plans performed comparatively well at providing childhood and adolescent immunizations for their members in 2001. Rhode Island's rates (74.4% and 63%, respectively) were higher than the national rates (70.1% and 44.8%, respectively) and higher than the regional rate for adolescent immunizations (60.6%). Rhode Island plans also exceeded regional and national rates for

well child visits and adolescent well care visits. In 2001, 80.7% of members ages 3-6 received a well child visit and 54.1% of members ages 12-21 had an adolescent well care visits. In contrast, 77.7% of members ages 3-6 in New England and 59.7% of those in the nation had a well child visit during this same period. With respect to adolescent visits, 49.9% of members ages 3-6 in New England and 33.6% if those in the nation had an adolescent visit during this same period.

## Statewide Health Care Delivery Systems

Rhode Island has a long tradition of public investment in health services, with special attention to pregnant women, infants, and children with special health care needs (CSHCN). A well-distributed mix of private practitioners, multi-specialty groups, and a statewide network of community health centers and hospital-based primary care clinics provide health care. Tertiary perinatal and pediatric centers in Providence back up the state's 8 acute care hospitals.

Although Rhode Island has a large health care workforce relative to its population, primary care access remains a problem among the state's most vulnerable residents. The communities of Providence, Woonsocket, Pawtucket, Central Falls, Newport, East Providence, South Kingstown, Burrillville, and Hopkinton have been designated Health Professional Shortage Areas (HPSAs) by the federal Bureau of Primary Health Care (BPHC) and there are often care delays and other symptoms of stressed and understaffed providers in these neighborhoods. The state correctional and mental health hospital facilities and the Narragansett Indian Health Center have also been designated as HPSAs by the BPHC.

//2004/ In the United States, about 73% of all children and 67% of children enrolled in Medicaid or some other public insurance have seen a dentist in the past year. Among Rhode Island children under age 21 enrolled in public insurance programs, only 33% accessed dental services during 2000. Sixty-percent (60%) of commercially insured children in Rhode Island accessed dental services in the past year and fewer than half of CSHCN in Rhode Island receives dental care. In addition, fewer than half (45%) of employers in Rhode Island offered dental insurance as a benefit in 1999. A 1999 study found that 2,600, or 3%, of children under the age of 5 years in Rhode Island lost a tooth to causes other than trauma //2004//.

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. There is a decreasing supply of dentists nationally and locally, most acutely in traditionally under-served areas. /2004/ As of 12/30/02, there were 474 active licensed dentists in Rhode Island, representing a dentist to population ratio of 1:2,136 (the optimal ratio would be between 1:1,500 and 1:1,700).

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 and 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. /2004/ In addition, school-based health centers (SBHCs) are an important vehicle for mental health service delivery to adolescents in Rhode Island.

During 2002, the state's 8 community mental health centers provided services to 7,924 children. Of these children, 22% were being treated for attention deficit disorder, 16% for depressive or mood disorders, 14% for conduct disorders, 9% for anxiety disorders, and 39% for other and/or unknown disorders. More than half (58%) of the children who received services through the state's community health centers were between the ages of 12 and 17 and over one-third (34%) were between the ages of 6 and 11. Eight percent (8%) were under age six //2004//.

Schools serve as the primary point of entry to the mental health system for children in Rhode Island. In the 2001-2002 school year, 2,857 children between the ages of 3 and 21 were identified within the state's special education system as being disabled because of behavioral disorders. /2005/ **The 8**

**school-based health centers (SBHCS) in the state report high demand for services as well. The total number of behavioral health visits for all SBHCS during the 2002-2003 school year was 1,925 (14%) //2005//.** Children's mental health remains a widely recognized, frustrating gap in Rhode Island.

## State Title V Priorities

*/2004/* The Rhode Island Department of Health's Division of Family Health (DFH) 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 children, and for the management of maternal and child health programs providing services to women and children through community-based agencies. The DFH identified these 10 priorities from a longer list through a comprehensive strategic planning process. The DFH's strategic planning process is one that relies on data collection and surveillance, parent and community input, and interagency collaboration. The DFH's community input is gathered from community meetings, a public hearing, and parent surveys. All of these priorities relate to the state's plans for Healthy People 2010 objectives.

***/2005/ The specific priorities for the DFH are set by analysis of needs and by extensive conversations with the public, parents, professionals, community agencies, elected leaders, and many others. The DFH has analyzed vital statistics, newborn screening, KIDSNET, parent surveys, and many other sources of information for critical family health issues that need attention and has come up with the following key strategic priorities for action under Title V in FY2005:***

***Early Childhood Development -- "Successful Start", our statewide early childhood partnership, has***

***been very productive, and its priorities are reflected throughout Family Health Rhode Island '05. We expect to support specific initiatives in early parent education, breastfeeding support, safe and healthy childcare (especially emotional development), literacy, and safe, stable housing for young families.***

***Medical Homes -- Building on long partnerships with community primary care practices, we plan***

***to strengthen their capacity to help families recognize and respond to developmental and mental health challenges, and build family support and care coordination capacity with parent consultants.***

***School Age Kids -- We are establishing a state School Health Leadership Forum, which will focus public and policy attention on issues of physical activity, nutrition, tobacco use, and adolescent mental health. We also expect to join many other leaders to address teen pregnancy and parenting, and teens' mentoring needs.***

***Quality and System Performance Measures -- PRAMS, SALT, BRFS, and other survey data will be critical to monitor acute needs and the reach and impact of program investments with a constrained budget. KIDSNET is expanding its coordination and quality assurance of complex vaccination, screening, and other data among primary care, community and school providers.***

***Outreach -- Vigorous outreach to isolated families, to groups and neighborhoods with disproportionately poor outcomes, and to families with unaddressed developmental and mental health needs will be a major focus, using parent-to-parent, church, recreation, and other avenues.***

***The annual Title V process also sets priorities for its other programs (including Early Intervention, Immunization, Lead Poisoning, Family Planning, WIC, School and Adolescent Health) and so "Family Health in Rhode Island (FHRI) 2004" is intended to be a comprehensive and integrated plan. A condensed version of FHRI 2004 will be used to solicit feedback from community stakeholders, professional and parent groups, legislators, and others in coming months //2005//.***

## B. AGENCY CAPACITY

/2004/ As the recipient of the state's federal Title V Maternal & Child Health (MCH) block grant funds, the Division of Family Health (DFH) plays an important role in addressing the state's maternal & child health needs. The DFH utilizes its MCH funds to, among other things, conduct outreach activities to enhance Medicaid enrollment and to improve access to preventive and primary care health services for women and children, including children with special health care needs (CSHCN). Under the overarching umbrella that makes up its Title V priorities, the DFH assures that all Rhode Islanders, (especially those who are under-served) have access to a full array of comprehensive, quality, health care services. For a summary of the DFH's capacity to provide:

- 1) preventive and primary care services for pregnant women, mothers, and infants,
- 2) preventive and primary care services for children, and
- 3) services for CSHCN

see attachment.

With respect to providing rehabilitative services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI to the extent medical services for such services are not provided under Title XIX, it is important to point out that Rhode Island is a 1914 A state (i.e. all children with SSI receive Medicaid benefits which includes rehabilitative services). Given that the state is a 1914 A state, the DFH is working closely with the RI Department of Human Services (RIDHS) Disability Determination Unit to develop a "welcome Packet" for families with CSHCN who have applied for SSI benefits. The packet will include linguistically and culturally appropriate materials on a variety of topics, including CEDARR, Family Voices, and the RI Parent Information Network (RIPIN). By doing so, the DFH will ensure that families with CSHCN who receive SSI and those that are turned down have timely access to information about CSHCN services and supports in Rhode Island.

With respect to providing and promoting family-centered, community-based, coordinated care, including care coordination for CSHCN, and facilitating the development of community-based systems of services for such children and their families, it is important to point out that much of the DFH's work focuses on infrastructure building activities in this areas. In fact, the DFH provides very few direct services to the state's maternal & child health populations, including CSHCN. The DFH is also committed to ensuring that DFH services provide culturally competent services. Rhode Island 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. DFH staff has received training on cultural competency and the DFH employs culturally diverse parent consultants. The DFH also supports culturally diverse staff and supports many community-based initiatives in culturally diverse communities in Rhode Island. DFH information and educational materials have been translated into other languages and low-literacy English. In addition, the DFH's Communication Unit is working to increase the DFH's reach in the Latino community.

Chapter 23-13 of the Rhode Island General Laws (1937 & 1999) designates the Rhode Island Department of Health (HEALTH) as the state agency responsible for administering the provisions of Title V of the federal Social Security Act in Rhode Island relative to maternal and child health services.

Other state statutes directly involving the DFH include the following:

Chapter 16-21-7 of the RIGLs (1938 & 1996) requires local schools to have a school health program

that is approved by HEALTH and the Rhode Island Department of Education (RIDE).

Chapter 23-1-18 of the RIGLs (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 old.

Chapter 23-1-49 of the RIGLs (1985 & 1997) authorizes HEALTH to establish and maintain registries for traumatic brain and spinal cord injuries //2004//.

***//2005/ Chapter 213-13-3 of the RIGLs (2003) creates a birth defects surveillance registry //2005//.***

//2004/ Chapter 23-13-13 of the RIGLs (1979) requires all newborns to be screened for hearing impairments.

Chapter 23-13-14 of the RIGLs (1987 & 2001) requires all newborns to be screened for metabolic, endocrine, and hemoglobinopathy disorders.

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

Chapter 23-13-17 of the RIGLs (1987 & 1996) designates HEALTH as the state agency for administering the provisions of the WIC Program.

Chapter 23-13-20 of the RIGLs (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.

Chapter 23-13-21 of the RIGLs (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.

Chapter 23-13-22 of the RIGLs (1991) authorizes HEALTH to ensure that all developmentally disabled infants and children from birth to three years of age are enrolled in the early intervention program.

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

Chapter 40-19.1 of the RIGLs (1997) requires HEALTH, the RI Department of Human Services (RIDHS), the RI Department of Children, Youth, & Families (RIDCYF), 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 DFH activities are included as an attachment.

#### CSHCN Program Capacity

The DFH's OCSHCN ensures a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care, which are essential for effectively fostering and facilitating activities. The OCSHCN collaborates with other state agencies and numerous private organizations and associations. These collaborations include the following:

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

Rhode Island Department of Human Services (RIDHS): The OCSHCN has formal Medicaid

agreements with RIDHS for Early Periodic Screening, Diagnosis, & Treatment (EPSDT), Early Intervention, and the Child Development Center (CDC). In addition to formal agreements, staff from the DFH provides consultation and professional expertise to the RIDHS in the areas of assessment, assurance, and policy development through formalized workgroups and program specific discussions. The DFH has plans to assign a staff person to work at the RIDHS two days a week to assist with the implementation of CEDARR and the planned transition of CSHCN from fee-for-service Medicaid to Medicaid managed care (i.e. Rite Care). The DFH also collaborates extensively with RIDHS to create a statewide infrastructure for addressing the problem of childhood lead poisoning among children with Medicaid in Rhode Island. RIDHS 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. It is notable to point out that RIDHS covers replacement windows as a medically necessary service for lead poisoned children through Medicaid.

Rhode Island Department of Education (RIDE): Through a network of statewide providers, the DFH's Early Intervention (EI) Program supports families in promoting the growth and development of children, from birth to three, with developmental challenges. The DFH will continue to work with RIDE to ensure that children in EI who are turning three years old transition to RIDE smoothly and that they continue to receive services that are comprehensive, community-based, coordinated, and family-centered. The DFH, through the OCSHCN, is also working with RIDE to ensure an integrated educational system that serves CSHCN transitioning to adulthood (i.e. 21 years of age).

Child Development Center (CDC): The OCSHCN supports the CDC, which is a RIDHS certified CEDARR Family Center located at Rhode Island Hospital. The CDC provides specialty and sub-specialty services to medically complex CSHCN from birth to 21 years of age. The DFH's OCSHCN is working closely with the CDC on issues relating to quality of care, identification of services, and access to reimbursement //2004//. **//2005/ Two OCSHCN parent consultants have been assigned to work at the CDC on these issues //2005//.**

//2004/ Rhode Island Hearing Screening Assessment Program (RIHAP): RIHAP provides support and follow-up for children with hearing impairments identified through the DFH's newborn screening process. DFH participate on RIHAP's Hearing Screening & follow-Up Committee on an on-going basis.

Rhode Island Transition Council: The DFH 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.

Child Maltreatment Surveillance Project: The goals of this initiative include evaluation alternative approaches to surveillance of fatal and non-fatal child maltreatment and piloting methods that may be used for surveillance of violence. DFH staff meets with representatives from the Child Advocate's Office, the Medical Examiners' Office, the Attorney General's Office, the RIDCYF, Brown University, and Hasbro Children's Hospital staff regularly. The group reviews 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 ICDP codes related to possible child maltreatment to look for "missed opportunities". The group also compares hospital discharge data of non-fatal cases of children under 21 with RIDCYF case data. The grant provides the DFH with a promising opportunity to evaluate and pilot new, more sophisticated approaches to surveillance in this area.

Family Voices Rhode Island: The OCSHCN works closely with leadership from the Rhode Island Chapter of Family Voices on an ongoing basis. The Director of Family Voices meets regularly with the DFH's Medical Director and the Chief of the OCSHCN. The Director of Family Voices is a member of the OCSHCN's SSI Team. Family Voices RI is one of a few state Family Voices chapters to implement a Family-to-Family Information Center. In addition, the Director of Family Voices participated in the planning phase of the DFH's recent reorganization of the OCSHCN.

Rhode Island Parent Information Network (RIPIN): RIPIN is a statewide, non-profit agency that

provides information, training, support, and advocacy to parents seeking help for their children in Rhode Island. The DFH works closely with RIPIN on several initiatives. RIPIN provides training and oversees the administrative aspects of the DFH's Parent Consultant Program (including the EI Parent Consultant Program). In addition, the DFH's 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.

Rhode Island Chapter of the March of Dimes (MOD): The DFH is collaborating with the MOD on two major initiatives. The first one focuses on ensuring that women (especially low-income women) in Rhode Island have access to folic acid education and multi-vitamins with folic acid prior to becoming pregnant or early in pregnancy in order to prevent birth defects. The other initiative focuses on working with the MOD and other key community partners to develop statewide initiatives to reduce prematurity in Rhode Island.

Interagency Coordinating Council (ICC): The ICC is made up of parents, concerned citizens, administrators, and representatives of HEALTH, RIDE, RIMHRH, and the Rhode Island Department of Business Regulation's (DBR's) Division of Insurance. The ICC advises the DFH on policy issues related to Early Intervention (EI) service delivery //2004//.

***//2005/ Interagency Coordinating Council on Environmental Lead (ICCEL): The ICCEL was 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 the RIDHS, the RI Department of Environmental Management (RIDEM), the Office of the Attorney General, the RI League of Cities and Towns, and the RI Housing Resources Commission. The ICCEL is charged with the responsibility to oversee the implementation of the Lead Hazard Mitigation Law //2005//.***

//2004/ Brain Injury Association of RI: The DFH's Traumatic Brain & Spinal Cord Injury (TBSCI) Program is mandated to maintain a registry of individuals with traumatic brain and spinal cord injuries in RI for the purpose of helping children and adults with TBSCIs access appropriate services, including SSI and rehabilitative services. The TBSCI Program sends individuals with TBSCIs a follow-up letter informing them of the Brain Injury Association of RI as a potential resource.

#### State Support for Communities

Ready to Learn Providence (RLP): The DFH continues to support the Providence Plan's community-driven strategic planning initiative to increase utilization of MCH services (including CSHCN services) among young families living in the City of Providence. RLP, through federal Early Learning opportunity funding, will continue 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 to learning at school entry. Linking children, including CSHCN, to needed health related services through a "medical home" represents an important part of RLP activities. In addition, parents participate in all phases of RLP activities //2004//.

***//2005/ Newport County & Mt. Hope CATCH: The DFH continues to support these community driven strategic planning initiatives to implement strategies to better connect children, including CSHCN, in Newport County and the Mt. Hope section of Providence with a "medical home" //2005//.*** //2004/ Strategies include providing "medical home" training to pediatric and social service providers and families, developing ways to utilize existing data on families without "medical homes" (i.e. local emergency room records), connecting pediatric and social service providers to existing case management resources, and securing funding to support case management for families who do not meet existing criteria for such services. Newport CATCH has received \$50,000 per year for two years to implement its strategic plan. Newport County's experiences in developing an infrastructure to support a coherent and integrated system of care for children, including CSHCN, will be shared with other communities throughout the state for possible replication purposes. As with RLP,

parents participate in all phases of Newport County CATCH's activities.

Successful Start: The DFH's new early childhood comprehensive systems development initiative, Successful Start, will engage 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 CSHCN. As with RLP and Newport County CATCH, parents will participate in all phases of Successful Start activities.

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

Healthy Schools!/Healthy Kids! (HS/HK): The DFH's Office for Family, Youth & School Success (OFYSS) is responsible for coordinating the internal work of HEALTH relating to the health of school-age children. 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 OFYSS has convened an internal working group to develop an ideological framework for organizing work, to make recommendations for coordinating work, and to identify information needs. Recommendations will include the initiation of formative research with schools and communities to identify key issues and concerns that the OFYSS can address and the preparation of a report identifying state and local policies and programs that enhance or impede the health of school-age children in RI.

The DFH's Family Outreach Program (FOP) provides home assessments, connection to community services, and help with child development and parenting for almost one-third of families with newborns each year. Home visitors also serve as the follow-up staff for the DFH's Newborn Screening, Early Intervention, Lead Poisoning, and Immunization Programs. Recent data suggest an improvement in the acceptance rate for "hard-to reach" families. The DFH is working to build prenatal home visiting capacity and develop greater linkages with CEDARR.

#### Coordination of Health Services with Other Services at the Community Level

The DFH's 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. A newborn developmental risk module, integrated with a new electronic birth certificate system, began rolling out in May of 2003. Consumer input into genetics and newborn screening policy development was obtained through outreach, focus groups, surveys, and other means. The DFH will work closely with local hospitals to implement the new integrated electronic developmental risk assessment/birth certificate system in RI.

As part of the DFH's genetics initiatives, DFH parent consultants are working with parents to develop "medical passports" for families with CSHCN, which will contain information about services for CSHCN and their families in Rhode Island. The DFH 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 includes a focus on issues related to access to genetics services, including genetics counseling.

The DFH's Birth Defects Surveillance Program is working to ensure that children with birth defects have a "medical home" and that families have access to preventive services. The DFH is working to design a template for for birth defects, a data book, and newsletter. The DFH's Birth Defects Advisory Committee will continue to include parents to ensure their participation in monitoring the program and to ensure that all children with birth defects have a "medical home". In addition, a DFH parent consultant is working with the Advisory Committee to develop and implement statewide birth defects prevention strategies.

The DFH's Connecting Families with Technology (CFT) Project links families with CSHCN and family child care providers with information and support through the Internet. The DFH supported computer

hardware, Internet access, and training activities. Families with CSHCN and family child care providers may be isolated and often have limited access to information and support. The DFH has successfully integrated CFT activities into the work of the Day Care Justice Coop and Family Voices. The DFH is working with the RI Parent Information Network (RIPIN) to seek sources of long-term support for CFT activities //2004//.

## C. ORGANIZATIONAL STRUCTURE

/2004/ The DFH is a major component of HEALTH, which is a cabinet agency that directly reports to the Governor. The DFH is organized into five sections: the Office for Children's Preventive Health Services (CPHS), the Office for Families Raising Children with Special Health Care Needs (CSHCN), the Office for Family, Youth, & School Success (formerly known as the Adolescent & Young Adult Health Unit), the Office for Women, Infants, & Children (WIC), and the Office of the Medical Director. The DFH has a Medical Director, an Assistant Medical Director, parent leadership, appropriate chiefs and program managers, and senior staff responsible for management, data and evaluation, policy, and communications.

The DFH's activities include a special emphasis on eliminating health disparities among racial/ethnic minority and other under-served populations. In fact, most of the DFH's programs serve a high proportion of low-income, racially and ethnically diverse families. Over the last decade, the DFH has developed a strong Parent Consultant Program, which assures that a wide variety of parents, including those with CSHCN, are included in all aspects of the DFH's activities (i.e. program policy, planning, implementation, and evaluation) on an on-going basis.

It is important to point out that although several of the DFH's programs continue to provide direct services to vulnerable populations (i.e. WIC, Family Resource Counselor Program, Family Outreach Program, Women's Health Screening & Referral Program, Family Planning, Early Intervention, Childhood Lead Poisoning Prevention Program, School-Based Health Center Program, Immunization, etc.) through contracts with community partners, they have also matured over time and now include a sophisticated focus on strengthening existing community care infrastructures and assuring effective quality improvement activities. A good example of this maturation can be found in the DFH's Family Resource Counselor (FRC) Program.

The FRC Program supports FRCs in several community health center and outpatient hospital clinics to link families to important MCH services, including WIC, Rlte Care/Rlte Share, Food Stamps, and the Family Independence Program (FIP) //2004//. **/2005/ Three years ago, much of the FRC's focus involved helping the Rhode Island Department of Human Services (RIDHS) identify and enroll newly eligible families into the expanding Rlte Care Program //2005//.** /2004/ Recognizing the value of the FRC Program in assuring that families were linked with important services, the RIDHS agreed to provide the DFH with a 90/10 match for the FRC Program, which has served to strengthen the program 1) by leveraging existing Title V dollars and 2) by making FRCs a permanent part of the state's MCH infrastructure //2004//.

**/2005/ The DFH has strengthened the FRC Program further by developing a strong support network, which includes Covering Kids RI, the RIDHS, the RI Health Center Association (RIHCA), the state's major health insurance plans, and the Poverty Institute. The network provides training, technical assistance, and policy leadership to the program //2005//.**

/2004/ Although the DFH does not have direct responsibility for addressing several important initiatives (i.e. Rlte Care/Rlte Share, CEDARR, children's mental health, etc.), it has been a visible and effective presence in collective statewide efforts designed to address concerns related to these initiatives. For example, the DFH has been participating in Children's Cabinet, the Northeast Injury Prevention Network, Governor's Council on Mental Health, and RIDH Mental & Behavioral Health

Workgroup discussions on the topic of children's mental health needs. In addition, the DFH's Healthy Child Care Rhode Island initiative has provided direct training to child care providers on children's mental health and is in the process of developing workshops on various mental health topics for child care providers. As a way to address emerging consumer concerns relative to the new RIte Care/RIte Share premiums, a DFH staff person continues to participate on the RIte Care/RIte Share Consumer Advisory Committee, which is charged with making identifying issues and making recommendations to RI Department of Human Services (RIDHS) //2004//.

***/2005/ With respect to recent organizational changes, the DFH staffed the DFH's Office of Children With Special Health Care Needs (OCSHCN) with a new office chief, parent-consultant, and quality assurance specialist in FY2003. The DFH's OCSHCN, now titled the Office for Families Raising CSHCN, was transferred out of the Medical Director's Office in FY2003 and the Office for Families Raising CSHCN is now responsible for overseeing the DFH's former, current, and future CSHCN activities, including the Early Intervention (EI) Program, the SSI Team, the Disability & Health Program, the Traumatic Brain & Spinal Cord Injury (TBSCI) Program, the Child Maltreatment Initiative, the Child Development Center (CDC), and the Family Outreach Program (FOP). The OCSHCN will continue to be responsible for addressing the important concerns of CSHCN and their families through advocacy, coordination, and collaboration with other state departments and agencies serving this population and by promoting and monitoring the quality of services that CSHCN receive.***

***In addition, the DFH's Adolescent & Young Adult (AYA) Unit was reorganized and expanded in FY2003 and is now titled the Office for Family, Youth, & School Success (OFYSS). In addition to overseeing the DFH's Family Planning Program, Women's Health Screening & Referral Program (WHSRP), Vasectomy Program, School-Based Health Center (SBHC) Program, Men 2B Program, Healthy Child Care Rhode Island (HCCRI), and the state's systems development initiatives (i.e. Ready To Learn Providence, Newport CATCH, Mt. Hope CATCH, & Successful Start), the OFYSS will be responsible for coordinating the internal work of HEALTH relating to the health of school-age children through Health Schools!/Healthy Kids!. The OFYSS has convened an internal working group to develop an ideological framework for organizing Healthy Schools!/Healthy Kids! work, to make recommendations for coordinating work, and to identify information needs. Recommendations will include the initiation of formative research with schools and communities to identify key issues and concerns that the OFYSS can address and the preparation of a report identifying state and local policies and programs that enhance or impede the health of school-age children in Rhode Island.***

***More recently, the DFH's Chief of Staff, Janice Cataldo, left for another position in mid-FY2004. Laurie Petrone, formerly the Chief of the DFH's Communications Unit, has assumed the role of Chief of Staff for the DFH. Andrea Bagnall-Degos, formerly the Deputy Chief of the DFH's Communications Unit has assumed the role of Director of the DFH's Communications Unit. The DFH is pleased to report that these transitions occurred simultaneously and smoothly without creating any vacant positions. Further, Ms. Petrone has held a variety of positions in the DFH since 1986. Ms. Bagnall-Degos has worked in the DFH's Communications Unit since 1999 //2005//.***

*/2004/ See Attachment for a copy of the DFH's organizational chart //2004//.*

#### **D. OTHER MCH CAPACITY**

***/2005/ There are approximately 85 individuals who work in the Division of Family Health (DFH). This number includes staff that provide planning, evaluation, and data analysis. It also includes DFH parent consultants, including those with children with special health care needs (CSHCN), on staff. Of the 85 individuals, 65 are HEALTH employees, 12 are contract employees, 3 are temporary employees, and 5 are DFH parent consultants. Of the 5 parent***

**consultants, 4 are employed in CSHCN programs.**

**The 5 DFH parent consultants are assigned to the DFH's OCSHCN (N=2), Office for Family, Youth, & School Success (N=1), WIC Program (N=1), and Immunization Program (N=1). Parent consultants are culturally diverse and are assigned to DFH programs based on the program's need for parent participation and the parent consultant's experience with the program//2005//. /2004/ All DFH staff, with the exception of local EI parent consultants, are centrally located at the Department of Health (HEALTH). Below are brief biographies of senior level management staff in lead positions. Also, see attachment.**

William Hollinshead, MD, MPH is the Medical Director for the DFH. 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 or comprehensive primary care, especially in a managed care environment.

Peter Simon, MD, MPH is the Deputy Director for the DFH. He is responsible for establishing medical policy for all DFH 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 other state agencies //2004//.

**/2005/ Laurie Petrone, MS, RD is the Chief of Staff for the DFH, which works out of the Office of the Medical Director. In this capacity, Ms. Petrone is responsible for implementing strategies, management oversight, personnel planning, and providing support to the DFH's medical Director. Her activities include setting program direction and resource allocation with the DFH's Office Chiefs, overseeing the DFH's operations including personnel, purchasing and budgeting, and aligning resources appropriately to meet DFH priorities //2005//.**

/2004/ Jonathan Seamans, MPA is the DFH Key Administrator, which works out of the Office of the Medical Director under the supervision of the Chief of Staff. In this capacity, Mr. Seamans is responsible for managing DFH resources (budget and personnel) and investments (purchases and contracts). Mr. Seamans monitors and manages federal grants, state and private funding, and other federal and state requirements. He also provides managerial assistance to DFH programs.

Adrianna Leon is the Program Manager for the DFH's Parent Consultant Program, which works out of the Office of the Medical Director. In this capacity, Ms. Leon is responsible for recruiting, supervising, and supporting the DFH's paid parent consultants as partners in outreach, public education, policy development, and quality improvement for DFH programs //2004//.

**/2005/ Andrea Bagnall-Degos, MPH is the Chief of the DFH's Communication Unit, which works out of the Office of the Medical Director. In this capacity, Ms. Bagnall-Degos develops and supports DFH communication & public engagement efforts in partnership with DFH programs, ensures that clear and consistent messages are communicated through all DFH campaigns, provides consultation on communication and policy issues in support of DFH goals, and coordinates policy option development and inter-departmental policy initiatives. Ms. Bagnall-Degos also manages the DFH's poison control activities //2005//.**

/2004/ Sam-Viner Brown, SM is the Chief of the DFH's Data & Evaluation Unit, which works out of the Office of the Medical Director. In this capacity, Ms. Viner-Brown is responsible for developing, supporting, collecting, and analyzing data for DFH needs assessment, policy development, program management, quality assurance, and reporting purposes in collaboration with national, state, and local partners.

Becky Bessette, MS, RD is the Chief for the DFH's Office for Women, Infants & Children (WIC)

Program. In this capacity, Ms. Bessette is responsible for the overall administration of the Immunization Program and the WIC Program, which includes nutrition, farmers market, and breastfeeding initiatives, support and promotion, education and outreach, food delivery, financial management, and management information systems (MIS).

Amy Zimmerman, MPH, RD is the Chief of the DFH's Office for Children's Preventive Health Services (OCPHS). In this capacity, Ms. Zimmerman has responsibility for the management and administration of the DFH's Childhood Lead Poisoning Prevention Program, Newborn Screening Program, and KIDSNET.

Deb Garneau is the Chief of the DFH's Office for Families Raising Children with Special Health Care Needs (OCSHCN). In this capacity, Ms. Garneau has responsibility for the management and administration of the DFH's Early Intervention (EI) Program, Disability & Health Program, Child Development Center (CDC), Family Outreach Program (FOP), Child Maltreatment Initiative, and other DFH initiatives impacting CSHCN //2004//.

