2025 Community Health Needs Assessment

Care New England
Women & Infants Hospital

Final Report

July 2025

About Care New England and the 2025 CHNA

Care New England Health System (CNE) is dedicated to prioritizing its patients and the community in all its endeavors. As an integrated healthcare organization, CNE is committed to advancing medical research, attracting top specialty-trained doctors, offering renowned services, and implementing innovative programs. It aims to improve the wellbeing of individuals and communities through comprehensive healthcare services and essential discussions about health and end-of-life preferences.

At CNE, we believe that community engagement is essential to providing high-quality, compassionate care to all individuals, especially those in under-resourced communities. Healthcare is not just about clinical care, it is about building strong, trusting relationships with the communities we serve. By collaborating with local organizations and communities, we can better understand the unique health-related challenges people face, identify gaps in care, and create tailored solutions that meet the needs of the community. Engaging with our neighbors ensures that healthcare is not only accessible but also culturally responsive, equitable, and inclusive.

CNE is focused on improving healthcare by meeting the needs of individuals and communities. We serve the same areas where we live, work, and have fun. Community engagement is key to building trust with community members, patients, and employees. By involving our internal and external community in our health programs, we improve access, quality of care, and service delivery. We know that health equity and community engagement are closely connected. To improve health outcomes, we are finding ways to expand our community engagement efforts and focus on innovative healthcare solutions that put patients and the community first. Together with our partners, we are working to break down barriers to health, empower individuals, and contribute to a healthier, more resilient community for all.

CNE is dedicated to understanding and addressing the most pressing health and wellness concerns for the communities we serve. In collaboration with the Hospital Association of Rhode Island (HARI) and its member hospitals, CNE undertook a Community Health Needs Assessment (CHNA) for each of its hospitals' service areas. The goal of the CHNA is to monitor the health of community members and to identify common and unique challenges across the region. The CHNA informs the development of Community Health Improvement Plans (CHIPs) to address identified priority needs and align community investments with the highest needs.

Care New England Health System 2025 CHNA Leadership

Kevin Martins, Ed.D, Vice President and Chief Diversity Officer

Aleyra Lamarche Baez, DEI Community Engagement Liaison

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The 2025 Community Health Needs Assessment

The goal of the CHNA was to gather data and community input to inform strategies and policies to support a healthy and thriving Rhode Island and to foster collaboration among community organizations in developing and delivering services to the residents they serve.

CHNA Study Objectives:

- Compile a comprehensive profile of the factors that impact health and wellbeing for residents
- Compare community health indicators with previous CHNAs to document trends and changes
- Demonstrate the impact of Social Drivers of Health; document disparities experienced by populations and communities
- Strengthen community member engagement and partnerships; engage residents in the study process
- Define three-year priority areas and develop action planning
- Develop a community resource to monitor the progress of community health initiatives

The results of the CHNA will help us identify priorities and strategies to improve health and wellbeing in the region and promote health for all residents. Responding to the study findings and sharing data with other community-based organizations, HARI and its hospital members aim to ensure that all residents benefit from our local resources, robust social service network, and the high-quality healthcare available in our community to help residents live their healthiest lives.

We thank you for partnering with us in this effort. We invite our community partners to learn more about the CHNA and opportunities for collaboration to address identified health needs. Please visit our website at https://www.carenewengland.org/community-health-needs-assessment or contact Aleyra Lamarche Baez, DEI Community Engagement Liaison at ALamarchebaez@CareNE.org.

Research Partner

HARI and its member hospitals contracted with *Build Community* to conduct the CHNA. *Build Community* is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. An interdisciplinary team of researchers and planners, *Build Community* has worked with hundreds of healthcare and community-based organizations and their partners to reimagine policies and achieve measurable impact. Learn more about their work at buildcommunity.com.

2025 CHNA Leadership and Oversight

The Hospital Association of Rhode Island (HARI) is a statewide trade organization that assists member hospitals in effectively meeting the healthcare needs of Rhode Island through advocacy, representation, education, and services. HARI and its members work collaboratively to address issues impacting Rhode Island's healthcare system. Issues include increasing healthcare costs, healthcare transformation, eliminating patient harm, rising medical liability premiums, and decreasing reimbursement. Together with its members, HARI works to ensure that all Rhode Islanders receive comprehensive, high-quality care.

Since 2011, HARI has convened a steering committee of its member hospitals to collaborate on a statewide Community Health Needs Assessment (CHNA). This collaboration ensures a comprehensive study and comparisons of communities across the state and fosters collective impact to address the most pressing issues that impact health for Rhode Islanders. The following individuals served on the CHNA committee as liaisons to their organizations and the communities they serve.

HARI 2025 CHNA Partners and Steering Committee Members

Hospital Association of Rhode Island
Lisa Tomasso, *Senior Vice President*

Brown University Health
Carrie Bridges Feliz, *Vice President Community Health and Equity*

Care New England
Aleyra Lamarche Baez, *DEI Community Engagement Liaison*
Kevin Martins, *Vice President and Chief Diversity Officer*

CharterCARE
Otis Brown, *Vice President Marketing and External Affairs*

Eleanor Slater Hospital
Hector Guerreiro*, Associate Director of Admissions and Clinical Liaison*

Landmark Medical Center
Carolyn Kyle, *Director of Marketing, Physician Relations, and Business Development*

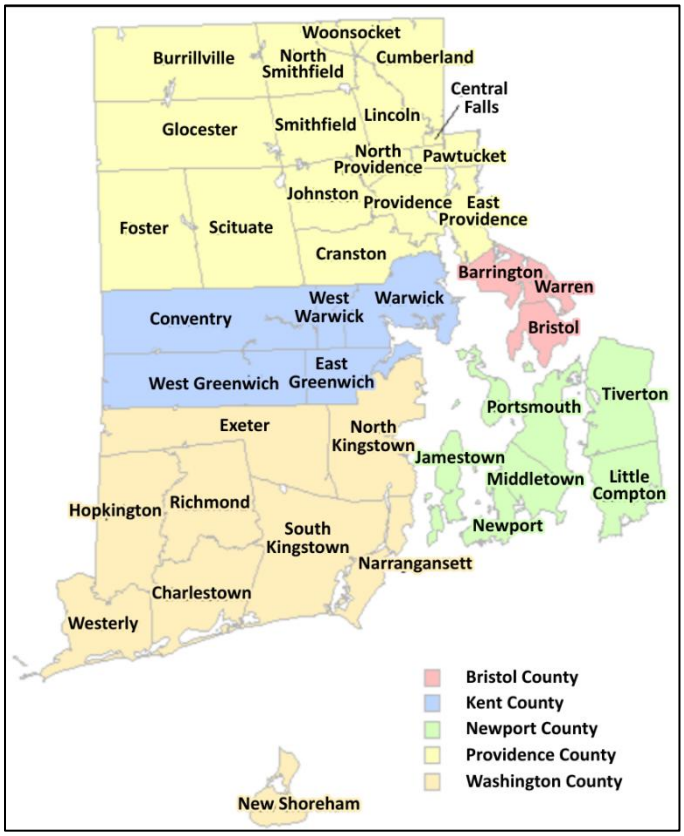
South County Health
Lynne Driscoll, *Assistant Vice President Community Health*
Holly Fuscaldo, *Clinical Medical Social Worker and Wellness Lead*
Nina Laing, *Manager Case Management*

Yale New Haven Health Westerly Hospital
Lindsey Greene-Upshaw, *Senior Manager Office of Health Equity and Community Impact*
Melissa Sigua, *Community Health Project Coordinator*

2025 CHNA Study Area

The CHNA data findings are reported for all Rhode Island counties with comparisons to state and national benchmarks.

Rhode Island Counties and Communities



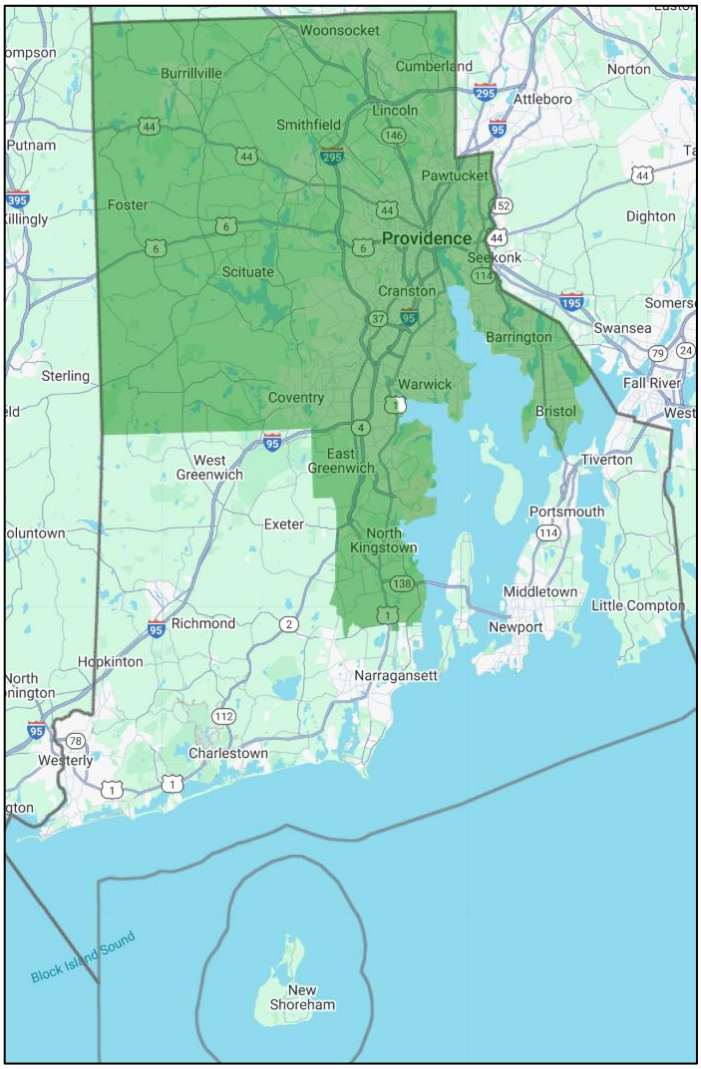
HARI 2025 CHNA Participating Member Hospitals and Locations

Health System	Member Hospital	City, Zip Code
Brown University Health	Bradley Hospital	Riverside, 02915
Brown University Health	The Miriam Hospital	Providence, 02906
Brown University Health	Newport Hospital	Newport, 02840
Brown University Health	Rhode Island Hospital	Providence, 02903
Care New England	Butler Hospital	Providence, 02906
Care New England	Kent Hospital	Warwick, 02886
Care New England	Women & Infants Hospital	Providence, 02905
CharterCARE Health Partners	Our Lady of Fatima Hospital	North Providence, 02904
CharterCARE Health Partners	Roger Williams Medical Center	Providence, 02908
Prime Healthcare	Landmark Medical Center	Woonsocket, 02895
Rhode Island Behavioral Healthcare, Developmental Disabilities & Hospitals	Eleanor Slater Hospital	Cranston, 02920
South County Health	South County Hospital	Wakefield, 02879
Yale New Haven Health	Westerly Hospital	Westerly, 02891

The hospitals defined their service areas as the county(ies) served and used the zip codes of residence for the majority of patients seen at their facilities to define their primary service area. Demographics and other available indicators for zip codes and neighborhoods within each hospital's primary service area were analyzed to determine opportunities for prioritized interventions to address health and social disparities.

As one of the nation's leading specialty hospitals for women and newborns, Women & Infants Hospital serves residents across Rhode Island. The hospital identified its primary service area as 64 zip codes spanning all of Providence County and portions of Bristol, Kent, and Washington counties.

Women & Infants Hospital Primary Service Area



Research Methods

The CHNA was conducted from October 2024 to June 2025 and included primary and secondary research methods to determine health trends and disparities.

Primary Research and Community Engagement

Community engagement was an integral part of the CHNA. Collaborating with community-based organizations across Rhode Island, input was invited and received from a wide array of community members with a particular focus on diverse populations, under-resourced areas, and communities that have been historically marginalized. Study participants provided perspectives on unmet health and social needs; community resources available to meet those needs; barriers to accessing services; service delivery gaps; and recommendations to improve health and wellbeing.

Key Stakeholder Survey

We conducted an online survey with 120 individuals that serve diverse communities and populations across Rhode Island to collect input about local health needs, client experiences in receiving and accessing services, and opportunities for collective impact.

Community Conversations and Engagement

We invited wide participation with diverse stakeholders and residents through community meetings and small group discussions to share CHNA findings and gather feedback on priority health issues. Participants included Rhode Island Department of Health officials, local Health Equity Zone (HEZ) members, and other community partners and coalitions to align efforts and promote collaboration across existing initiatives.

2025 CHNA Community Engagement Partners and Events

- Health Equity Zone (HEZ) Learning Community Quarterly Conferences
- HEZ Partners Evaluation Collaboration
- HEZ Leadership Collaboration
- Rhode Island Department of Health (RIDOH), Health Equity Institute Collaboration
- RIDOH/Providence HEZ Collaboration
- Narragansett Older Adults Focus Group
- Newport Partnership for Families Partner Meeting
- Partnership to Reduce Cancer Meeting
- Washington County Healthy Bodies, Healthy Minds Collaboration
- Washington County HEZ Housing Summit
- Washington County Partner Forum
- Westerly Older Adults Focus Group
- West Warwick HEZ Partner Forum
- Woonsocket HEZ Partner Forum
- West Warwick HEZ ODPR Workgroup

Secondary Data Analysis

Secondary data are reported by county and by zip code, as available, to demonstrate localized health needs and disparities. Data for Rhode Island's "core cities," identified as Central Falls, Pawtucket, Providence, and Woonsocket, are also reported. The core cities are communities that have historically experienced greater economic distress and potential for poor health outcomes. The most recently available data at the time of publication is used throughout the study. Due to the time required to collect and analyze these data, it is typical for these data to reflect prior years rather than current year. A comprehensive list of secondary data sources is included in Appendix A.

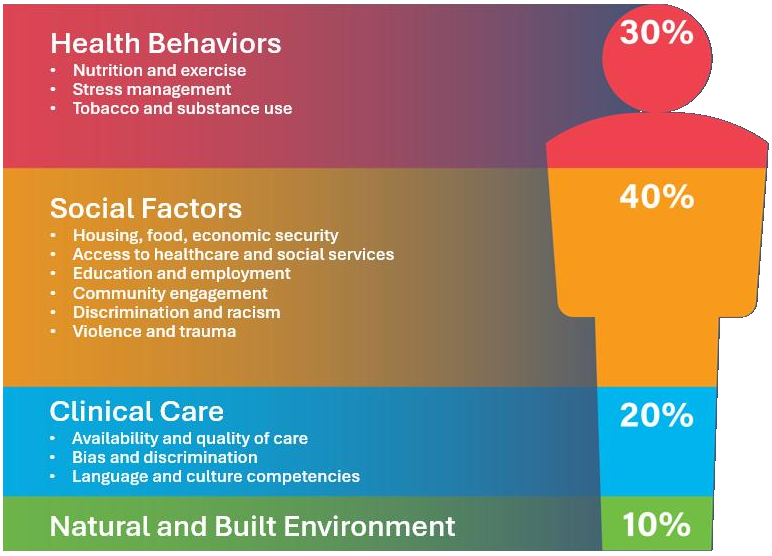
Social Drivers of Health

Where we live impacts choices available to us

The CHNA was conducted to provide deeper insights into the differences in health and wellbeing experienced between groups of people in Rhode Island. We used the Social Drivers of Health (SDoH) framework to study and document income and poverty; housing and food security; early learning and education; social factors and the environment and built community. We analyzed data across these five domains of SDoH to identify strengths and challenges in our community that impact our health and wellbeing.