***//2005/ Jan Shedd, MEd is the Chief of the DFH's Office for Family, Youth & School Success (OFYSS). In this capacity, Ms. Shedd is responsible for the management and administration of the DFH's Family Planning Program, Women's Health Screening & Referral Program (WHSRP), School-Based Health Center (SBHC) Program, Men 2B Program, Healthy Schools!/Healthy Kids!, early childhood development, community partnerships, youth development, and out-of-school time programming initiatives //2005//.***

## **E. STATE AGENCY COORDINATION**

*//2004/ The DFH actively collaborates with other state agencies and community organizations and associations on a variety of levels. For a detailed description of the DFH's relationships with other entities, please refer to Attachment //2004//.*

## **F. HEALTH SYSTEMS CAPACITY INDICATORS**

### ***//2005/ Health Systems Capacity Indicators***

***#01: The rate of children hospitalized for asthma (per 10,000 children less than five years of age. The asthma hospitalization rate has increased significantly over the past three years. In FY2001, it was 65.3. In FY2002, it was 74.2 and in FY2003, it was 90.3. These increases reflect national trends. About 50% of the children who are hospitalized for asthma in RI live in one the state's older, urban, "core" communities. 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, which includes a focus on health disparities.***

***#02: The percentage of Medicaid enrollees whose age is less than one year who received at least one periodic screen. In FY2001, it was 92.6%. In FY2002, it was 88.4% and in FY2003, it was 91.4%. This is up a bit from last year's rate, but still within normal limits of annual variations. It is important to point out that there were considerably more infants this year than in previous years due to increased births and increased enrollment in Rlte Care.***

***#03: The percentage of SCHIP enrollees whose age is less than one year who received at least one periodic screen. Not applicable, since SCHIP enrollees in Rhode Island are eight years old and older.***

**#04: The percentage of women (15-44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index. This percentage appears to be stable over the past three years. In FY2001, the percentage was 87.3. In FY2002, it was 86.8 and in FY2003, it was 88.1.**

**#05: Comparison of health systems capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the state. The percentage of low birth weight infants for Medicaid, Non-Medicaid, and all MCH populations in the state in FY2003 was 9.4, 8.1, and 8.7, respectively. The percentage of infant deaths per 1,000 live births in FY2003 was 5.1, 8.4, and 6.4, respectively. The percentage of infants born to pregnant women receiving care in the first trimester in FY2003 was 83.7, 95, and 90.8, respectively. 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 FY2003 was 82, 91.5, and 88.1, respectively.**

**#06: The percent of poverty level for eligibility in the state's Medicaid and SCHIP programs for infants (0-1), children, and pregnant women. Infants (0-1) qualify for Medicaid if < 250% of the federal poverty level (FPL). SCHIP does not include infants. Children (1-18) qualify for Medicaid if <250% of the FPL. Children (1-18) qualify for SCHIP if <250% of the FPL. Pregnant/postpartum women qualify for Medicaid if < 185% of the FPL. Pregnant/postpartum women qualify for SCHIP if 185-250% of the FPL. Families with incomes >150% of the FPL are subject to a family partial premium. Threshold increases to 185% for families consisting only of pregnant women and infant(s).**

**#07: The percent of EPSDT eligible children aged 6-9 years who have received any dental services during the year. This percentage appears to be stable over the past three years. In FY2001, the percentage was 55.9%. In FY2002, it was 54.6%, and in FY2003, it was 54.1%. As the RI Department of Human Services (RIDHS) continues to work to improve the existing state infrastructure for providing dental services for Medicaid eligible populations, it is expected that this percentages will rise over time.**

**#08: The percentage of SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHCN Program. This percentage continues to decrease as more and more CSHCN (including SSI beneficiaries less than 16 years old receiving rehabilitative services) are transitioned to services provided through the Rhode Island Department of Human Services (RIDHS). In FY2001, this percentage was 15.6, in FY2002, it was 10.2, and in FY2003, it was 9.1 (provisional).**

**#09(A): The ability of states to assure that the MCH Program and Title V agency have access to policy and program relevant information and data. The DFH obtains electronic data through annual linkage of infant birth and death certificates, annual linkage of birth records and WIC eligibility files, and annual linkage of birth records and newborn screening files. It also 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. 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.**

**#09(B): The ability of states to determine the percentage of adolescents in the grades 9-12 who report using tobacco products in the last month. HEALTH participates in the Youth Risk Behavior Survey (YRBS) and the DFH has direct access to the YRBS database for analysis. The state also participates in the School Accountability for Learning and Teaching (SALT) Survey and the Youth Tobacco Survey (which began in 2001 and is conducted every two years). The DFH does not have direct access to either the SALT or Youth Tobacco Survey databases for analysis.**

**#09(C): The ability of states to determine the percentage of children who are obese or**

***overweight. The DFH participates in the YRBS and the RI Health Interview Survey (RHIS) and the DFH has direct access to the YRBS & RHIS databases for analysis. It also collects data on childhood obesity through the DFH's WIC Program and Immunization Program. The Immunization Program began collecting height and weight information for Kindergarteners beginning in FY2002. The state does not participate in the Pediatric Nutrition Surveillance System (PedNSS) //2005//.***

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

/2004/ Results from the statewide needs assessment, state, and national performance measures, capacity indicators, and community-stakeholder input provide a comprehensive picture of the maternal and child health needs in RI. From this combination of quantitative and qualitative information, the DFH has identified 10 priorities. Linked to these priorities are state and national performance measures. Together, the priorities represent each of the four levels of MCH services (direct health, enabling, population-based, & infrastructure building) and all MCH population groups. Because the priorities relate to more than one level of services, the service level assigned to the priority was determined to be by its performance measure. For example, the state performance measure selected to address the priority "reduce and manage pregnancy risks" has been determined to be an infrastructure building activity. Assuring that systems are in place for pregnant women will hopefully lead to a reduction in pregnancy risks. As with many of the other state and national performance measures, the state performance measure that focuses on early prenatal care for select population subgroups at risk (SPM #4) also reflects other levels of service. The DFH's Women's Health Screening & Referral Program (WHSRP) (a direct service) identifies and addresses pregnancy risks. The DFH's Family Outreach Program (an enabling service) is seeking to expand its home visiting services to pregnant women. The DFH's PRAMS surveillance and public education activities (population-based services) focus heavily on women at risk in prenatal care. In fact, this capacity to address serious public health challenges at several levels in an integrated way is the special mandate and strength of Title V. The DFH is proud of its coordinated, leveraged, and evaluated investments in community care and in communities' capacity to care for all children in Rhode Island //2004//.

### **B. STATE PRIORITIES**

/2004/ State Performance Measures

This section looks at the relationship between the DFH's priority state needs and its state performance measures by the four levels of MCH services (direct health, enabling, population-based, infrastructure building).

#### Direct Health Care Services

The DFH has identified two priority areas that relate to direct services: "improve the health, safety, and optimal development of adolescents" and "assure access to appropriate services during periods of transition for CSHCN and other children". These priorities are derived from the DFH's needs assessment and health status indicators.

The corresponding state performance measures for these two priorities are: "the percentage of students in schools with SBHCs who are enrolled in SBHCs (SPM #2)" and "the percentage of children in the EI Program with IFSPs discharged to Special Education for whom an IEP is developed (SPM #7)", respectively. Rhode Island survey data and vital statistics records reveal that teens are taking risk in the areas of tobacco, alcohol and drugs, sexual intercourse, and other behaviors that might result in unintentional or intentional injuries or deaths. The DFH's SBHCs are an important resource for addressing these risks. The number of children enrolled in EI has been rising and nearly half of the children enrolled in EI transition to Special Education. The transition of these children into Special Education is critical.

#### Enabling Services

The DFH has identified two priority areas that relate to enabling services: "improve the nutritional status of children, youth, and their families" and "assure that eligible individuals participate in MCH programs through intensive outreach efforts". 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 DFH's WIC Program (SPM #8)" and the percentage of at risk newborns who receive a home visit from the DFH's Family Outreach Program (FOP) during the

early newborn period (SPM #9)", respectively. Childhood obesity continues to be a significant health risk in Rhode Island. One in five children enrolled in the DFH's 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 DFH home visiting services.

### Population-Based Services

The DFH has identified three priority areas that relate to population-based services: "provide education, support, and environmental risk reduction to families"; "strengthen partnerships between schools, neighborhood and home"; and "increase community/family feedback/involvement regarding DFH program services and policies". 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 in at-risk population subgroups with lead levels greater than or equal to 10 ug/dl (SPM #5)", and "the number of completed family surveys (SPM #10)", respectively. Although the proportion of children who have elevated lead levels is decreasing, still nearly one in ten children under the age of six have elevated lead levels in Rhode Island. Quality education is linked to school success. High school dropouts are more likely to be unemployed, to be on public assisting, and to earn less money than high school graduates. A significant proportion of students drop out of high school in Rhode Island. By strengthening partnerships between school, neighborhood, and home, long term improvements in the state's high school graduation rate may be achieved. In addition, community and family input is key to understanding the MCH needs and priorities of Rhode Islanders.

### Infrastructure Building Services

The DFH has identified three priority areas that relate to infrastructure building services: "assure the health, safety, and optimal development of children in child care settings", "expand access to genetics services during the preconception and prenatal periods", and "reduce and manage pregnancy risks". The corresponding state performance measures for these three priorities are: "the number and percentage of children > 18 months in child care who are up-to-date on their immunizations (SPM #1)", "the proportion of women who receive an AFP test (SPM #3)", and, as previously noted, "the percentage of pregnant women who receive prenatal care in the first trimester by population subgroups (SPM #4)." 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. In addition, ensuring access to genetics services, including AFP testing, can lead to a decrease in birth defects.

Activities that correspond to the DFH's priorities and state performance measures are included in Table 4B.

### National Performance Measures

The DFH has described the relationship of the state's priority needs and its state performance measures by the four levels of MCH services (direct health, enabling, population-based, infrastructure building) above. The following represents discussion of the relationship between the state's priority needs and the national performance measures by the four levels of the pyramid. Again, the service level assigned to each priority was determined by its performance measure.

### Direct Health Care Services

The DFH has identified two priority areas that relate to direct services: "improve the health, safety, and optimal development of adolescents" and "assure access to appropriate services during periods of transition for CSHCN and other children." The corresponding national performance measures that relate to these two priorities are as follows:

1. Improve the health, safety, and optimal development of adolescents: the birth rate per 1,000 for teenagers aged 15 through 17 years (NPM #8) and the rate per 1000,000 of suicide deaths among youth ages 15-19 (NPM #16).

2. Assure access to appropriate services during periods of transition for CSHCN and other children: the percentage of youth with CSHCN who received the services necessary to make transitions to all aspects of adult health (NPM #6).

### Enabling Services

The DFH has identified two priority areas that relate to enabling services: "improve the nutritional status of children, youth, and their families" and "assure that eligible families participate in MCH programs through intensive outreach efforts." The corresponding national performance measures that relate to these two priorities are as follows:

1. Improve the nutritional status of children, youth, and their families: the percentage of mothers who breastfeed their infants at hospital discharge (NPM #11).
2. Assure that eligible families participate in MCH programs through intensive outreach efforts: 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), percent of children without health insurance (NPM #13), and the percentage of potentially Medicaid children who have received a services paid for by Medicaid (NPM #14).

### Population-Based Services

The DFH has identified three priority areas that relate to population-based services: "provide education, support, and environmental risk reduction to families", "strengthening partnerships between schools, neighborhood and home", and "increase community/family feedback regarding DFH program services and policies." The corresponding national performance measures that relate to these three priorities are as follows:

1. Provide education, support, and environmental risk reduction to families: the rate of deaths to children ages 14 years and younger caused by motor vehicle crashes per 100,000 (NPM # 10).
2. Strengthening partnerships between schools, neighborhood and home: the percentage of CSHCN ages 0-18 who receive coordinated, ongoing, comprehensive care within a medical home (NPM #3) and the percentage of third grad children who have received protective sealants on at least one permanent molar tooth (NPM #9).
3. Increase community/family feedback regarding DFH program services and policies: 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

The DDH has identified three priority areas that relate to infrastructure building services: "assure the health, safety, and optimal development of children in child care settings", "expand access to genetics services during the preconception and prenatal periods", and "reduce and manage pregnancy risks". The corresponding national performance measures that relate to these three priorities are as follows:

1. Assure the health, safety, and optimal development of children in child care settings: the percentage of 19-25 month olds who have received full schedule of age-appropriate immunizations

(NPM #7).

2. Reduce and manage pregnancy risks: the percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates (NPM #17) and the percentage of infants born to pregnant women receiving prenatal care in the first trimester (NPM #18).

3. Expand access to genetics services during the preconception and prenatal periods: the percentage of very low birth weight infants among all live births (NPM #15)

Activities that correspond to the DFH's priorities and the national performance measures are included in Table 4A //2004//.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

### a. Last Year's Accomplishments

***/2005/ Screening programs for newborns have proven to be cost effective and successful and have been shown to prevent mortality and morbidity. Their success reflects the systems approach from early screening and diagnosis to appropriate early intervention and treatment. During FY2003, the DFH' Newborn Screening Program continued to provide universal newborn screening for 9 inherited conditions, hearing impairment, and developmental risks (including socio-economic risks). The 9th condition (MCAD) was added in FY2003.***

***HEALTH's Genetics Advisory Committee reviewed the pros and cons associated with informed consent for newborn screening and presented a final recommendation to the Director of HEALTH that focuses on informing parents of the screening and the right to refuse rather than require a parental signature. This recommendation was approved and implemented in FY2003.***

***The DFH's Newborn Screening Program began to collaborate with the DFH's Communications Unit to begin the process for developing integrated culturally and linguistically appropriate informing brochures (prenatal, perinatal, and postnatal) for families that includes bloodspot, hearing, developmental risk, home visiting, and birth defects surveillance, and KIDSNET. During FY003, stakeholder surveys and focus groups with parents were completed.***

***During FY2003, RI PRAMS surveyed approximately 2,000 women who delivered babies and asked whether respondents were aware that babies are tested in the hospital for conditions that run in the family, such as sickle cell disease and PKU //2005//.***

### b. Current Activities

***/2005/ The DFH continues to assure early screening, diagnosis, and intervention for all newborns with special health care needs. Specifically, the DFH provides universal newborn screening for 9 inherited conditions, hearing impairment, and developmental risks (including socio-economic risks).***

***A CQI Plan has been developed by the DFH and is being implemented for bloodspot newborn screening. The CQI Plan includes data and system level quality issues. A Policy and Procedure Manual has been drafted. Computer programming and system***

**testing to allow for automatic transfer of bloodspot newborn screening laboratory data to KIDSNET was completed and tested. Hepatitis B data is now transferred daily to an ACCESS database to facilitate tracking and follow-up of infants born to Hepatitis B positive mothers.**

**A DFH Parent Consultant, in collaboration with families and RI Hospital, has completed a draft parent guide (i.e. "medical passport") for PKU, which includes disease specific information and information on services and resources available in RI. This same Parent Consultant continues to serve on the New England Regional Genetics Group (NERGG) Board of Directors and the DFH's Newborn Screening Advisory Group as a Rhode Island consumer.**

**Draft informing brochures (prenatal, perinatal, postnatal) have been developed by the DFH, based on survey and focus group results with families. An integrated informing approach was used and includes bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET. The DFH will develop a strategy to distribute the informing brochures to prenatal, hospital, and pediatric health providers. The goal is to assure that the providers understand their role in the newborn screening informing process, routinely give material to their patients, and answer questions from their patients.**

**The DFH developed a resource binder for health care providers to give to families with CSHCN. The binder includes a list of services and resources in RI, worksheets for parents to track information about health care appointments and the child's conditions, sheets for recording emergency information, and tips for building partnerships with health care providers. A cost study of newborn screening (bloodspot and hearing) was conducted during FY2004 to determine the actual costs, including screening, follow-up, diagnosis, treatment, and information systems.**

**RI PRAMS surveyed approximately 2,000 women who delivered babies during FY2003 and asked whether respondents were aware that babies are tested in the hospital for conditions that run in the family, such as sickle cell disease and PKU. During FY2004, RI PRAMS received weighted data from the CDC, which indicated that 74.1% of the respondents indicated that they were aware that babies are tested in the hospital for genetic conditions. PRAMS will be used as a measure to monitor the impact of the new informing materials once they are produced and distributed //2005//.**

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

**/2005/ The DFH's will provide universal newborn screening for 9 inherited conditions, hearing impairment, and developmental risks (including socio-economic risks). In FY2005, pre-populating newborn screening laboratory and hearing databases with electronic birth certificate data system will be completed. Newborn screening results will continue to be sent to KIDSNET so that newborns not screened will be identified. The CQI plan includes capacity to check against birth certificate records. KIDSNET will provide primary care providers with immediate newborn screening results (both positives and negatives) for their pediatric patients. Hepatitis B data will be transferred daily to an ACCESS database to facilitate tracking and follow-up of infants born to Hepatitis B positive mothers.**

**Families with infants identified through the DFH's Newborn Screening Program will continue to be offered home visits through the DFH's FOP. Identified infants are also referred to the EI Program.**

**The DFH's Newborn Screening Program will work to ensure that newborns with a**

**confirmed diagnosis are reported to the DFH's Birth Defects Surveillance Initiative. The DFH will address data and system level quality issues as outlined in the DFH's CQI Bloodspot Plan as appropriate, including meeting with each hospital to review data and work toward selected improvements.**

**A policy and procedures manual for bloodspot screening has been drafted. In FY2005, the Newborn Screening Advisory Committee and other key partners will finalized the draft manual and then disseminate them to relevant partners throughout the state.**

**The PKU parent guide develop by a DFH Parent Consultant will be disseminated and similar guides for other newborn screening conditions will be developed in FY2005. The Parent Consultant will continue to serve on the New England Regional Genetics Group (NERGG) Board of Directors and on the DFH's Newborn Screening Advisory Committee as a consumer member.**

**The DFH will develop a strategy to distribute newborn screening informing materials to prenatal, hospital, and pediatric health care providers. The goal is to ensure that providers understand their role in the newborn screening informing process, routinely give materials to families, and can answer questions from families.**

**Maternal awareness of newborn screening will continue to be monitored through RI PRAMS. Previous PRAMS survey results will be utilized as baseline data (before and after the implementation of the informing process) //2005//.**

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)*

**a. Last Year's Accomplishments**

**//2005/ The DFH continued to work to increase the number of families with CSHCN who partner in decision-making and are satisfied with the services they receive. The DFH's Office for Families Raising CSHCN (OCSHCN) continued to take a lead role in implementing the DFH's activities in this area. However, some other DFH programs also continued to implement activities related to this performance measure.**

**During FY2003, the DFH's Data & Evaluation Unit, in collaboration with the DFH's OCSHCN, analyzed data from the National Survey of CSHCN. In addition, the DFH's "Medical Homes" Work Group worked to develop measures of family satisfaction with services and decision making //2005//.**

**b. Current Activities**

**//2005/ The DFH continues to work to increase the number of families with CSHCN who partner in decision-making and are satisfied with the services they receive. The DFH's Office for Families Raising CSHCN (OCSHCN) continues to take a lead role in implementing the DFH's activities in this area. However, some other DFH programs also continued to implement activities related to this performance measure.**

**The OCSHCN continues to support the activities of the SSI Team, which was created in 1994 to help address the needs of children eligible for SSI and their families. The SSI**

**Team includes the OCSHCN parent consultant and the Director of the Rhode Island Chapter of Family Voices as members. In FY2004, the OCSHCN worked with the RI Department of Human Services (RIDHS) and other partners to develop a "welcome packet" for families who have applied for SSI benefits. The "welcome packet" includes linguistically and culturally appropriate materials on a variety of topics including, but not limited to, CEDARR, Family Voices, & the RI Parent Information Network (RIPIN). Members of the SSI team visited each SSA Office in RI to train staff on local resources and deliver Family Voices Resources Guides.**

**There are now two DFH parent consultants working at the Child Development Center (CDC). The CDC, which is located at RI Hospital and is a state-certified CEDARR family center, provides medical services (including care coordination) to medically complex CSHCN. The two parent consultants are assisting families with CSHCN receiving services through CDC with navigating the process of specialty evaluation and services delivery.**

**The DFH's Data & Evaluation Unit has been working collaboratively with the DFH's Communications Unit and the DFH's Office for CSHCN to publish a chart book that describes data from the National Survey of CSHCN. Data will include family satisfaction with services received //2005//.**

**c. Plan for the Coming Year**

**//2005/ The DFH will continue to work to increase the number of families with CSHCN who partner in decision-making and are satisfied with the services they receive. The DFH's OCSHCN will continue to take a lead role in implementing the DFH's activities in this area. However, some other DFH programs will also continue to implement activities related to this performance measure.**

**The DFH's Data & Evaluation Unit has been working with the DFH's Communications Unit and the DFH's OCSHCN to publish a chart book that describes data from the National Survey of CSHCN. The DFH plans to publish and disseminate the chart book during FY2005. The chart book will include data on family satisfaction with services provided to CSHCN.**

**The OCSHCN will continue to support the activities of the SSI Team, which was created in 1994 to help address the needs of children eligible for SSI and their families. The SSI Team includes the OCSHCN parent consultant and the Director of the Rhode Island Chapter of Family Voices as members. In FY2004, members of the SSI team visited each SSA Office in RI to train staff on local resources and deliver Family Voices Resources Guides. These visits will occur bi-annually throughout FY2005.**

**The DFH's EI Program, which is housed in the OCSHCN, is mandated to ensure that parents participate in the EI services planning process. The EI Program will continue to use parent consultants to provide outreach and education, translation and interpretation, program monitoring, materials review, community advocacy, family satisfaction surveys, grant reviews, parent-to-parent support, and the parent perspective during EI annual program site reviews.**

**The DFH's OCSHCN will continue to support the hospital-based Child Development Center (CDC), which provides specialty services to medically complex CSHCN from birth to 21 years of age. The CDC is a certified CEDARR Family Center. The DFH's contract current with the CDC includes a stronger quality assurance component. Two OCSHCN parent consultants will continue to help families navigate the process of specialty evaluation and service delivery.**

**Healthy Child Care Rhode Island (HCCRI) will continue to work with families to ensure that CSHCN have adequate access to childcare in a "natural setting". There is a shortage of child care slots in "natural settings" for CSHCN in RI. HCCRI will continue to work with the DFH's OCSHCN, RIPIN, the Child Care Support Network (CCSN), the HCCRI Advisory Board, the RIDHS's Therapeutic Integrations Specialist Program, and DFH parent consultants to provide training, technical assistance, and information to child care providers to help them to better accommodate CSHCN in child care. HCCRI will continue to include parents with CSHCN on the HCCRI Advisory Board to assure that the identification of resources for this population remains a priority //2005//.**

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)*

**a. Last Year's Accomplishments**

**/2005/ The DFH continued to work to increase the number of CSHCN in RI who have a "medical home". The DFH's Early Intervention (EI) Program, which is housed in the DFH's OCSHCN, contains a strong service coordination component. The DFH's Early Intervention (EI) Program, which is housed in the DFH's OCSHCN, contains a strong service coordination component, which ensures that CSHCN receiving services through EI have a "medical home".**

**The DFH also continued to support community needs assessment and systems development activities in culturally diverse urban communities in RI. The DFH remained actively involved in the Ready to Learn Providence (RLP). In FY2003, RLP continued to work on implementing activities related to expanding the capacity and cultural competency of early childhood learning programs in the city. Newport County CATCH utilized new funding to work on developing an infrastructure to support "medical homes" in participating communities. Mt Hope CATCH conducted a comprehensive assessment of "medical homes" during FY2003. Lastly, the DFH's Successful Start initiative began to engage in a statewide planning process to assess quality, capacity, and integration surrounding five core areas, one of which focuses on "medical homes", including those for CSHCN.**

**The DFH continued its contract with the New England Regional Genetics Group (NERGG) to provide technical assistance and administrative support for genetics related activities and to facilitate the ongoing implementation of the state genetics plan. In FY2003, a 4th annual genetics conference, titled "Genetics, Diabetes, and Public Health", was held.**

**During FY2003, the DFH's Data & Evaluation Unit analyzed data from the National Survey of CSHCN, which includes data on coordination and comprehensiveness of care. In addition, the DFH's "Medical Homes" work group developed measures of coordinated and comprehensive care //2005//.**

**b. Current Activities**

**/2005/ The DFH continues to work to ensure that CSHCN ages 0-18 receive coordinated, ongoing, comprehensive care within a "medical home". EI contains a strong service coordination component, which ensures that CSHCN receiving services through EI have a "medical home". It is significant to point out that The Zero to Three Policy Center reported in 2003 that national data suggests that RI has the highest percentage of children less than 12 months enrolled in EI of states with moderate eligibility.**

**A CEDARR Interdepartmental Team is made up of the RIDHS, HEALTH's OCSHCN, the RIDE, and the RIDCYF. The Interdepartmental Team is responsible for program monitoring and oversight, policy review and revision, and program development. Recent CEDARR developments have resulted in the enhancement of the Basic Services and Supports offered by the CEDARR Family Centers and the new and enhanced Direct Services (Enhanced Home Based Therapeutic Services).**

**The DFH continues to work to enroll all pediatric providers in the state in KIDSNET to ensure that all children, including CSHCN, are identified and are linked to a "medical home" and appropriate support services. KIDSNET continues to generate daily electronic referrals to the FOP, which provides home visiting to infants identified to be at developmental risk.**

**During FY2004, KIDSNET went through a major upgrade to allow secure web-based access. The upgrade facilitates KIDSNET's capacity for more rapid expansion to additional primary care providers, school nurse teachers, and audiologists. All Head Start agencies are now connected to KIDSNET and using it to verify immunization and lead screening.**

**HEALTH's Genetics Advisory Committee decided to work on the issue of access to genetics services, especially genetics counseling and family studies, over the next year. An initial meeting with medical directors of major health insurance plans in the state was held during FY2004. HEALTH participated in a RI Public Health Foundation effort to develop a culturally and linguistically appropriate genetics brochure targeted at low literacy populations.**

**The DFH supports community needs assessment and systems development activities in culturally diverse urban communities through RLP, Newport County CATCH and Mt. Hope CATCH, which are working on developing local infrastructures to support "medical homes" for children (including CSHCN). Successful Start continues to engage in a statewide planning process to assess quality, capacity, and integration surrounding five core areas, one of which focuses on "medical homes".**

**The DFH's Data & Evaluation Unit has been working collaboratively with the DFH's Communications Unit and the DFH's OCSHCN to develop a chart book that describes data from the National Survey of CSHCN, which includes data on coordination and comprehensiveness of care //2005//.**

**c. Plan for the Coming Year**

**//2005/ The DFH will continue to work to increase the number of CSHCN in RI who have a "medical home". EI contains a strong service coordination component, which ensures that CSHCN receiving services through EI have a "medical home".**

**The DFH's OCSHCN will continue to participate on the CEDARR Interdepartmental Team during FY2005. The Team will continue to be responsible for program monitoring and over-sight, policy review and revision, and program development.**

**The OCSHC will collaborate with the RIDHS and RIPIN will implement the Pediatric Enhancement Project (PEP), which was developed to alleviate some of the administrative burden faced by pediatricians and to support pediatric practices in providing comprehensive and coordinated care to CSHCN within a "medical home". The PEP will place trained parent consultants into eight pediatric primary care practices statewide. The primary role of the parent consultant will be to create linkages between**

**families with CSHCN and the pediatric practice and the community as a whole.**

**The DFH has been working to develop a chart book that describes data from the National Survey of CSHCN, which includes data on coordination and comprehensiveness of care. The DFH plans to publish and disseminate the chart book in FY2005.**

**In addition to the OCSHCN, other DFH programs will work to ensure that CSHCN have a "medical home". The DFH will work to enroll all pediatric providers in the state in KIDSNET to ensure that all children, including CSHCN, are identified and are linked to a "medical home" and appropriate support services.**

**In FY2004, a DFH work group developed selected performance indicators of "medical homes". During FY2005, the work group will continue to work with internal and external partners to refine and implement tracking of "medical home" performance indicators.**

**The DFH's FOP will continue to link children, including CSHCN, from birth to six years old, to a "medical home". FOP home visitors will continue to provide culturally appropriate family support, outreach, referral, education, and assistance with linkages to health insurance (i.e. Rlte Care, SSI, Katie Beckett) and other health care needs. Home visitors will continue to refer CSHCN to EI, Special Education, or CEDARR, depending on their age and presenting concerns.**

**The DFH will continue to contract with the New England Regional Genetics Group (NERGG) to provide technical assistance and administrative support for genetics related activities and to facilitate ongoing implementation of the state genetics plan. Ensuring coordinated, ongoing, comprehensive care within a "medial home" represents and important part of the state genetics plans A 6th annual genetics conference will be held during FY2005 //2005//.**

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)*

**a. Last Year's Accomplishments**

**/2005/ The DFH continued 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 DFH's Family Resource Counselor Program (FRC) continued to screen and enroll eligible families into Medicaid (including Rlte Care or Rlte Share) and other health financing programs (including SSI and Katie Beckett). During FY2003, culturally diverse FRCS were located in 12 community health centers and 4 hospital-based clinics throughout the state. As the RIDHS transitioned CSHCN from fee-for-service Medicaid to Medicaid managed care, the DFH worked with the RIDHS, the RI Health Center Association, and Covering Kids RI to train FRCS to support the particular needs of this population during the transition.**

**The DFH's Family Outreach Program (FOP) continued to identify families with no or inadequate health insurance and refer them to appropriate health funding programs, including Medicaid, SSI, and Katie Beckett. Culturally diverse FOP home visitors continued to help families complete applications as needed. The DFH's Communication Unit continued to support the toll-free Family Health Information Line, which continued**

**to refer families to appropriate resources, including financial assistance. The Family Health Information Line, which 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 Communication Unit's centralized Distribution Center.**

**During FY2003, the DFH's Data & Evaluation Unit analyzed data from the National Survey of CSHCN. Data included information related to adequacy of health insurance //2005//.**

**b. Current Activities**

**/2005/ The DFH continues 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. EI Program contains a strong service coordination component, which ensures that the families of CSHCN receiving services through EI are linked to financial resources for which they may be eligible (i.e. SSI, Medicaid, Katie Beckett, etc.).**

**The DFH's OCSHCN continues to actively participate in the implementation of CEDARR. A CEDARR Interdepartmental Team is made up of the RIDHS, HEALTH's OCSHCN, the RIDE, and the RIDCYF. The Interdepartmental Team is responsible for program monitoring and oversight, policy review and revision, and program development. CEDARR includes a strong care coordination component, which includes the coordination of financial resources for which families with CSHCN may be eligible (i.e. SSI, Medicaid, Katie Beckett, etc.).**

**The DFH's FRC Program continues 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 diverse FRCS are located in 12 community health centers and 4 hospital-based clinics throughout the state.**

**The DFH's FOP refers families with no or inadequate health insurance to appropriate funding programs. FOP home visitors help families complete applications as needed. The DFH supports the toll-free Family Health Information Line, which refers families to appropriate resources, including financial assistance.**

**The DFH's Newborn Screening Parent Consultant, in collaboration with families and the metabolic clinic at RI Hospital, has developed a draft parent guide (i.e. medical passport) for PKU, which includes disease specific information and information on services and resources (including health insurance and other financing information) available in Rhode Island.**

**The DFH's OCSHCN is supporting pediatric practices with high concentrations of CSHCNs through placing trained parent consultants in the offices to assist families with systems navigation and accessing health insurance.**

**The DFH's Data & Evaluation Unit has been working with the DFH's Communications Unit and OCSHCN to develop a chart book that describes data from the National Survey of CSHCN, which includes data regarding adequacy of health insurance //2005//.**

**c. Plan for the Coming Year**

**/2005/ The DFH 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 RIDHS is in the process of transferring CSHCN from traditional fee-for-service Medicaid to Rlte Care. The DFH's OCSHCN will continue to partner with Family**

**Voices and other partners to advocate for more coverage for CSHCN with private insurance. The OCSHCN's EI Program will continue to ensure that families with CSHCN, from birth to three years of age, are linked to adequate health financing programs, including Medicaid, SSI, and Katie Beckett.**

**The DFH's OCSHCN will continue to participate on the CEDARR Interdepartmental Team during FY2005. The Team will continue to be responsible for program monitoring and over-sight, 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 DFH's newborn Screening Parent Consultant, in collaboration with families and the metabolic clinic at RI Hospital, has developed a draft parent guide (i.e. medical passport) for PKU, which includes disease specific information and information on services and resources (including health insurance and other financing information) available in Rhode Island. The DFH will utilize FY2005 to develop similar guides for other newborn screening conditions.**

**The DFH's Data & Evaluation Unit has been working with the DFH's Communications Unit and OCSHCN to develop a chart book that describes data from the National Survey of CSHCN, which includes data on adequacy of health insurance. The DFH plans to publish and disseminate the chart book in FY2005.**

**The DFH's FRC Program will continue to screen and enroll eligible families into Medicaid (including Rite Care or Rite Share) and other health financing programs (including SSI and Katie Beckett). Culturally diverse FRCS are located in 10 community health centers and 4 hospital-based clinics throughout the state. As the RIDHS continues to transition CSHCN from fee-for-service Medicaid to Medicaid managed care, the DFH will continue to work with the RIDHS, the RIHCA, and Covering Kids RI to train FRCS to support the particular needs of this population during the transition.**

**The DFH's FOP will continue to identify families with no or inadequate health insurance and refer them to appropriate health funding programs, including Medicaid, SSI, and Katie Beckett. Culturally diverse FOP home visitors will continue to help families complete applications as needed. The DFH's Communication Unit will continue to support the toll-free Family Health Information Line, which will continue to refer families to appropriate resources, including financial assistance. Culturally appropriate informational materials will continue to be distributed through the Communication Unit's centralized Distribution Center //2005//.**

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)*

**a. Last Year's Accomplishments**

**/2005/ The DFH continued to work to ensure that families with CSHCN ages 0-18 report that services are organized so that they can use them easily. The DFH's new state early childhood comprehensive systems development initiative, Successful Start, began to engage in a two-year planning project to assess capacity, quality, and integration issues surrounding 5 core components of the state's early childhood system. The 5 components are: "medical home", social and emotional development, childcare, parenting education, and family support for all children, including CSHCN. Ongoing family input will represent an important part of this initiative //2005//.**

b. Current Activities

***//2005/ The DFH continues to work to ensure that families with CSHCN ages 0-18 report that services are organized so that they can use them easily. The DFH's OCSHCN continues to actively participate in the implementation of CEDARR. CEDARR is administered by the RI Department of Human Services (RIDHS). A CEDARR Interdepartmental Team is made up of the RIDHS, HEALTH's OCSHCN, the RI Department of Education (RIDE), and the RI Department of Children, Youth, & Families (RIDCYF). The Interdepartmental Team is responsible for program monitoring and oversight, policy review and revision, and program development. Family and program input is provided through the CEDARR Policy Advisory committee and the CEDARR Quality Panel to facilitate quality improvement.***

***The DFH's state early childhood comprehensive systems development initiative, Successful Start, is engaging in a two-year planning project to assess capacity, quality, and integration issues surrounding 5 core components of the state's early childhood system. The 5 components are: "medical home", social and emotional development, childcare, parenting education, and family support for all children, including CSHCN. Ongoing family input represents an important part of this initiative //2005//.***

c. Plan for the Coming Year

***//2005/ The DFH will continue to work to ensure that families with CSHCN ages 0-18 report that services are organized so that they can use them easily. The OCSHCN will actively participate in the implementation of CEDARR. A CEDARR Interdepartmental Team is made up of the RIDHS, HEALTH's OCSHCN, the RIDE, and the RIDCYF. The Interdepartmental Team is responsible for program monitoring and oversight, policy review and revision, and program development. Family and program input will be provided through the CEDARR Policy Advisory Committee and the CEDARR Quality Panel to facilitate quality improvement.***

***The OCSHC (lead agency) will collaborate with the RIDHS and the RIPIN to implement the Pediatric Enhancement Project (PEP), which was developed to alleviate some of the administrative burden faced by pediatricians and to support pediatric practices in providing comprehensive and coordinated care to CSHCN within a "medical home". The PEP will place trained parent consultants into eight pediatric primary care practices statewide. The primary role of the parent consultant will be to create linkages between families with CSHCN and the pediatric practice and the community as a whole.***

***The DFH will increase the number of families with CSHCN who have access to easy-to-use community based services systems. EI will continue to support a statewide system of early intervention agencies to provide specialty and sub-specialty services, including service coordination, to CSHCN from birth to three years of age. In FY2005, EI will continue to work with KIDSNET to develop methods to estimate the total number of CSHCN eligible for EI who have not accessed services.***

***EI is mandated to ensure that parents participate in the EI services planning and quality assurance process. EI will continue to use parent consultants to provide outreach and education, translation and interpretation, program monitoring, materials review, community advocacy, family satisfaction surveys, grant reviews, parent-to-parent support, and the parent perspective during EI annual program site reviews.***

***The Genetics Screening Advisory Committee will examine issues of access to genetics services, especially genetics counseling. The DFH will develop culturally and linguistically appropriate materials to support families with a child with a condition identified through the newborn screening process.***

***The DFH's state early childhood comprehensive systems development initiative, Successful Start, will complete its comprehensive plan to improve and integrate early childhood systems surrounding 5 core components of the state's early childhood system. The 5 components are: "medical home", social and emotional development, childcare, parenting education, and family support for all children, including CSHCN. Ongoing family input will continue to represent an important part of this initiative as the plan is implemented //2005//.***

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

**a. Last Year's Accomplishments**

***//2005/ The DFH's OCSHCN worked closely with the RI Department of Human Services (RIDHS), Family Voices, and other partners to help implement CEDARR and the transitioning of CSHCN from fee-for-service Medicaid to Medicaid managed care. CSHCN of all ages will be affected by this transition.***

***The OSCHCN was a key partner in the implementation of the Ticket to Work Self-Sufficiency Program, which is a new statewide Social Security initiative that will impact individual's ages 18-21 years with disabilities or blindness. The initiative offers support services for transition to independence through no cost employment services previously limited to the RIDHS's Office of Rehabilitative Services.***

***In addition, the OCSHCN participated in the Rhodes To Independence, Youth in Transition Workshop, which is funded through a Medicaid infrastructure Grant (MIG). The purpose of the MIG is to facilitate statewide collaboration, and one of the MIG's key target groups is young adults with disabilities transitioning to work. Young adults receiving SSI or SSDI are targeted. This group includes CSHCN transitioning to adulthood and young working individuals who develop a disability.***

***In addition, the DFH OCSHCN continued to participate on the RI Transition Council, which was created by state statute to coordinate the activities of state agencies and school districts for youth with disabilities transitioning from school to adult life. The Council continued to monitor the RI Transition Academy, promote transition activities such as the Youth Leadership Forum, and review current agency transition policies and practices. The Council also reviewed intra-agency agreements for state member agencies and develop new goals and objectives through a strategic planning process.***

***The DFH's Disability & Health Program continued to produce and disseminate an annual "Disability Data Book" to provide a basis for developing effective needs assessments & interventions for individuals with disabilities, including CSHCN who are transitioning to adulthood. The first version of the Data Book was produced in FY2000 and the next update will be completed during FY2004. The DFH will host a disability data forum to disseminate the book. In addition, the DFH will continue to disseminate the book to community-based agencies and policy-makers throughout the state.***

***In collaboration with RI Department of Education (RIDE), the DFH's Disability & Health Program continued to support a 3-year evaluation study of students who have graduated***

**from high school to determine the effectiveness of CSHCN services. The DFH continued to support the Child Development Center (CDC), which provides services to medically complex CSHCN //2005//.**

**b. Current Activities**

**/2005/ The DFH continues to work to increase the percentage of CSHCN, ages 0- 18, who have received the services necessary to transition to adult health care, work, and independence. The DFH's OCSHN works closely with the RI Department of Human Services (RIDHS), Family Voices, and other partners to help implement CEDARR and the transitioning of CSHCN from fee-for-service Medicaid to Medicaid managed care. CSHCN of all ages will be affected by this transition.**

**The OSCHCN is a key partner in the implementation of the Ticket to Work Self-Sufficiency Program, which is a new statewide Social Security initiative that will impact individuals ages 18-21 years with disabilities or blindness. The initiative offers support services for transition to independence through no cost employment services previously limited to the RIDHS's Office of Rehabilitative Services.**

**In addition, the OCSHCN is participating in the Rhodes To Independence, Youth in Transition Workshop, which is funded through a Medicaid infrastructure Grant (MIG). The purpose of the MIG is to facilitate statewide collaboration, and one of the MIG's key target groups is young adults with disabilities transitioning to work. Young adults receiving SSI or SSDI are targeted. This group includes CSHCN transitioning to adulthood and young working individuals who develop a disability.**

**In addition, DFH OCSHCN staff continues to participate on the RI Transition Council, which was created by state statute to coordinate the activities of state agencies and school districts for youth with disabilities transitioning from school to adult life. The Council continues to monitor the RI Transition Academy, promote transition activities such as the Youth Leadership Forum, and review current agency transition policies and practices. The Council also reviews intra-agency agreements for state member agencies and develop new goals and objectives through a strategic planning process.**

**The DFH's Disability & Health Program will continue to produce and disseminate an annual "Disability Data Book" to provide a basis for developing effective needs assessments & interventions for individuals with disabilities, including CSHCN who are transitioning to adulthood. The first version of the Data Book was produced in FY2000 and the next update will be completed during FY2004. The DFH will host a disability data forum to disseminate the book. In addition, the DFH will continue to disseminate the book to community-based agencies and policy-makers throughout the state.**

**In collaboration with RI Department of Education (RIDE), the DFH's Disability & Health Program will continue to support a 3-year evaluation study of students who have graduated from high school to determine the effectiveness of CSHCN services. The DFH continues to support the Child Development Center (CDC), which provides services to medically complex CSHCN //2005//.**

**c. Plan for the Coming Year**

**/2005/ The DFH will continue to work to increase the percentage of CSHCN, ages 0- 18, who have received the services necessary to transition to adult health care, work, and**

**independence. The OCSHCN will work to ensure that all CSHCN are healthy and ready to work in two ways: 1) through transitioning from child to adult health care systems and 2) through transitioning to secondary education and employment.**

**With respect to activities related to transitioning from child to adult health care systems, the OCSHCN's initial efforts will focus on a statewide needs assessment to determine the current practice of transitioning adolescents to the adult health care system. The OCSHCN, in collaboration with the RI AAP, will administer a survey to all licensed, practicing primary care pediatricians in the state. The goal of the survey is to establish a baseline of current practices in the transition and transfer of adolescent CSHCN and to identify barriers that prevent a seamless transition to adult care. Once the needs assessment is complete and a baseline of current practices has been identified, the plan is to foster collaboration among pediatricians, family practice physicians, and other primary care physicians to address the issue.**

**With respect to activities related to transitioning to secondary education and employment, the OCSHCN will continue to participate on the "Rhodes To Independence" Youth and Transition Committee. This initiative is funded through a Medicaid infrastructure Grant (MIG). The purpose of the MIG is to facilitate statewide collaboration, and one of the MIG's key target groups is young adults with disabilities transitioning to work. Activities will include the following: 1) development of a white paper highlighting the gaps in health care coverage for young adults with disabilities, 2) a campaign to increase awareness of the work incentives section of the Social Security Act, 3) establishment of a subcommittee focusing on ensuring smooth transitions from secondary education to higher education, and 4) development of a comprehensive training manual for families and professionals involved in the care of adolescent CSHCNs. The manual will cover state specific resources, including job skills, meaningful employment, social security work incentives, and transportation.**

**In addition, OCSHCN staff will continue to participate on the RI Transition Council, which was created by state statute to coordinate the activities of state agencies and school districts for youth with disabilities transitioning from school to adult life. In FY2005, the Council will continue to monitor the RI Transition Academy, promote transition activities such as the Youth Leadership Forum, and review current agency transition policies and practices. The Council will also continue to review intra-agency agreements for state member agencies and implement new goals and objectives that were developed through a comprehensive strategic planning process //2005//.**

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.*

**a. Last Year's Accomplishments**

**/2005/ The DFH provided vaccine to all 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 DFH participated in a CDC-sponsored "missed opportunities" research grant identifying areas of high mobility and immigration in under-immunized children during FY2003.**

**The DFH was the first in the nation to offer influenza vaccine to healthy children between the ages of 6 and 23 months. The DFH sponsored a press conference to publicize the new recommendation. Press releases were sent to all print and electronic media outlets in the state. A press release in Spanish was also sent out to Hispanic media outlets.**

**The DFH developed a strategic plan to address the following long-term issues: 1) maintaining a universal system of vaccine, 2) enhancing communications, 3) coordinating and collaborating with immunization consumers and stakeholders, and 4) strengthening internal systems for collecting, monitoring, and acting on vaccine-related data.**

**The DFH sponsored an event at the Rhode Island Mall to raise awareness about the importance of immunizations for all ages. Families with young children were referred to primary care providers or free immunization clinics. The event was promoted through press releases to the media. The DFH hosted a conference for school nurse teachers and Head Start coordinators to provide up-to-date information on health topics (including immunizations).**

**KIDSNET sent families of all newborns a congratulations card, which includes information about the importance of timely immunizations. KIDSNET continued to track immunizations for all children born after 1/1/97 and continued to send reports to on-line PCPs regarding their pediatric patients' immunization status. PCPs can refer children who are behind on their immunizations to the FOP for assistance in follow-up. Auto-dial messages or mailed "well-child reminders" were sent to families at specified intervals.**

**The DFH used KIDSNET to capture maternal Hepatitis B information. Infants with Hepatitis B positive mothers were referred to FOP. WIC assessed the immunization status of children receiving WIC services. Children who are behind on their immunizations were referred to their primary care provider or one of the free immunization clinics.**

**HCCRI provided culturally appropriate immunization informational materials to families through the CCSN). HCCRI also continued to send immunization informational materials directly to child care providers throughout the state.**

**The DFH developed a health and safety record to help families keep track of their children's important health information, including immunizations. The records were distributed to physicians, health centers, health plans, birthing hospitals, and child care providers. Families can also request a copy of the record by calling the DFH's toll-free Family Health Information Line //2005//.**

#### **b. Current Activities**

**/2005/ The DFH is providing all recommended vaccines for all children in the state, with no differentiation or tiered system for privately insured, Medicaid eligible or uninsured children. Influenza vaccine is now available to all children ages 6 months through 18 years. The DFH is utilizing a number of strategies to increase awareness of the new policy including broadcasts to health care providers, childcare providers, schools, and the media. The DFH is working to develop a process for determining the immunization status of children receiving childcare through about 1,200 home childcare providers.**

**The DFH developed a story for placement in the Rhode Island Family Guide on the importance of immunization for young children. The story included the current recommended immunization schedules and addressed common questions parents have about immunizations. The article referred families to the Family Health Information Line and encouraged them to request a health & safety record for their child.**

***The DFH developed a new culturally and linguistically appropriate immunizations brochure to supplement the DFH's existing vaccine-specific brochures. The DFH redesigned the immunization website to include specific sections for families, health care providers, childcare professionals, and school professionals.***

***The DFH hosted an annual conference for school nurse teachers and Head Start coordinators to provide up-to-date information on health issues (including immunizations). The DFH developed a resource binder for health care providers. The binder includes a variety of reference documents for health care providers as well as educational materials for them to use with the families they serve.***

***KIDSNET sends families of all newborns a congratulations card, which includes information about the importance of timely immunizations. KIDSNET tracks immunizations for all children born after 1/1/97 and sends reports to on-line primary care providers regarding their pediatric patients' immunization status. All Head Start agencies are now connected to KIDSNET and are using it to verify immunization screening. PCPs can refer children who were behind on their immunizations to the DFH's FOP for follow-up. Auto-dial messages or mailed "well-child reminders" are sent to families at specified intervals.***

***KIDSNET captures maternal Hepatitis B information. Infants with Hepatitis B positive mothers are referred to the FOP. WIC assesses the immunization status of children receiving WIC services. Children who are behind on their immunizations are referred to their PCP or one of the free immunization clinics.***

***HCCRI provides culturally appropriate immunization informational materials to families through the CCSN. HCCRI also continues to send immunization materials directly to childcare providers throughout the state and provides training and on-site technical assistance to child care providers that includes information about the importance of timely immunizations //2005//.***

**c. Plan for the Coming Year**

***//2005/ The DFH will continue to provide vaccine to all 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 DFH will focus its improvement rates on populations new to the country and state, utilizing information obtained through the CDC-sponsored "missed opportunities" research grant.***

***Along with the universal provision of childhood vaccines to all vaccine providers in the state for all children (privately insured, Medicaid eligible, and uninsured), the DFH will pilot test and then implement a full immunization assessment of all children receiving childcare through licensed home childcare providers. HCCRI will provide culturally appropriate immunization informational materials to childcare providers for families through the CCSN.***

***KIDSNET will send families of all newborns congratulations cards, which will include messages about the importance of immunizations. KIDSNET will track immunizations for all children born after 1/1/97 and send reports to on-line PCPs regarding their pediatric patients' immunization status. PCPs will refer children who are behind on their immunizations to the FOP. Auto-dial messages or mailed "well-child reminders" will be sent to families at specified intervals.***

***KIDSNET will continue to roll out a new web-based version of KIDSNET to provide***

**participating providers and other authorized users (including school nurse teachers and WIC sites) with easier access to KIDSNET. All Head Start agencies will continue to use KIDSNET to verify immunizations.**

**KIDSNET will be used to capture maternal Hepatitis B information. Infants with Hepatitis B positive mothers will be referred to the FOP. WIC will continue to assess the immunization status of children receiving WIC services, implementing the newly mandated assessment of DTAP shots based on age. WIC Children who are behind on their immunizations will be referred to their PCP or one of the free immunization clinics. The DFH will develop a plan for distributing newly developed Chicken Pox and Hepatitis B materials //2005//.**

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

**a. Last Year's Accomplishments**

**/2005/ The DFH made a strategic decision to reduce teen birth rates and other risk behaviors through the following three pronged approach: 1) access to health care services, including family planning services, 2) youth development programming that focuses on preparing adults and institutions to meet the developmental needs of youth, and 3) coordinated school health programs, including quality health education and comprehensive sexuality education.**

**The DFH continued to support 10 Title X family planning clinics to provide confidential and low cost reproductive health services to teens. The DFH's Women's Health Screening & Referral Program (WHSRP) continued to provide no cost pregnancy testing and comprehensive health risk assessment to teens in 9 Title X clinics. Teens with a negative pregnancy test were linked to family planning services and teens with a positive pregnancy test were referred to the Rhode Island Department of Human Services (RIDHS) Adolescent Self-Sufficiency Program. A youth-led community-based organization (i.e. Youth In Action) partnered with the DFH to provide family planning outreach, education, and referral services to young men living in Providence during FY2003. In addition, the DFH's 7 SBHCs continued to provide teenagers with access to no cost comprehensive preventive health and mental health services in racially and ethnically diverse communities. Teens in need of birth control were referred to the SBHC's parent community health center.**

**In FY2003, the DFH continued to implement a statewide adolescent media campaign, titled "Be There For Teens". Consumers who called the DFH's Family Health Information Line were provided with "Ten Tips on Parenting Teens" and referrals to the Men 2 B Program. Due to staffing and funding priority shifts, a second wave of the campaign was postponed and focus was placed on collaborating with the Children's Cabinet to develop an umbrella theme and unifying messages directed to parents of teens.**

**The DFH also continued to support the Men 2B Program in Pawtucket/Central Falls, Newport, Providence, and Woonsocket to train adult males to be effective role models for boys. Men 2 B, which is funded with Title V abstinence education funds, promotes abstinence from sexual intercourse, violence, and substance use among adolescent and pre-adolescent boys. The DFH continued to work with the Fathers and Family Network, which is designed to enhance the capacity of community-based service providers to develop and implement programs for fathers in Rhode Island. The Network held two fatherhood conferences that included workshops highlighting the Men 2 B Program.**

**The DFH assumed responsibility for managing the CDC Comprehensive School Health**

***Programs Grant, Healthy Schools!/Healthy Kids! (HS/HK) in FY2003. Specifically, the DFH partnered with the RI Department of Education (RIDE) to advance the development of a strong statewide infrastructure for coordinated school health programs //2005//.***

**b. Current Activities**

***//2005/ The DFH is working to reduce the teen birth rate by working with networks such as the RI After-School Plus Alliance, the Children's Cabinet Youth Development Advisory Committee, the Children's Mental/Behavioral Health Work Group, and the Teen Pregnancy Prevention Partnership. These groups, grounded in a youth development/assets building philosophy, are working to communicate common messages and to implement aligned policies and practices, to prepare school-age youth for responsible, productive adulthood. The DFH participates in an interagency (HEALTH, RIDHS, RIDE) work group that is focusing on using data to better understand teen birth trends and outcomes. Data have also been linked across programs to determine what services pregnant and parenting teens and their babies receive.***

***Ten Title X family planning clinics provide confidential and low cost family planning services to teens. The DFH's WHSRP continues to provide no cost pregnancy testing and comprehensive health risk assessment to teens receiving service in 9 Title X clinics. Teens with a negative pregnancy test are linked to family planning services and teens with a positive pregnancy test are referred to RIDHS's Adolescent Self-Sufficiency Program. A youth-led CBO has partnered with the DFH to provide family planning outreach, education, and referral services to young men living in Providence. SBHCs provide teenagers with access to no cost comprehensive preventive health and mental health services in racially and ethnically diverse communities. Teens in need of birth control are referred to the SBHC's parent community health center.***

***The DFH built on its "Be There For Teens" campaign through the development of a website for parents of children 9-17 years old. The website provides parents and providers with connections to RI programs and resources and includes monthly parenting tips. The website is intended to help parents and other adults build meaningful relationships with pre-teens and teens and meet their developmental needs.***

***The DFH continues to support the Men 2B Program. Preliminary results of evaluation data demonstrate effectiveness and role model behavior change. New outreach and education materials are being developed to increase Men 2B enrollment in worksites, schools, and faith-based organizations in RI.***

***The DFH continues to manage Healthy Schools!/Healthy Kids!. Issue briefs around weight management and physical activity, tobacco, alcohol and other drugs, sexual behavior, and injury and violence were produced to integrate data from the YRBS and SALT data sources. Formative research with schools has been conducted identifying local policies that enhance and impede the health of school-age children in RI. The DFH is collaborating with the United Way and other partners to develop a RI After School Plus Alliance, which will build a state infrastructure for quality out-of-school time programming //2005//.***

**c. Plan for the Coming Year**

***//2005/ The DFH will continue to work to reduce the teen birth rate. The DFH will continue implementing its three-pronged approach to reduce teen births and other risk behaviors. The DFH will participate in the interagency workgroup (HEALTH, RIDHS, RIDE) that is focusing on using data to better understand birth trends and outcomes and to***

*coordinate with other state partnerships and initiatives.*

*The DFH support 10 Title X family planning clinics to provide confidential and low cost reproductive health services. The DFH's WHSRP will provide no cost pregnancy testing and comprehensive health risk assessment to teens receiving services in Title X clinics. Teens with a negative pregnancy test are linked to family planning services on-site and teens with a positive pregnancy test are referred to the RIDHS's Adolescent Self-Sufficiency Program.*

*In addition, the DFH's 8 SBHCs will continue to provide teenagers with access to no cost comprehensive preventive health and mental health services in racially and ethnically diverse communities. Teens in need of birth control will be referred to the SBHC's parent community health center. The DFH will continue to support local efforts to implement new SBHCs.*

*The DFH will continue to support a website for parents of children 9-17 years old. In FY2005, The DFH will work with its community-based partners and a social marketing firm to implement revisions to the website that will make it more user-friendly. A planned promotional campaign is expected to increase user numbers and expand the number of resources listed.*

*The DFH will continue support the Men 2 B Program. The DFH will partner with the RI Department of Corrections during FY2005 to pilot the Men 2 B Program with men who are transitioning out of prison. The DFH will also continue to work with the Father and Family Network. Men 2B grantees will continue to participate as members of the Network and DFH staff serve on the Steering Committee during FY2005.*

*The DFH will continue to manage Healthy Schools!/Healthy Kids!. The DFH will continue to focus on developing leadership in the following areas: 1) school smoking polices, 2) physical activity, obesity, and nutrition, 3) school health data needs, 4) implementation of school rules and regulations, 5) professional development, 6) school environmental health, and 7) out-of-school time programming.*

*The DFH will participate in the Children's Cabinet Youth Development Advisory Committee to prepare youth for responsible productive adulthood. The DFH will take a leadership role in the RI After School Plus Alliance to build a network of stakeholders with resources and expertise to develop policies and advocacy for quality after-school programming with connections to health and mental/behavioral health services. The DFH will participate in the Children's Mental/Behavioral Health Group to implement strategies that will help schools implement social emotional learning strategies //2005//.*

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

**a. Last Year's Accomplishments**

*/2005/ The DFH continued to work to prevent dental caries in children. In FY2003, the DFH continued to support the education and outreach component of Providence Smiles, which is a school based oral health program operating in 10 Providence elementary schools. Providence Smiles provides the DFH with the data utilized to track this indicator.*

*Parents of young children receiving home visiting services through the DFH's Family Outreach Program (FOP) continued to receive culturally and linguistically appropriate*

**information and education about early childhood caries and the importance of preventive dental care throughout FY2003. Families receiving DFH WIC services were provided with information about early childhood caries as well. All local WIC staff received technical training on oral health topics in FY2003. The DFH's Healthy Child Care RI (HCCRI) initiative continued to support activities to ensure that parents of children in child care and childcare providers had access to culturally and linguistically appropriate information about childhood dental caries and the importance of preventive dental care.**

**Three of the DFH's 7 School-Based Health Center (SBHC) sites continued to provide dental services to youth. Two of the sites were located in Pawtucket and one was located in Central Falls. Two of the SBHC sites provided direct oral health services on-site. The other SBHC dental site had to be moved to a local elementary school due to the severity of the students' oral health needs. The Providence Community Health Center (PCHC) did not have an oral health program so Providence SBHC students were referred to dental providers in the community, who have long waiting lists. SBHCS in Woonsocket, Pawtucket, and Central Falls referred students to dental facilities in the SBHC's parent community health center**

**The DFH continued to participate on HEALTH's Oral Health Coordinating Team, which is charged with developing recommendations to improve the oral health of school-age children, including CSHCN. The Oral Health Coordinating Team is managed by HEALTH's Oral Health Program, which is housed in HEALTH's Division of Disease Prevention and Control (DDPC). The DFH also continued to work with Rhode Island Department of Human Services (RIDHS) as it proceeds with plans to restructure the oral health service delivery system for children with Medicaid in Rhode Island //2005//.**

#### **b. Current Activities**

**/2005/ The DFH continues to work to prevent dental caries in children. In FY2004, the DFH is supporting the education and outreach component of Providence Smiles, which is a school based oral health program operating in 10 Providence elementary schools. Providence Smiles provides the DFH with the data utilized to track this indicator.**

**Parents of young children receiving home visiting services through the DFH's FOP receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care. Families receiving WIC services are provided with information about early childhood caries as well. All local WIC staff receive technical training on oral health topics. The DFH's HCCRI initiative supports activities to ensure that parents of children in child care and childcare providers had access to culturally and linguistically appropriate information about childhood dental caries and the importance of preventive dental care.**

**Three of the DFH's SBHCs provide dental services to youth. Two of the sites are located in Pawtucket and one is in Central Falls. Two of the SBHC sites provide direct oral health services on-site. The other SBHC dental site had to be moved to a local elementary school due to the severity of the students' oral health needs. The Providence Community Health Center (PCHC) does not have an oral health program so Providence SBHC students are referred to dental providers in the community, who have long waiting lists. SBHCS in Woonsocket, Pawtucket, Central Falls, and West Warwick refer students to dental facilities in the SBHC's parent community health center.**

**The DFH participates on HEALTH's Oral Health Coordinating Team, which is charged with developing recommendations to improve the oral health of school-age children,**

**including CSHCN. The Team is managed by HEALTH's Oral Health Program, which is housed in HEALTH's DDPC. The Oral Health Program is currently developing an oral health state plan, implementing a coordinated oral disease surveillance system, assessing oral health workforce capacity, promoting water fluoridation management, establishing statewide oral health coalitions, and providing oral health training and technical assistance to community agencies and other partners to facilitate improved oral health access in RI.**