Graphic Credit: U.S. Department of Health and Human Services

Social Drivers of Health are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.



50% of a person's health is determined by social factors and their environment.

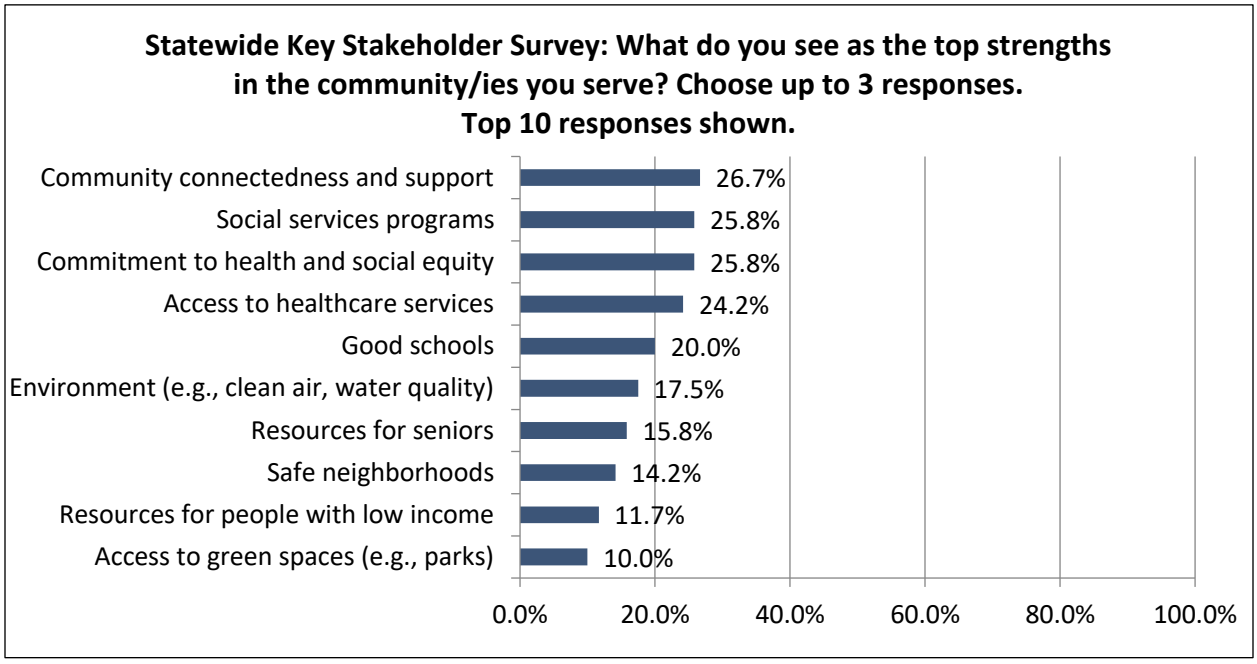
Only 20% of health outcomes are attributed to clinical care.

Examining data across SDoH domains helps us understand factors that influence differences in health status, access to healthcare, and outcomes between groups of people**.** These differences include higher prevalence of chronic diseases like diabetes, lack of health insurance, inability to afford essential medications, and shortened life expectancy. Advancing health for all residents means ensuring that all people in a community have the resources and care they need to achieve optimal health and wellbeing. To advance health for all, we need to look beyond the healthcare system to address "upstream" SDoH issues like education attainment, job opportunities, affordable housing, and safe environments.

Our Strengths and Opportunities

Rhode Island is one of the healthiest states in the nation. Residents as a whole live longer and enjoy better health while they're alive. When asked what they see as the top strengths for the community, participants of the statewide Key Stakeholder Survey saw social cohesion factors like *community connectedness and support* and *commitment to health and social equity* among the top attributes. Key stakeholders also identified community resources like *social service programs*, *healthcare services*, and *schools* as top strengths across the state.

When asked to rate various SDoH factors for Rhode Island communities, approximately 50% of Key Stakeholder Survey participants rated *access to green spaces and outdoor recreation*, *community safety*, and *civic participation* as "good" or "excellent." Over one-third rated *inclusion and appreciation of diversity in people and ideas* and *job training and education opportunities* as "good" or "excellent."

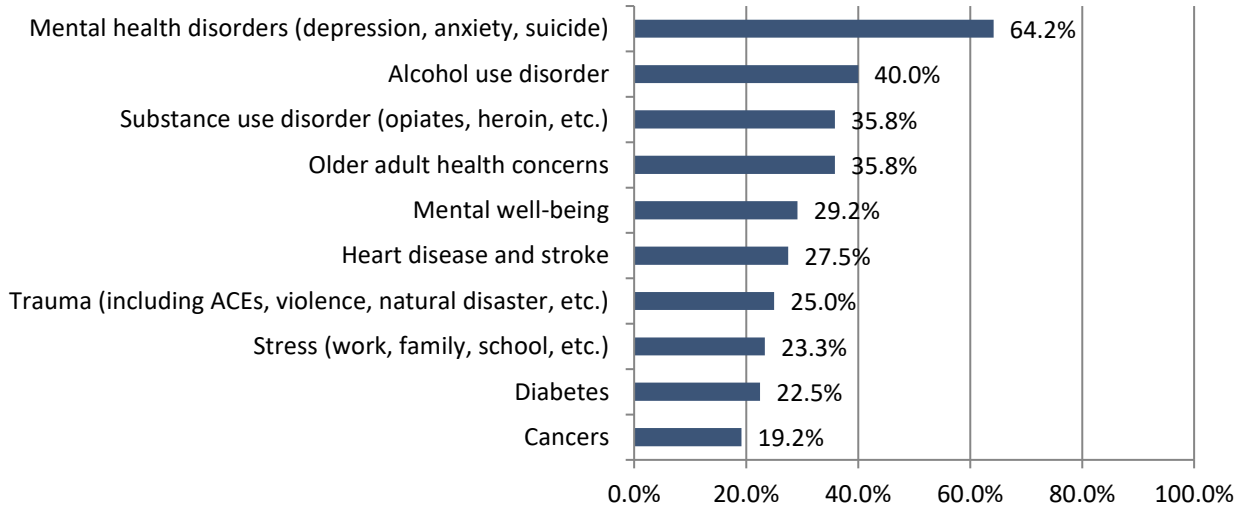


Community Strengths

- Economic vitality and strong anchor institutions
- Sense of community and civic engagement
- Commitment to health and social equity
- Natural recreational resources and green spaces
- Strong social service safety net
- High quality healthcare services
- Lower prevalence of disease burden and death
- Resources for older adults
- Good schools and universities

Using these existing strengths and community assets, communities can work together to improve health. When asked to name the top health concerns affecting the people they serve, Key Stakeholder Survey participants overwhelmingly identified issues related to *behavioral health* (e.g., mental health, substance use, trauma, stress). Other identified issues included *older adult health concerns* and *chronic conditions* (e.g., heart disease, diabetes, cancer). Key stakeholders' perceptions of these health concerns were in line with the secondary data statistics for the state.

Statewide Key Stakeholder Survey: What are the top health concerns of the community/ies you/your organization serve? Choose up to 5 responses. Top 10 responses shown.



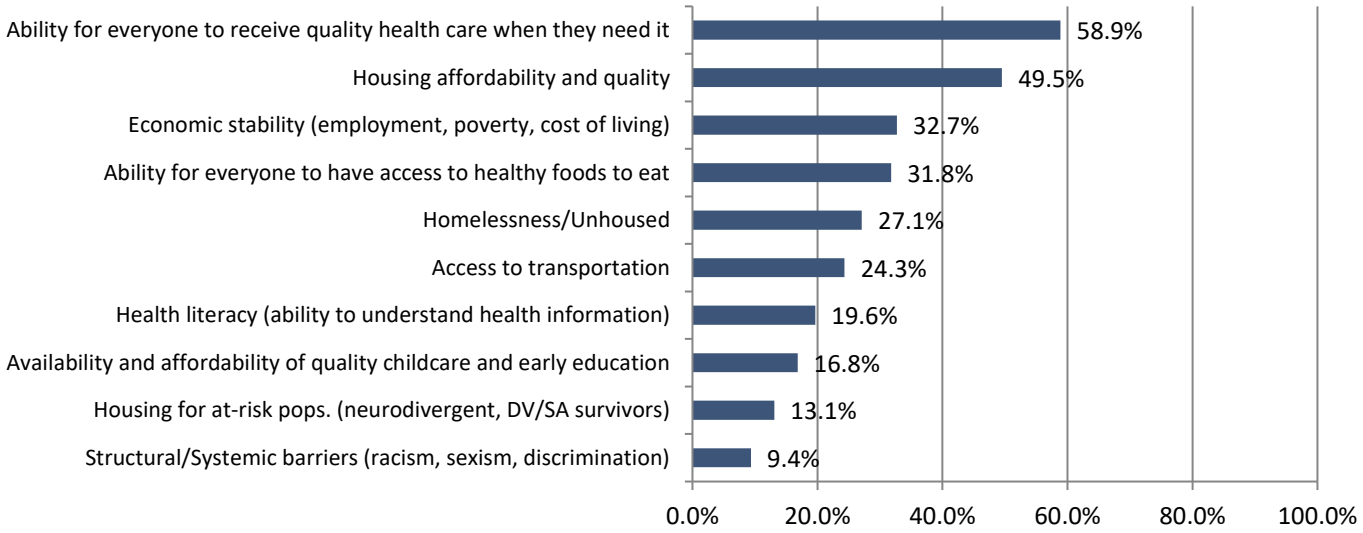
Community perception and public health data suggest that many of the identified health concerns worsened in recent years due to the lingering impact of the COVID-19 pandemic (e.g., isolation, delayed healthcare, developmental delays) and underlying SDoH factors, including rising cost of living, housing instability, and declining access to care. More than 70% of Key Stakeholder Survey participants rated *housing affordability and availability* as "poor." Approximately 75% of Key Stakeholder Survey participants rated *healthcare access and quality*, *healthy food access and affordability*, and *public transportation options* as "fair" or "poor."

> *"Access to healthcare is poor in the state (RI). We need better reimbursement rates to allow the health systems and groups to recruit and retain physicians." (Key Stakeholder Survey)*
>
> *"The state needs to develop a comprehensive transportation and housing plan." (Key Stakeholder Survey)*
>
> *"Make affordable housing a priority instead of a talking point that is never resolved." (Key Stakeholder Survey)*
>
> *"Housing and food are extremely expensive, and this is creating a negative driver for the community's overall health" (Key Stakeholder Survey)*

When asked which SDoH to prioritize in order to have the biggest impact on the overall health of the people they serve, nearly 60% of key stakeholders selected the *ability for everyone to receive quality healthcare when they need it*. *Housing affordability and quality* and *economic stability* were the next most selected factors.

Key Stakeholders saw healthcare access—particularly primary care access—as being at a critical point in Rhode Island due to an aging healthcare workforce, low statewide reimbursement for primary care that hinders recruitment and retention of providers, and healthcare environments that have failed to adequately support providers and staff.

Statewide Key Stakeholder Survey: Which of the following issues related to Social Drivers of Health should we prioritize to have the biggest impact on the overall health of the people you serve? Choose up to 3 responses. Top 10 responses shown.



Community Challenges

- Growing behavioral health concerns for adults and youth
- Rising cost of living and lack of affordable housing, childcare, food, and other basic needs
- Declining primary care access
- Healthcare and social service recruitment and retention
- Aging community with more health and social concerns
- Chronic condition prevention and management
- Economic and health disparities for people of color and income constrained households
- Care and support for growing unhoused population
- Limited public transportation options
- Political engagement and financial investment in systemic issues

Determining Community Health Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining health priorities on which to focus its efforts over the next three-year cycle, Care New England (CNE) leadership reviewed findings from the CHNA and sought to align with its health improvement programs and population health management strategies.

CNE applied the following rationale and criteria to define priorities:

- Prevalence of disease and number of community members affected.
- Rate of disease compared to state and national benchmarks
- Health differences between community members.
- Existing programs, resources, and expertise to address the issue.
- Input from community partners and representatives.
- Alignment with concurrent public health and social service organization initiatives.

CNE adopted systemwide priorities to address common and interrelated health needs for Rhode Island residents. CNE will leverage the unique specialties and strengths of its individual hospitals when developing and implementing Community Health Improvement Plans (CHIPs) to address identified priority needs.

Based on the CHNA findings, CNE will focus on the following priority areas, addressing Access to Care and underlying Social Drivers of Health and the needs of distinct population groups as cross-cutting strategies:

Other health issues identified as significant health needs for the state include affordable housing and older adult health and wellbeing. While these areas are not named priorities for CNE due to the need to prioritize resources, the system is committed to collaborating with and supporting other community agencies focused on these needs. CNE will also consider these areas when developing nuanced and whole-person strategies to improve identified priority areas.