**The DFH is also working with the RIDHS as it proceeds with plans to restructure the oral health service delivery system for children and families with Medicaid. In FY2004, the RI Oral Health Access Project (a collaboration between the RIDHS, the RI Foundation, and RI KIDS COUNT) announced 14 new grants for three years to increase access to dental care for Medicaid families and individuals with special health care needs (including CSHCN). The grant will increase the number of dentists, enable CBOs to provide dental services and expand school-based dental exams and treatment. The services are paid for through the RWJ Foundation //2005//.**

**c. Plan for the Coming Year**

**/2005/ The DFH will continue to work to prevent dental caries in children 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 DFH's FOP 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 information about early childhood caries as well. In FY2005, WIC will partner with the DFH's Communication Unit and HEALTH's Oral Health Program to develop new culturally and linguistically appropriate educational materials on the topic of early childhood caries prevention.**

**Three of the DFH's 8 SBHCs will continue to provide dental services to youth. The Providence Community Health Center (PCHC) does not have an oral health program so Providence SBHC students will continue to be referred to dental providers in the community, who have long waiting lists. SBHCS in Woonsocket, Pawtucket, Central Falls and West Warwick will continue to refer students to dental facilities in the parent community health center.**

**The DFH's Healthy Child Care RI (HCCRI) initiative will continue to support activities to ensure that parents of children in child care and childcare providers had access to culturally and linguistically appropriate information about childhood dental caries and the importance of preventive dental care**

**The DFH will continue to participate on HEALTH's Oral Health Coordinating Team, which is charged with developing recommendations to improve the oral health of school-age children, including CSHCN. The Oral Health Coordinating Team is managed by HEALTH's Oral Health Program, which is housed in HEALTH's DDPC. In FY 2005, the Oral Health Program will continue to work on developing an oral health state plan, implementing a coordinated oral disease surveillance system, assessing oral health workforce capacity, promoting water fluoridation management, establishing statewide oral health coalitions, and providing oral health training and technical assistance to community agencies and other partners to facilitate improved oral health access in RI.**

**The DFH also will also continue to work with theRIDHS as it proceeds with plans to restructure the oral health service delivery system for children and families with Medicaid. In FY2004, the RI Oral Health Access Project (a collaboration between the RIDHS, the RI Foundation, and RI KIDS COUNT) announced 14 new grants totaling**

***\$737,308 for a three-year period to increase access to dental care for Medicaid families and individuals with special health care needs (including CSHCN). The grant will increase the number of dentists, enable community health organizations to provide dental services and expand school-based dental exams and treatment. The services are paid for through the RWJ Foundation //2005//.***

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

**a. Last Year's Accomplishments**

***//2005/ The DFH continued to work to reduce the number of deaths to children ages 14 years old and younger caused by motor vehicle crashes. In FY2003, the DFH's Family Outreach Program (FOP) continued to provide families with young children culturally and linguistically appropriate information regarding the proper use of care seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low-income families receiving FOP home visits were referred to RI Safe Kids which, among other things, provides free car seats and auto safety education.***

***The DFH's Healthy Child Care RI (HCCRI) initiative continued to provide culturally and linguistically appropriate informational materials to families with children in child care and to child care providers through the Child Care Support Network (CCSN). HHCRI also continued to support training and resource materials to the child care community on the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat) through the state's child care training agencies //2005//.***

**b. Current Activities**

***//2005/ The DFH continues to work to reduce the number of deaths to children ages 14 years old and younger caused by motor vehicle crashes. In FY2004, the DFH's Family Outreach Program (FOP) 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 FOP home visits continue to be referred to RI Safe Kids which, among other things, provides free car seats and auto safety education.***

***The DFH's Healthy Child Care RI (HCCRI) initiative continues to provide culturally and linguistically appropriate informational materials to families with children in child care and to child care providers through the Child Care Support Network (CCSN). HHCRI also continues to support training and resource materials to the child care community on the proper use of care seats, air bag safety, and the safest location in the car for children (i.e. the back seat) through the state's child care training agencies //2005//.***

**c. Plan for the Coming Year**

***//2005/ The DFH will continue to work to reduce the number of deaths to children ages 14 years old and younger caused by motor vehicle crashes. In FY2005, the DFH's Family Outreach Program (FOP) will continue to provide families with young children culturally and linguistically appropriate information regarding the proper use of care seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low income families receiving FOP home visits will continue to be referred to RI Safe Kids which, among other things, provides free car seats and auto safety education.***

**The DFH's Healthy Child Care RI (HCCRI) initiative will continue to provide culturally and linguistically appropriate informational materials to families with children in child care and to child care providers, particularly family home childcare providers, through the Child Care Support Network (CCSN). HHCRI will also continue to support training and resource materials to the child care community on the proper use of care seats, air bag safety, and the safest location in the car for children (i.e. the back seat) through the state's child care training agencies //2005//.**

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

**a. Last Year's Accomplishments**

**//2005/ The DFH continued to work to increase the percentage of mothers who breastfeed their infants at hospital discharge. In FY2003, the DFH's WIC Program continued to support the Tender Loving Care (TLC) breastfeeding support program for WIC participants 6 days a week in birthing hospitals. It also continued to support a "mother-to-mother" peer-counseling program to provide culturally competent breastfeeding support to WIC participants at up to 22 sites. The WIC Program continued to support infant feeding classes for expectant mothers on WIC to inform them about the benefits of breastfeeding as a preferable alternative to formula feeding at two local WIC sites.**

**In FY2003, the WIC Program continued to support World Breastfeeding Month, which was designed to encourage women to breastfeed their infants, by holding a statewide breastfeeding promotion event and promoting breastfeeding in local WIC clinics. In collaboration with the RI Breastfeeding Coalition and the DFH's WIC Program, the DFH's Communication Unit: 1) coordinated a Q & A series on breastfeeding and 2) conducted Grand Rounds with "Dr. Ruth" Lawrence during FY2003. In addition, the Physician's Committee on Breastfeeding in Rhode Island introduced legislation to ensure "safe places" for employees to pump breast milk. This legislation was signed into law in FY2003.**

**The WIC Program, in partnership with the DFH's Communications Unit, developed culturally and linguistically appropriate materials to support the DFH's goal to increase breastfeeding rates. A poster was developed to promote breastfeeding and World Breastfeeding Week. In addition, the Breastfeeding Resource Directory was revised and updated during FY2003. The DFH's Communications unit also continued to support the toll-free Family Health Information Line. Bi-lingual (English & Spanish) staff continued to take calls from breastfeeding women and refer them to appropriate community resources, in accordance with the DFH's breastfeeding protocol. In FY2003, a Family Health Information Line staff person participated in the breastfeeding peer counselor training program. The DFH's centralized Distribution Center continued to provide agencies and breastfeeding women with culturally and linguistically appropriate printed informational brochures on breastfeeding.**

**KIDSNET continued to track the percentage of mothers who breastfeed and the percentage of mothers who formula feed their infants through Family Outreach Program (FOP) data. The DFH continued to collect information on intended feeding practices at the time of hospital discharge as a part of the developmental risk screening process. The DFH's Pregnancy Risk Assessment Monitoring Program (PRAMS) surveyed new mothers on the topic of breastfeeding (PRAMS includes 5 questions related to breastfeeding). Families with infants who received FOP home visiting services received culturally and linguistically appropriate information and support on the topic of breastfeeding //2005//.**

b. Current Activities

*//2005/ The DFH continues to work to increase the percentage of mothers who breastfeed their infants at hospital discharge. The WIC Program supports the Tender Loving Care (TLC) breastfeeding support program for WIC participants 6 days a week in birthing hospitals. It also supports a "mother-to-mother" peer-counseling program to provide culturally competent breastfeeding support to WIC participants at 17 sites. WIC continues to support infant feeding classes for expectant mothers on WIC to inform them about the benefits of breastfeeding as a preferable alternative to formula feeding at two local WIC sites.*

*In FY2004, WIC will promote World Breastfeeding Month through the local media and at local WIC sites. The DFH has partnerships with the RI Breastfeeding Coalition and the Physicians' Committee for Breastfeeding in RI and has collaborated with these groups to develop a statewide breastfeeding promotion plan. Through this plan, the DFH engages worksites in program development to support breastfeeding mothers and to place culturally and linguistically appropriate campaign materials in the media and in provider's offices, with a special emphasis on low-income women and women from diverse cultures.*

*Bi-lingual Family Health Information Line staff take calls from breastfeeding women and refer them to appropriate community resources. The DFH's centralized Distribution Center provides CBOs and breastfeeding women with culturally and linguistically appropriate printed informational brochures on breastfeeding.*

*The DFH is working to develop a website with breastfeeding information and resources for parents, health care providers, and childcare providers. The DFH is in the process of developing posters for childcare providers with breast milk storage and handling instructions as well as resources for breastfeeding mothers and tips for helping mothers continue to breastfeed. The DFH conducted formative research with employers, which will be used to develop breastfeeding promotion materials for the workplace.*

*KIDSNET tracks the percentage of mothers who breastfeed and the percentage of mothers who formula feed their infants through FOP data. Families with infants who receive FOP home visiting services receive culturally and linguistically appropriate information and support on the topic of breastfeeding, including referrals to breastfeeding support services.*

*RI PRAMS continues to survey new mothers on the topic of breastfeeding. Data show that two-thirds (67%) of 2002 respondents indicated that they ever breastfed and 56% were still breastfeeding at the time of the survey (2-4 months post delivery) //2005//.*

c. Plan for the Coming Year

*//2005/ The DFH will continue to work to increase the percentage of mothers who breastfeed their infants at hospital discharge. In FY2005, the DFH's WIC Program will continue to support the Tender Loving Care (TLC) breastfeeding support program for WIC participants 6 days a week in birthing hospitals and will advocate for changes based on FY2004 evaluation results to ensure program effectiveness and compatibility with the host hospital. The DFH's WIC Program will also continue to support a "mother-to-mother" peer-counseling program to provide culturally competent breastfeeding support to WIC participants at 17 sites. The WIC Program will continue to support infant*

**feeding classes for expectant mothers on WIC to inform them about the benefits of breastfeeding as a preferable alternative to formula feeding at two local WIC sites.**

**The WIC Program will continue to support World Breastfeeding Month, which was designed to encourage women to breastfeed their infants. In FY2005, the DFH will continue to partner with the RI Breastfeeding Coalition and the Physicians' Committee on Breastfeeding in RI and to collaborate with these groups and other health care organizations throughout the state to implement the statewide breastfeeding promotion plan. Through this plan, the DFH will continue to engage worksites in program development to support breastfeeding mothers and to place linguistically and culturally appropriate campaign materials in the media and in provider's offices, with a special emphasis on low-income women and women from diverse cultures.**

**Based on formative research conducted in FY2004, the DFH will develop breastfeeding promotion materials for worksites, pretest them, produce them, and distribute them to worksites in FY2005. In addition, a mechanism for recognizing breastfeeding-friendly worksites (e.g. awards and advertisements in business journals) will be implemented. The DFH will develop culturally appropriate breastfeeding brochures for WIC and community distribution. The development process will include formative research with WIC mothers. Breastfeeding information will be integrated into a packet of prenatal materials to be distributed to prenatal care providers.**

**KIDSNET will continue to track the percentage of mothers who breastfeed and the percentage of mothers who formula feed their infants through FOP data. Families with infants who receive FOP home visiting services will continue to receive culturally and linguistically appropriate information and support on the topic of breastfeeding, including referrals to breastfeeding support services. The DFH will continue to collect information on intended feeding practices at the time of hospital discharge as a part of the developmental risk screening process. RI PRAMS will continue to survey new mothers on the topic of breastfeeding (PRAMS includes 5 questions related to breastfeeding) //2005//.**

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

**a. Last Year's Accomplishments**

**/2005/ The DFH continued to work to reduce the morbidity associated with hearing impairment through early detection. In FY2003, the DFH's RI Hearing & Assessment Program (RIHAP) continued to ensure that all newborns received hearing screening prior to hospital discharge. The DFH continued to utilize KIDSNET to track RIHAP screening information, which originates through the DFH's newborn screening process.**

**During FY2003, KIDNET developed a report, which is sent to RIHAP monthly. The report indicates which children born in the previous month do not have a hearing screening result in KIDSNET. RIHAP then follows up to identify whether the child was missed or if the data was never entered into KIDSNET. The DFH worked to link the newborn hearing screening data with other newborn data. This included plans for pre-populating the newborn hearing screening database with birth information collected on a new, integrated newborn developmental risk assessment and birth certificate system. This will ensure that all babies get screened for hearing impairment.**

**The DFH's Newborn Screening Program collaborated with the DFH's Communications Unit to begin the process for developing integrated culturally and linguistically**

**appropriate informing brochures (prenatal, perinatal, and postnatal) for families that includes bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET. During FY003, stakeholder surveys and focus groups with parents were completed.**

**The DFH's Pregnancy Risk Assessment Monitoring System (PRAMS) worked with the DFH's Newborn Screening Program to develop a state specific question regarding parental knowledge that babies are tested in the hospital for hearing impairment.**

**Infants who are identified with hearing impairment prior to discharge were referred to the RI School for the Deaf's Family Guidance Program, which provides families with children with hearing impairment with culturally and linguistically appropriate information and referrals. FOP home visitors also continued to track infants who are lost to follow-up by RIHAP. Families with children with a hearing impairment continued to be referred to the DFH's Early Intervention (EI) Program //2005//.**

#### **b. Current Activities**

**//2005/ RIHAP ensures that all newborns received hearing screening prior to hospital discharge. The DFH utilizes KIDSNET to track RIHAP screening information, which originates through the DFH's newborn screening process. Infants who are identified with hearing impairment are referred to the RI School for the Deaf's Family Guidance Program and EI. FOP home visitors also continue to track infants who are lost to follow-up by RIHAP.**

**KIDNET developed a report, which is sent to RIHAP monthly. The report indicates which children born in the previous month do not have a hearing screening result in KIDSNET. RIHAP then follows up to identify whether the child was missed or if the data was never entered into KIDSNET. The DFH has begun to work on linking the newborn hearing screening data with other newborn data. This includes plans for pre-populating the newborn hearing screening database with birth information collected on a new, integrated newborn developmental risk assessment and birth certificate system. This will ensure that all babies get screened for hearing impairment.**

**A grant was secured to link school hearing data to KIDSNET. Since primary care providers, school nurse teachers, and audiologists all have access and are working with KIDSNET, the hope is to better facilitate tracking, diagnostic audiology, and follow-up of school-age children who fail their hearing screening.**

**A flow chart, or algorithm, for primary care providers of infants who were referred from the DFH for diagnostic hearing testing was developed by modifying a document produced by the AAP and the "EHDI" community. Contract language for pediatric audiologists and EI sites in the state was developed. The first set of contracts was put in place during FY2004.**

**A list of pediatric audiologists in the state was compiled. Gaps in equipment needed to comply with pediatric audiology guidelines were identified through the DFH's HRSA "First Connections" grant. Several of these gaps have been or are in the process of being corrected.**

**Draft informing brochures have been developed by the DFH, based on survey and focus group results. An integrated informing approach was used and includes bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET. The DFH will develop a strategy to distribute the informing brochures to prenatal, hospital,**

**and pediatric health providers. The goal is to assure that the providers understand their role in the newborn screening informing process, routinely give materials to their patients, and answer questions from their patients.**

**RI PRAMS developed a state specific question regarding parental knowledge that babies are tested in the hospital for hearing impairment. Nearly 9 out of every 10 respondents (89.5%) in 2002 indicated that they were aware of the hearing test //2005//.**

**c. Plan for the Coming Year**

**/2005/ RIHAP will ensure that all newborns received hearing screening prior to hospital discharge. The DFH will utilize KIDSNET to track RIHAP screening information, which originates through the DFH's newborn screening process. Infants who are identified with hearing impairment will continue to be referred to the RI School for the Deaf and to EI. FOP home visitors will also continue to track infants who are lost to follow-up by RIHAP.**

**KIDSNET will continue to send a report to RIHAP monthly. The report indicates which children born in the previous month do not have a hearing screening result in KIDSNET. RIHAP will continue to follow up to identify whether the child was missed or if the data was never entered into KIDSNET. IN FY2005, RIHAP will implement a data system upgrade which will include capacity to pre-populate records using the new electronic integrated birth certificate and newborn developmental risk assessment system. A common ID will allow linkage to other data in KIDSNET. KIDSNET will utilize FY2005 to make its planned web version of KIDSNET available to audiologists. Also, KIDSNET will look into the possibility of obtaining school late onset hearing results in addition to newborn hearing screening results.**

**The Communication Unit, in collaboration with the DFH's Newborn Screening Program, is continuing with its plans to develop an integrated informing strategy targeting families about newborn screening programs, including RIHAP. Formative research conducted in 2003 will be used to guide the development and implementation of the informing strategy. The informing strategy will include new culturally and linguistically appropriate informational materials on hearing screening for families.**

**An SSDI grant was secured to link school hearing data to KIDSNET. Since primary care providers, school nurse teachers, and audiologists all have access and are working with KIDSNET, the hope is to better facilitate tracking, diagnostic audiology, and follow-up of school-age children who fail their hearing screening. Developing a school hearing screening database, exploring methods to populate it, and connecting and training school nurse teachers and audiologists will take place during FY2005.**

**Contract language for pediatric audiologists and Early Intervention sites was developed and the first set of contracts was put in place during FY2004. The DFH will utilize FY2005 to encourage additional EI/Audiology contracts to facilitate the inclusion of Audiologists in IFSP development.**

**The DFH's Birth Defects Surveillance Initiative (BDSI) will continue to work with the DFH's Newborn Screening Program to ensure that a final diagnosis of hearing loss in an infant is recorded and reported to the BDSI. In addition, RI PRAMS will continue to survey new mothers regarding parental knowledge that babies are tested in the hospital for hearing impairment //2005//.**

a. Last Year's Accomplishments

***/2005/ The DFH continued to work to ensure access to needed and continuous health care services for children. Much of the DFH's work in this area in FY2003 continued to center on ensuring that eligible families are enrolled in Rlte Care and other state-sponsored financial assistance programs. In addition, the DFH focused on training to reflect recent changes to Rlte Care. The DFH continued to support culturally diverse Family Resource Counselors (FRCs) in 12 health centers and 4 outpatient hospital clinics to identify and enroll eligible families into Rlte Care. The DFH continued to provide training to FRCs through quarterly meetings, special topics trainings, and on-site technical assistance. Training was provided in collaboration with the RI Department of Human Services (RIDHS), the RI Health Center Association (RIHCA), and Covering Kids RI.***

***Family Health Information Line information specialists and DFH parent consultants continued to receive training about Rlte Care and assisted with outreach activities. Family Health Information Line Staff continued to refer callers without health insurance to Rlte Care and referred them to FRCs in the community for further assistance in completing applications. DFH parent consultants continued to provide information about Rlte Care in numerous schools, childcare centers, health fairs, and community agencies.***

***DFH FOP home visitors continued to help families fill out Rlte Care enrollment forms and put them in touch with FRCs, who helped them complete the enrollment process. The Family Planning, SBHC, COZ, Immunization, Lead Screening, and WIC programs continued to refer families without health insurance to FRCs. The DFH's EI Program continued to refer potentially eligible families to fee-for-service Medicaid, SSI, and Katie Beckett. The DFH's HCCRI initiative continued to utilize childcare settings throughout the state to outreach to families potentially eligible for Rlte Care.***

***The DFH's RLP, Newport County CATCH, and Mt. Hope CATCH systems development initiatives continued to support community assessment and planning activities designed to increase utilization of maternal & child health services, including Rlte Care. RLP, Newport County CATCH, and Mt. Hope CATCH plans focus on issues related to "medical homes" and care coordination. Ensuring that eligible families are enrolled in Rlte Care represents an important part of the DFH's work in this area.***

***It is also important to point out that the DFH's RI PRAMS surveyed women 2-4 months after delivery and asked about their baby's health insurance status. This information will be used to assess whether women have different access experiences based on their health insurance status //2005//.***

b. Current Activities

***/2005/ The DFH is working to ensure access to needed and continuous health care services for children. Much of the DFH's work in this area centers on ensuring that eligible families are enrolled in Rlte Care and other state-sponsored financial assistance programs. The DFH has been focusing on training to reflect recent changes to Rlte Care. The DFH supports culturally diverse FRCs in 12 health centers and 4 outpatient hospital clinics to identify and enroll eligible families into Rlte Care. The RIHCA now has an expanded contract through RIDHS, which supports intensive technical assistance, training, and quality assurance for the FRC Program.***

***Family Health Information Line information specialists and DFH parent consultants***

**continue to receive training about Rlte Care and assist with outreach activities. Staff refer callers without health insurance to Rlte Care and refer them to FRCs in the community for further assistance in completing applications. DFH parent consultants provide information about Rlte Care in numerous schools, childcare centers, health fairs, and CBOs.**

**FOP home visitors help families fill out Rlte Care enrollment forms and put them in touch with FRCs, who helped them complete the enrollment process. The Family Planning, COZ, Immunization, and WIC programs refer families without health insurance to FRCs. The EI Program refers potentially eligible families to fee-for-service Medicaid, SSI, and Katie Beckett. HCCRI utilizes childcare settings throughout the state to outreach to families potentially eligible for Rlte Care.**

**The DFH ensures access to critical health and mental health services to teens in school through SBHCs. The DFH is working on an evaluation model linking school-based health data for key health conditions with time lost from school. The DFH is working with CHCs and schools to address technical issues to facilitate the evaluation process. SBHCs are developing strategies to ensure that teens that have parental permission to be seen at a SBHC are seen at least once during the school year. A risk questionnaire given to students at preventive health visits is being revised.**

**The RLP, Mt. Hope CATCH, and Newport County CATCH initiatives continue to support community assessment and planning activities designed to increase utilization of MCH services, including Rlte Care. These plans focus on issues related to "medical homes" and care coordination. Ensuring that eligible families are enrolled in Rlte Care represents an important part of the DFH's work in this area.**

**RI PRAMS data are being analyzed to determine health insurance coverage among women and their babies. Preliminary data indicate that less than 5% (4.65%) of respondents indicated that they did not have health insurance for their baby. Of those that did have health insurance for their baby (95.35%), 46.9% were covered by Medicaid or Rlte Care //2005//.**

**c. Plan for the Coming Year**

**/2005/ Much of the DFH's work in this area will continue to center on ensuring that eligible families are enrolled in Rlte Care and other financial assistance programs. The DFH will support FRCs in 10 health centers and 4 outpatient hospital clinics to identify and enroll eligible families into Rlte Care. The DFH will ensure that FRCs are trained on RIDHS's universal application form that includes Rlte Care, Food Stamps, FIP, and the state's child care subsidy program. The RIHCA now has an expanded contract through RIDHS, which supports TA, training, and QA for the FRC Program.**

**Family Health Information Line information specialists and DFH parent consultants will receive similar training about changes to Rlte Care and assist with outreach activities. Staff will refer callers without health insurance to Rlte Care and refer them to FRCs for further assistance in completing applications. DFH parent consultants will provide information about Rlte Care in numerous schools, childcare centers, health fairs, and CBOs.**

**FOP home visitors help families fill out Rlte Care enrollment forms and put them in touch with FRCs, who help them complete the enrollment process. The Family Planning, COZ, Immunization, and WIC programs will refer families without health insurance to FRCs. EI will refer potentially eligible families to SSI and Katie Beckett. EI service coordinators will be trained on RIDHS's plan to transfer CSHCN from fee-for-service**

**Medicaid to Rlte Care. HCCRI will utilize childcare settings throughout the state to outreach to families potentially eligible for Rlte Care. DFH parent consultants will continue to be members of the RIDHS's Rlte Care Consumer Advisory Committee.**

**The DFH will implement an evaluation plan in at least 2 SBHCs. The DFH will work with the SBHCs to ensure that data is reported in a timely and consistent fashion. The SBHCs will implement a risk behavior questionnaire at each preventive health visit. Information will be aggregated on site and be used to inform the development of health promotion programs targeting youth. The DFH will work with the SBHCs to ensure that students have access to family planning services within the framework of existing statutes and that consent forms are reflective of current state and federal statutes.**

**RLP, Newport County CATCH, and Mt. Hope CATCH will support community assessment and planning activities designed to increase utilization of MCH services, including Rlte Care. The DFH was awarded funding for Successful Start, a statewide systems development initiative that will assess capacity, quality, and integration issues surrounding 5 core components of RI's early childhood system. Successful Start expects to complete its comprehensive plan during FY2005.**

**RI PRAMS will continue to survey women and ask about their baby's health insurance status and analyze the survey data to get a better understanding of the needs of uninsured women who have babies //2005//.**

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

**a. Last Year's Accomplishments**

**/2005/ The DFH worked to enroll all Medicaid-eligible children in Medicaid to ensure better access to health care systems. Much of the DFH's work in this area in FY2003 continued to center on ensuring that eligible families are enrolled in Rlte Care and other state-sponsored financial assistance programs. In addition, the DFH focused on training to reflect recent changes to Rlte Care. The DFH supported culturally diverse Family Resource Counselors (FRCs) in 12 health centers and 4 outpatient hospital clinics to identify and enroll eligible families into Rlte Care. The DFH provided training to FRCs through quarterly meetings, special topics trainings, and on-site technical assistance. Training was provided in collaboration with the RI Department of Human Services (RIDHS) and Covering KIDS RI.**

**Bi-lingual DFH Family Health Information Line information specialists and DFH parent consultants received training about Rlte Care and assisted the DFH on outreach activities. Family Health Information Line Staff referred callers without health insurance to Rlte Care and referred them to FRCs in the community for further assistance in completing an application. DFH parent consultants provided information about Rlte Care in numerous schools, childcare centers, health fairs, and community agencies throughout RI.**

**The DFH's Family Outreach Program (FOP) home visitors helped families fill out Rlte Care enrollment forms and put them in touch with FRCs, who helped them complete the enrollment process. The DFH's Family Planning, School-Based Health Center (SBHC), Child Opportunity Zone (COZ), Immunization, Lead Screening, and WIC programs continued to refer families without health insurance to FRCs. The SBHC Program worked to increase the number of students enrolled in SBHCs during this period and to ensure that each child enrolled in a SBHC received a preventive health visit. DFH EI Program**

**service coordinators were trained about fee-for-service Medicaid, SSI, and Katie Beckett and referred families to these resources for appropriate follow-up. In FY2003, the EI Program moved to a fee-for-service based system and increased the number of centers providing services to 7. The DFH's Healthy Child Care RI (HCCRI) initiative utilized childcare settings throughout the state to outreach to families potentially eligible for Rlte Care.**

**The DFH's Ready to Learn Providence (RLP), Newport County CATCH, and Mt. Hope CATCH systems development initiatives supported community assessment and planning activities designed to increase utilization of maternal & child health services, including Rlte Care. RLP, Newport County CATCH, and Mt. Hope CATCH plans focus on issues related to "medical homes" and care coordination. Ensuring that eligible families are enrolled in Rlte Care represents an important part of the DFH's work in this area**

**During FY2003, the DFH's RI PRAMS surveyed women 2-4 months post delivery. RI PRAMS includes questions about health insurance status //2005//.**

#### **b. Current Activities**

**/2005/ The DFH is working to enroll all Medicaid-eligible children in Medicaid to ensuring better access to health care. Much of the DFH's work in this area in FY2003 continues to center on ensuring that eligible families are enrolled in Rlte Care and other state-sponsored financial assistance programs. The DFH is focusing on training to reflect recent changes to Rlte Care. The DFH is supporting culturally diverse FRCs in 12 health centers and 4 outpatient hospital clinics to identify and enroll eligible families into Rlte Care. The RI Health Center Association (RIHCA) now has an expanded contract through RIDHS, which supports intensive technical assistance, training, and quality assurance for the FRC Program.**

**Bi-lingual DFH Family Health Information Line information specialists and DFH parent consultants continue to receive training about Rlte Care and assist the DFH on outreach activities. Family Health Information Line Staff refer callers without health insurance to Rlte Care and refer them to FRCs in the community for further assistance in completing an application. DFH parent consultants are providing information about Rlte Care in numerous schools, childcare centers, health fairs, and community agencies throughout RI.**

**The DFH's FOP home visitors help families fill out Rlte Care enrollment forms and put them in touch with FRCs, who help them complete the enrollment process. The DFH's Family Planning, SBHC, COZ, Immunization, Lead Screening, and WIC programs refer families without health insurance to FRCs. SBHCs are working to increase the number of students enrolled in SBHCs during this period and to ensure that each child enrolled in a SBHC receives a preventive health visit. DFH EI Program service coordinators continue to trained about fee-for-service Medicaid, SSI, and Katie Beckett and continued to refer families to these resources for appropriate follow-up. In FY2003, the EI Program moved to a fee-for-service based system and increased the number of centers providing services to 7. The DFH's HCCRI initiative is utilizing childcare settings throughout the state to outreach to families potentially eligible for Rlte Care.**

**The DFH's RLP, Newport County CATCH, and Mt. Hope CATCH systems development initiatives support community assessment and planning activities designed to increase utilization of maternal & child health services, including Rlte Care. RLP, Newport County CATCH, and Mt. Hope CATCH plans focus on issues related to "medical homes" and care**

**coordination. Ensuring that eligible families are enrolled in Rlte Care represents an important part of the DFH's work in this area.**

**RI PRAMS data are being analyzed to determine health insurance coverage among women and their babies. Preliminary data indicate that less than 5% (4.65%) of respondents indicated that they did not have health insurance for their baby. Of those that did have health insurance for their baby (95.35%), 46.9% were covered by Medicaid or Rlte Care //2005//.**

**c. Plan for the Coming Year**

**//2005/ The DFH will work to enroll all Medicaid-eligible children in Medicaid to ensure better access to health care. Much of the DFH's work in this area in FY2005 will center on ensuring that eligible families are enrolled in Rlte Care and other state-sponsored financial assistance programs and that DFH staff are trained about recent changes to Rlte Care. The DFH will support culturally diverse FRCs in 10 health centers and 4 outpatient hospital clinics to identify and enroll eligible families into Rlte Care. The RIHCA now has an expanded contract through RIDHS, which supports intensive technical assistance, training, and quality assurance for the FRC Program. The DFH will continue to work to secure long-term funding for FRCs.**

**Bi-lingual DFH Family Health Information Line information specialists and DFH parent consultants will receive similar training about changes to Rlte Care and assist the DFH on outreach activities. Information Line staff will refer callers without health insurance to Rlte Care and refer them to FRCs in the community for further assistance in completing an application. DFH parent consultants will provide information about Rlte Care in schools, childcare centers, health fairs, and community agencies. DFH parent consultants will continue to be members of the RIDHS's Rlte Care Consumer Advisory Committee.**

**The DFH's FOP home visitors will help families fill out Rlte Care enrollment forms and put them in touch with FRCs, who help them complete the enrollment process. The DFH's Family Planning, SBHC, COZ, Immunization, and WIC programs will refer families without health insurance to FRCs. The DFH will work with SBHCS on strategies to ensure that students enrolled in a SBHC receive a preventive health visit. EI Program services coordinators will be trained on RIDHS's plan to transfer CSHCN from fee-for-service Medicaid to Rlte Care. The DFH's HCCRI initiative will utilize childcare settings to outreach to families potentially eligible for Rlte Care.**

**The DFH's RLP, Newport County CATCH, and Mt. Hope CATCH systems development initiatives will continue to support community assessment and implementation activities designed to increase utilization of MCH services, including Rlte Care. RLP, Newport County CATCH, and Mt. Hope CATCH plans focus on issues related to "medical homes" and care coordination. Ensuring that eligible families are enrolled in Rlte Care represents an important part of the DFH's work in this area. The DFH was awarded funding for Successful Start, a statewide systems development initiative that will assess capacity, quality, and integration issues surrounding 5 core components of RI's early childhood system. Successful Start expects to complete its comprehensive plan during FY2005.**

**RI PRAMS will continue to survey women and ask about their baby's health insurance status. RI PRAMS data will continue to be analyzed to better understand issues such as health insurance status and access to services //2005//.**

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

*//2005/ The DFH continued to work to reduce the proportion of all live deliveries with very low birth weight. In FY2003, the DFH continued to support the Title X Family Planning Program, which works to prevent unintended pregnancies and promote reductive health and well being. The DFH continued to support family planning services to women being discharged from the state prison. Brochures, posters, postcards, radio ads were developed in English and Spanish for the DFH's media campaign to increase family planning client utilization and the campaign was launched in FY2003.*

*The Family Planning Program also continued collaborate with the state laboratory and HEALTH's STD Program to screen women for Chlamydia to ensure healthier pregnancies (and prevent infertility). The DFH also continued to support vasectomies for uninsured and under-insured adult men as a way to help prevent unintended pregnancies. The DFH continued to distribute brochures and to run periodic radio ads about the Vasectomy Program, in English and Spanish, in FY2003.*

*The DFH also continued to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 of the DFH's 10 federally funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks continue were referred to Rlte Care and WIC through FRCS, early prenatal care, and other community-based supports early in pregnancy. Pregnant women can also be referred to the DFH's FOP. FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rlte Care).*

*In FY2003, the DFH implemented the "Keep Your Baby Lead Safe" Program in Providence. Pregnant women were referred to the DFH's FOP for a prenatal visit, including lead education and linkage to lead hazard reduction services through local HUD funding. Adequate funding for prenatal home visiting services remains a concern.*

*The DFH's Ready to Learn Providence (RLP), Newport County CATCH, and Mt. Hope CATCH systems development initiatives continued to support community assessment and planning activities designed to increase utilization of maternal & child health services, including Rlte Care. RLP, Newport County CATCH, and Mt. Hope CATCH plans focus on issues related to "medical homes" and care coordination. Preventing low birth weight babies represents an important part of the DFH's work in this area.*

*During FY2003, RI PRAMS surveyed women who delivered low birth weight (including very low birth weight) infants to better understand the mother's experiences and behavior, before, during, and after pregnancy. This information may help provide a better understanding of the factors that may contribute to poor birth outcomes such as low birth weight and very low birth weight //2005//.*

## b. Current Activities

*/2005/ The DFH continues to work to reduce the proportion of all live deliveries with very low birth weight. The DFH continues to support the Title X Family Planning Program, which works to prevent unintended pregnancies and promote reductive health and well-being. The DFH continues to support family planning services to women being discharged from the state prison. The Family Planning Program also continues collaborate with the state laboratory and HEALTH's STD Program to screen women for Chlamydia to ensure healthier pregnancies (and prevent infertility). The DFH also continues to support vasectomies for uninsured and under-insured adult men as a way to help prevent unintended pregnancies. The DFH continued to distribute brochures & run periodic radio ads in English and Spanish.*

*The DFH also continues to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 of the DFH's 10 federally funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks continue to be referred to Rlte Care and WIC through FRCS, early prenatal care, and other community-based supports early in pregnancy. The DFH's WHSRP has also been working with the DFH's Childhood Lead Poisoning Prevention Program (CLPPP) to identify newly pregnant women and encourage their participation in the DFH's "Keep Your Baby Lead Safe" Program. Pregnant women can also be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rlte Care). Adequate funding for prenatal home visiting services remains a concern.*

*The DFH's Ready to Learn Providence (RLP), Newport County CATCH, and Mt. Hope CATCH systems development initiatives continue to support community assessment and planning activities designed to increase utilization of maternal & child health services, including Rlte Care. RLP, Newport County CATCH, and Mt. Hope CATCH plans focus on issues related to "medical homes" and care coordination. Preventing low birth weight babies represents an important part of the DFH's work in this area.*

*During FY2003, RI PRAMS surveyed women who delivered low birth weight (including very low birth weight) infants to better understand the mother's experiences and behavior, before, during, and after pregnancy. During FY2004, the DFH has been analyzing data, including comparing birth weight and other variables such as stresses experienced prior to delivery, to determine factors associated with low birth weight.*

*Lastly, the DFH is working closely with the RI Chapter of the March of Dimes, Women & Infants Hospital, OB/GYNs, and other partners to develop statewide initiatives to reduce prematurity. Currently, this group is planning to hold a prematurity awareness day in October of 2004 //2005//.*

## c. Plan for the Coming Year

*/2005/ The DFH will continue to work to reduce the proportion of all live deliveries with very low birth weight. The DFH will support the Title X Family Planning Program, which works to prevent unintended pregnancies and promote reductive health and well-being. The DFH will support family planning services to women being discharged from the state prison. The DFH's family planning media campaign ended in FY2003 after increasing client utilization by 20% in FY2003 over FY2001. The DFH will revise and improve current informational materials for family planning clients. The Family Planning*

**Program will continue collaborate with the state laboratory and HEALTH's STD Program to screen women for Chlamydia. The DFH will continue to support vasectomies for uninsured and under-insured adult men, distribute program brochures, and run periodic radio ads.**

**The DFH will continue to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 of the DFH's 10 federally funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks will continue to be referred to Rlte Care and WIC through FRCS, early prenatal care, and other community-based supports early in pregnancy. The WHSRP will continue to work with the DFH's Childhood Lead Poisoning Prevention Program (CLPPP) to identify newly pregnant women and encourage their participation in the CLPPP's "Keep Your Baby Lead Safe" Program. Pregnant women can also be referred to the DFH's FOP. FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rlte Care). Adequate funding for prenatal home visiting services remains a concern. The DFH will explore additional sources of funding for prenatal home visiting services.**

**The DFH's RLP, Newport County CATCH, and Mt. Hope CATCH systems development initiatives will continue to support community assessment and implementation activities designed to increase utilization of MCH services, including Rlte Care. These plans focus on issues related to "medical homes" and care coordination. Preventing low birth weights represent an important part of the DFH's work in this area. More recently, the DFH was awarded funding for Successful Start, a statewide systems development initiative that will assess capacity, quality, and integration issues surrounding 5 core components of RI's early childhood system. Successful Start expects to complete its comprehensive plan to integrate and improve early childhood systems in RI during FY2005.**

**The DFH will continue to analyze PRAMS data to determine the association of factors, such as access to prenatal care, pregnancy intent, and time during pregnancy, with low birth weight. Lastly, the DFH will continue to work closely with the RI Chapter of the March of Dimes & other partners to develop statewide initiatives to reduce prematurity //2005//.**

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

**a. Last Year's Accomplishments**

**/2005/ During FY2003, the DFH continued to work to eliminate self-induced, preventable morbidity and mortality among youths ages 15-19 years. In FY2003, the DFH's 7 School-Based Health Centers (SBHCs) continued to provide teenagers with access to no cost comprehensive preventive health and mental health services in racially and ethnically diverse communities. Teens in need of mental health services were referred for appropriate follow-up.**

***In FY2003, the DFH continued to address responses to its FY2002 statewide adolescent media campaign, titled "Be There For Teens". Consumers who called the DFH's Family Health Information Line were provided with "Ten Tips on Parenting Teens" and referrals to the Men 2 B Program. Due to staffing priority shifts, a second wave of the campaign was postponed and focus was placed on collaborating with the children's cabinet to develop an umbrella theme and unifying messages directed to parents of teens.***

***The DFH also continued to support the MEN 2B Program in Pawtucket/Central Falls, Newport, Providence, and Woonsocket to train adult males to be effective role models to boys. Men 2B, which is funded with Title V abstinence education funds, promotes abstinence from sexual intercourse, violence and substance abuse among pre-adolescent and adolescent boys. Training continued to include information on normal adolescent behavior, communications skills, and identifies when and where to refer youth for help with mental health and/or substance abuse issues.***

***Results of evaluation data demonstrate effectiveness of Men 2B and role model behavior change. Outreach materials were developed in FY2002 and were used in FY2003 used to increase Men 2B enrollment in worksites, schools, and faith-based organizations in RI.***

***The DFH also continued to participate in a regional suicide prevention project, titled the Northeast Injury Prevention Project, in collaboration with HEALTH's Division of Disease Prevention & Control (DPC) in FY2003. The Rhode Island Team developed a suicide prevention framework for Rhode Islanders ages 15-24 years.***

***As an outgrowth of the DFH's work on the Northeast Injury Prevention Project (NEIPP), the DFH, in collaboration with HEALTH's DPC, assisted the RI Training School for Boys with an application for funding for a project to decrease suicide attempts at the school. The Training School is the state's correctional facility for youth. The DFH also began to participate on a statewide children's mental and behavioral health work group during FY2003.***

***Lastly, the DFH's Regional Center for Poison Control & Prevention (RCPCP) reported, and continues to report, data on intentional self-poisonings among teens. The RCPCP and its advisory committee continued to monitor and develop strategies to address intentional self-poisonings among youth in RI during FY2003 //2005//.***

#### **b. Current Activities**

***/2005/ The DFH continues to work to eliminate self-induced, preventable morbidity and mortality among youths ages 15-19 years. In FY2004, the DFH's 7 School-Based Health Centers (SBHCs) continue to provide teenagers with access to no cost comprehensive preventive health and mental health services in racially and ethnically diverse communities. Teens in need of mental health services are referred for appropriate follow-up.***

***In FY2004, the DFH continues to address responses to its FY2002 statewide adolescent media campaign, titled "Be There For Teens". Consumers who called the DFH's Family Health Information Line continue to be provided with "Ten Tips on Parenting Teens" and referrals to the Men 2 B Program. In FY2004, focus was placed on collaborating with the Children's Cabinet to develop an umbrella theme and unifying messages directed to parents of teens.***

***The DFH also continues to support the MEN 2B Program in Pawtucket/Central Falls,***

**Newport, Providence, and Woonsocket to train adult males to be effective role models to boys. Men 2B, which is funded with Title V abstinence education funds, promotes abstinence from sexual intercourse, violence and substance abuse among pre-adolescent and adolescent boys. Training continues to include information on normal adolescent behavior, communications skills, and identifies when and where to refer youth for help with mental health and/or substance abuse issues.**

**Preliminary results of evaluation data demonstrate effectiveness of Men 2B and role model behavior change. Outreach materials were developed in FY2003 and are being used to increase Men 2B enrollment in worksites, schools, and faith-based organizations in RI.**

**The DFH continues to participate on the statewide children's mental and behavioral health work group. The work group has selected three priority areas for focused attention. Priority areas include data/research/evaluation; current state/community/school initiatives; and communications/collaboration. Members of the work group are working with a planning team to convene a summit of high-level stakeholders to work with the National Center for Mental Health in Schools.**

**In FY2004, the DFH collaborated with HEALTH's Division of Disease Prevention & Control (DDPC) on an application to CDC which, if funded, would enhance state capacity to address child and adolescent health through violence prevention.**

**Lastly, the DFH's Regional Center for Poison Control & Prevention (RCPCP) reported, and continues to report data on intentional self-poisonings among teens. The RCPCP and its advisory committee continue to monitor and develop strategies to address intentional self-poisonings among youth in RI //2005//.**

**c. Plan for the Coming Year**

**//2005/ The DFH will continue to work to eliminate self-induced, preventable morbidity and mortality among youth ages 15-19 years. In FY2005, the DFH's 8 School-Based Health Centers (SBHCs) will continue to provide teenagers with access to no cost comprehensive preventive health and mental health services. Recently, the Town of West Warwick implemented a new SBHC and a statewide technical school is exploring funding strategies to support a SBHC there. SBHC teens in need of mental health services will continue to be referred for appropriate follow-up.**

**In FY2005, the DFH will continue to implement an on-line resource directory for parents of 9 to 17 year olds. The directory is intended to help parents and other adults build meaningful relationships with pre-teens and teens and meet their developmental needs. The directory reflects an umbrella theme with the goal of unifying messages from a range of providers and other partners and builds on the DFH's statewide adolescent media campaign. Issues related to the mental health needs of youth are included.**

**The DFH will continue to support the Men 2B Program. Outreach materials developed in FY2003 will continue to be used to increase enrollment in worksites, schools, and faith-based organizations in RI. Analysis of Men 2B evaluation data will be published to demonstrate program effectiveness and to solicit partnerships with sponsoring programs. Men 2B training continues to include information on normal adolescent behavior, communications skills, and identifies when and where to refer youth for help with mental health and/or substance abuse issues.**

**The DFH will continue to participate in a statewide children's mental and behavioral**

**health work group. Adequate mental health service capacity for youth remains a concern in RI. Next steps will include implementation of a child and adolescent violence prevention work group, if funded by CDC. The group will develop a strategic plan that delineates shared risk and protective factors and identifies strategies that address ecological factors that influence and prevent violence, including suicide.**

**Lastly, the DFH's Regional Center for Poison Control & Prevention (RCPCP) will continue to report data on intentional self-poisonings among teens. The RCPCP and its advisory committee will continue to monitor and develop strategies to address intentional self-poisonings among youth //2005//.**

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

**a. Last Year's Accomplishments**

**/2005/ The DFH continued to work to ensure that high-risk mothers and newborns deliver at appropriate hospital levels. The majority of RI's high-risk pregnancies are delivered at Women & Infants Hospital, which is appropriately staffed and equipped to care for high-risk admissions. In FY2003, 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 9 of the DFH's 10 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. Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assessed women for low birth weight risks and ensured that women are linked to appropriate prenatal care and financial resources (i.e. Rlte Care).**

**A pediatric development physician working as a consultant for the DFH at the Child Development Center (CDC) continued to provide training to personnel at the NICU at Women & Infants Hospital to help ensure that infants who are delivered in a high-risk facility were referred to the DFH's Early Intervention (EI) Program prior to discharge. The DFH's Newborn Screening Program worked with the DFH's EI Program to improve the numbers of low birth weight babies who are referred to the EI Program at the time of hospital discharge. In RI, very low birth weight is considered to be a "single established condition", and low birth weight babies are automatically eligible for EI services. Physician materials developed by the DFH's Communication Unit for the EI Program were provided NICU staff with information on the other risk factors that make a child eligible for EI services as well during FY2003 //2005//.**

**b. Current Activities**

**/2005/ The DFH continues to work to ensure that high-risk mothers and newborns deliver at appropriate hospital levels. The majority of RI's high-risk pregnancies are delivered at Women & Infants Hospital, which is appropriately staffed and equipped to care for high-risk admissions. In FY2004, the DFH continues 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 9 of the DFH's 10 federally-funded 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. Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rlte Care).**

**A pediatric development physician working as a consultant for the DFH at the Child Development Center (CDC) continues to provide training to personnel at the NICU at Women & Infants Hospital to help ensure that infants who are delivered in a high-risk facility are referred to the DFH's Early Intervention (EI) Program prior to discharge. The DFH's Newborn Screening Program is working with the DFH's EI Program to improve the numbers of low birth weight babies who are referred to the EI Program at the time of hospital discharge. In RI, very low birth weight is considered to be a "single established condition", and low birth weight babies are automatically eligible for EI services. Physician materials developed by the DFH's Communication Unit for the EI Program continue to provide NICU staff with information on the other risk factors that make a child eligible for EI services as well //2005//.**

**c. Plan for the Coming Year**

**//2005/ The DFH will continue to work to ensure that high-risk mothers and newborns deliver at appropriate hospital levels. The majority of RI's high-risk pregnancies are delivered at Women & Infants Hospital, which is appropriately staffed and equipped to care for high-risk admissions. In FY2005, the DFH 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 services in 9 of the DFH's 10 federally-funded 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. Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rlte Care).**

**A pediatric development physician working as a consultant for the DFH at the Child Development Center (CDC) will continue to provide training to personnel at the NICU at Women & Infants Hospital to help ensure that infants who are delivered in a high risk facility are referred to the DFH's Early Intervention (EI) Program prior to discharge. The CDC is now a certified CEDARR Family Center. The DFH's Newborn Screening Program continues to work with the DFH's EI Program to improve the numbers of low birth weight babies who are referred to the EI Program at the time of hospital discharge. A protocol for referring very low birth weight babies to EI was developed. The DFH's efforts in this area will include working with hospital discharge planners at maternity hospitals with a NICU //2005//.**

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

**a. Last Year's Accomplishments**

***//2005/ The DFH continued to ensure early entry into prenatal care to enhance pregnancy outcomes. In FY2003, 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 9 of the DFH's 10 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.***

***Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assessed women for low birth weight risks and ensured that women were linked to appropriate prenatal care and financial resources (i.e. Rlte Care). They also stressed the importance of prenatal care. Adequate funding for prenatal home visits continues to be a concern.***

***In FY2003, the DFH's Lead Program implemented the "Keep your Baby Lead Safe" Program in Providence. Participating women were refereed through the WHSRP early in pregnancy. The FOP provided the participating women with education and referral to community resources, demonstration in proper lead cleaning techniques, collection of lead dust wipe samples analyzed by the state laboratory and, if eligible, referral to reduced cost lead hazard reduction work through the city of Providence.***

***The DFH's Family Resource Counselor (FRC) Program continued to support culturally diverse FRCs in 12 health centers and 4 hospital outpatient clinics to identify and enrolled pregnant women into Rlte Care, WIC, Food Stamps, and the Family Independence Program (FIP). Like the WHSRP, the FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.***

***The DFH's Communication Unit continued to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answered families' questions and referred them to appropriate community resources, including Rlte Care and FRCs. Culturally and linguistically appropriate informational materials were distributed through the Communication Unit's centralized Distribution Center.***

***The DFH's Newborn Screening Program continued to collect data on the adequacy of prenatal care among pregnant women in RI. This data is utilized to monitor the adequacy of prenatal care in the state. The DFH's Data & Evaluation Unit analyzes data.***

***In addition, RI PRAMS surveyed women 2-4 months post-delivery in FY2003. The survey includes 6 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 //2005//.***

**b. Current Activities**

***//2005/ The DFH continues to ensure early entry into prenatal care to enhance pregnancy outcomes. In FY2004, the DFH continues to support the WHSRP, which provides no-cost***

**pregnancy testing and comprehensive health risk assessment to women receiving services in 9 of the DFH's 10 federally-funded 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.**

**Pregnant women with health risks identified through the WHSRP can be referred to the DFH's FOP. FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rlte Care). They also stress the importance of prenatal care. FOP promotional materials (brochures and posters) are mailed to all OB/GYN practices across the state quarterly. The goal is to increase the number of pregnant women who are referred to the FOP. However, adequate funding for prenatal home visits continues to be a concern.**

**In FY2003, the DFH's Lead Program implemented the "Keep your Baby Lead Safe" Program. Participating women are referred through the WHSRP early in pregnancy. The FOP provides the participating women with education and referral to community resources, demonstration in proper lead cleaning techniques, collection of lead dust wipe samples analyzed by the state laboratory and, if eligible, referral to weatherization and/or lead hazard reduction work through different funding agencies.**

**The DFH's FRC Program continues to support culturally diverse FRCs in 12 health centers and 4 hospital outpatient clinics to identify and enroll pregnant women into Rlte Care, WIC, Food Stamps, and the FIP. Like the WHSRP, the FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy. The RI Health Center Association (RIHCA) now has an expanded contract through the RI RIDHS, which supports intensive technical assistance, training, and quality assurance for the FRC Program.**

**The DFH's Communication Unit continues to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answer families' questions and refer them to appropriate community resources, including Rlte Care and FRCs. Culturally and linguistically appropriate informational materials are distributed through the DFH's centralized Distribution Center.**

**The DFH's Newborn Screening Program continues to collect data on the adequacy of prenatal care among pregnant women in RI. This data is utilized to monitor the adequacy of prenatal care in the state. The DFH's Data & Evaluation Unit analyzes data. In addition, the DFH has been analyzing PRAMS data from respondents who delivered during 2002 to determine issues related to access to prenatal care, including barriers to care and maternal stressors //2005//.**

**c. Plan for the Coming Year**

**/2005/The DFH will work to ensure early entry into prenatal care to enhance pregnancy outcomes. In FY2005, the DFH will support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 of the DFH's 10 federally-funded 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. In FY 2005, the WHSRP and other programs and providers will refer pregnant women to the DFH's "Keep Your Baby Lead Safe" Program.**

**Pregnant women with health risks identified through the WHSRP can be referred to the DFH's FOP. FOP home visitors assess women for low birth weight risks and ensure that**

women are linked to appropriate prenatal care and financial resources (i.e. Rlte Care). They also stress the importance of prenatal care. Adequate funding for prenatal home visits continues to be a concern. For FY2005, FOP agencies will be encouraged to develop linkages with the obstetrical community and local referral resources.

The DFH will support culturally diverse FRCs in 10 health centers and 4 outpatient hospital clinics to identify and enroll eligible families into Rlte Care. Like the WHSRP, the FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy. The DFH will ensure that FRCs are trained on the RIHCA's new electronic reporting system. The RIHCA now has an expanded contract through the RIDHS, which supports intensive technical assistance, training, and quality assurance for the FRC Program. The WIC Program will refer uninsured pregnant women to Rlte Care and FRCs. For women who are over-income or uninsured WIC applicants, enrollment in Rlte Care will also confer adjunctive WIC eligibility.

The DFH's Communication Unit will support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answer families' questions and refer them to appropriate community resources, including Rlte Care and FRCs. Culturally and linguistically appropriate informational materials will be distributed through the DFH's centralized Distribution Center.

The DFH's Newborn Screening Program will collect data on the adequacy of prenatal care among pregnant women in RI through the newborn screening process. The number of prenatal visits and dates of care are collected by chart review on all births where prenatal care records are available and from the birth certificate worksheet in the absence of a prenatal care record. FY2004 saw the integration of data collection for this information through an electronic integrated birth certificate and newborn development risk assessment system. In addition, the DFH will conduct RI PRAMS and analyze existing data to determine factors associated with prenatal care //2005//.

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Ensures early newborn screening for 9 inherited conditions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Ensures appropriate follow-up for 9 inherited conditions including referral to the FOP & EI Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Tracks newborn screening and follow-up activity through an integrated data management system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Working to link newborn screening lab results with new electronic birth				

certificate system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Will develop a CQI plan, including capacity to check against electronic birth certificates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Is working to supply providers with newborn screening results (positives & negatives) immediately.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is working to ensure that final diagnoses are captured for birth defects surveillance purposes.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Surveys about 160 recent mothers each month as a part of PRAMS.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Will develop an integrated informing strategy to increase awareness about newborn screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Will utilize parent consultants to assist with the development of the informing strategy.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				
1. Coordinates the SSI Team, which includes parents, to address the needs of CSHCN eligible for SSI.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Conducts annual customer satisfaction & effective surveys of EI families.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Will continue to ensure that parents are involved in the EI Program's planning & QA process.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Will utilize parent consultants to develop informational materials & website for the EI Program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Will continue to utilize parent consultants to conduct outreach activities for the EI Program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ensures parent consultant involvement at the Child Development Center(CDC)for QA purposes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is working to build capacity for CSHCN in child care in "natural settings".	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Provides training, information, & TA to child care providers to help them accommodate CSHCN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Sustains a parent on the HCCRI Advisory board to address the child care needs of CSHCN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. Continues to support 7 statewide Early Intervention sites to ensure "medical homes" for young CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Tracks all children born as of 1/1/97 to ensure that all are linked to "medical home".	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

3. Refers children without a "medical home" for follow-up through home visiting services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Ensures that children who are eligible for EI are referred to the EI Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Ensures that lead exposed children < or = 6 years of age receive education, home inspections, and case management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Supports 7 SBHCS & is working to build mental health capacity in SBHCS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Supports school-linked COZS to connect children with "medical homes".	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Supports community needs assessment & planning in Providence & Newport County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Will implement statewide needs assessment and planning related to RI's early childhood system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Will help RIDHS implement CEDARR and transition CSHCN from fee-for service Medicaid to RITE Care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) 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)				
1. Will help RIDHS implement CEDARR and transition CSHCN from fee-for service Medicaid to Rite Care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to partner with Family Voices to advocate for more coverage for CSHCN w/ private coverage.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ensures that CSHCN in EI are linked to Medicaid/SSI/Katie Beckett.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is working to develop a "medical passport" with information for families with CSHCN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ensures that eligible families are screened and enrolled into Medicaid/Rite Care/SSI/Katie Beckett.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Provides training to ensure that FRCs are informed about changes to Rite Care and other programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Supports home visiting services which link families to Rite Care & other financing programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Supports a statewide toll-free telephone resource for families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Provides informational materials to families through a centralized distribution center.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. Supports 7 statewide EI sites, which provide specialty and sub-specialty services to young CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Will continue to work to identify children eligible for EI who have not				

accessed services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ensures parent involvement in EI program planning and QA activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Utilizes parents to conduct outreach and to develop informational materials for CSHCN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Will track infants identified through newborn screening to assess long-term participation in care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Will examine issues of access to genetics services, especially genetics counseling.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Will review RIHAP to determine strengths & weaknesses of the program in order to improve it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Working to improve reimbursement rates for audiologist participation in IFSPs & IEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Will implement statewide needs assessment & planning around RI's early childhood system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Will help RIDHS implement CEDARR and transtion CSHCN from fee-for-service Medciaid to RITE Care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Participates on the RI Transition Council.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Is working with partners to implement support services for transition for individuals 18-21.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Is working with other partners to implement a Medicaid Infrastructure Grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Will continue to produce and disemminate a Disability Data Book.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Supports a 3-year evaluation study of CSHCN who graduated from high school.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Ensures services for medically complex CSHCN up to age 21 years.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) 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.				
1. Ensures free immunizations to uninsured and under-insured children and vaccines to providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Conducts assesments/provides training/TA at licensed child care centers/Head Starts/kindergartens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Tracks immunization status of children born as of 1/1/97 and sends parents and providers reminders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Ensures follow-up and education to families with children who are behind on their immunizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Captures maternal Hepatitis B information and follows-up on infants with positive results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Assesses immunization status of WIC participants and refers children who are behind for follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Provides child care providers and families with immunization information through the CCSN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Will develop CQI plans with health insurance plans to further increase immunization rates.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Conducts statewide immunization communication activities, including development of new materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Supports school-linked COZs to provide families with immunization information.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Supports 7 SBHCS in urban communities and supports activities to increase SBHC enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Supports 10 Title X family planning clinics to prevent unintended pregnancies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Ensures no cost pregnancy testing and risk assessment and referral in Title X clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Links non-pregnant teens with family planning services and refers pregnant teens for follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Will create an on-line resource directory for parents of 9-17 year olds.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Developed informational materials for teens, parents of teens and other adults involved with teens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Provides training to adult men on how to become effective role models for boys.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Participates on a statewide network working to enhance programs for fathers in RI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Is working to develop a statewide infrastructure for school health programs in RI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Is working to build capacity for youth development activities and out-of-school time programs in RI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Supports the education/outreach component of an oral health program in 10 Providence schools.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Participates on the Oral Health Coordinating Team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