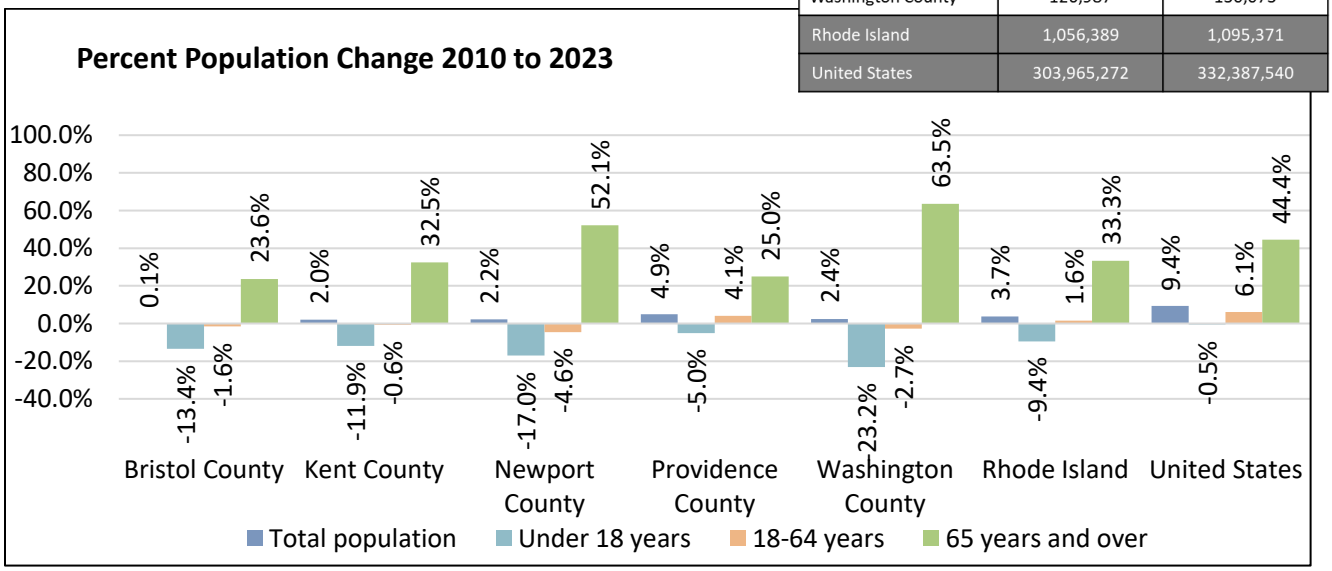
Full Report of 2025 CHNA Findings

Our Community and Residents

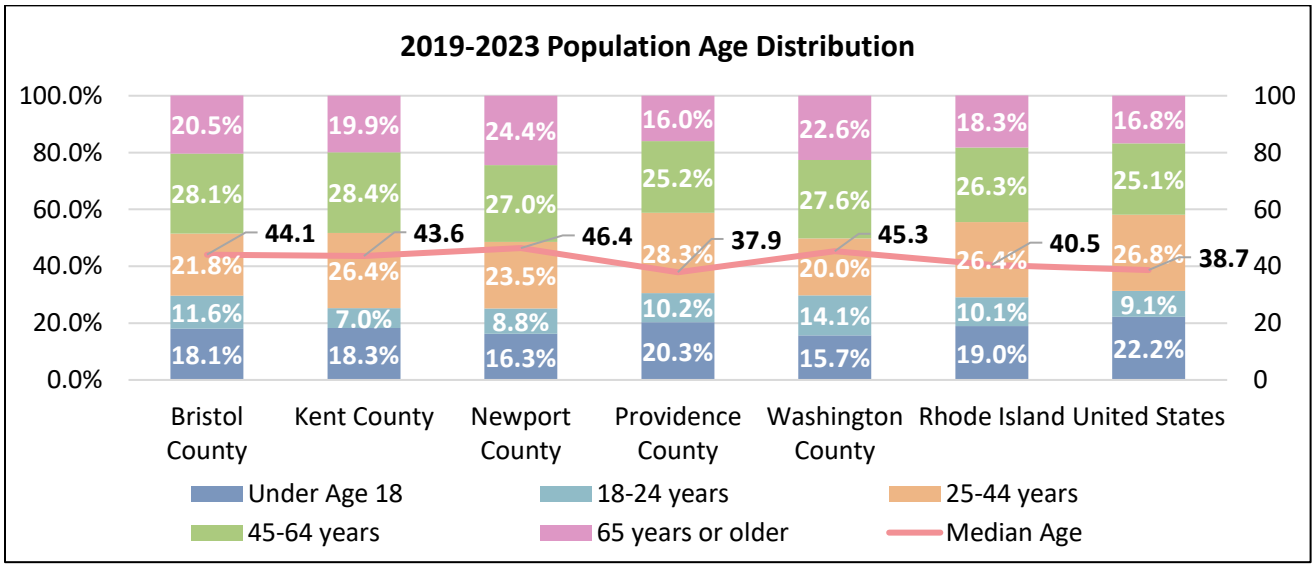
Rhode Island had a total population of 1,095,371 people in 2023 and overall population growth of approximately 3.7% from 2010 to 2023. The total population of Rhode Island and its counties is growing at a slower rate than the nation. However, the state saw a 33.3% increase in older adults aged 65 from 2010 to 2023. Rhode Island is one of the oldest states in the nation with nearly 1 in 5 residents aged 65 or older. Older Rhode Islanders are choosing to stay in their communities, while low birth rates and increased longevity contribute to the overall aging trend.

Total Population by Year

	2010	2023
Bristol County	50,501	50,568
Kent County	167,235	170,658
Newport County	83,253	85,095
Providence County	628,413	658,977
Washington County	126,987	130,073
Rhode Island	1,056,389	1,095,371
United States	303,965,272	332,387,540



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

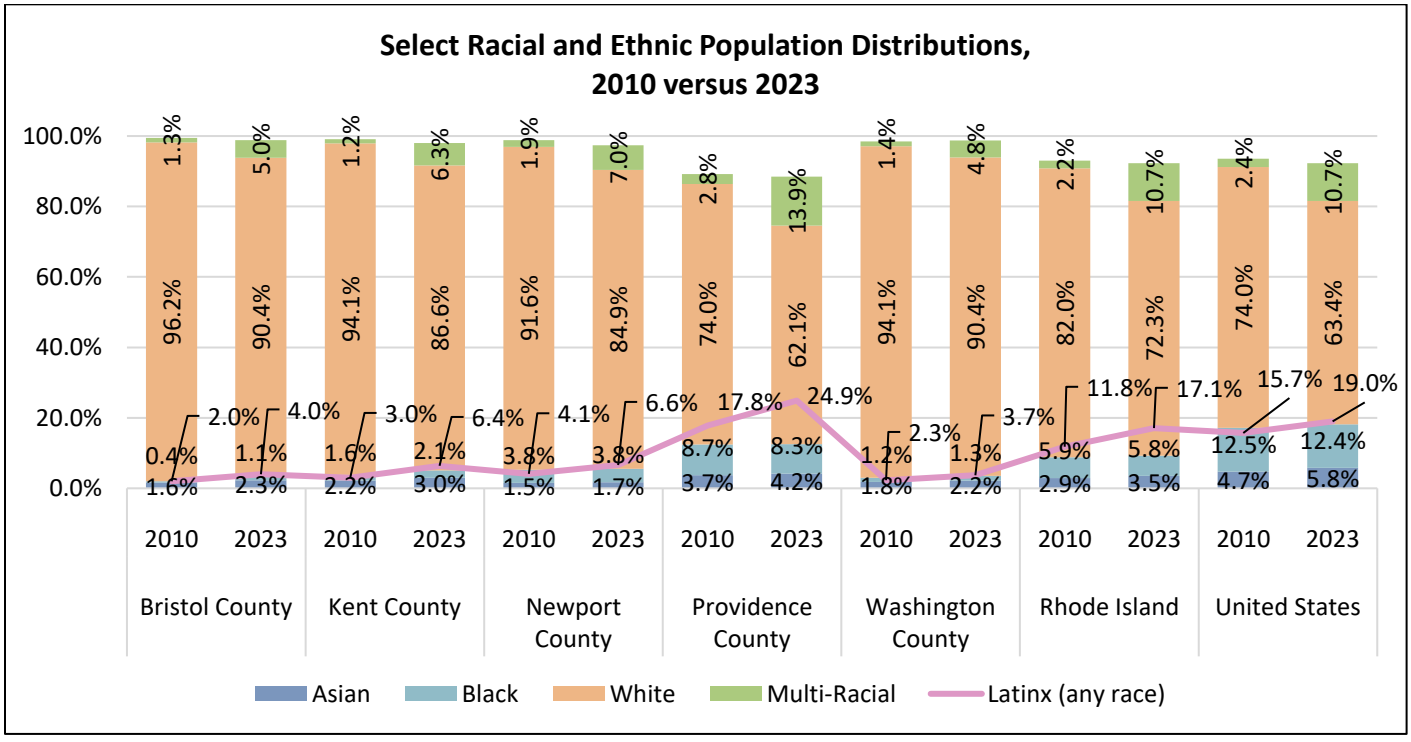
Disability is a physical or mental condition that limits a person's movements, senses, or activities. Across the US, 13% of the population and about 33% of older adults live with a disability. Rhode Island state averages are in line with the nation. Experiences of disability, particularly among older adults, varies by county with higher prevalence in Kent and Providence counties.

2019-2023 Population with a Disability

	Bristol County	Kent County	Newport County	Providence County	Washington County	Rhode Island	United States
Total population	11.6%	15.1%	11.7%	14.2%	10.7%	13.6%	13.0%
Youth under 18 years	4.0%	6.3%	5.6%	5.9%	3.6%	5.6%	4.7%
Older adults 65+ years	29.4%	32.3%	24.6%	33.6%	24.7%	30.9%	32.9%

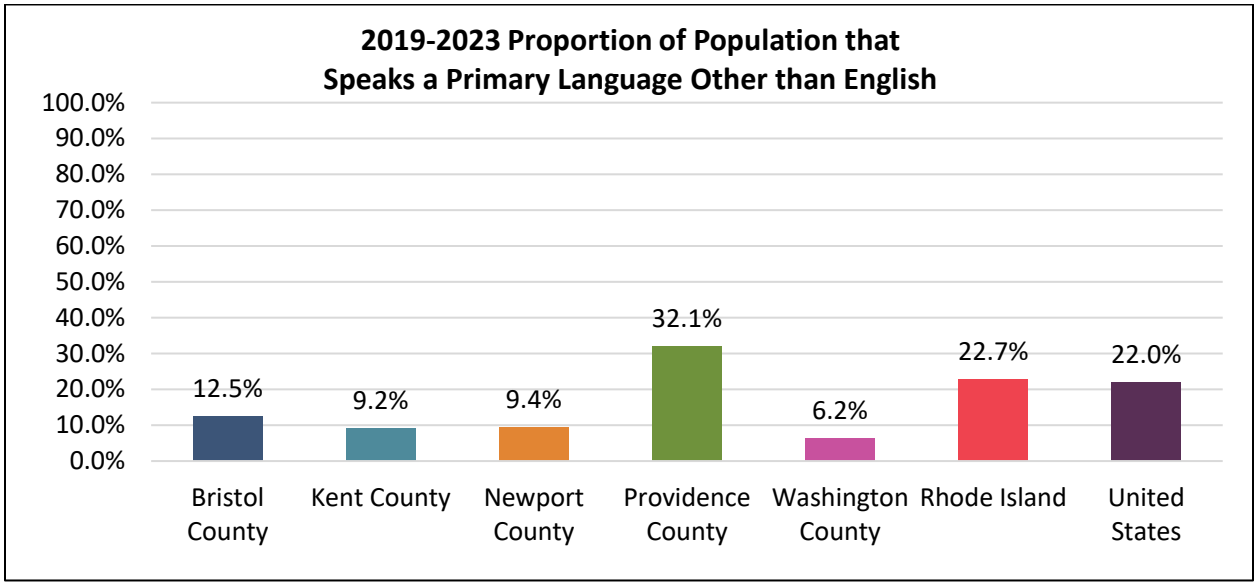
Source: US Census Bureau, American Community Survey

Consistent with national trends, population diversity is increasing across Rhode Island. People of color, particularly those that identify as Latinx and/or multiracial, make up a larger portion of the population than in prior years. Providence County has the most diverse population in Rhode Island; more than 1 in 3 residents identify as a person of color and 1 in 4 residents identify as Latinx (of any race). Across all other Rhode Island counties, approximately 9 in 10 residents identify as white.



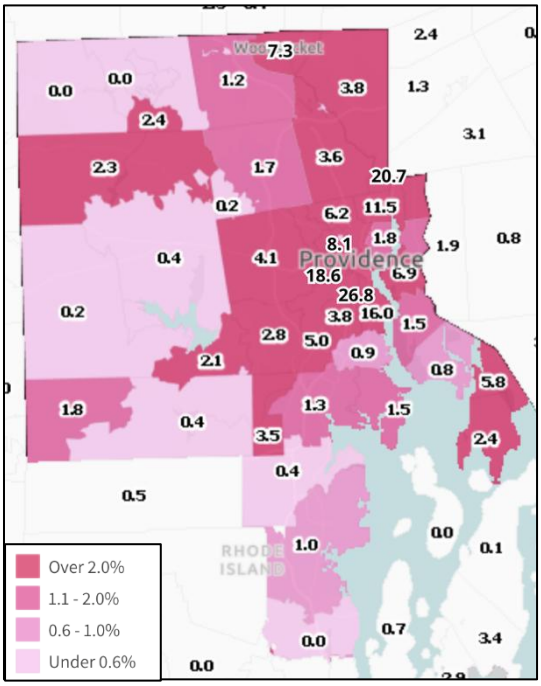
Source: US Census Bureau, American Community Survey

Nearly 1 in 4 Rhode Island residents speak a primary language other than English; in Providence County, the proportion is 1 in 3 residents. Within Women & Infants Hospital's Providence service area, in 20% or more of households, no one aged 14 or older speaks English at least "very well" and another language is often spoken in the home. These findings inform a heightened community need for multilingual and culturally appropriate resources and workforce efforts to ensure that providers and staff reflect the diversity of residents.



Source: US Census Bureau, American Community Survey

2019-2023 Linguistically Isolated Households by Zip Code^



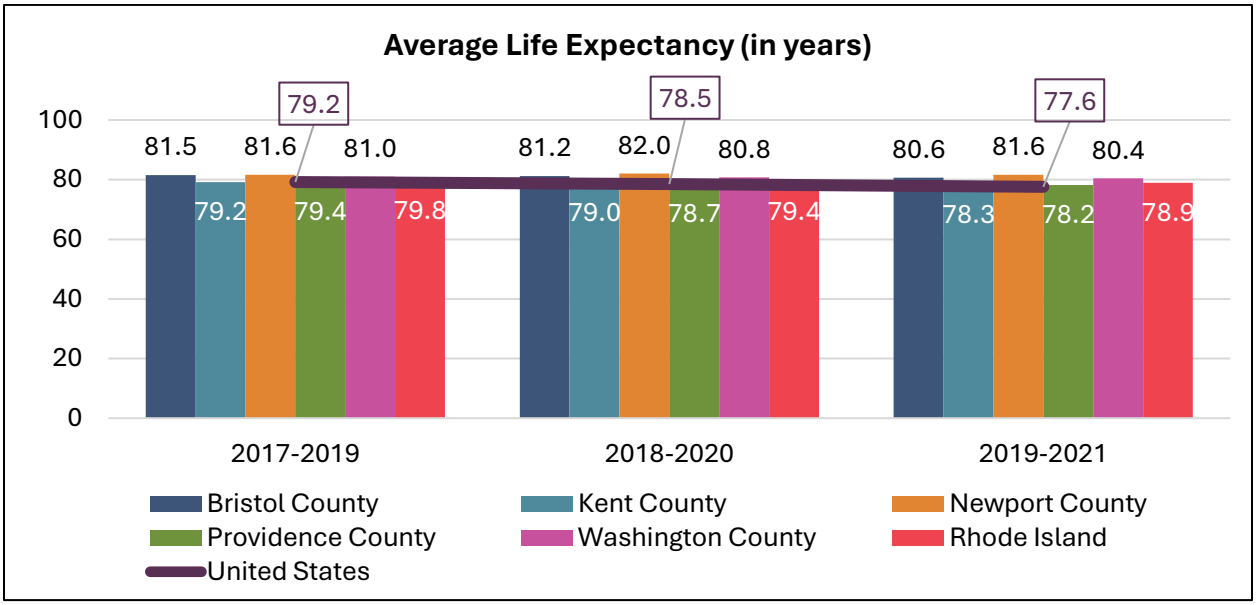
Source: US Census Bureau, American Community Survey

^Defined as households with no one aged 14 or older who speaks English "very well."