3. Tracks data on protective sealants through Providence Smiles, which provides sealants.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Ensures that WIC families receive oral health & early childhood caries information.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ensures child care providers receive oral health & early childhood caries information.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ensures families receiving home visits receive oral health & early childhood caries information.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Supports direct oral health services in 2 SBHCs on-site.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Supports direct oral health services in 4 SBHCs off-site.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Is working to build oral health capacity at 1 SBHC site.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Working with RIDHS to restructure Medicaid oral health service system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Ensures that families receiving FOP services obtain information on car seats and air bag safety.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ensures that low-income families receiving home visits are referred for free car seats.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provides child care providers and families with information on car seats and air bag safety.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Tracks this indicator through vital records data (rates are low in RI).	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Collaborates with RI Safe Kids, which provides free car seats and auto safety education.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Supports a breastfeeding support group for WIC participants at birthing hospitals.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Supports a mother-to-mother peer counseling program for WIC participants at 16 sites.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Supports feeding classes informing new mothers about the benefits of breastfeeding at 2 WIC sites.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Conducts statewide World Breastfeeding Month activities annually.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Is working to build breastfeeding support capacity in worksites in RI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Provides families with informational materials on breastfeeding.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Utilizes parent consultants to assist w/ development of breastfeeding informational materials.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Tracks the percentage of mothers who breastfeed through newborn risk assessment & FOP data.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Surveys about 160 recent mothers each month on breastfeeding through PRAMS.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Will continue to work with the Physicians' Breastfeeding Committee.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Ensures that all newborns receive hearing screening prior to discharge from the hospital.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Tracks hearing screening information, which originates through the newborn screening process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Sends reports to RIHAP monthly indicating children born the previous month who have no screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Will implement a data system upgrade to integrate data with birth certificate/newborn screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provides follow-up for families through the FOP & refers children w/ hearing impairment to EI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provides information to families w/ a child w/ hearing impairment through the FOP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Follows-up on lost children through the FOP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Will develop integrated informing strategy targeting families with a child w/ hearing impairment.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Will continue to work to ensure that final diagnoses are captured for birth defects surveillance.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Surveys about 160 recent mothers each month regarding parental knowledge about hearing screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Assists eligible families with the completion of applications for Rlte Care through FRCs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Supports a statewide toll-free telephone resource for families.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provides Rlte Care informational materials to families through a centralized distribution center.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provides training to ensure that FRCs & DFH staff are current on changes to Rlte Care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continued to assess & refer eligible families to FRCs/Rite Care through DFH programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Trained EI staff on Mediciad, SSI, & Katie Beckett.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Utilizes parent consultants to provide families with information about				

Rlte Care/SSI/Katie Beckett.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Supports community needs assessments and planning in Providence and Newport County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Will implement statewide needs assessment & planning around RI's early childhood system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Will help RIDHS implement CEDARR and transition CSHCN from fee-for-service Medicaid to Rlte Care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Assists eligible families with the completion of applications for Rlte Care through FRCs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Supports a statewide toll-free telephone resource & distribution center for families.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Assesses & refers eligible families to FRCs/Rlte Care through DFH programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Utilizes parent consultants to provide families with information about Rlte Care/SSI/Katie Beckett.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Supports community needs assessment, planning, and implementation in Providence and Newport County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Is implementing statewide needs assessment, planning, and implementation around RI's early childhood system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Will help RIDHS implement CEDARR and transition CSHCN from fee-for-service Medicaid to Rlte Care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Will provide training to ensure that FRCs and DFH staff are current on changes to Rlte Care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Will continue to work to increase enrollment and reimbursement in SBHCs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Will explore adding WIC to RIDHS's new integrated enrollment form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Supports 10 Title X family planning clinics to prevent unintended pregnancies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Developed & implemented statewide media campaign to increase Title X client utilization.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Ensures no cost pregnancy testing and risk assessment and referral in Title X clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Supports chlamydia screening and treatment & vasectomy services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provides pregnant women with home visiting services which assess for low birth weight risks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Working to secure additional sources of funding for home visiting services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

7. Assists pregnant women with the completion of applications for RItE Care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Supports community needs assessments and planning in Providence and Newport County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Will implement statewide needs assessment & planning around RI's early childhood system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Will work w/ MOD & other partners to develop statewide strategies to reduce prematurity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

1. Supports 7 SBHCs to provide teens with preventive health and mental/behavioral health services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Ensures SBHC students with mental/behavioral health concerns are linked to appropriate follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Will create an online resource directory for parents of 9-17 year olds.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Developed informational materials for teens, parents of teens and other adults involved with teens.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Provides training to adult men on how to become effective role models for boys.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Will provide TA to the RI Training School to address suicide attempts among boys.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is working to build capacity for youth development activities and out-of-school time programming.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Participated in a regional suicide prevention project and will develop suicide prevention materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Tracks data on intentional self-poisonings by youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Participates on the statewide children's mental health workgroup to build capacity in schools.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

1. Ensures no cost pregnancy testing and risk assessment and referral in Title X clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Ensures that pregnant women are referred to home visiting services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Is working to build capacity for prenatal home visiting services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provides training to NICU staff to ensure prompt referrals to EI.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Developed/distributed informational materials for providers/families on EI eligibility criteria.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Utilized parent consultants to help with the development of informational EI materials.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is working to improve the numbers of infants who are referred to EI prior to or at discharge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

8. Developed a protocol for referring infants to EI prior to or at discharge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Will provide training to hospital staff to ensure that eligible infants are referred to EI.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Ensures no cost pregnancy testing and risk assessment and referral in Title X clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Refers pregnant women for home visiting services to ensure that they are linked to prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provides pregnant women with information about the importance of prenatal care and lead-safe homes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assists pregnant women w/ the completion of applications for Rlte Care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Maintains a statewide toll-free telephone resource and distribution center.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Tracks information on prenatal care participation.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Ensures pregnant women have lead education and referral to lead hazard reduction work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Surveys about 160 recent mothers each month about their prenatal care through PRAMS.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Is analyzing PRAMS data from 2002 respondents to determine issues related to prenatal care access.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The number and percentage of children greater than or equal to 19 months old in childcare who are up-to-date on their immunizations.*

a. Last Year's Accomplishments

***/2005/ The DFH assessed childcare centers, Head Starts, and kindergartens and provided these sites with ongoing information and TA on current immunization recommendations and regulations. The DFH provided vaccine to all providers, free immunizations to uninsured children, and immunization education to providers and the public.***

***The DFH was the first in the nation to offer influenza vaccine to healthy children between the ages of 6 and 23 months. The DFH sponsored a press conference to publicize the new recommendation. A press release (English and Spanish) was sent to all print and electronic media outlets in the state.***

***The DFH sponsored an event at the Rhode Island Mall to raise awareness about the importance of immunizations for all ages. Families with young children were referred to primary care providers or free immunization clinics. The DFH hosted a conference for school nurse teachers and Head Start coordinators to provide up-to-date information on health topics, including immunizations.***

***KIDSNET sent the families of all newborns a congratulations card, which includes information about the importance of immunizations. KIDSNET tracked immunizations for all children born after 1/1/97 and sent reports to on-line PCPs regarding their patients' compliance with immunization protocols. PCPs can refer children who are behind on their immunizations to the FOP for assistance in facilitating immunizations. Auto-dial messages or mailed "well-child reminders" were sent to families at specified intervals. All Head Starts were connected to KIDSNET. KIDSNET assessed the immunization status of children enrolled in the EI Program.***

***KIDSNET captured maternal Hepatitis B information. Infants with Hepatitis B positive mothers were referred to the FOP to facilitate the completion of immunizations and treatment. The families of other children who are referred to the FOP received information regarding the importance of immunizations. The DFH assessed the immunization status of children receiving WIC services. Children who were behind on their immunizations were referred to their PCP or one of the free immunization clinics.***

***The DFH's HCCRI initiative provided childcare providers and families with culturally and linguistically appropriate immunization information through the CCSN. Information was targeted to both providers and families. HCCRI provided childcare providers with training and technical assistance on immunizations.***

***The DFH developed a health and safety record to help families keep track of their children's important health information, including immunizations. The records were distributed to physicians, health centers, health plans, birthing hospitals, and childcare providers. Families can also request the record by calling the DFH's toll-free Family Health Information Line //2005//.***

#### **b. Current Activities**

***//2005/ The DFH is assessing childcare centers, Head Starts, and kindergartens. The DFH provides these sites with ongoing information and TA on current recommendations & regulations. The DFH is working to develop a process for assessing the immunization status of children receiving childcare through about 1,200 home childcare providers.***

***The DFH is providing vaccine to all providers, free immunizations to uninsured children, and immunization education to providers and the public. Influenza vaccine is now available to all children ages 6 months through 18 years. The DFH is increasing awareness of the new policy through health care providers, childcare providers, schools, and the media.***

***The DFH placed a story in the Rhode Island Family Guide on the importance of immunizations. The story included the current recommended immunization schedules and addressed common questions parents have about immunizations. Families were referred to the Family Health Information Line and encouraged to request a health & safety record for their child. The DFH will sponsor an event at the Rhode Island Mall to raise awareness about immunizations for all ages.***

***The DFH developed a new culturally and linguistically appropriate brochure on immunizations to supplement existing vaccine-specific brochures. The DFH redesigned the Immunization website to include specific sections for families, health care providers, childcare professionals, and school professionals. The DFH hosted its annual conference for school nurse teachers and Head Start coordinators to provide up-to-date information on health issues including immunizations.***

***KIDSNET is sending the families of all newborns a congratulations card, which includes information about immunizations. KIDSNET tracks immunizations for all children born after 1/1/97 and is sending reports to on-line PCPs regarding their pediatric patients' compliance with immunization protocols. PCPs can refer children who were behind on their immunizations to the FOP for assistance in facilitating immunizations. Auto-dial messages or mailed "well-child reminders" also continue to be sent to families at specified intervals. Head Starts are using KIDSNET to verify immunization screening. KIDSNET continues to assess the immunization status of children enrolled in the EI Program.***

***KIDSNET continues to capture maternal Hepatitis B information. Infants with Hepatitis B positive mothers are referred to the FOP to facilitate the completion of immunizations and treatment. The families of other children who are referred to the FOP receive information regarding immunizations. Children who are behind continue to be referred to their PCP or free immunization clinics.***

***The HCCRI initiative continues to provide child care providers with culturally and linguistically appropriate immunization information for families through the CCSN. Information is targeted to both providers and families. HCCRI also continues to provide child providers with training & TA //2005/***

c. Plan for the Coming Year

***//2005/ The DFH will conduct assessments at childcare centers, Head Starts, and kindergartens. The DFH will provide these sites with ongoing information and TA on current immunization recommendations and regulations. The DFH will pilot test and then implement a full immunization assessment of all children receiving childcare through about 1,200 licensed home childcare providers. The DFH will provide vaccine to all providers, free immunizations to uninsured children, and immunization education to providers and the public.***

***The DFH will sponsor an event at the RI Mall to raise awareness about immunizations for all ages. Families with young children will be referred to PCPs or free immunization clinics for follow-up. The event will be promoted through culturally diverse television interviews, phone banks, and targeted mailings.***

***KIDSNET will send the families of all newborns a congratulations card, which includes information about the importance of timely immunizations. KIDSNET will track immunizations for all children born after 1/1/97 and will continue to send reports to on-line PCPs regarding their pediatric patients' compliance with immunization protocols. PCPs can refer children who were behind on their immunizations to the DFH's FOP for assistance in getting the parent to bring their child in for immunization. Auto-dial messages or mailed "well-child reminders" will be sent to families at specified intervals. Head Start agencies will use KIDSNET to verify immunizations. The DFH will continue to review the potential of EI sites as a mechanism for increasing immunization rates among young CSHCN.***

***The DFH will utilize KIDSNET to capture maternal Hepatitis B information. Infants with Hepatitis B positive mothers will be referred to the FOP to facilitate the completion of appropriate immunizations and treatment. Other children who are referred to the FOP will continue to receive information and education regarding the importance of timely immunizations. The WIC Program will assess the provision of DTAP shots as compared to the child's age. Children who are behind on their immunizations will be referred to their PCP or one of the free immunization clinics for follow-up //2005//.***

State Performance Measure 2: *The percentage of students in schools with school-based health centers (SBHCs) who are enrolled in SBHCs.*

**a. Last Year's Accomplishments**

***/2005/ The DFH continued to support 7 School-Based Health Centers (SBHCS) in racially and ethnically diverse urban communities in RI. In FY2003, the DFH continued its efforts to increase enrollment in the 7 SBHCS.***

***In FY2003, the SBHC Program and the DFH's Family Planning Program worked collaboratively to provide SBHC staff with training and technical assistance about Title X family planning services. SBHC teens in need of confidential birth control services were referred to a Title X site. The SBHC Program also worked with the Rite Care plan, Neighborhood Health Plans of RI (NHPRI), to expand the range of preventive health care services being provided to NHPRI members in SBHCS.***

***In FY2003, the DFH's Communication Unit, in collaboration with the SBHC Program developed and disseminated a report on the effectiveness of SBHCS in RI. The purpose of the report was to provide information about services at each SBHC and report on progress of recommendations to sustain funding and expand the number of SBHCs in RI identified in the first report. The report was disseminated to state policy-makers, including the legislature, and about 500 other stakeholders throughout the state.***

***The DFH's SBHC Program continued to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. For FY2003, 49 schools (including those with a SBHC) and two public clinics hosted VBYG. Of the 1,640 students identified as needing vaccines, 87.3% completed all needed doses. //2005//.***

**b. Current Activities**

***/2005/ The DFH continues to support 7 School Based Health Centers (SBHCS) in racially and ethnically diverse urban communities in RI. In FY2003, the DFH continued its efforts to increase enrollment in the 7 SBHCS. Currently, staff are working on an evaluation model linking SBHC data for key health conditions with time lost from school. Staff work with community health center and school staff to address technical issues to facilitate the evaluation process. The SBHCs are developing and implementing strategies to ensure that teens that have parental permission to be seen at the SBHC are seen at least once during the school year. A risk questionnaire given to students at preventive health visits is being revised. Staff continue to support the efforts of a statewide career and technical school to open a SBHC.***

***In FY2004, the SBHC Program and the DFH's Family Planning Program also worked collaboratively to provide SBHC staff with training and technical assistance about Title X family planning services. SBHC teens in need of confidential birth control services are referred to a Title X site. The SBHC Program also worked with the Rite Care plan, Neighborhood Health Plans of RI (NHPRI), to expand the range of preventive health care services being provided to NHPRI members in SBHCS.***

***In FY2002, The DFH's Communication Unit, in collaboration with the SBHC Program developed and disseminated a report on the effectiveness of SBHCS in RI. The purpose of the report was to gather community support for an action plan to sustain funding for***

**and expand the number of SBHCS in RI. The report was disseminated to state policy-makers, including the legislature, and about 1,000 other stakeholders throughout the state. In FY2003, the DFH developed and distributed a progress report on the recommendations contained in the first report. The second report was distributed to about 50 stakeholders throughout the state.**

**The DFH's SBHC Program continued to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. The number of schools (including those with a SBHC) and alternative education sites increased to 58. However, the number of students identified as needing immunizations appears to have decreased slightly. This is expected as more and more Rhode Island physicians (and SBHCs) "catch-up" adolescents in their practices. Influenza is being offered in FY2004 as an addition //2005//.**

**c. Plan for the Coming Year**

**//2005/ Increasing the number of adolescents enrolled in School-Based Health Centers (SBHCs) helps ensure their access to health services and ultimately improves their health, safety, and well-being. The DFH will continue to support 8 SBHCS in racially and ethnically diverse urban communities in RI. The SBHC Program and the Communication Unit will utilize FY2005 to continue with efforts to further increase SBHC utilization. In FY2004, an 8th SBHC was added to the states' SBHC network. Several more schools want to start SBHCs, but funds are lacking to support further expansions. In addition, the SBHC Program will work to address SBHC capacity to address the mental health needs of students in SBHCs. Adequate capacity to address the mental health needs of adolescent's remains a statewide concern.**

**Currently staff are working on an evaluation model linking school based health data for key health conditions with time lost from school. In FY2005, staff will implement the evaluation plan in at least 2 SBHCs. The SBHCS will supply the DFH with a data disk that can be matched with school-based data. Data will be submitted monthly to ensure accuracy. The DFH will work with the SBHCs to ensure that data is reported in a timely and consistent fashion between and within each SBHC. The SBHCs will implement a risk behavior questionnaire to each preventive health visit. Information will be aggregated on-site and be used to inform the development of health promotion programs. Staff will work with the SBHCs to ensure that students have access to reproductive health services within the framework of existing statutes. Staff will work with the 8 SBHCs to ensure that consent forms are reflective of current state and federal statutes.**

**In FY2005, the SBHC Program and the DFH's Family Planning Program will continue to work collaboratively to provide SBHC staff with training and technical assistance about Title X family planning services. SBHC teens in need of confidential birth control services will continue to be referred to a Title X site. The SBHC Program will continue to work with the Rlte Care plan, Neighborhood Health Plans of RI (NHPRI), to expand the range of preventive health care services being provided to NHPRI members in SBHCS.**

**The DFH's SBHC Program will continue to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. FY2005 is the time when all RI students in all grades must be fully immunized to enter school. VBYG will offer clinics to those schools with any students not fully immunized as a "clean sweep effort". In addition, VBYG will have a comprehensive evaluation, and discussions will be held to determine future needs of VBYG, if any //2005//.**

State Performance Measure 3: *The proportion of pregnant women who receive an alpha-fetoprotein (AFP) test.*

a. Last Year's Accomplishments

***//2005/ Access to genetics services, including testing and counseling, is key in reducing the occurrence of birth defects and poor birth outcomes. AFP screening is one measure of genetics service access. The DFH's WHSRP provided no cost pregnancy testing and comprehensive health risk assessment to women, including teens, receiving services in 9 Title X clinics.***

***Pregnant women participating in the WHSRP who report that they have a family member with history of birth defects or developmental delay in their family or their partner's family were referred for genetics counseling and testing services, including AFP screening. Pregnant and non-pregnant women received folic acid information through culturally and linguistically appropriate materials produced by the March of Dimes (MOD). Samples of multi-vitamins with folic acid were provided to pregnant and non-pregnant women through the WHSRP. The MOD provided the vitamins. All local WIC agencies received folic acid informational materials produced by the MOD to distribute to post-partum WIC participants during this period as well.***

***During FY2003, the DFH worked with the MOD to increase the supply of multivitamins provided to the WHSRP. Vitamins supplied through a MOD Folic Acid Grant and a vitamin price-fixing settlement negotiated through the RI Attorney General were secured. The Folic Acid Grant was also used to support the purchase of additional consumer informational materials on folic acid in English and in Spanish.***

***Some pregnant women were referred to the DFH's FOP during FY2003. FOP home visitors assessed women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rite Care). Home visitors also provided support and education to pregnant women about AFP testing, as appropriate. Adequate funding for prenatal home visiting services remains a concern.***

***The DFH continued to distribute a culturally and linguistically appropriate brochure to increase public awareness about the importance of genetics testing, including AFP testing, throughout the state during FY2003. A DFH parent consultant continued to provide input to the DFH's Newborn Screening Program on genetics issues on an ongoing basis. The head of prenatal testing (including AFP testing) at Women & Infants Hospital is a member of the DFH's Newborn Screening Advisory Committee.***

***The DFH repeated a study during FY2003 for the period 1998-2000 to compare rates of open neural tube defects before and after the fortification of grains with folic acid. The earlier study, which was done for the period 1991-1997, provided a baseline for open neural tube defects prior to grain fortification //2005//.***

b. Current Activities

***//2005/ The DFH's WHSRP provides no cost pregnancy testing and comprehensive health risk assessment to women, including teens, receiving services in 9 Title X clinics. Pregnant women who report that they have a family member with history of birth defects or developmental delay in their family or their partner's family are referred for genetics counseling and testing services, including AFP screening.***

***Pregnant and non-pregnant women continue to receive folic acid information through culturally and linguistically appropriate materials produced by the March of Dimes (MOD). In addition, all local WIC agencies received folic acid informational materials produced by the MOD to distribute to post-partum WIC participants during this period as well.***

***The DFH received large quantities of vitamins with folic acid through a MOD Folic Acid Grant and a vitamin price-fixing settlement negotiated through the RI Attorney General's Office in FY2004. The grant also supported the purchase of additional consumer informational materials on folic acid in English and Spanish. The DFH is working to develop a distribution plan for the vitamins. The vitamins will be distributed to the DFH's Title X family planning clinics during FY2004 and FY2005.***

***Pregnant women continue to be referred to the DFH's FOP. FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. RIte Care). Home visitors also provide support and education to pregnant women about AFP testing, as appropriate. Adequate funding for prenatal home visiting services remains a concern.***

***The DFH & the RI Public Health Foundation worked collaboratively to develop and distribute a new genetics brochure. The goal of the brochure is to increase awareness of genetics testing (including AFP testing) and counseling services and to help consumers understand when genetics testing is of value. The brochure targets all Rhode Islanders with a focus on low-income and low-literacy populations. It is being distributed to families through OB/GYNs, pediatricians, family practice doctors, community health centers and community action programs.***

***A DFH parent consultant continues to provide input to the DFH's Newborn Screening Program on genetics issues on an ongoing basis. The head of prenatal testing (including AFP testing) at Women & Infants Hospital is a member of the Newborn Screening Advisory Committee.***

***Data from the neural tube defects study were analyzed by the DFH & show that the rate of neural tube effects in RI decreased by 13% from 10.5 per 10,000 population during 1991-1997 (prior to grain fortification) to 9.4 per 10,000 population during 1998-2000. The DFH continues to review medical records of newborns with birth defects to determine any tests, services, or referrals they received, or the mother received, during the prenatal period. The program also continues to work with RI Hospital to obtain data on children with //2005//.***

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

***//2005/ Access to genetics services, including testing and counseling, is key in reducing the occurrence of birth defects and poor birth outcomes. AFP screening is one measure of genetics service access. The DFH's WHSRP will continue to provide no cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 Title X clinics.***

***Pregnant women who report that they have a family member with history of birth defects or developmental delay in their family or their partner's family will continue to be referred for genetics counseling and testing services, including AFP screening. Pregnant and non-pregnant women will continue to receive folic acid information through culturally and linguistically appropriate materials produced by the March of Dimes.***

***The DFH received large quantities of vitamins with folic acid through a MOD Folic Acid grant and a vitamin price-fixing settlement negotiated through the RI Attorney General's Office in FY2004. The Folic Acid grant also supported the purchase of additional consumer informational materials on folic acid in English and Spanish. The DFH will continue to distribute the vitamins to the DFH's Title X family planning clinics during FY2005 until they run out.***

***Pregnant women will continue to be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rlth Care). Home visitors will also continue to provide support and education to pregnant women about AFP testing, as appropriate. The DFH will utilize FY2005 to explore additional sources of funding for prenatal home visiting services.***

***The DFH will continue to distribute the culturally and linguistically appropriate brochure to increase public awareness about the importance of genetics testing, including AFP testing, throughout the state. A DFH parent consultant will continue to provide input to the DFH's Newborn Screening Program and the RI Genetics task Force on genetics issues on an ongoing basis.***

***The DFH's Birth Defects Surveillance initiative will continue to review medical records of newborns with birth defects to determine any tests, services, or referrals they received, or the mother received, during the prenatal period. The program will also continue to work with Women & Infants Prenatal Diagnosis Center and RI Hospital's Genetics Counseling Center and Child Development Center to obtain prenatal diagnosis and other testing and service data //2005//.***

State Performance Measure 4: *The percentage of pregnant women in at-risk population sub-groups who received prenatal care beginning in the first trimester (Data reflects African American/Black women only).*

**a. Last Year's Accomplishments**

***//2005/ The DFH ensured early entry into prenatal care to enhance pregnancy outcomes. In FY2003, the DFH continued to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 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. All educational materials utilized by the Title X clinics continued to be reviewed and approved by a 5-9 member committee, broadly representative of the populations served, prior to their distribution.***

***Pregnant women with health risks identified through the WHSRP can be referred to the DFH's FOP. FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rlth Care). They also stress the importance of prenatal care and provide women with culturally and linguistically appropriate materials on a wide variety of topics, including prenatal care.***

***In FY2003, the DFH implemented the "Keep your Baby Lead Safe" Program in Providence. Newly identified pregnant women were referred to the program through the WHSRP early in pregnancy. Participating women received a home visit from the DFH's FOP and referrals to weatherization and lead hazard reduction resources. Lastly, The***

**DFH's FOP) provided participating women with education and referral to community resources and, if eligible, referral to reduced cost lead hazard reduction work through the city of Providence.**

**The DFH's FRC Program continued to support culturally diverse FRCs in 12 health centers and 4 hospital outpatient clinics to identify and enroll pregnant women into Rlte Care, WIC, Food Stamps, and the Family Independence Program (FIP) throughout FY2003. Uninsured women applying for WIC services were also referred to FRCs. Like the WHSRP, the FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.**

**The DFH's Communication Unit continued to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI, throughout FY2003. Bi-lingual information specialists answer families' questions and refer them to appropriate community resources, including Rlte Care and FRCs. Culturally and linguistically appropriate informational materials are distributed through the DFH's centralized Distribution Center.**

**The DFH's Newborn Screening Program continued to collect data on the adequacy of prenatal care among pregnant women in RI by race/ethnicity and socio-economic status. This data is utilized to monitor the adequacy of prenatal care in the state. The DFH's Data & Evaluation Unit analyzes statewide prenatal care data. Lastly, the DFH's PRAMS initiative surveyed recent mothers in FY2003. Several PRAMS questions focus on prenatal care //2005//.**

#### **b. Current Activities**

**/2005/ The DFH ensures early entry into prenatal care to enhance pregnancy outcomes. The DFH supports the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 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.**

**Pregnant women with health risks identified through the WHSRP can be referred to the DFH's FOP. FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. Rlte Care). They also stress the importance of prenatal care and provide women with culturally and linguistically appropriate materials on a wide variety of topics, including prenatal care. FOP promotional materials (brochures and posters) are mailed to all OB/GYN practices across the state quarterly. The goal is to increase the number of pregnant women who are referred to the FOP.**

**The DFH phased out the "Keep your Baby Lead Safe" Program in Providence and started it in the cities of Pawtucket and Woonsocket. Newly identified pregnant women are referred through the WHSRP and other prenatal providers early in pregnancy. Participating women are contacted by the DFH's FOP for a home visit (which includes prenatal education) and referral to community resources and, if eligible, referral to weatherization and/or lead hazard reduction funding through several funding streams available in the state.**

**The DFH's FRC Program continues to support culturally diverse FRCs in 10 health centers and 4 hospital outpatient clinics to identify and enroll pregnant women into Rlte Care, WIC, Food Stamps, and FIP. Uninsured pregnant women applying for WIC services continue to be referred to FRCs for assistance with enrollment into Rlte Care.**

***Like the WHSRP, the FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.***

***The DFH's Communication Unit continues to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answer families' questions and refer them to appropriate community resources, including RIte Care and FRCs. Culturally and linguistically appropriate informational materials is distributed through the DFH's centralized Distribution Center.***

***The DFH's Newborn Screening Program continues to collect data on the adequacy of prenatal care among pregnant women in RI by race/ethnicity and socio-economic status. This data is utilized to monitor the adequacy of prenatal care in the state. The DFH's Data & Evaluation Unit analyzes data. The DFH is analyzing PRAMS data (from 2002 respondents) to determine issues related to access to prenatal care, including barriers to care. Maternal characteristics, including race and ethnicity, are also included //2005//.***

**c. Plan for the Coming Year**

***//2005/ The DFH will support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 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.***

***Pregnant women with health risks identified through the WHSRP can be referred to the DFH's FOP. FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. RIte Care). They also stress the importance of prenatal care. Adequate funding for prenatal home visits continues to be a concern. For FY2005, FOP agencies will continue to be encouraged to develop linkages with the obstetrical community and local referral resources.***

***The DFH will continue to implement the "Keep your Baby Lead Safe" Program in Pawtucket and Woonsocket. Newly identified pregnant women will be referred through the WHSRP and other prenatal providers early in pregnancy. Participating women will continue to be contacted by the DFH's FOP for a home visit (which includes prenatal education) and referral to community resources and, if eligible, referral to weatherization and/or lead hazard reduction funding through several funding streams available in the state.***

***The DFH's FRC Program will continue to support culturally diverse FRCs in 10 health centers and 4 hospital outpatient clinics to identify and enroll pregnant women into RIte Care, WIC, Food Stamps, and FIP. Uninsured pregnant women applying for WIC services will continue to be referred to FRCs for assistance with RIte Care enrollment. Like the WHSRP, the FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.***

***The DFH's Communication Unit 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 families' questions and refer them to appropriate community resources, including RIte Care and FRCs. Culturally and linguistically appropriate informational materials will continue to be distributed through the DFH's centralized Distribution Center.***

***The DFH's Newborn Screening Program will continue to collect data on the adequacy of prenatal care among pregnant women in RI by race/ethnicity and socio-economic status through the newborn screening process. The DFH will continue to conduct PRAMS and analyze existing data to determine factors associated with prenatal care. Maternal characteristics, including race and ethnicity, will also continue to be analyzed //2005//.***

State Performance Measure 5: *The percentage of children less than 6 years of age in at-risk sub-populations with lead levels greater than or equal to 10 ug/dl (Data presented reflects lead levels among children in core cities).*

**a. Last Year's Accomplishments**

***//2005/ Although lead levels among RI's children have been declining, childhood lead poisoning remains a significant problem in RI. The proportion of children with blood lead levels greater than or equal to 10 mcg/dl decreased from 6.1% in CY2000 to 3.7% in CY2003. In January of 2003, the infrastructure for case management of lead poisoned children in the state was increased with the certification of three more lead centers to provide comprehensive care to this population. Lead centers (certified by the RIDHS) received referrals of all significantly lead poisoned children, as well as children with first time blood lead levels between 15 and 19 mcg/dl. There are now four certified lead centers in the state.***

***In June 2003, the DFH implemented the newly developed "Lead Information Surveillance System" ("LESS") database which improves and facilitates the collection, tracking and devaluation of screening, case management, and environmental data. Following the requirements of the new Lead Hazard Mitigation Law from 2002, which was scheduled to go into effect on 7/1/04, the DFH (in collaboration with the RI Housing Resources Commission, the Childhood Lead Action Project, and other partners involved with the implementation of the law) participated in the preparation of a statewide strategic plan. Similarly, the DFH participates in the policy discussions that occur through the Interagency Coordinating Council on Environmental Lead (ICCEL), which was created following the passage of the law.***

***The DFH supported two hospital-based clinics in Providence to screen uninsured and underinsured children under age six for lead poisoning. Lead safety remained a part of the DFH's Family Outreach Program's (FOP's) standard home assessment protocols for all families who receive home visiting services, including those with newborns.***

***The DFH revised and improved its informational materials on lead. The DFH utilized parent consultants to educate providers about lead issues and to staff community health fairs and workshops on lead in culturally diverse neighborhoods throughout the state.***