Measuring Health in Our Community

Rhode Island is one of the healthiest states in the nation, and all Rhode Island counties report overall better health outcomes and higher average life expectancy than the national average. Life expectancy is a key measure of health and wellbeing within a community, often reflecting the underlying socioeconomic and environmental factors.

Life expectancy measures how long people generally live within the defined geography and is the culmination of living conditions, health status, economic security, and the overall experience of residents within a community.



Source: Centers for Disease Control and Prevention

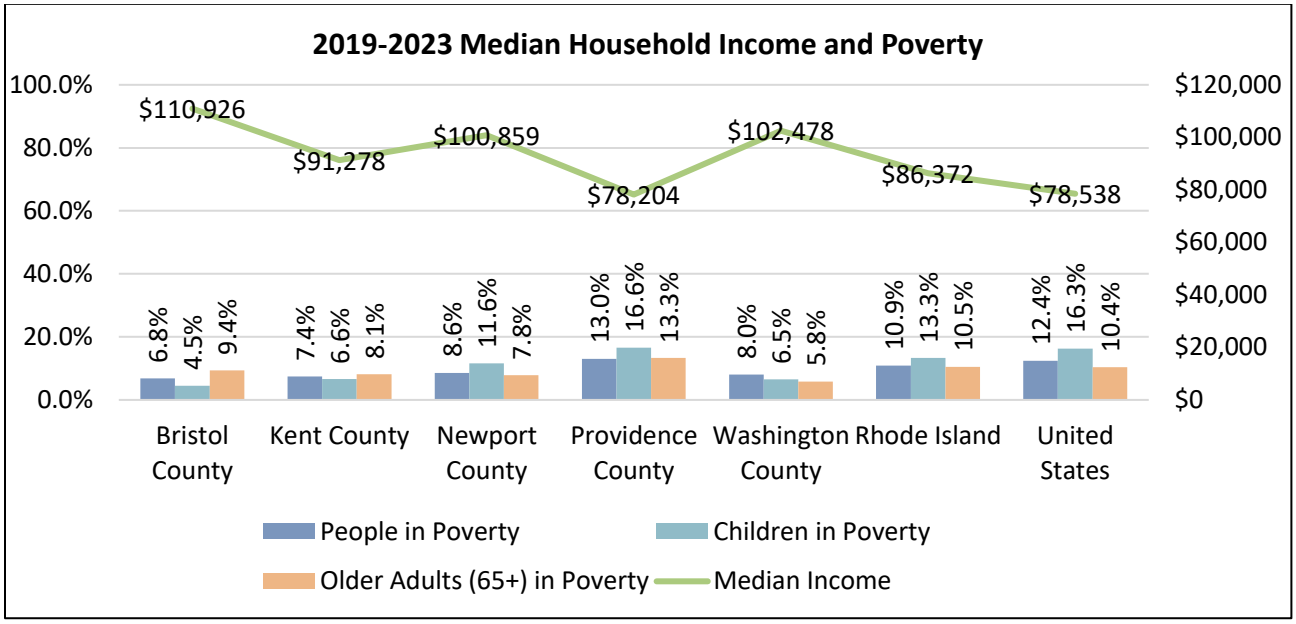
The Social Drivers of Health framework shows that at least 50% of a person's health profile is influenced by the socioeconomic and environmental factors that they experience. Understanding the impacts and addressing the conditions in the places where people live is essential to improving health outcomes and advancing health equity. Rhode Island's overall higher life expectancy reflects strong SDoH factors, including a diverse economy, highly educated workforce, rich health and social services, civic engagement, and robust recreational and green spaces.

> *"[There are] grassroots efforts to ensure community members have the opportunity to participate in voting and have access to education. [There are] people wanting to make sure their communities are empowered." (Key Stakeholder Survey)*

> *"In general, Rhode Island is a civic-minded state and promotes diverse thinking." (Key Stakeholder Survey)*

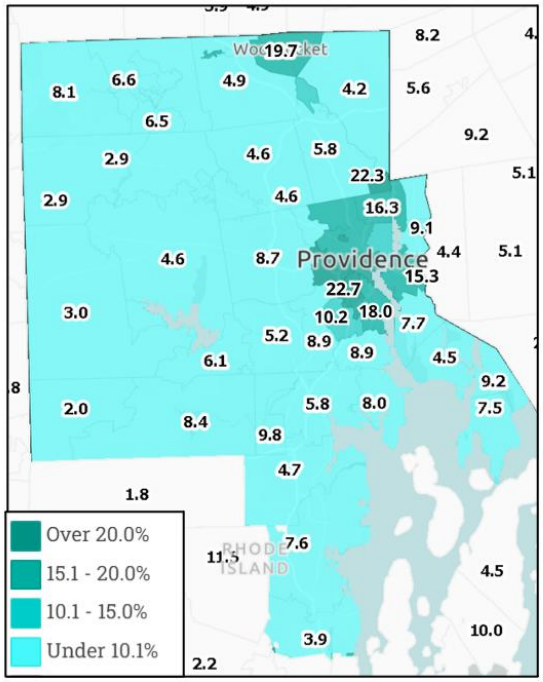
> *"[We have] strong community values and leadership in protecting the special places and scenic areas of our state, including beaches, forests, ponds, parks, etc." (Key Stakeholder Survey)*

However, not all people across Rhode Island share these positive outcomes. Within Rhode Island, there is a more than 3-year difference in life expectancy between counties with the highest and lowest averages, reflecting the impact of SDoH and historical disparities. As a whole, Rhode Island residents have higher median incomes and fewer experiences of poverty than their peers nationwide. But, looking more closely at neighborhoods and populations, clear disparities are present.

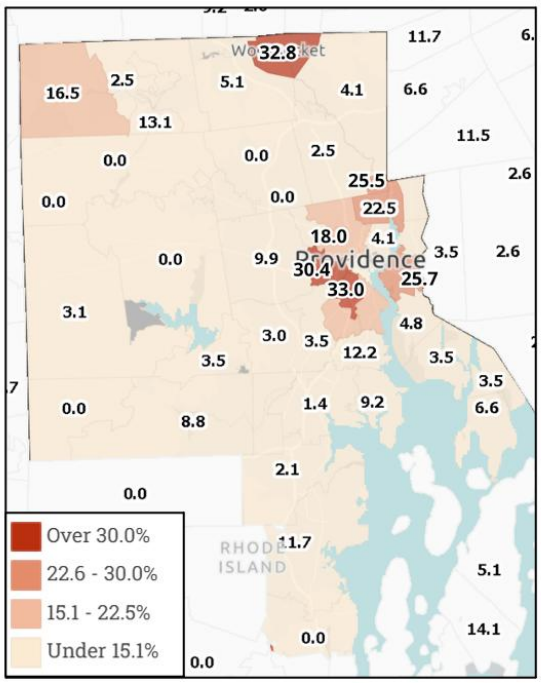


Source: US Census Bureau, American Community Survey

2019-2023 Population in Poverty by Zip Code



2019-2023 Children in Poverty by Zip Code



Source: US Census Bureau, American Community Survey

Health Resources and Services Administration (HRSA) Unmet Need Score

The Health Resources and Services Administration Unmet Need Score (UNS) helps in allocation of resources—including primary and preventive healthcare services—across communities with higher unmet need based on social, economic, and health status. The UNS evaluates zip codes using a weighted sum of 28 health and social measures with values ranging from 0 (least need) to 100 (greatest need).

In Women & Infants Hospital's service area, there is 73-point difference between zip codes with the highest and lowest UNS value, demonstrating community-level health and social disparities. Zip codes with a UNS value exceeding 50 are depicted below, along with select SDoH indicators that contribute to UNS values.

Women & Infants Hospital Service Area Zip Codes with an Unmet Need Score Exceeding 50 (Out of Maximum of 100) and Select Social Drivers of Health Indicators (Years 2019-2023)^

Zip Code	Total Population in Poverty	Children in Poverty	Families with Low Income*	No High School Diploma	No Health Insurance	Unmet Need Score
02863, Central Falls	22.3%	25.5%	49.1%	39.6%	13.9%	79.11
02907, Providence	22.7%	33.0%	43.1%	26.5%	9.6%	72.57
02909, Providence	22.5%	30.4%	33.4%	20.2%	8.4%	62.59
02895, Woonsocket	19.7%	32.8%	31.0%	18.1%	6.5%	59.43
02860, Pawtucket	16.3%	22.5%	26.9%	20.1%	4.5%	59.03
02905, Providence	17.9%	18.1%	24.3%	23.5%	4.7%	59.00
02903, Providence	20.9%	4.0%	18.8%	11.2%	2.7%	54.19
02914, East Providence	15.3%	25.7%	22.0%	17.6%	3.4%	52.73
02908, Providence	16.1%	18.0%	24.4%	16.3%	9.2%	52.50
Rhode Island	10.9%	13.3%	15.9%	10.5%	4.3%	NA

Source: Health Resources & Services Administration (HRSA) & US Census Bureau, American Community Survey
^Select SDoH indicators are presented to illustrate measures that influence the calculation of the Unmet Need Score.
*Families with incomes at or below 185% of the Federal Poverty Level (FPL). In 2024, a family of four people at 185% of the FPL had an income of $57,720.

Social Vulnerability Index

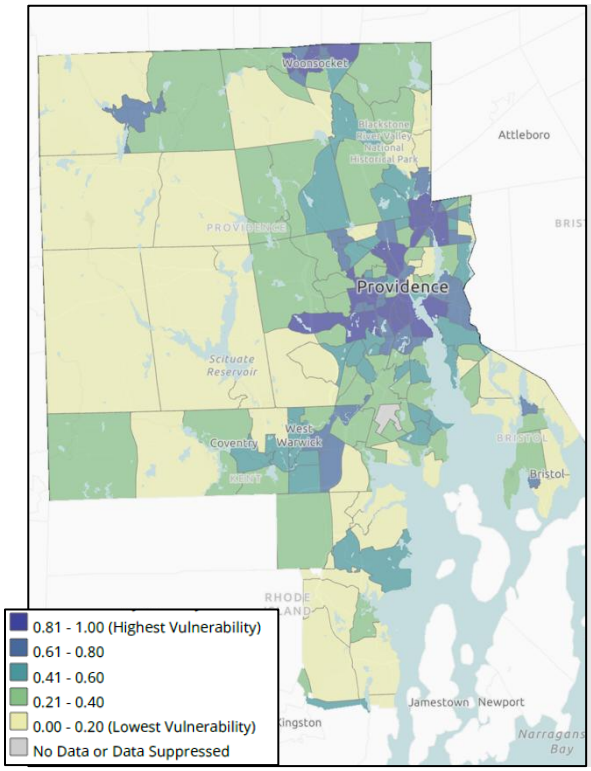
The Social Vulnerability Index (SVI) goes a level deeper than the UNS to demonstrate vulnerability to health disparities at a census tract-level.

Census tracts are small geographic regions defined for the purpose of taking a census, designed to be relatively homogeneous in terms of population characteristics, economic status, and living conditions. Census tracts cover the entire United States and typically contain between 1,500 and 8,000 people.

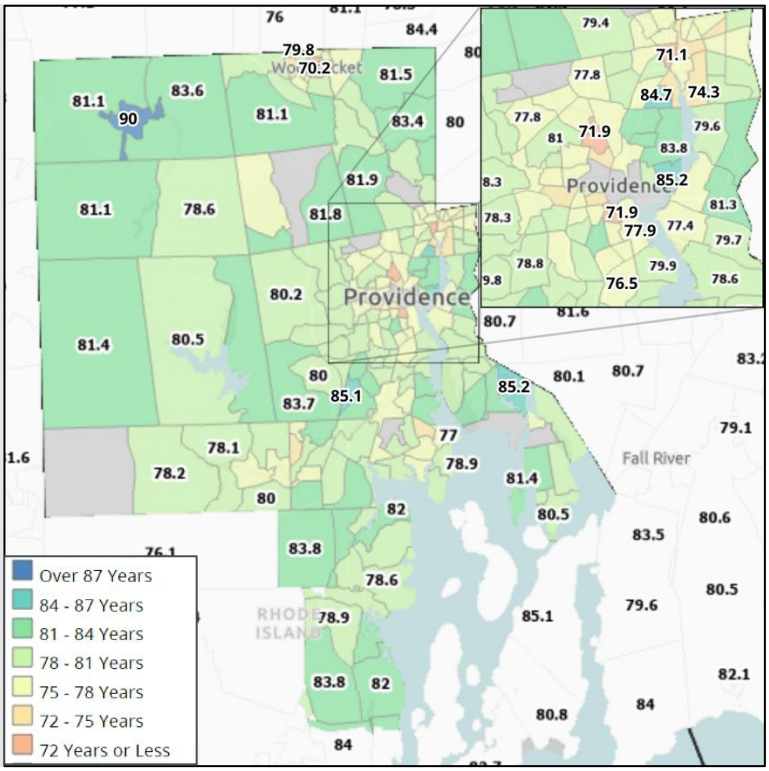
The SVI scores census tracts on a scale from 0.0 (lowest) to 1.0 (highest) vulnerability based on factors like poverty, lack of transportation, and overcrowded housing.

Examining the SVI in conjunction with average life expectancy demonstrates how SDoH impact health outcomes. Within the Women & Infants Hospital service area, historical data indicates potential for over a 15-year difference in average life expectancy between communities with the lowest and highest averages. Affected areas, including Rhode Island's core cities also have SVI values of 0.81 or higher out of a maximum score of 1.0, reported as recently as 2022.

2022 Social Vulnerability Index by Census Tract



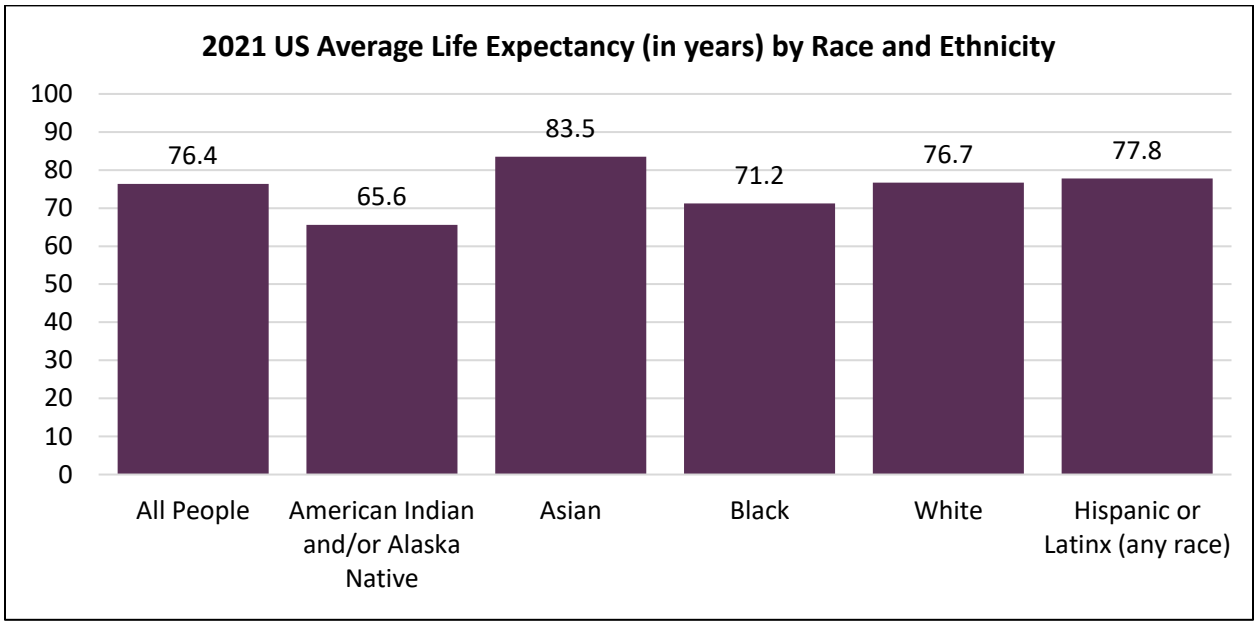
2010-2015 Life Expectancy by Census Tract



Source: Centers for Disease Control and Prevention

Community Disparities

Average life expectancy also varies by population group, reflecting underlying health and social disparities. National data for 2021 show a more than 10-year difference in life expectancy between racial and ethnic groups with the highest and lowest reported averages, a disparity that starkly aligns with unequal experiences of poverty and other social barriers.



Source: Centers for Disease Control and Prevention

Rhode Island Life Index

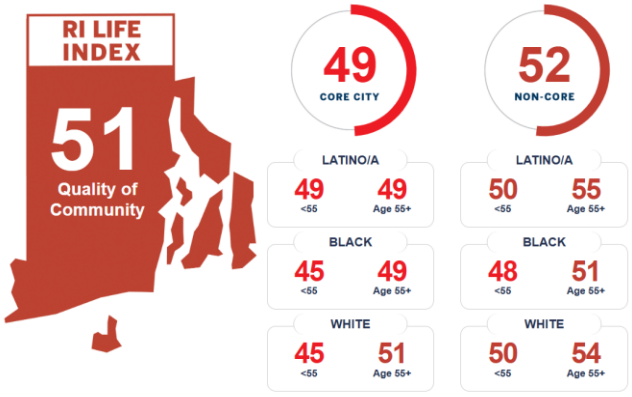
Blue Cross & Blue Shield of Rhode Island (BCBSRI) and the Brown University School of Public Health have produced the RI Life Index each year since 2019 to capture Rhode Islanders' perceptions of SDoH and wellbeing, including quality of community and quality of life. Scores are presented in aggregate (max score of 100) and broken down by respondent's residence (core city vs. non-core areas), race, ethnicity, and age. The Rhode Island core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

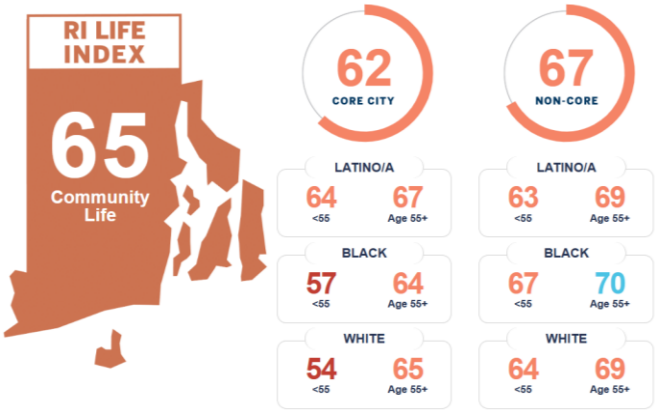
Quality of Community scoring represents a summary of how residents rate social and economic aspects of their community, including the following topics:

- Access to childcare
- Activities for youth
- Employment
- Access to affordable food
- Cost of living
- Availability and quality of services and programs for seniors

Community Life scoring represents a summary of how residents perceive the lived experiences of typical individuals in their community, in the following areas:

- Employment
- Education
- Convenient locations for nutritious food
- Access to affordable housing
- Access to healthcare
- Feeling safe at home





The RI Life Index saw improved scores in 2024 in the *core cities* related to perceptions about community life, programs and services for children, and healthcare access, with particular improvement in perceptions about healthcare access among Black and Latino/a residents.

Overall perceptions of quality of community and community life for the state continued to decline from prior surveys, including declines in perceptions of affordable housing, cost of living, job opportunities, access to nutritious food, and experiences with food security. CHNA secondary data findings and resident feedback reinforced these key areas of need.

Community Health Needs

The CHNA was a comprehensive study of health and socioeconomic indicators for Rhode Island residents. The following section highlights key health and wellbeing needs as determined by secondary data statistics and community stakeholder feedback.

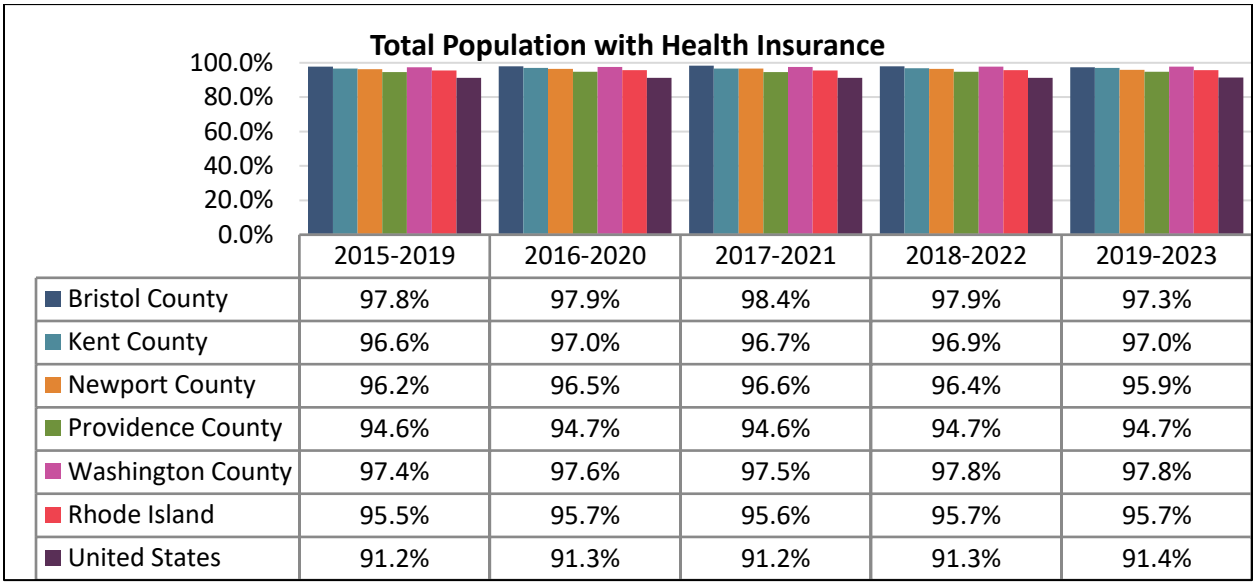
A full summary of secondary data findings is also provided on CNE's website and available to our community partners as a resource to support their many programs and services.

Access to Care and Services

Rhode Island is home to high quality and comprehensive healthcare and social services. Residents benefit from programs that provide free and reduced cost healthcare for uninsured and underinsured people, and a wide array of human service agencies committed to helping residents. Agencies, providers, and advocates are active partners in community planning and coordinated service delivery.

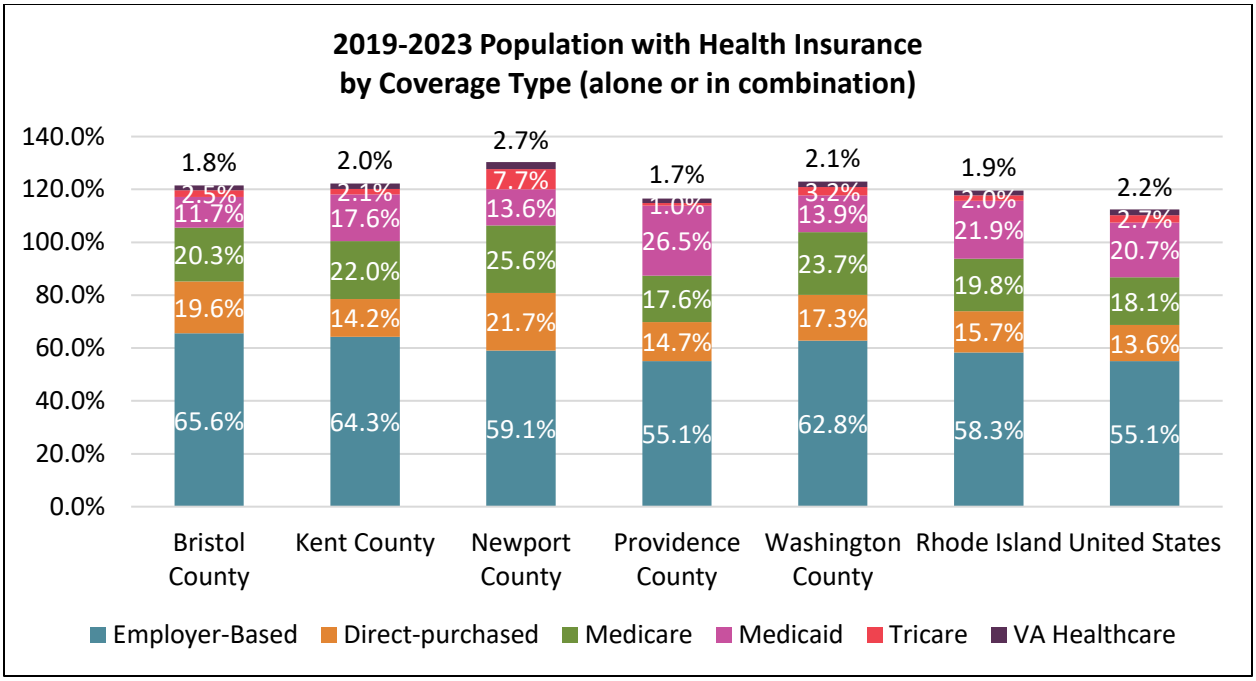
Health insurance coverage among Rhode Island residents has been consistently high with 95.7% of residents covered in 2023 compared to 91.4% of residents nationally. Statewide, a high proportion of insured residents obtain their insurance through an employer (58.3%), providing cost-sharing benefits and typically more comprehensive coverage. Across Rhode Island counties, 81%-83% of adults received a routine primary care visit or checkup in 2022 compared to 74.2% of adults nationally.

Differences in healthcare access exist between Rhode Island counties and the healthcare environment has changed since the 2022 CHNA. The proportion of residents with Medicare coverage increased for every county, a finding that is consistent with the state's aging demographic. Medicaid coverage, providing coverage for people with low income, also increased in Newport and Washington counties. More than 1 in 4 Providence County residents are Medicaid-insured, with higher coverage among core city residents. The core cities are primary care Health Professional Shortage Areas (HPSAs) for people with low income, indicating a shortage of healthcare providers for vulnerable residents.



	2015-2019	2016-2020	2017-2021	2018-2022	2019-2023
Bristol County	97.8%	97.9%	98.4%	97.9%	97.3%
Kent County	96.6%	97.0%	96.7%	96.9%	97.0%
Newport County	96.2%	96.5%	96.6%	96.4%	95.9%
Providence County	94.6%	94.7%	94.6%	94.7%	94.7%
Washington County	97.4%	97.6%	97.5%	97.8%	97.8%
Rhode Island	95.5%	95.7%	95.6%	95.7%	95.7%
United States	91.2%	91.3%	91.2%	91.3%	91.4%

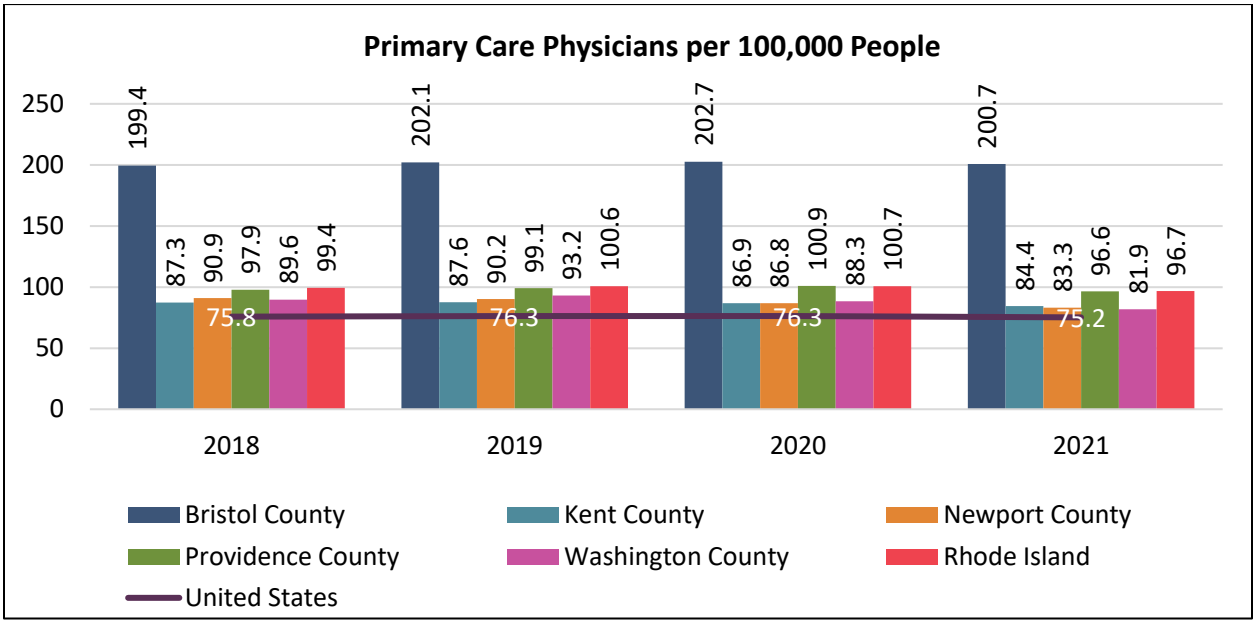
Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Availability of primary care physicians in Rhode Island remains above national levels but declined in 2021. Feedback from healthcare leaders and recent reports from the Rhode Island Office of the Health Insurance Commissioner (OHIC) indicate that provider availability is a growing challenge with reported months long waits for primary care appointments and more limited access to preventive screenings.