***The DFH conducted lead poisoning awareness and prevention activities on an ongoing basis, with a new emphasis on reaching pregnant women. DFH staff visited OB/GYNs and gave them a package of informational materials on lead poisoning prevention during pregnancy (which included culturally appropriate informational brochures for their clients in English and in Spanish).***

***WIC continued to monitor lead screening in WIC enrolled children with lead levels at or above 10 mcg/dl and continue to provide them with nutrition counseling and education and nutritious foods. The Immunization Program continued to include questions about lead screening on immunization forms utilized by schools and childcare centers as a prerequisite for entry. EI service coordinators continued to incorporate children's lead-***

*related needs as a part of the IFSP process /2005//.*

**b. Current Activities**

*/2005/ The proportion of children with blood lead levels greater of equal to 10 mcg/dl decreased from 6.1% in CY2000 to 3.7% in CY2003. The DFH continues to support two hospital-based clinics in Providence to screen uninsured and underinsured children under age six for lead poisoning. With the addition of three more certified lead centers to provide case management, the DFH is now referring significantly lead poisoned children, as well as those with first time lead levels between 15 and 19 mcg/dl to the lead centers. While significantly lead poisoned children receive a comprehensive environmental lead inspection through HEALTH certified private inspectors, the group of children with blood lead levels between 15 and 19 mcg/dl are offered case management and referrals to other social services.*

*Families of children with blood lead levels between 10 and 14 mcg/dl receive a letter from the DFH, encouraging them to contact the DFH's FOP for a home-based lead education visit. Lead safety also remains a part of the FOP's standard assessment protocol for all families who receive home visiting services, including those with newborns.*

*KIDSNET to generates post cards to families of all 12-month old children reminding them to schedule a lead screening visit for their child. KIDSNET also provides lists of 19-35 month old unscreened children to pediatric providers. These lists provide the basis for quality assurance visits conducted at pediatric practices linked to KIDSNET. In FY2004, quality assurance was conducted in 14 sites. Two received excellence awards for screening at least 96% of their population. All Head Start agencies are now connected to KIDSNET and are using it to verify lead screening.*

*In FY2004, DFH staff continued to conduct childhood lead poisoning awareness and prevention activities. For the 6th consecutive year, RI celebrated May as "Lead Poisoning Prevention Month" and awarded community partners and pediatricians for continuing efforts in lead poisoning prevention at a special event. The DFH also continues to utilize parent consultants to educate providers about lead issues and to staff community health fairs and workshops on lead throughout the state.*

*WIC continues to monitor lead screening in WIC-enrolled children with lead levels at or above 10 ug/dl and to provide them with nutrition counseling and education and nutritious foods. The Immunization Program continues to include questions about lead screening on immunization forms utilized by schools and childcare centers as a prerequisite for entry. EI service coordinators continue to incorporate children's lead-related needs as a part of the IFSP process.*

*The DFH continues to survey new mothers through PRAMS. PRAMS data show that 96.7% of 2002 espondents believed that parents could prevent childhood lead poisoning //2005//.*

**c. Plan for the Coming Year**

*/2005/ The DFH will support two hospital-based clinics in Providence to screen uninsured and under-insured children for lead poisoning. The DFH will refer significantly lead poisoned children for comprehensive home inspections through HEALTH's Environmental Lead Program and for case management services through one of four lead centers certified by the RIDHS in the state. Children with first time lead*

**levels of 15-19 mcg/dl will receive a referral to a lead center for case management.**

**Children with lead levels 10-14 mcg/dl will receive a letter encouraging them to contact the DFH's FOP for lead education home visiting services. Lead safety will remain a part of the FOP's standard home assessment protocols for all families who receive home visiting services, including those with newborns.**

**The DFH's "Keep Your Baby Lead Safe" initiative will provide pregnant women with lead and prenatal education through FOP home visitors and, if eligible, referrals to the weatherization program and lead hazard reduction resources. Participating women will be identified through the DFH's WHSRP, as well as other prenatal providers in the state.**

**KIDSNET will send post cards to the families of 12-month old children as a reminder to schedule lead screening. With the newly implemented web-based application, KIDSNET will continue to be used as a tracking tool and mechanism for pediatric practices to generate their own reports of unscreened children as a monthly quality assurance tool. For those practices currently participating in KIDSNET that are not yet connected to the web-based application, KIDSNET will continue to generate reports of individual pediatric practices to identify children 19-35 months of age with no evidence of lead screening for quality assurance purposes. Screening performance will continue to be communicated to each provider, along with an offer of technical assistance. Head Start agencies in the state will continue to use KIDSNET to verify lead screening.**

**The DFH will continued to conduct lead poisoning awareness and prevention activities, with a primary emphasis on pregnant women, on an ongoing basis. For the 7th consecutive year, RI will celebrate May as "Lead Poisoning Prevention Month" with statewide outreach and education efforts. The DFH will continue to utilize parent consultants to conduct workshops and capitalize efforts on quality assurance and education about the new Lead Hazard Mitigation Law, especially to property owners and tenants.**

**WIC will monitor lead screening in WIC-enrolled children with lead levels at or above 10 mcg/dl and provide them with nutrition counseling and education and nutritious foods. The Immunization Program will include questions about lead screening on immunization forms utilized by schools and childcare centers as a prerequisite for entry. EI will continue to incorporate children's lead-related needs as a part of the IFSP process.**

**The DFH will continue to conduct RI PRAMS during FY2005 //2005//.**

State Performance Measure 6: *The percentage of 9th graders who are expected to graduate from high school.*

**a. Last Year's Accomplishments**

**/2005/ The DFH continued to work to increase the percentage of 9th graders who are expected to graduate from high school. The DFH continued to support 7 SBHCs in culturally diverse communities during FY2003. The DFH utilized FY2003 to continue its efforts to increase enrollment in the 7 SBHCS.**

**Unintended pregnancy can interfere with educational goals. During FY2003, The DFH continued to support 10 Title X family planning clinics to provide confidential and low cost reproductive health services to teens. In addition, the DFH's WHSRP continued to provide no cost pregnancy testing and comprehensive health risk assessment to teen**

***in Title X clinics. Teens with a negative pregnancy test were linked to family planning services on-site and teens with a positive pregnancy test were referred to the Rhode Island Department of Human Services (RIDHS) Adolescent Self-Sufficiency Program, which provides pregnant teens with case management and other support services and strives to prevent further pregnancies.***

***In FY2003, the DFH continued to build on its statewide adolescent media campaign, titled "Be There For Teens". Consumers who called the DFH's Family Health Information Line were provided with "Ten Tips on Parenting Teens" and referrals to the Men 2 B Program.***

***The DFH also continued its support of the Men 2B Role Model Support Capacity Program in Pawtucket/Central Falls, Newport, Providence, and Woonsocket during FY2003. Outreach materials, developed in FY2003, were used to increase Men 2B enrollment in worksites, schools, and faith-based organizations in RI. The DFH continues to work with the Father and Family Network in FY2003. Men 2B grantees continued to participate as members of the Network and DFH staff continued to serve on the Steering Committee.***

***The DFH assumed responsibility for managing Healthy Schools!/Healthy Kids!, in FY2003. The DFH convened an internal working group to develop a framework for organizing work and to identify information needs. Formative research with schools identified issues and a report identified local policies that enhance and impede the health of school-age children in RI. In FY2003, the DFH also collaborated with the United Way and other partners to develop and infrastructure for advocacy and support that focuses on building local capacity for out-of-school time programming in middle schools.***

***The DFH's SBHC Program continued to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. For FY2003, 49 schools (including those with a SBHC) and two public clinics hosted VBYG. Of the 1,640 students identified as needing vaccines, 87.3% completed all needed doses. In addition, the DFH hosted its annual conference for school nurse teachers and Head Start coordinators to provide up-to-date information on critical health topics (including immunizations) //2005//.***

#### **b. Current Activities**

***/2005/ The DFH continues to work to increase the percentage of 9th graders who are expected to graduate from high school. The DFH supports 7 SBHCs in culturally diverse communities.***

***Unintended pregnancy can interfere with educational goals. The DFH continues to support 10 Title X family planning clinics to provide confidential and low cost reproductive health services to teens through community-based providers. The DFH's WHSRP continues to provide no cost pregnancy testing and comprehensive health risk assessment to teens receiving services in Title X clinics.***

***The DFH built upon the "Be There for Teens" media campaign through development of a website for parents of children 9-17 years old. The website provides parents and providers with connections to RI programs and resources and includes monthly***

***parenting tips. The directory is intended to help parents and other adults build meaningful relationships with pre-teens and teens and meet their developmental needs.***

***The DFH also continues to support the Men 2B Program. Preliminary results of evaluation data demonstrate effectiveness and role model behavior change. Outreach materials, developed in FY2003, continue to be used to increase Men 2B enrollment in worksites, schools, and faith-based organizations in RI.***

***The DFH is working with networks such as the RI After-School Plus Alliance, the Children's Cabinet Youth Development Advisory Committee, the Children's Mental/Behavioral Health Work Group and the Teen Pregnancy Prevention Partnership. These groups grounded in a youth development/assets building philosophy, are working to communicate common messages and to implement aligned policies and practices to prepare school age youth for responsible productive adulthood.***

***The DFH assumed responsibility for managing Healthy Schools!/Healthy Kids!, in FY2003. Formative research conducted with schools identified issues and local policies that enhance and impede the health of school-age children in RI. Issue briefs around weight management and physical activity, tobacco, alcohol and other drugs, sexual behavior, and injury and violence were produced to integrate data from the YRBS and SALT data sources.***

***The DFH, in partnership with the RIDE, the Brown University Equity Center, and the RI Principals Association, sponsored a two-day conference on learning & discipline for teachers and administrators. The conference focused on the principles of social emotional learning, asset building, and the link between safe and nurturing schools and improved school achievement.***

***The DFH's SBHC Program continued to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. The number of schools (including those with a SBHC) and alternative education sites increased to 58 //2005//.***

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

***/2005/ The DFH will continue to work to increase the percentage of 9th graders who are expected to graduate from high school. The DFH will support 8 SBHCs in culturally diverse communities. In addition, the DFH's SBHC Program will work to address SBHC capacity to address the mental health needs of students in SBHCs.***

***The DFH will support 10 Title X family planning clinics to provide confidential and low cost reproductive health services to teens through community-based providers. The DFH's WHSRP will continue to provide no cost pregnancy testing and comprehensive health risk assessment to teens receiving services in Title X clinics.***

***The DFH will continue its three-pronged approach to reduce teen birth rates and other risk behaviors which focuses on: 1) access to health care services, including reproductive health services, 2) youth development programming that focuses on preparing adults and institutions to meet the developmental needs of youth, and 3) coordinated school health programs, including quality health education and comprehensive sexuality education.***

***The DFH will work with community partners and a social marketing firm to implement revisions to the [www.ParentLinkRI.org](http://www.ParentLinkRI.org) website that will make it more user friendly. A promotional campaign will increase user numbers and expand resources listed.***

***The DFH will support the Men 2B Program. Analysis of Men 2B evaluation data will be published to demonstrate program effectiveness and to solicit partnerships with sponsoring programs. In FY2005, the DFH will partner with the RI Department of Corrections to pilot the Men 2B Program in the adult correctional institution with men who are transitioning out of the prison.***

***The DFH will continue to manage Healthy Schools!/Healthy Kids! by focusing on the following areas: 1) school smoking polices, 2) physical activity, obesity, and nutrition, 3) school health data needs, 4) implementation of school rules and regulations, 5) professional development, 6) school environmental health, and 7) community schools/out-of-school time programming.***

***The DFH will participate in the Children's Cabinet Youth Development Advisory Committee. The DFH will participate in the RI Afterschool Plus Alliance to build a network of stakeholders with resources and expertise to develop policies and advocacy for quality after-school programming with connections to health and mental/behavioral health services. The DFH will participate in the Children's Mental/Behavioral Health Group to implement strategies that will help schools implement emotional learning strategies. The DFH will work to expand membership in the Teen Pregnancy Prevention Partnership, and explore opportunities to improve services to pregnant and parenting teens.***

***The DFH will offer "Vaccinate Before you Graduate" clinics to those schools with any students not fully immunized during FY2005 //2005//.***

State Performance Measure 7: *The percentage of children in the Early Intervention Program with Individual Family Service Plans (IFSPs), discharged to Special Education, for whom an Individual Education Plan (IEP) is developed.*

**a. Last Year's Accomplishments**

***//2005/ During FY2003, The DFH's 7 statewide Early Intervention (EI) sites continued to provide comprehensive transition services for CSHCN reaching the age of three years. The EI Program continued to implement transition goals to ensure that timelines specified in IDEA were met. Transition planning for IEP development begins on or before a child's 30th month of life and is completed by the child's 36th month. Regional EI Program parent consultants continued to support families with CSHCN at transition meetings and informed them about EI procedural safeguards.***

***Transition meetings occurred on an on-going basis to address systems issues related to transition and aggregate information was shared with the Inter-Agency Coordinating Council (ICC), which includes the information in its annual report. The ICC is made up of EI agencies, families with children receiving EI services, state legislators, representatives of the Rhode Island Department of Health (HEALTH), the Rhode Island Department of Children, Youth, & Families (DCYF), the Rhode Island Department of Education (RIDE), and others.***

***Planning and research for the EI media campaign occurred in FY2002. In FY2003, new materials consisting of procedural safeguards, eligibility criteria, and description of services were developed in English and in Spanish and distributed to pediatric physicians, childcare centers, and other community partners. Special attention was given to issues of transition, as this was an area of concern identified through the***

***qualitative research conducted by the DFH's Communications Unit in FY2002. DFH visits to pediatric practices in FY2003 included discussion of transition //2005//.***

**b. Current Activities**

***/2005/ The DFH 7 statewide Early Intervention (EI) sites continue to provide comprehensive transition services for CSHCN reaching the age of three years. The EI Program continues to implement transition goals to ensure that timelines specified in IDEA are met. Transition planning for IEP development begins on or before a child's 30th month of life and is completed by the child's 36th month. Transition meetings occur on an on-going basis to address systems issues related to transition and this information continues to be shared with the Inter-Agency Coordinating Council, which includes the information in its annual report. Regional EI Program parent consultants continue to support families with CSHCN at transition meetings and inform them about EI procedural safeguards. In FY2004, a transition coordinator position was developed jointly between the DFH's EI Program and the RI Department of Education (RIDE). This new position helps to enhance the existing transition process.***

***Planning and research for the EI media campaign occurred in FY2002. New materials consisting of procedural safeguards, eligibility criteria, and description of services were developed and distributed to pediatric physicians, child care centers, and other community partners. special attention was given to issues of transition, as this was an area of concern identified through the qualitative research conducted by the DFH's Communication Unit in FY2002. DFH visits to pediatric practices included discussion of transition //2005//.***

**c. Plan for the Coming Year**

***/2005/ The DFH 7 statewide Early Intervention (EI) sites continue to provide comprehensive transition services for CSHCN reaching the age of three years. The EI Program continues to implement transition goals to ensure that timelines specified in IDEA are met. Transition planning for IEP development begins on or before a child's 30th month of life and is completed by the child's 36th month. Transition meetings occur on an on-going basis to address systems issues related to transition and this information continues to be shared with the Inter-Agency Coordinating Council, which includes the information in its annual report. Regional EI Program parent consultants continue to support families with CSHCN at transition meetings and inform them about EI procedural safeguards. In FY2004, a transition coordinator position was developed jointly between the DFH's EI Program and the RI Department of Education (RIDE). This new position helps to enhance the existing transition process.***

***Planning and research for the EI media campaign occurred in FY2002. New materials consisting of procedural safeguards, eligibility criteria, and description of services were developed and distributed to pediatric physicians, child care centers, and other community partners. Special attention was given to issues of transition, as this was an area of concern identified through the qualitative research conducted by the DFH's Communication Unit in FY2002. DFH visits to pediatric practices will continue to included discussion of transition //2005//.***

(high weight for stature) in the WIC Program.

a. Last Year's Accomplishments

*//2005/ WIC data indicated that, in FY2002, 2.8% of infants and 3.2% of children were underweight and that 22.1% of infants and 23.4% of children were overweight in WIC. These data were based on revised growth standards. Last year, the WIC Program revised its definition of overweight and excluded infants (i.e. less than two years of age) and children in the 90-94th percentile. Based on this revised definition, it was determined that 2.7% of infants and 3.5% of children were overweight and that 19% of children were overweight in WIC.*

*WIC continued to provide specialized foods packages based on individual needs and educate WIC participants about basic nutrition and the importance of physical activity. During FY2003, WIC focused on the development of local WIC staff counseling skills designed to empower families in coping with the issue of childhood obesity. WIC also continued to participate in a community-based coalition to develop anticipatory guidance for childhood obesity prevention. The goal of the coalition is to implement and sustain a long-term approach to pediatric obesity prevention and management in RI.*

*The DFH's Communication Unit worked collaboratively with the WIC Program during FY2003 to revitalize WIC nutrition informational materials. Materials were revised based on demand and utilization rates. Local WIC nutritionists along with DFH parent consultants assisted the Communication Unit with the development of informational materials. DFH parent consultants also continued to play a key role in coordinating WIC outreach and other activities to ensure that they are culturally and linguistically competent.*

*The DFH's Farmers Market Nutrition Program (FMNP) continued to provide low-income families, including those participating in WIC, in urban areas with access to fresh fruits and vegetables. In FY2003, 17,660 individuals throughout the state received FMNP benefits. All FMNP participants received helpful hints on storing and shopping for fresh produce and recipes for preparing fresh produce. "Veggin' Out" multi-cultural cooking demonstrations, sponsored by volunteer chefs, were held at several FMNP sites. The DFH supported translators at FMNP sites, as appropriate. In FY2003, the DFH's WIC Program, in partnership with the DFH's Communications Unit, and Johnson & Wales University, developed a new "Veggin' Out" recipe book for distribution at local Farmers Markets //2005//.*

b. Current Activities

*//2005/ During FY2004, height and weight data from the 2001 Rhode Island Health Interview Survey were analyzed and it was found that 19.6% of children ages 6-19 had Body Mass Indexes (BMIs) > the 95th percentile. Data were also analyzed from the WIC and Immunization Programs, both of which collect height and weight information. Data from the WIC Program indicate that 10.4% of children ages 2-5 enrolled in WIC had BMIs > the 95th percentile. WIC data were based on revised national growth standards. Height and weight data collected by the Immunization Program through clinical assessments of children entering Kindergarten indicate that 16.9% had BMIs > the 95th percentile //2005//.*

In FY2004, WIC continues to provide specialized foods packages based on individual needs and educate WIC participants about basic nutrition and the importance of physical activity. WIC

has been focusing on the development of local WIC staff counseling skills designed to empower families in coping with the issue of childhood obesity. WIC also continues to participate in a community-based coalition to develop anticipatory guidance for childhood obesity prevention. The goal of the coalition is to implement and sustain a long-term approach to pediatric obesity prevention and management in RI.

The DFH's Communication Unit continues to work collaboratively with the WIC Program to revitalize WIC nutrition informational materials. Materials are being revised based on demand and utilization rates. Currently, WIC is in the process of revising its materials on childhood activity. Local WIC nutritionists along with DFH parent consultants continue to assist the Communication Unit with the development of informational materials. DFH parent consultants play a key role in coordinating WIC outreach and other activities to ensure that they are culturally and linguistically competent.

The DFH's Farmers Market Nutrition Program (FMNP) continues to provide low-income families, including those participating in WIC, in urban areas with access to fresh fruits and vegetables. During FY2003, 20,491 individuals throughout the state received FMNP benefits. All FMNP participants continue to receive helpful hints on storing and shopping for fresh produce and recipes for preparing fresh produce. "Veggin' Out" cooking demonstrations, sponsored by volunteer chefs, continue to be held FMNP sites. The DFH continues to support translators at FMNP sites, as appropriate. Participant surveys are being conducted in FY2004 to determine customer satisfaction and effectiveness of the FMNP //2005//.

#### c. Plan for the Coming Year

***//2005/ The DFH's Data & Evaluation Unit will continue to analyze data related to Body Mass Index (BMI) from the RI Health Interview Survey, the WIC Program, and the Immunization Program. In FY2005, WIC will continue to provide specialized foods packages based on individual needs and educate WIC participants about basic nutrition and the importance of physical activity. WIC will also continue to participate in a community-based coalition to develop anticipatory guidance for childhood obesity prevention. The goal of the coalition is to implement and sustain a long-term approach to addressing childhood obesity prevention and management in RI. WIC will continue to provide training to local and state WIC staff, and collaborate with other key partners in focusing on family dynamics and its impact on childhood obesity. WIC will utilize FY2005 to research programs from other states, including FIT WIC, and pilot some strategies in local RI WIC sites.***

***The DFH's Communication Unit will continue to work collaboratively with the WIC Program to revitalize WIC nutrition informational materials and improve the current WIC Allowed Food List. Materials will continue to be revised based on demand and utilization rates. The DFH will utilize FY2005 to refine the WIC website for diverse audiences, including current WIC participants, potential WIC participants, and WIC vendors. DFH parent consultants will continue to assist the Communication Unit with the development of informational materials. DFH parent consultants will continue to play a key role in coordinating WIC outreach and other activities to ensure that they are culturally and linguistically competent.***

***The DFH's Farmers Market Nutrition Program (FMNP) will continue to provide low-income families, including those participating in WIC, in urban areas with access to fresh fruits and vegetables. All FMNP participants will continue to receive helpful hints on storing and shopping for fresh produce and recipes for preparing fresh produce. "Veggin' Out" cooking demonstrations, sponsored by volunteer chefs, will continue to***

**be held FMNP sites. The DFH will continue to support translators at FMNP sites, as appropriate. Participant surveys will continue be conducted in FY2005 to determine customer satisfaction and effectiveness of the FMNP //2005//.**

State Performance Measure 9: *The percentage of at-risk (risk positive) newborns who receive a home visit from the Family Outreach Program (FOP).*

**a. Last Year's Accomplishments**

***/2005/ The DFH's Family Outreach Program (FOP) provides home assessments, connection to community supports, and help with child development and parenting for almost one-third of all families with newborns each year. The DFH defines the early newborn period as being up to 90 days after an infant is born, since most premature and low birth weight infants are not discharged from the hospital immediately after birth. Home visitors also serve as the follow-up mechanism for the DFH's Newborn Screening, Early Intervention (EI), Lead Poisoning, and Immunization Programs. However, not all eligible families accept FOP services.***

***A little more than half of newborns in the state qualify for FOP services. Home visits are voluntary, but if the family accepts the visit, there are seen within 7 days of discharge from the hospital. Priority referrals are seen within 24 hours of discharge. KIDSNET tracks all at-risk newborns to ensure that they have a Level II screening through the DFH's Newborn Screening Program and, if appropriate, referral to the DFH's Early Intervention (EI) Program. Developmental risk factors include maternal age status under 19 or over 37 years, first baby status, and maternal education status < 11th grade. The majority of children eligible for EI services are identified through the state's "Child Find" infrastructure, which includes the FOP. Families with children in EI receive home visits from EI service coordinators on an ongoing basis.***

***"Hard-to-reach" families, including those who move frequently, are of particular concern. In FY2003, the DFH's EI Program provided additional funding to the FOP to provide outreach to "hard-to-reach" families. In addition, the DFH's Communication Unit developed new culturally and linguistically appropriate informational brochures for families about the FOP in English and in Spanish during FY2003. 300 additional hours of training was provided to FOP home visitors on the issues and needs of "hard-to-reach" families. FOP data suggests an improvement in the acceptance rate for this population //2005//.***

**b. Current Activities**

***/2005/ The DFH's Family Outreach Program (FOP) continues to provide home assessments, connection to community supports, and help with child development and parenting for almost one-third of all families with newborns. The DFH continues to define the early newborn period as being up to 90 days after an infant is born, since***

**most premature and low birth weight infants are not discharged from the hospital immediately after birth. Home visitors also continue to serve as the follow-up mechanism for the DFH's Newborn Screening, Early Intervention (EI), Lead Poisoning, and Immunization Programs. KIDSNET generates daily electronic referrals to the FOP for infants identified to be at developmental risk.**

**A little more than half of newborns in the state qualify for FOP services. Home visits are voluntary, but if the family accepts the visit, there are seen within 7 days of discharge from the hospital. Priority referrals are seen within 24 hours of discharge. KIDSNET continues to track all at-risk newborns to ensure that they have a Level II screening through the DFH's Newborn Screening Program and, if appropriate, referral to the DFH's Early Intervention (EI) Program.**

**The majority of children eligible for EI services are identified through the state's "Child Find" infrastructure, which includes the FOP. Families with children in EI continue to receive home visits from EI service coordinators on an ongoing basis. KIDSNET data is being utilized to help develop a newborn risk assessment CQI plan, which will include the FOP. The DFH's EI Program has provided additional funding to the FOP to provide outreach to "hard-to-reach" families.**

**The DFH's Birth Defects Surveillance Initiative worked with the DFH's FOP to ensure that children with birth defects receive appropriate services and referrals. Data from the birth defects surveillance system were compared with data from selected FOP organizations to determine referrals.**

**In addition, the DFH's Communication Unit developed new culturally and linguistically appropriate informational brochures for families about the FOP. 300 additional hours of training was provided to FOP home visitors on the issues and needs of "hard-to-reach" families. FOP data suggests an improvement in the acceptance rate for this population //2005//.**

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

**/2005/ The DFH's Family Outreach Program (FOP) will continue to provide home assessments, connection to community supports, and help with child development and parenting for almost one-third of all families with newborns in FY2004. The DFH will continue to define the early newborn period as being up to 90 days after an infant is born, since most premature and low birth weight infants are not discharged from the hospital immediately after birth. Home visitors will also continue to serve as the follow-up mechanism for the DFH's Newborn Screening, Early Intervention (EI), Lead Poisoning, and Immunization Programs. KIDSNET will continue to generate daily electronic referrals to the FOP for infants identified to be at risk for developmental delay.**

**A little more than half of newborns in the state qualify for FOP services. Home visits will continue to be voluntary and, if the family accepts the visit, they will continue to be seen within 7 days of discharge from the hospital. Priority referrals will continue to be seen within 24 hours of discharge. KIDSNET will continue to track all at-risk newborns to ensure that they have a Level II screening through the DFH's Newborn Screening Program and, if appropriate, referral to the DFH's Early Intervention (EI) Program. The majority of children eligible for EI services are identified through the state's "Child Find" infrastructure, which includes the FOP. Families with children in EI will continue to**

**receive home visits from EI service coordinators on an ongoing basis.**

**Beginning in FY2004 and throughout FY2005, the DFH will phase in the use of an electronic integrated birth certificate and developmental risk assessment at all maternity hospitals in RI. This initiative will help cross check that all babies are included and sent to KIDSNET. KIDSNET will then begin to generate electronic referrals for all at-risk infants. KIDSNET will continue to provide support in data analysis and respond to FOP data requests. To increase the number of families accepting home visits, families will receive information about the FOP prenatal or in the hospital prior to discharge. Culturally and linguistically appropriate informational brochures about the FOP that were developed by the DFH's Communication Unit in FY2003 will be used for this purpose.**

**The DFH's Birth Defects Surveillance Initiative will continue to work with FOP organizations to ensure that children with birth defects receive appropriate services and referrals. The Birth Defects Surveillance Initiative will continue to work with its advisory committee to implement a referral process for infants with sentinel conditions to assure outreach and follow-up. In FY2005, babies identified with sentinel conditions will continue to be referred to the FOP to ensure that they have "medical homes" and receive appropriate referrals to other support services //2005//.**

State Performance Measure 10: *The number of completed family surveys.*

**a. Last Year's Accomplishments**

**//2005/ The DFH's WIC Program conducts an annual survey of WIC participants. The WIC survey is used to determine the nutrition education needs of WIC participants and customer satisfaction with WIC. The information from this survey is used to develop a nutrition education plan for the year at each local WIC agency. The WIC Program utilizes the information to plan training for local WIC staff on the nutrition education topics identified through the survey process. In FY2002, the WIC Program received 600 completed surveys (408 in English and 192 in Spanish).**

**WIC also conducted a survey of 253 individuals who participated in the Farmers Market Nutrition Program (FMNP) during FY2003. Of the 253 respondents, 34% reported improved attitudes and eating habits with respect to fruit and vegetable consumption and 22% said that they attended a "Veggin Out" educational session that teaches participants about the importance of fruit and vegetable consumption for good health and provides recipe ideas through culturally appropriate cooking demonstrations.**

**The DFH's Early Intervention (EI) Program conducted an annual survey of families with children enrolled in EI in FY2003. 459 families completed this survey. In addition, the EI Program conducted a second survey of 102 families to gather data on families' experiences with the EI transition process, the strengths and weaknesses of the EI transition process, and the families' knowledge of available resources for their child. Both EI surveys were available in English and in Spanish.**

**The DFH's Healthy Child Care Rhode Island (HCCRI) initiative surveyed 30 parents of children in childcare in FY2003. The survey was conducted to determine parents'**

**perspectives around what kind of child educational resources they felt would be helpful beyond the topic of just child care (i.e. health information, parenting information, community resources, etc.)**

**The DFH continued to support Ready To Learn Providence (RLP), Newport CATCH, and Mt. Hope CATCH community needs assessment, strategic planning, and implementation to increase utilization of maternal and child health services in Newport County and Providence. As a part of the DFH's efforts in these areas, families were surveyed.**

**The DFH applied for and received funding in FY2002 to develop and implement the Pregnancy Risk Assessment Monitoring System (PRAMS) in RI and the DFH sent surveys to over 2,000 women, 2-4 months post delivery, during FY2003. PRAMS includes 60 core questions and 26 state specific questions. The information collected will address many national and state MCH performance measures, including those related to prenatal care, breastfeeding, genetics, childhood lead screening, immunization, and health insurance. Prior to the development of the materials, the DFH's Communications Unit conducted formative research with the targeted audience and pre-tested and revised materials based on feedback from the targeted audience //2005//.**

#### **b. Current Activities**

**/2005/ In FY2003, the DFH conducted 3,215 family surveys. In FY2003, 796 WIC participants completed the annual WIC survey. In addition, 295 WIC families completed Farmers Market Nutrition Program (FMNP) surveys (200 in English and 95 in Spanish).**

**The DFH's OCSHCN conducted its annual survey of families with CSHCN receiving services through the DFH's Early Intervention (EI) Program. The purpose of the survey is to assess family satisfaction with the EI Program (in particular, with EI specialty providers and the transition from EI to Special Education process). In FY2003, 212 families completed surveys (181 in English and 31 in Spanish).**

**The DFH's "Keep Your Baby Lead Safe" Program conducted 102 pre-intervention surveys (60 in Spanish and 42 in English) and 67 post-intervention surveys (42 in Spanish and 24 in English) during FY2003.**

**The DFH's Communications Unit conducted two family surveys in FY2003. The first one surveyed 112 racially and ethnically diverse residents from urban and rural communities to assess their understanding and information needs around bio-terrorism. The second surveyed 31 youth ages 11-20 affiliated with services such as Traveler's Aid for the purposes of developing materials targeting "hard-to-reach" youth with Hepatitis messages.**

**An internal DFH "Medical Home" Performance Measure Work Group began to develop performance measures to measure the quality of "medical homes" statewide. Newport County CATCH collaborated with the DFH on this initiative by conducted focus groups with families (including Spanish-speaking families), providers, and school nurse teachers to develop descriptive definitions for "medical homes".**

**The DFH's Community Partnership Programs conducted or is conducting several family surveys: Mt. Hope CATCH (120 parent surveys and 4 focus groups with parents on access to quality medical homes), Newport County CATCH (10 discussions with 100 parents on medical homes), Washington County CATCH (so far, 125 parent surveys on the topic of mental health services), and Child Opportunity Zone Centers (health surveys to assess family needs targeting 785 families will be completed in June of**

2004). In addition, Successful Start includes 4 workgroups. The workgroups include parent members.

During 2003, the DFH received a total of 1,414 completed PRAMS surveys. Weighted data from CDC indicate that RI PRAMS achieved a 70% overall response rate. Survey data are currently being analyzed //2005//.

c. Plan for the Coming Year

/2005/ The DFH's WIC Program will continue to conduct an annual survey of about 800 WIC participants. The WIC survey is used to determine the nutrition education needs of WIC participants and customer satisfaction with WIC. WIC will also conduct a survey of about 250 individuals who participate in the Farmers Market Nutrition Program (FMNP).

The DFH's Early Intervention (EI) Program will continue to conduct an annual survey of families with children enrolled in EI in FY2005. Through this survey, families are asked about the quality of the services they received through EI.

As a part of the DFH's community needs assessment and strategic planning efforts, Ready To Learn Providence (RLP), Newport County CATCH, and Mt. Hope CATCH will continue to obtain input from families on an ongoing basis. More recently, the DFH was awarded funding for Successful Start, a statewide systems development initiative that will assess capacity, quality, and integration issues surrounding 5 core components of RI's early childhood system. Family input will continue to represent an important part of this initiative.

/2005/ The DFH will continue to conduct PRAMS, analyze data, and work with its Steering Committee for reporting and data dissemination. The DFH will also utilize FY2005 to implement the PRAMS "toddler" survey, which will be sent to about 1,100 mothers each year. The "toddler" survey will be sent to those respondents who agreed to be contacted in two years (805 of respondents agreed). Reminder letters continue to be sent to those respondents one year after their completion of PRAMS to ask if they would still like to participate and to provide updated contact information. The information collected through PRAMS and the PRAMS "toddler" survey will continue to address many national and state performance measures, including those related to prenatal care, breastfeeding, genetics, lead screening, immunization, and health insurance //2005//.

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The number and percentage of children greater than or equal to 19 months old in childcare who are up-to-date on their immunizations.				
1. Conducts assessments at licensed child care centers, Head Starts, & kindergartens.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Provides information and TA to licensed child care centers, Head Starts, & kindergartens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Will assess home child care provider sites.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provides free immunizations to uninsured and under-insured children and vaccines to providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Tracks immunization status of children born as of 1/1/97 and sends parents and providers reminders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Captures maternal Hepatitis B information and follows-up on infants with positive results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Assesses immunization status of WIC participants and refers children who are behind for follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Ensures follow-up and education to families with children who are behind on their immunizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Sponsors special events about the importance of immunizations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Provides child care providers and families with immunization information through the CCSN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percentage of students in schools with school-based health centers (SBHCs) who are enrolled in SBHCs.				
1. Supports 8 SBHCs in urban communities and supports activities to increase SBHC enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Produced a report on the effectiveness of SBHCs in RI to gather support for and expand SBHCs in RI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Ensures vaccinations to SBHC students who are graduating from high school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Developed and distributed marketing materials for the "Vaccinate Before You Graduate" initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Helped the City of West Warwick and a statewide technical school apply for SBHC funding.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Worked with NHPRI to enhance preventive health care services for SBHC students with Rite Care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Collaborated with the Title X family planning program to train SBHC providers about Title X.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Developed SBHC guidelines, which incorporate GAPS and Bright Futures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Provides ongoing information and TA to SBHC providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The proportion of pregnant women who receive an alpha-fetoprotein (AFP) test.				
1. Ensures no cost pregnancy testing and risk assessment and genetics referrals in Title X clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Ensures that pregnant and non-pregnant women have access to folic				

acid education and multi-vitamins.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Refers pregnant women to home visiting services for support and education about prenatal testing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Developed/distributed a brochure to increase public awareness about genetics testing and counseling.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Conducted a study to determine the prevalence of open neural tube defects.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Utilizes parent consultants to obtain input about genetics activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is working with W & I Hospital and the RIGCC to explore information exchange.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Assesses if genetics services are offered prenatally to families with a child w/ birth defects.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Conducted a study to determine the prevalence of open neural tube defects before & after and grain fortification.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percentage of pregnant women in at-risk population sub-groups who received prenatal care beginning in the first trimester (Data reflects African American/Black women only).				
1. Ensures no cost pregnancy testing and risk assessment and referral in Title X clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Refers pregnant women for home visiting services to ensure that they are linked to prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provides pregnant women with information about the importance of prenatal care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assists pregnant women with the completion of applications for RItE Care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Maintains a statewide toll-free telephone resource and distribution center.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Tracks the race/ethnicity status of newborns & collects information on prenatal care participation.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Ensures pregnant women in Providence have lead education and referral to lead hazard reduction work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Surveys about 160 recent mothers each month about their prenatal care through PRAMS.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) The percentage of children less than 6 years of age in at-risk sub-populations with lead levels greater than or equal to 10 ug/dl (Data presented reflects lead levels among children in core cities).				
1. Funds lead screening and medical treatment for uninsured and				

underinsured children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Refers significantly lead poisoned children for case management, medical treatment, and lead inspections.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Encourages families of children with lower lead levels to request lead education home visiting services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Promotes prenatal education and referrals to lead hazard reduction resources for pregnant women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Works with the RI Housing Resources Commission to impleemnt the new Lead Hazard Mitigation Law.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Implements statewide lead poisoning prevention activities on an ongoing basis throughout the year.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Provides informational materials and maintains a website on lead for families, providers, homeowners, & others.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Includes lead screening status on immunization forms used for entry into child care and school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Refers WIC children with elevated lead levels for WIC nutrition counseling and nutritious foods.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Provides child care providers and families with lead information through the CCSN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of 9th graders who are expected to graduate from high school.				
1. Supports 7 SBHCs in urban communities and supports activities to increase SBHC enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Supports the "Vaccinate Before You Graduate" initiative in 31 high schools.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Ensures no cost pregnancy testing and risk assessment and referral in Title X clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Links non-pregnant teens with family planning services and refers pregnant teens for follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implemented a statewide media campaign projecting positive images of youth directed towards adults.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Developed informational materials for parents of teens and other adults involved with teens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Provides training to adult men on how to become effective role models for boys.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Participates on a statewide network working to enhance programs for fathers in RI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Is working to develop a statewide infrastructure for school health programs in RI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Is working to build capacity for youth development activities and out-of-school time programs in RI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The percentage of children in the Early Intervention Program				

with Individual Family Service Plans (IFSPs), discharged to Special Education, for whom an Individual Education Plan (IEP) is developed.				
1. Supports 7 statewide Early Intervention sites and implemented certification standards.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Established transition goals to ensure that timelines in IDEA are met.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Holds transition meetings and shares information w/ the Inter-Agency Coordinating Council.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Utilizes parent consultants to support families at transition meetings and to develop EI website.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Developed and distributed informational materials targeting families and providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Implemented a communications campaign to reach out to families with potentially eligible children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Will develop a transition coordinator position jointly w/the RI Department of Education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Will implement a process enabling audiologists to participate in IFSP development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Will assist RIDHS implement CEDARR and transition OCSHCN from fee-for service Medicaid to Rlte Care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Visits pediatric practices to discuss issues related to EI transition.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The percentage of infants who are underweight (low weight for stature)and the percentage of children who are underweight and overweight (high weight for stature) in the WIC Program.				
1. Revised RI growth standards to reflect current CDC & WIC standards.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Ensures that WIC families have access to nutritious foods & nutrition/physical activity education.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is working with a coalition to develop anticipatory guidance for childhood obesity prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Is working to enhance childhood obesity counseling skills at local WIC sites.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Supports the FMNP to provide low-income families w/ access to fresh fruits & vegetables.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Conducts customer satisfaction and effectiveness surveys for the WIC and FMNP programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Holds cooking demonstrations as part of the FMNP, and provides translators at FMNP sites.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Developed and distributed a WIC food guide and outreach materials targeting working families.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Utilizes parent consultants to assist w/ the development of WIC educational materials and outreach.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is working to develop new and revise existing WIC consumer educational materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) The percentage of at-risk (risk positive) newborns who receive a home visit from the Family Outreach Program (FOP).				
1. Ensures home assessments, connection to community supports, & help w/ child development & parenting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Serves as the follow-up mechanism for several DFH programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Supports outreach to "hard-to-reach" families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Supports training to FOP home visitors on "hard-to-reach" families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Tracks all at-risk newborns and, if appropriate, referral to the EI Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Is developing a new CQI plan for the FOP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Is working to develop an electronic integrated risk assessment and birth certificate form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Is working to inform families about FOP service prenatally or before hospital discharge.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Developed and distributed informational materials for the FOP.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Utilized parent consultants to help with the development of new informational materials.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The number of completed family surveys.				
1. Conducts an annual customer satisfaction and effectiveness survey targeting WIC participants.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Conducts an annual customer satisfaction and effectiveness survey targeting FMNP participants.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Conducts an annual survey targeting families w/ children in Early Intervention (EI).	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Conducts lead poisoning pre-intervention and post-intervention surveys with pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Developed/implemented communication strategies for programs, including focus groups w/ families.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Conducts focus groups on "medical homes" with families.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Supports community driven needs assessments in Providence, Newport County, Washington County, and COZ neighborhoods.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Supports statewide community driven needs assessment relating to RI's early childhood system.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Surveys about 160 recent mothers each month on a variety of topics as a part of PRAMS.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Will implement a PRAMS "toddler" survey 1 year after their mothers participated in PRAMS initially.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## E. OTHER PROGRAM ACTIVITIES

Other MCH Program Services

## Poison Center Services

*/2004/*: The Regional Center for Poison Control and Prevention, housed at Children's Hospital, Boston, received 77,390 calls in 2002. Of these calls, 52,181 were poison exposure calls and 25,209 were information calls. About 14% of the calls to the Center are from Rhode Islanders, including 8,335 poison exposure calls and 2,768 information calls. In 2002 the Center hired a part-time bi-lingual (English/Spanish) health educator. The Department funds the Center at a level of \$300,000 per year. State funding (\$250,000) eliminated in the June 2003. However, the Department of Health was able to fund the Center for 2004 at a level of \$250,000 using mostly bio-terrorism funds. Stable funding and staffing continue to be the major threats to the Center. The Poison Center Advisory Committee has recommended that the Center pursue additional funding sources that are more stable in nature, e.g., 911 subsidies. The Advisory Committee as part of its strategic plan has also recommended that the Center continue to pursue opportunities that lead to further regionalization of poison center services in New England *//2004//*.

***/2005/*: The Regional Center for Poison Control and Prevention, housed at Boston Children's Hospital, received 65,598 calls in FY2003. Of these calls, 52,739 were poison exposure calls and 15,859 were information calls. About 16% of the calls were from Rhode Islanders, including 7,415 exposure calls and 2,954 information calls. In FY2004, responsibility for the Poison Center was transferred from the DFH to HEALTH's division of Environmental Health, Office of Environmental Health Risk Assessment. This reorganization more closely aligns the Center with HEALTH's Bio-Terrorism and Environmental infrastructures. The DFH continues to work closely with the Center's Health Educator to integrate education and outreach efforts into the DFH's programs. The Center continues to be funded at a level of \$250,000 using mostly Bio-terrorism funds //2005//.**

## Child Maltreatment Surveillance Project

*/2003/*: The DFH applied for and received a new federal CDC grant to improve surveillance of child maltreatment and morbidity. The goals of this initiative include evaluating alternative approaches to surveillance of non-fatal child maltreatment and piloting methods that may be used for surveillance of violence. The DFH is working with pediatricians at Hasbro Children's Hospital and researchers at Brown University to conduct case studies of cases involving the Rhode Island Department of Children, Youth, and Families (RIDCYF) and to review hospital discharge and emergency room admissions. The grant provides the DFH with a promising opportunity to evaluate and pilot new, more sophisticated approaches to surveillance in this area.

*/2004/* DFH staff meets with representatives from the Child Advocate's Office, the Medical Examiner's Office, the Attorney General's Office, the RIDCYF, Brown University, and Hasbro Children's Hospital staff regularly. The group reviews hospital discharge data (including emergency room data) of all fatal cases of children, under age 21 years, who had one or more of 30 ICD9 codes related to possible child maltreatment to look for "missed opportunities". The group also compares hospital discharge data of non-fatal case of children under age 21 with RIDCYF case data *//2004//*. The Child Maltreatment Surveillance Project is expected to end in FY2005 *//2005//*.

## ***Toll-Free Family Health Information Line***

***The DFH supports a statewide toll-free telephone resource for all families in Rhode Island. Bi-lingual information specialists answer families' questions on a wide variety of topics and refer them to appropriate community resources. Culturally and linguistically appropriate consumer informational materials will continue to be disseminated through the DFH's centralized distribution center.***

***/2005/* Called the Family Health Information Line, this resource has received a total of 20,359 calls since it was implemented in 1998. Forty-nine percent (49%) of the calls were related to WIC; 14% to lead poisoning; 12% to immunizations; 8% to other "non-DFH" issues; 6% to**

**environmental issues (i.e. bio-terrorism, West Nile Virus, and mold/mildew); 5% to family planning; 3% to PRAMS, KIDSNET, the Family Outreach Program, or Rite Care; 2% to Early Intervention or disabilities; and 1% to adolescent health.**

**Ninety-six percent (96%) of the callers were from consumers. The remaining 4% were from professionals. Eighty-seven percent (87%) of the callers were English-speaking, 12% were Spanish-speaking, and 1% spoke some other language. Currently, the DFH's Communication Unit, which is responsible for managing the Family Health Information Line and centralized Distribution Center, is working to increase the DFH's reach in the Latino community //2005//.**

## **F. TECHNICAL ASSISTANCE**

*/2004/ Technical Assistance FY2004*

1. GENERAL SYSTEMS CAPACITY ISSUES: Technical assistance is requested for expanded use of national and state survey data in planning, management, and evaluation of critical Family Health investments. This request responds to our identified priorities in needs assessment, community capacity building, and communication, and addresses several national and state performance measures, as well as our data capacity needs.

Assistance is needed because Rhode Island has committed to prompt sophisticated use of survey data for public health leadership and accountability. We have developed extensive survey data within the state (PRAMS, Parent surveys, YRBS, state HIS, SALT survey of schools) and national data (SLAITS, Immunization) is available to inform MCH policy, as well. Completing a plan to use these data effectively for Family Health leadership, and engagement of academic and other partners in the work, will be the objective of this TA.

Preliminary discussions with Prof Milton Kotelchuck of the Boston University School of Public Health indicates that this assistance would be an appropriate expansion of their expanding support relationship to New England states.

2. NATIONAL AND STATE PERFORMANCE MEASURES: Technical assistance is requested in developing and staffing a broad state analysis and plan to address increasing rates of premature and VLBW births. As in other parts of the country, Rhode Island has disturbing increases in babies born too early and too small. Despite high levels of Medicaid coverage and enrollment in prenatal care, and an excellent system for managing high-risk pregnancies and sick newborns, this fundamental measure of pregnancy outcomes (and public health) is moving in the wrong direction. This request addresses SPM 4 and NPM 15,17, and 18.

Assistance is requested because there are important opportunities to engage nearby resources, both in Rhode Island and in New England, for excellent analysis and effective planning.

We propose to invite Dr Julius Richmond and several other members of the Massachusetts panel that studied infant mortality and designed the Mass Healthy Start program, for a day of preliminary discussions with Rhode Island leaders on keys to success with such an effort. Then we will likely request assistance to engage needed participation from the National Perinatal Information Center, for access to their excellent data on these issues in other comparable environments, and for analytic assistance //2004//.

***/2005/ Technical Assistance FY2005 -- General Systems Capacity Issues Category***

***1. The DFH is requesting technical assistance to help better understand the provisions of HIPAA and FERPA in terms of health information & data collected by schools. The DFH needs to better understand constraints related to sharing data between the DFH and schools and develop strategies to facilitate sharing of health information and data with a goal of improving***

**outcomes for students. The technical assistance will be done in consultation with Gail Hurlich of the national Immunization Program.**

**2. Technical assistance is requested for national champions for healthy child and human development. The DFH, the Rhode Island Department of Health, and the Children's Cabinet are all involved in strategic planning to incorporate modern models of child and human development into public health. To strengthen and support this opportunity, the DFH proposes to invite several national leaders of the SECCS projects and the recent IOM reports, as keynotes for public health forums and as consultants to the strategic planning teams. Examples of national leaders may include Doctors Halfron, Shonkoff, and Stein.**

**3. Technical assistance is requested to help the DFH and its partners better understand how to include youth in programmatic and policy-making processes and to build effective youth/adult advocacy networks. As recipients of services and programming, youth have expertise to inform the planning and policy-making processes at state and local levels. Youth and adults need training and technical assistance to learn how to interact in meaningful productive ways and how to measure success. The technical assistance will be done in consultation with Youth Infusion ([www.youthinfusion.com](http://www.youthinfusion.com)) //2005//.**

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

/2004/ Expenditures

#### Federal Grant Monitoring Procedures

The Division of Family Health (DFH) 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 Divisions and by HEALTH's Office of Management Services (OMS). The DFH's key administrator meets bi-weekly with DFH 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 DFH's key administrator. 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 DFH's key administrator and office chief. 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 DFH has established an inventory management plan that includes rules for purchasing of major equipment, monitoring equipment purchased with state dollars, and a plan for surplus 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 DFH's chief of staff and key administrator meet with the DFH office chiefs to review contracts 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 DFH has routinely held back payments or terminated contracts for issues around performance and progress. The DFH's program managers must review the appropriateness of all charges to the contract. Any variation in billing from the established contract must be requested in writing before reimbursements are made. DFH 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 or conducted at HEALTH annually. The DFH has frequently been audited ? the WIC Program is audited annually and Early Intervention and Family Planning were audited in FY2000. HEALTH's OMS conducts audits of the DFH's contracts regularly and monitors payments. In addition to external audits, the DFH routinely audits all of its sub-contracted agencies and requires formal audits to be sent to the DFH 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. In the past, the DFH has completed a financial control review of its personnel and contracting policies. Corrections to these policies, such as documented procedure manual contracting and elimination of budgetary changes without written permission, have been instituted as a result of these financial control reviews.

### Significant Year-To-Year Expenditure Variations On Forms 3, 4, & 5

#### Form #3

This form shows less state budget dollars available for FY04 than available for FY03. This represents a shift in Early Intervention state funds from those appropriated to an anticipated collection of these funds from private insurers. If the private insurers collections are not available, the division plans to request a supplemental appropriation for EI services. The increase in program income dollars from FY03 to FY04 represent additional immunization assessment funds from insurers to cover the cost of vaccines. There are more federal dollars available in FY04 than in FY03 representing a consistent shift in the use of federal funds rather than state funds to support division activities. Some of the grants that account for this increase include Early Hearing and Detection, Family Planning, Part C Early Intervention, Newborn Hearing and Birth Defects.

#### Form #4

More resources are budgeted for infants in FY03 and FY04 than for FY02 because of increase resources for immunization and federal funds listed above for this population. The increase of resources for the special needs population not only is due to our new Office for Families Raising Children with Special Needs but more federal funds for this population from both CDC and the Department of Education. Our anticipated increase in expenditures for FY04 represent our new funds that are anticipated from HRSA for our early childhood activities.

#### Form #5

Changes in expenditures by types of service vary slightly in all categories. The increases from FY02 expended to FY03 Budgeted to FY04 budgeted for population based services is due to our additional immunization payments. The increased for the same period for infrastructure activities is due to the additional federal funds and investments in our MCH Hotline, and communication activities, children with special needs and Early Intervention activities. The direct services decline is due to a loss of some Early Intervention funds in FY04 for this category //2004//.

### ***/2005/ Significant Year-to-Year Expenditure Variations on Forms 3, 4 & 5.***

#### ***Form #3***

***Our expenditures for FY03 increased from the amount budgeted to expended on Form #3 because of our unobligated balance from the prior year. The division spent an additional \$400,000 of Title V funds from FY02 to FY03 and over \$1million dollars in carry-forward from FY03 budgeted to FY03 spent. Most of the expenditures for FY03 were wraparound services***

**for children with special needs. The division relies on this prior year balance to fund new initiatives and unplanned expenditures. There were some changes in federal funds from FY02 spent to FY05 budget, most notably the Centers for Disease Control funding for the Childhood Lead grant, Meningitis funds but loss of funding for the Data and Evaluation and Birth Defects grants. Early Intervention resources increased from FY02 to FY03 spent to account for dollars budgeted for insurance payments. WIC funds increased from FY02 to FY03**

#### **Form #4**

**More resources are budgeted for infants in FY05 than in FY03 because of increase resources for immunization and federal funds listed above for this population. The increase of resources for the special needs population not only is due to our new Office for Families Raising Children with Special Needs but more federal funds for this population from both CDC and the Department of Education. There is additional immunization funds budgeted in FY05 than in FY03 and a \$50,000 grant for child cares services.**

#### **Form #5**

**Changes in expenditures for direct health services from FY02 to FY03 is due to a \$400,000 increase in Early Intervention Services. The largest change in expenditures is for direct services and population based services. The division has reduced the state funding for Early Intervention in anticipation of receiving revenues from private insurers //2005//.**

## **B. BUDGET**

/2004/ Budget

Title V expenditures for FY02 were 31% to preventive services for children, 33% to children with special health care needs and 7% for administrative match. In FY2004, the Division proposes to spend \$1,790,611 including a carryforward of \$175,000 from FY03. We continue to focus our attention on establishing a new Office of Children with Special Health Care Needs, the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments. Our Year 2004 budget allocates \$1,739,885, of which 33% (\$590,902) were spent on preventive services for children, 32% (\$572,995) were expended for children with special care needs and 8% (\$143,249) was allocated for administrative cost. The Division's MCH budget for FY2004 is \$42,866,665, with \$7,140,306 allocated from state resources not including program income and private funds. The Division's total budget for FY2004 includes new and additional federal resources from HRSA and CDC for Family Planning, Early Hearing and Detection, Early Intervention Part C and Data Utilization and Enhancement. Our Maternal and Child Health investment for FY02 was \$38,363,223 including \$6,818,017 of state funds, not including program income and private funds.

The difference in dollars budgeted to dollars spent in FY02 is due to less spending in the state account for Early Intervention Services. The expenditure for EI is accounted in the state Medicaid account which is not included in this calculation. The state match exceeds the three for four-requirement for the expended FY2002 funds and the proposed FY2004 funds, including the carry forward. The maintenance of effort amount for FY2002 and for proposed FY2004 exceeds the FY89 level of effort of \$1,875,000. Our commitment to Early Intervention, Kids Net, Family Outreach/ Home Visiting and School Based Health Centers 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 \$5,306,133 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities, representing a decrease in state investment in Early Intervention services. RI is planning to offset EI expenditures through collections from private insurance. RI proposed to expend \$7,852,933 on

population based services an increase from prior years reflecting our investment in Childhood Immunization as well as newborn screening. There is decrease in direct medical services from the prior year (\$2,459,381), mostly from change in categorizing EI investments. Enabling services equals \$502,314 which is a similar to prior years investments.

The Division plans to allocate its FY2004 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 administrator prior to reimbursement.

#### Significant Year-To-Year Expenditure Variations On Forms 3, 4, & 5

##### Form #3

This form shows less state budget dollars available for FY04 than available for FY03. This represents a shift in Early Intervention state funds from those appropriated to an anticipated collection of these funds from private insurers. If the private insurers collections are not available, the division plans to request a supplemental appropriation for EI services. The increase in program income dollars from FY03 to FY04 represent additional immunization assessment funds from insurers to cover the cost of vaccines. There are more federal dollars available in FY04 than in FY03 representing a consistent shift in the use of federal funds rather than state funds to support division activities. Some of the grants that account for this increase include Early Hearing and Detection, Family Planning, Part C Early Intervention, Newborn Hearing and Birth Defects.

##### Form #4

More resources are budgeted for infants in FY03 and FY04 than for FY02 because of increase resources for immunization and federal funds listed above for this population. The increase of resources for the special needs population not only is due to our new Office for Families Raising Children with Special Needs but more federal funds for this population from both CDC and the Department of Education. Our anticipated increase in expenditures for FY04 represent our new funds that are anticipated from HRSA for our early childhood activities.

##### Form #5

Changes in expenditures by types of service vary slightly in all categories. The increases from FY02 expended to FY03 Budgeted to FY04 budgeted for population based services is due to our additional immunization payments. The increased for the same period for infrastructure activities is due to the additional federal funds and investments in our MCH Hotline, and communication activities, children with special needs and Early Intervention activities. The direct services decline is due to a loss of some Early Intervention funds in FY04 for this category //2004//.

#### ***/2005/ Budget***

***Title V expenditures for FY03 were 30% to preventive services for children, 35% to children with special health care needs and 5% for administrative match. In FY2005, the Division proposes to spend \$1,768,713 including a carryforward of \$262,026 from FY04. Our new Office of Children with Special Health Care Needs is addressing the needs of vulnerable young children and adolescent, investing in Early Intervention, parent involvement and system building. Family Health continues to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments. Our Year 2005 budget allocates \$1,768,713, of which 30% (\$530,202) were spent on preventive services for children, 35% (\$619,050) were expended for children with special care needs and 7% (\$129,898) was allocated for administrative cost. The Division's MCH budget for FY2004 is \$45,538,216, with \$6,936,010 allocated from state resources not including program income and private funds. The Division's total budget for FY2005 includes new and additional federal***

**resources from HRSA and CDC for Family Planning, Early Hearing and Detection, Early Intervention Part C and Data Utilization and Enhancement. Due to a large expenditure for children with special needs, the division expended \$3,276,581 in FY03 but budgeted \$1,959,778. This expenditure includes a \$1,073,892 carry forward spend in FY03. Our Maternal and Child Health investment for FY03 was \$43,657,106 including \$9,335,723 of state funds, not including program income and private funds. The increase in dollars budgeted to dollars spent in FY03 is due to additional spending in the state account for Early Intervention Services. The expenditure for EI is accounted in the state Medicaid account which is not included in this calculation. The state match exceeds the three for four-requirement for the expended FY2003 funds and the proposed FY2005 funds, including the carry forward. The maintenance of effort amount for FY2003 and for proposed FY2005 exceeds the FY89 level of effort of \$1,875,000. Our commitment to Early Intervention, Kids Net, Family Outreach/ Home Visiting and School Based Health Centers 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 \$5,487,490 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities, representing a decrease in state investment in Early Intervention services. RI is planning to offset EI expenditures through collections from private insurance. RI proposed to expend \$7,391,122 on population based services an increase from prior years reflecting our investment in Childhood Immunization as well as newborn screening. There is decrease in direct medical services from the prior year (\$1,328,515), mostly from change in categorizing EI investments. Enabling services equals \$482,631, which is a similar to prior years investments.**

**The Division plans to allocate its FY2005 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 administrator prior to reimbursement.**

### **Significant Year-to-Year Expenditure Variations on Forms 3, 4 & 5.**

#### **Form #3**

**Our expenditures for FY03 increased from the amount budgeted to expended on Form #3 because of our unobligated balance from the prior year. The division spent an additional \$400,000 of Title V funds from FY02 to FY03 and over \$1million dollars in carry-forward from FY03 budgeted to FY03 spent. Most of the expenditures for FY03 were wraparound services for children with special needs. The division relies on this prior year balance to fund new initiatives and unplanned expenditures. There were some changes in federal funds from FY02 spent to FY05 budget, most notably the Centers for Disease Control funding for the Childhood Lead grant, Meningitis funds but loss of funding for the Data and Evaluation and Birth Defects grants. Early Intervention resources increased from FY02 to FY03 spent to account for dollars budgeted for insurance payments. WIC funds increased from FY02 to FY03**

#### **Form #4**

**More resources are budgeted for infants in FY05 than in FY03 because of increase resources for immunization and federal funds listed above for this population. The increase of resources for the special needs population not only is due to our new Office for Families Raising Children with Special Needs but more federal funds for this population from both CDC and the Department of Education. There is additional immunization funds budgeted in FY05 than in**

***FY03 and a \$50,000 grant for child cares services.***

***Form #5***

***Changes in expenditures for direct health services from FY02 to FY03is due to a \$400,000 increase in Early Intervention Services. The largest change in expenditures is for direct services and population based services. The division has reduced the state funding for Early Intervention in anticipation of receiving revenues from private insurers //2005//.***

## **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.