> *"A renewed focus on attracting and retaining medical professionals (doctors, PAs, NPs) for primary care is at a crisis point. Finding ways to increase payments to providers without undue impact on the consumer would be a high priority." (Key Stakeholder Survey)*



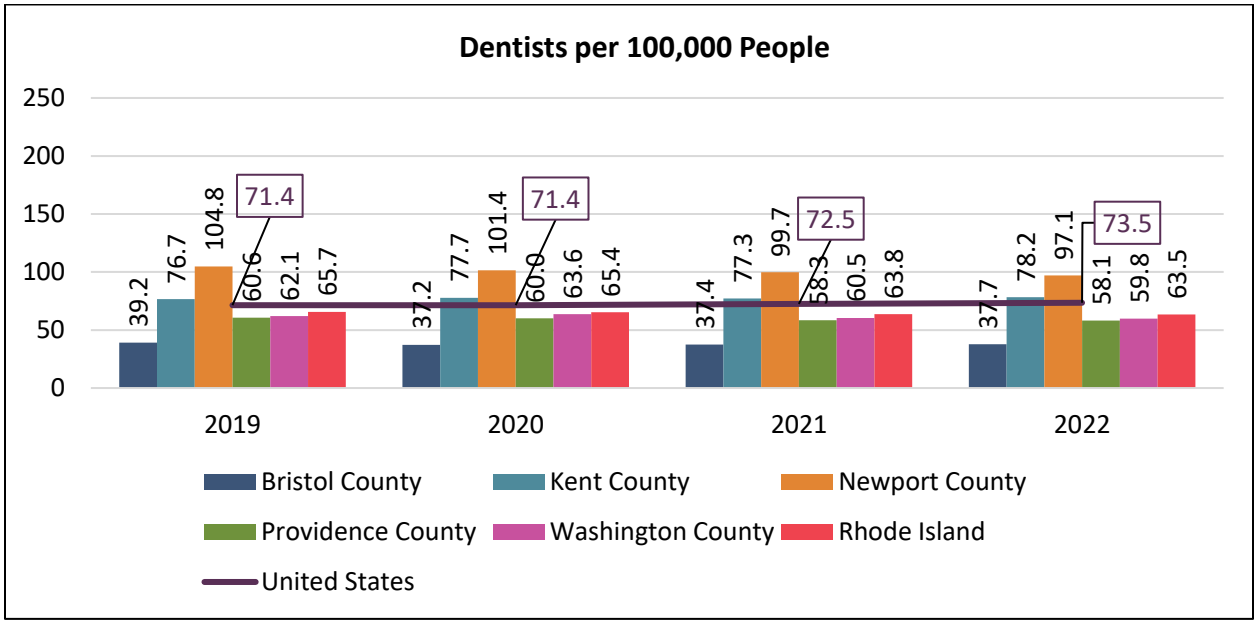
Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services

The Rhode Island OHIC published a report in December 2023, *"Primary Care in Rhode Island Current Status and Policy Recommendations,"* to evaluate primary care services in Rhode Island and inform future policy and regulation. Key findings from the report are highlighted below and continue to be primary focus areas for HARI member hospitals and others.

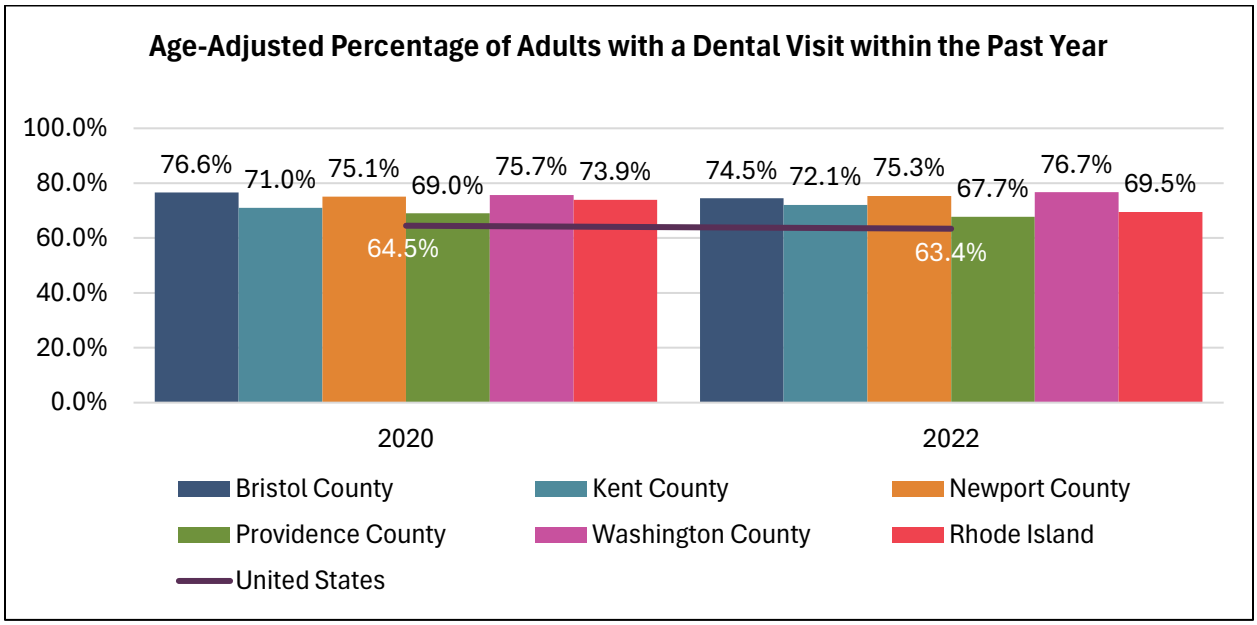
Primary Care Strengths and Challenges in Rhode Island (as reported by OHIC)

Primary Care Strengths	Primary Care Challenges
• Rhode Island has a higher number of primary care providers relative to population than most states. • Rhode Island has a higher percentage of residents who report a usual source of care. • Rhode Island's small size is an advantage because there are fewer barriers to collaboration among decisionmakers and interested parties. • Rhode Island has a track record of policy innovation and multi-payer engagement in activities to improve primary care.	• The primary care workforce is aging, and many providers are contemplating retirement. • Primary care is nationally reimbursed and compensated significantly less than most other medical specialties and there is evidence that primary care reimbursement in Rhode Island is not competitive with neighboring states. • Nationally, fewer medical students are choosing primary care as a career path, in part due to salary differentials. Medical students who do choose primary care and are trained in Rhode Island are not necessarily staying in Rhode Island. • Clinician burnout is a key concern and is driving primary care physicians and advanced practitioners to reduce or leave clinical practice.

Availability of dental care has also declined in Rhode Island and has historically been lower than national averages. Key stakeholders noted that access is especially limited for dental providers that accept Medicaid. Middletown and Newport in Newport County are HPSAs for professionals that serve Medicaid beneficiaries, and the core cities are HPSAs for people with low income. While all counties have a higher proportion of residents receiving annual routine dental care than the nation, there are stark differences between the counties which generally align with socioeconomic barriers.



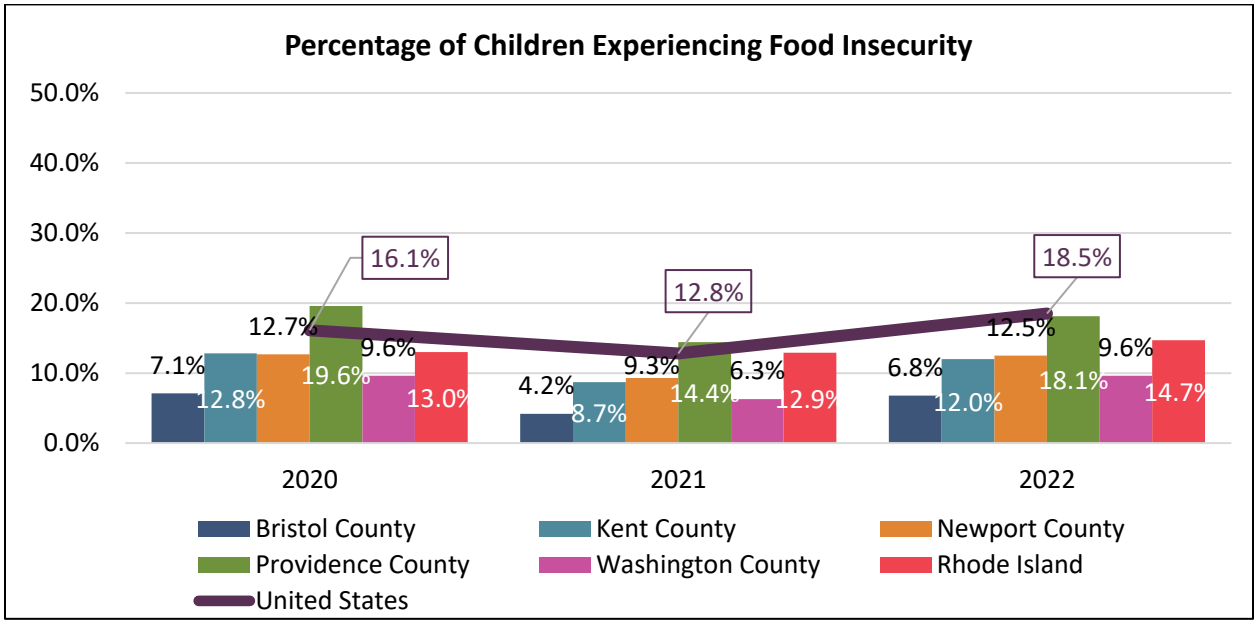
Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services



Source: Centers for Disease Control and Prevention

The rising cost of living has increased demand for social services and contributed to delays in accessing vital services. Statewide, the proportion of food insecure residents increased from 9.3% in 2021 to 10.9% in 2022, with an outsized impact on children. Statewide median home value rose 41% from 2019 to 2023; median rent rose 27%. The cost of childcare for a household with two children in Rhode Island, measured as a percentage of median household income, increased from 24.1% in 2021/2022 to 33.1% in 2022/2023.

Frontline social service providers described their work effort as being in "crisis mode," experiencing both organizational and personal stress in trying to meet increased resident needs.



Source: Feeding America

Childcare Availability and Affordability

	Number of childcare centers per 1,000 population under 5 years old	Childcare costs for a household with two children as a percentage of median household income
Bristol County	11.1	30.2%
Kent County	8.6	33.1%
Newport County	11.0	36.7%
Providence County	7.1	34.5%
Washington County	11.1	31.7%
Rhode Island	11.0	33.1%
United States	7.0	27.0%

Source: Homeland Infrastructure Foundation-Level Data, 2010-2022 & The Living Wage Calculator, Small Area Income and Poverty Estimates, 2023 & 2022

Key stakeholders also saw transportation as a key limiting factor for accessing community resources, noting that Rhode Island Public Transit Authority (RIPTA) offers limited services outside of urban areas. MTM Health, the state's non-emergency medical transportation manager, is helpful for people with Medicaid and/or eligible older adults but the service was reported to lack timeliness and coordination, contributing to missed appointments and stranded patients. Survey participants reported that Blue Cross Blue Shield's BlueCHiP Medicare coverage eliminated transportation and meal benefits.

Federal funding cuts planned for healthcare and social services are anticipated to further reduce access to community resources; cuts are expected to impact Medicaid, SNAP benefits, subsidized childcare, and low-income housing benefits. Stakeholders emphasized the need for elected leadership that respects and represents the lived experience of diverse populations in Rhode Island and the nation, and more opportunities for political leaders to intentionally engage with community members.

> *"Often decision makers are removed from those who are patients or are community-facing, leaving major gaps in how the solutions are implemented. We need those with lived experience at the table to influence and make the decisions, as well." (Key Stakeholder Survey)*
>
> *"Where do we catch our decision-makers to address these issues?" (Partner Forum Participant)*

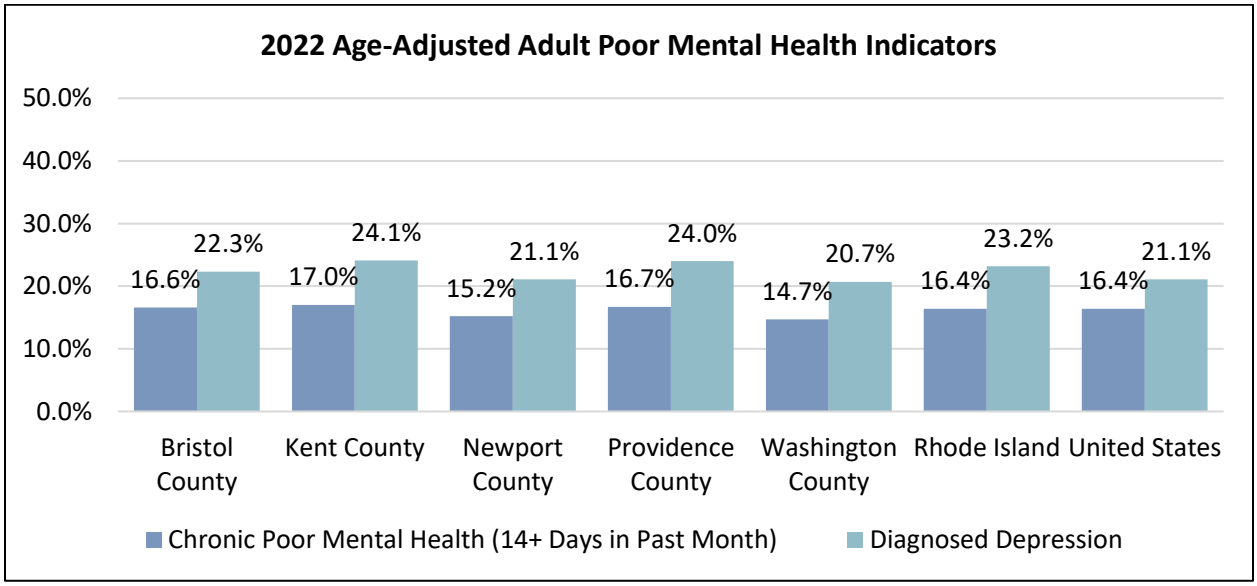
Key stakeholders recognized that groups who have been historically marginalized were more likely to experience health disparities. These underserved communities—including those that identify as people of color, LGBTQIA+, and/or people with disabilities—are more likely to face economic insecurity, have cultural and language barriers, and have experienced social injustices; all of which reduce their trust in social systems.

Stakeholders acknowledged that the political climate has increased fear and distrust for many, and further restricted access to appropriate care. They underscored the importance for staff and provider training in cultural competency and humility and increased health education materials that reflect the language and culture of communities. They also advocated for the inclusion of people with lived experience in developing community solutions.

> *"[They] keep cancelling appointments due to not enough interpreters available, or the doctor office didn't call until last minute." (Key Stakeholder Survey)*
>
> *"The top health concerns for the Deaf community include limited access to healthcare services that are linguistically and culturally competent, with providers fluent in ASL or supported by qualified interpreters." (Key Stakeholder Survey)*
>
> *"Queer people face everyday discrimination and that affects all aspects of life, from jobs to housing to making friends. The threats to existing rights are also causing distress, though the situation was never good, despite some affirming laws." (Key Stakeholder Survey)*
>
> *"There are system and structural barriers that prevent certain populations from accessing the care they need and resources to live a comfortable life. We need to work together to identify these barriers and make changes." (Key Stakeholder Survey)*

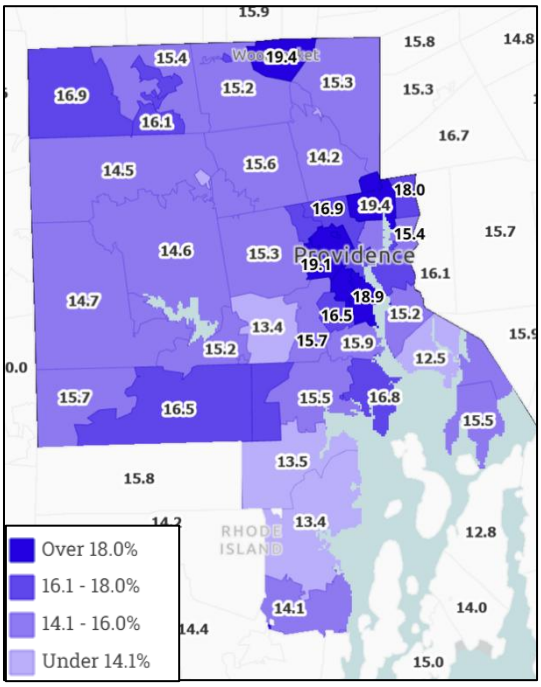
Behavioral Health

Experiences of mental distress have increased statewide and nationally. In 2022, approximately 16% of Rhode Island adults reported having chronic poor mental health (14 or more days in the past month) compared to 14% in 2020. Approximately 23% of adults reported being diagnosed with a depression disorder. Within the Women & Infants Hospital service area, experiences of mental distress are prevalent across communities, and more prevalent in communities experiencing socioeconomic barriers.



Source: Centers for Disease Control and Prevention

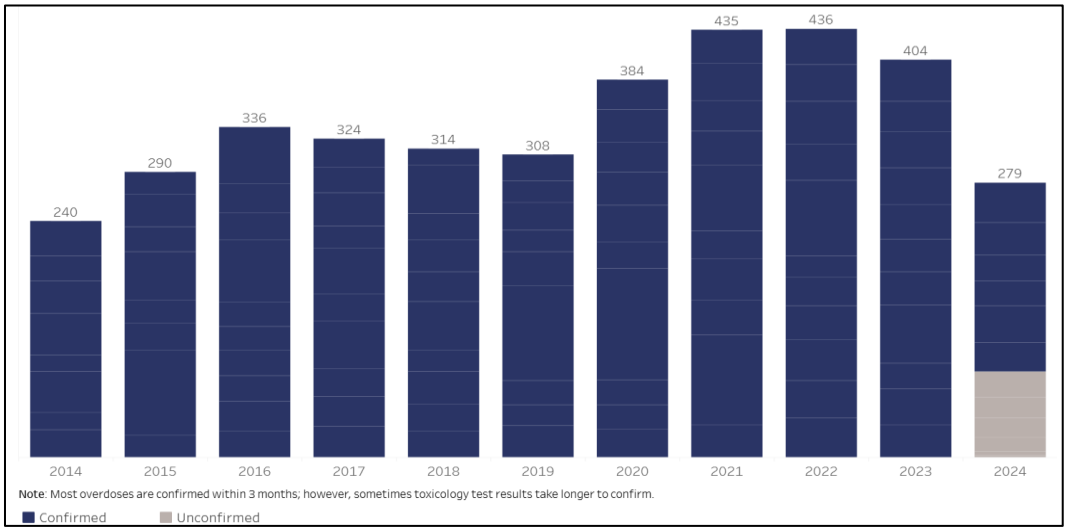
2022 Adults with Chronic Poor Mental Health by Zip Code



Source: Centers for Disease Control and Prevention

Fatal overdoses in Rhode Island have been on the rise since 2014 and peaked in 2021 and 2022, likely due in part to the COVID-19 pandemic which caused delays in care, social isolation, and unemployment. Data for 2024 suggest that overdose deaths are down, but professionals warn that the rise of new street drugs like medetomidine (a highly fatal additive to fentanyl) may reverse this trend. Ongoing training to prepare first responders is needed.

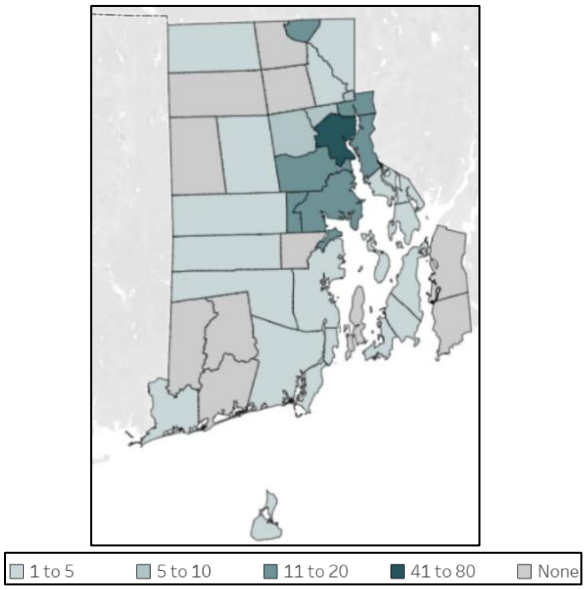
Rhode Island State Number of Drug Overdose-Related Deaths, 2014-2024



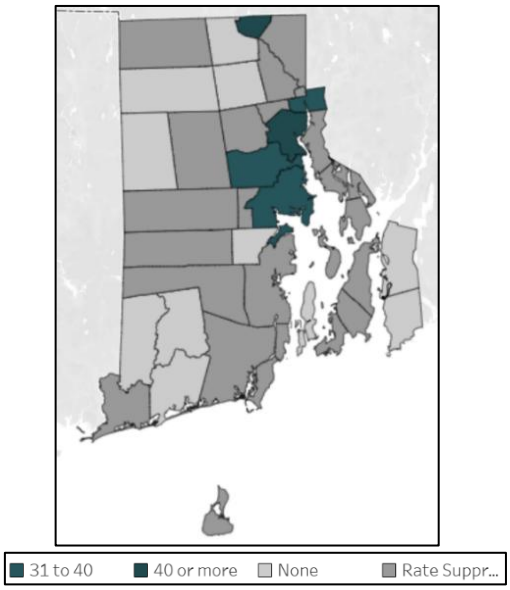
Source: Prevent Overdose RI

There has been an overdose in every Rhode Island town. The following maps use information from the Rhode Island Medical Examiner's Office to show overdose occurrences in 2024. Fatal overdoses were more prevalent in areas historically placed at risk, including core cities and areas in and around Warwick.

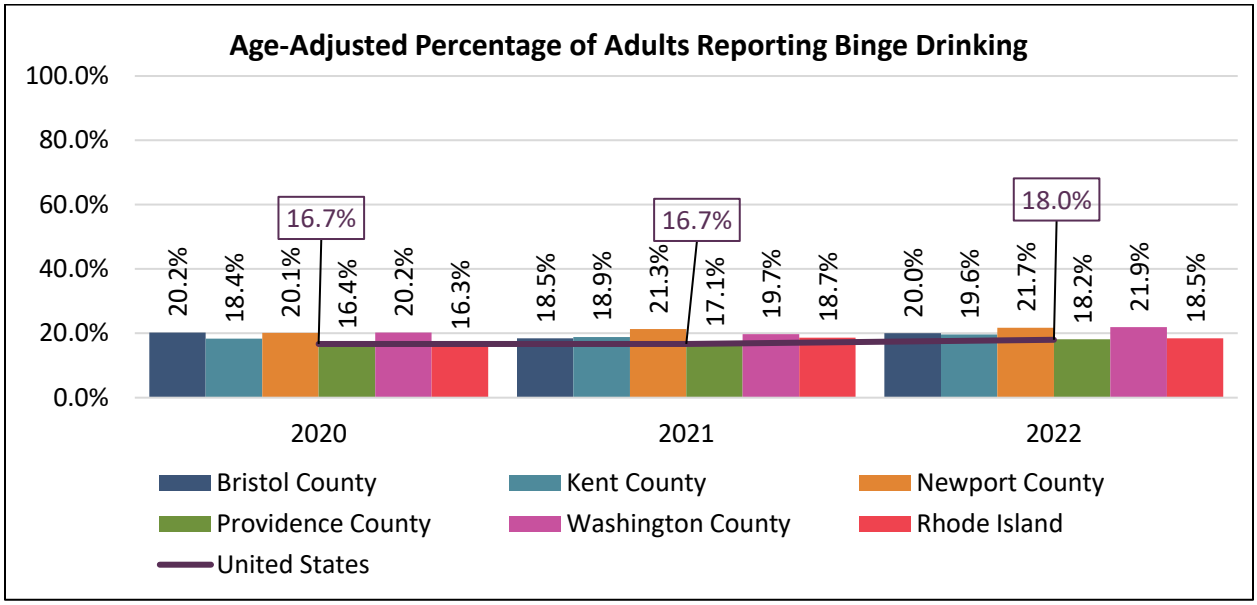
2024 Overdose Deaths by City/Town (counts)



2024 Overdose Deaths by City/Town (rate per 100,000)

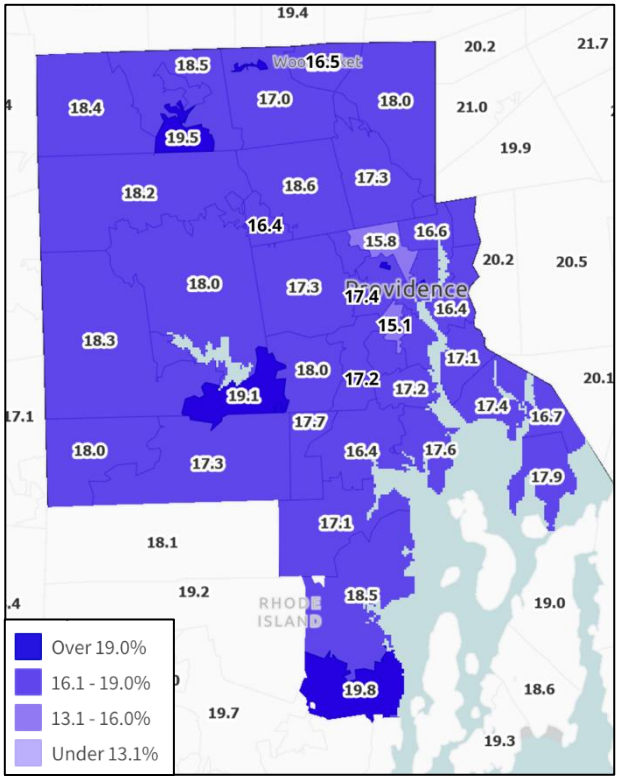


Alcohol use disorder is a growing concern nationally and for Rhode Island residents. Nearly 1 in 5 Rhode Island adults reported excessive alcohol use, with recent increases in all counties except Bristol. Zip code-level analysis shows that excessive alcohol use is prevalent across communities.



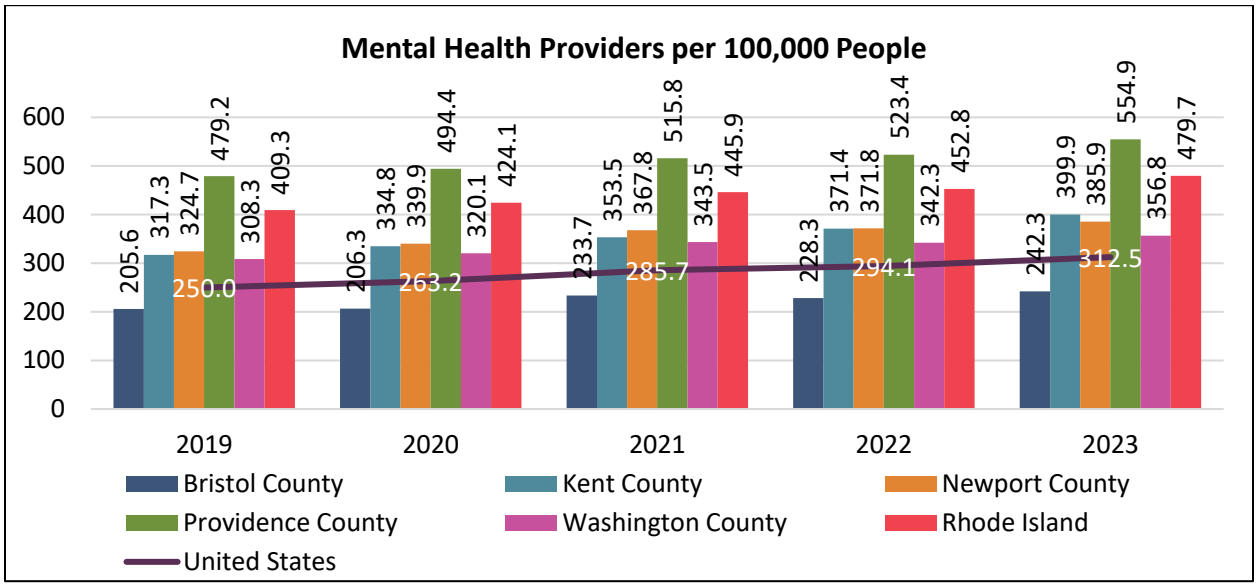
Source: Centers for Disease Control and Prevention

2022 Adults who Self-Report Binge Drinking by Zip Code



Source: Centers for Disease Control and Prevention

Rhode Island has a consistently higher rate of behavioral health providers compared to the national average, and the rate is increasing. Despite these trends, gaps in access to care and services persist. Newport and Washington counties are Health Professional Shortage Areas (HPSAs) for all people, and Providence County is a HPSA for people with low income.



Source: Centers for Medicare and Medicaid Services
*Mental health providers include those specializing in psychiatry, psychology, mental health, addiction or substance use disorders, or counselling.

Health and human service professionals reported an increase in patients presenting to acute hospital settings due to lack of outpatient resources (e.g., detox programs, psychiatrists, support groups), as well as lack of placement options post-discharge. Finding appropriate housing for discharge of patients with comorbidities or complex medical needs was especially challenging.

> *"[There is an] increase in patients seeking emergency room care [and] inadequate residential placement options for patients seeking treatment with skilled health care needs (i.e., with DME [durable medical equipment], IV abx [intravenous antibiotics] needs." (Key Stakeholder Survey)*

> *"Patients with chronic behavioral health issues that cannot be placed at SNFs [skilled nursing facilities] due to said behaviors and sit in acute care beds for weeks/months thus lessening available acute care beds." (Key Stakeholder Survey)*

> *"Those suffering with substance use disorder who end up having complex medical needs for 30-45 days, who then have no housing or shelter - there are limited safe discharge options." (Key Stakeholder Survey)*

Despite having an increasing number of behavioral health providers across the state, behavioral health care is not readily available for all that need it. Providers cited low reimbursement rates as one reason for limited providers, particularly those that participate with Medicaid. Low reimbursement rates have prompted some providers to move to private practice, opting to accept only self-pay clients. Stigma also continues to be a barrier to seeking treatment, particularly for people with substance use disorder.

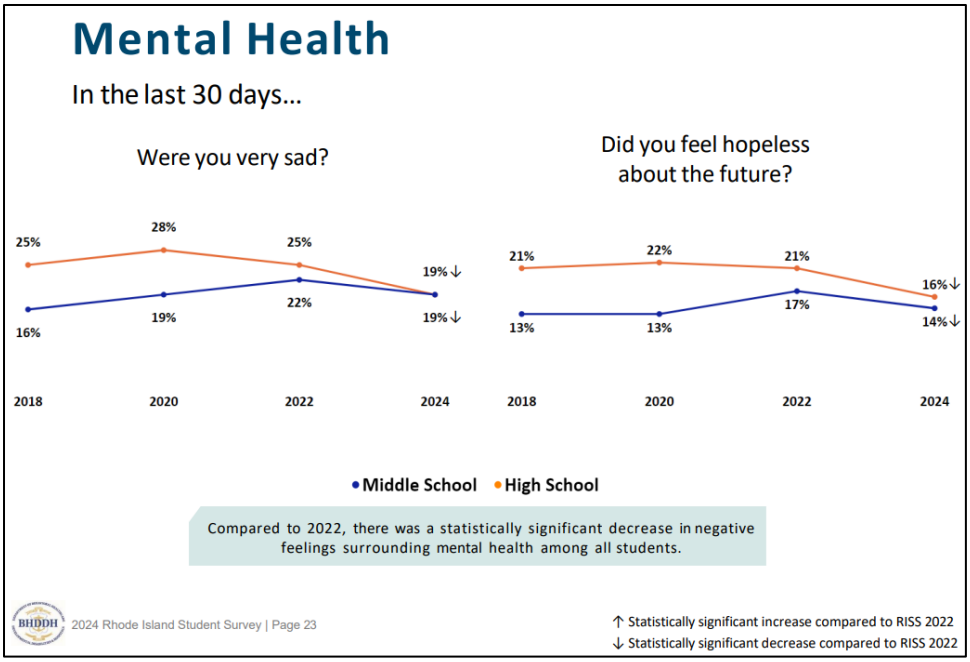
> *"The community's concern is that they will be stigmatized because of use, they will not be supported in safe use, or that they will not be supported in the 50th attempt to cut down." (Key Stakeholder Survey)*
>
> *"[There is] stigma surrounding alcoholism and dependence - social expectation in the area is to drink, not abstain." (Key Stakeholder Survey)*

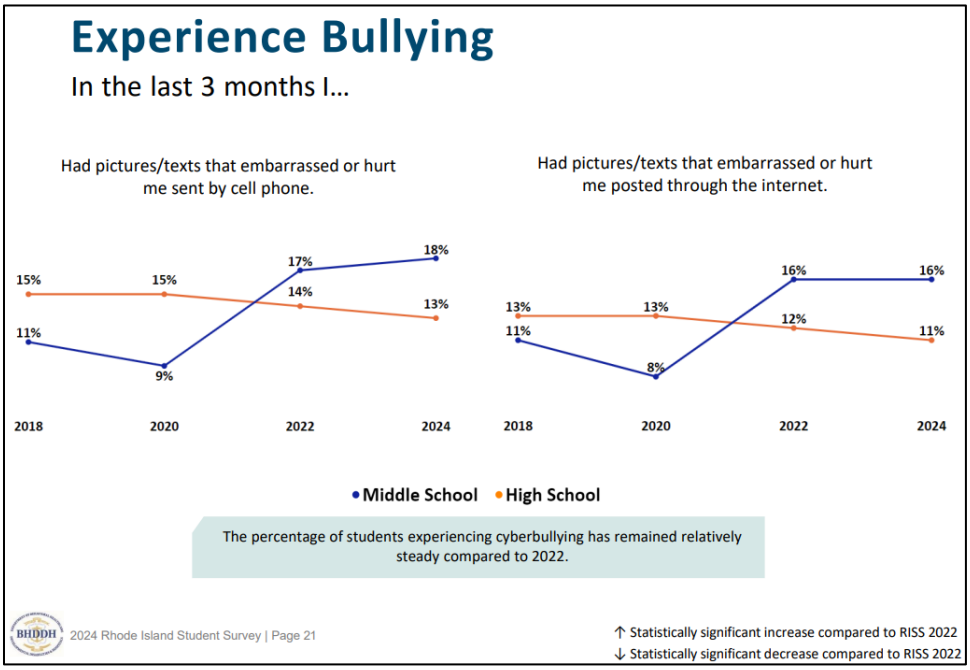
Health and human service professionals noted an increase in mental health and substance use concerns among youth, often rooted in adverse childhood experiences (ACEs) like living in poverty and exposure to violence. Isolation and developmental delays from the COVID-19 pandemic also have had lingering impact on youth.

Professionals reported that there has been an increase in EMS calls to schools for mental health crises and suicide attempts, with trends among younger age groups than in past years. Youth professionals also held concerns that the legalization of cannabis (marijuana) and lack of regulation contributed to increased use among students and kids *"greening out in school."* Community representatives noted that funding for children's mobile crisis services is largely limited to children with Medicaid, creating a deficit in resources for other children in need of services. Partners recommended more investment in upstream interventions like engagement and mentorship activities and graduation support for at-risk students.

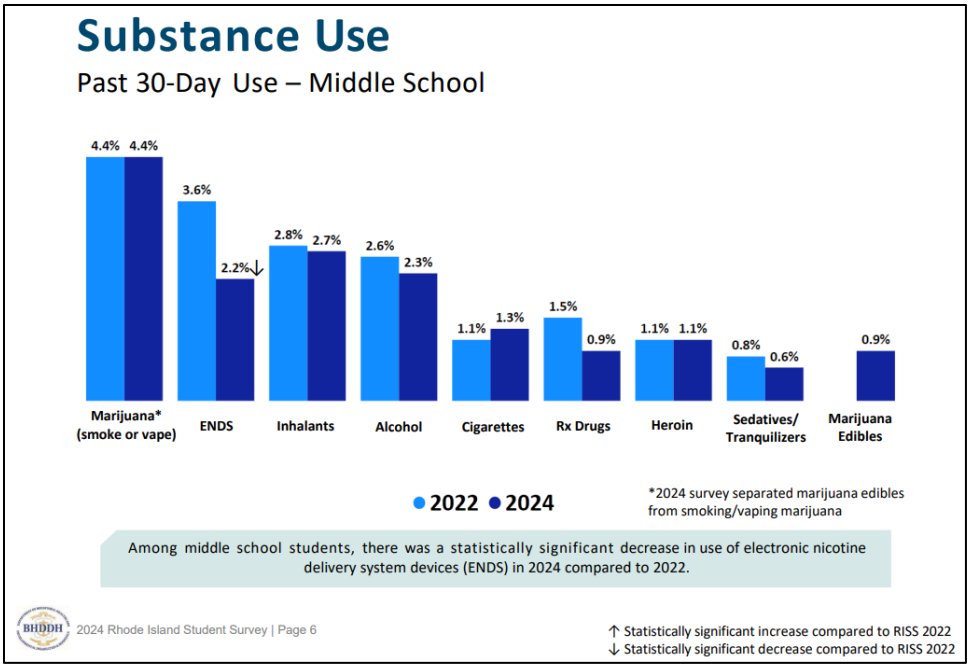
> *"The legalization of marijuana [during] COVID caused increases to an already growing problem that lacked resources. Specifically, we have many addicted students that need in-patient or intense treatment." (Key Stakeholder Survey)*
>
> *"Treatment options for youth (12-18 y.o.) need to be identified and shored up. While the focus of many efforts has been on treatment, prevention is what needs to be differently funded to have a real impact." (Key Stakeholder Survey)*
>
> *"Access to services is often limited due to long wait lists for therapy and psychiatry services for children and adolescents." (Key Stakeholder Survey)*

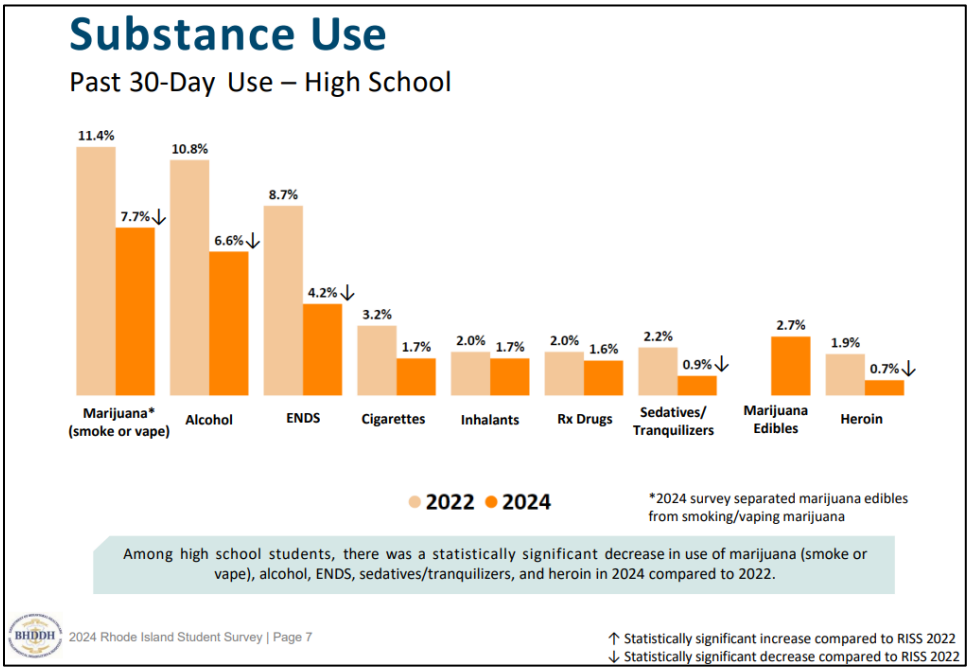
The Rhode Island Student Survey is a statewide survey administered every other year and examines the risk and prevalence of substance use, bullying, depression, suicide, and violence among Rhode Island youth in middle (MS) and high (HS) schools. The most recent survey administered in 2024 found significant improvement in mental health outcomes, but approximately 1 in 5 students still reported feeling very sad and/or hopeless about their future. Among students who considered attempting suicide, one-third or more attempted it. There were also significant increases in perpetrating bullying and cyberbullying among MS students, and experiences of bullying among both MS and HS students. Substance use declined significantly for students, except for a rise in cannabis use among MS students.





Source: Rhode Island Student Survey





Source: Rhode Island Student Survey

Concerted efforts to address increasing behavioral health needs have led to progress in improving community awareness and access to services. Health and human service professionals named the following successes within Rhode Island:

- Anchor ED and Anchor Peer Recovery Center
- Crisis Intervention Teams of Rhode Island (CIT-RI)
- Gateway Healthcare dedicated behavioral health services
- Hospital-initiated screening for behavioral health and SDoH
- Inclusion of people with lived experience as volunteers, staff, and advocates in developing programs (e.g., CIT-RI)
- Insurance reimbursement for peer recovery coaches
- Increased state and local funding for behavioral health programs and support

Community recommendations to improve behavioral health outcomes:
Health and human service professionals saw a need to better address behavioral health issues through a holistic care continuum, noting that the current system is "siloed" by individual needs or demographics. A holistic approach would include an open (immediate) access model and patient advocates to help navigate different levels of care and the healthcare system. Wraparound social services like housing were also seen as essential to help people be successful in their treatment.

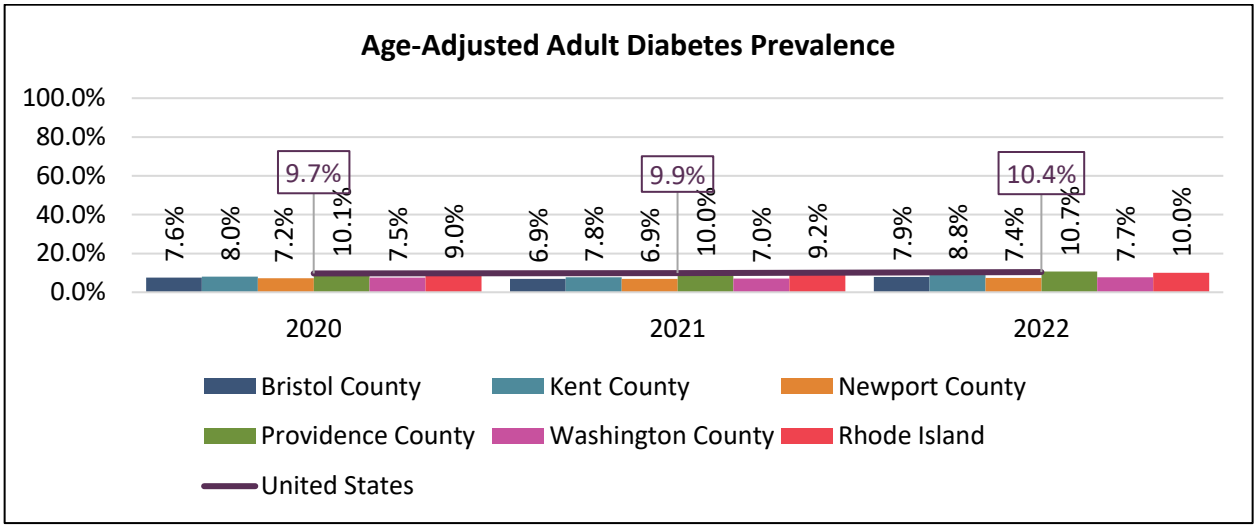
Other recommendations included the following:

- Mobile crisis programs that serve youth with all insurance types and/or uninsured
- Investment in upstream youth interventions like engagement and mentorship activities and graduation support for at-risk students
- Stigma reduction initiatives, particularly for substance use disorder
- Youth cannabis prevention programs, including more regulation by the state
- Regular first responder training to better understand and respond to new drug chemistries and new street drugs like medetomidine
- Better insurance reimbursement for behavioral healthcare workers
- Funding for community mental health workers

Chronic Diseases: Leading Causes of Death and Disease

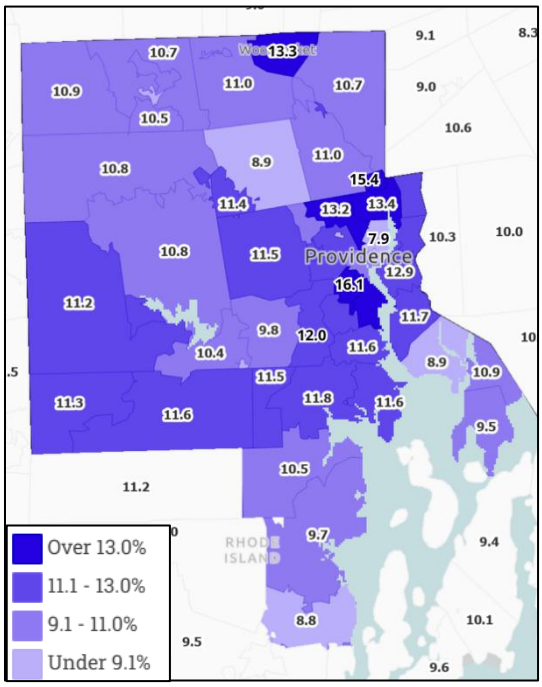
Behavioral health conditions and chronic physical health conditions are often co-occurring, one increasing the risk of the other. The following section focuses on the leading causes of disease burden and death, and management and prevention efforts.

Diabetes and heart disease are among the top causes of death for residents in Rhode Island. The proportion of adults in Rhode Island that are diagnosed with diabetes has increased since 2020 to approximately 1 in 10 adults. More than one-quarter of adults have high blood pressure and/or high cholesterol. Rates of disease outside of Providence County are historically lower than national averages.

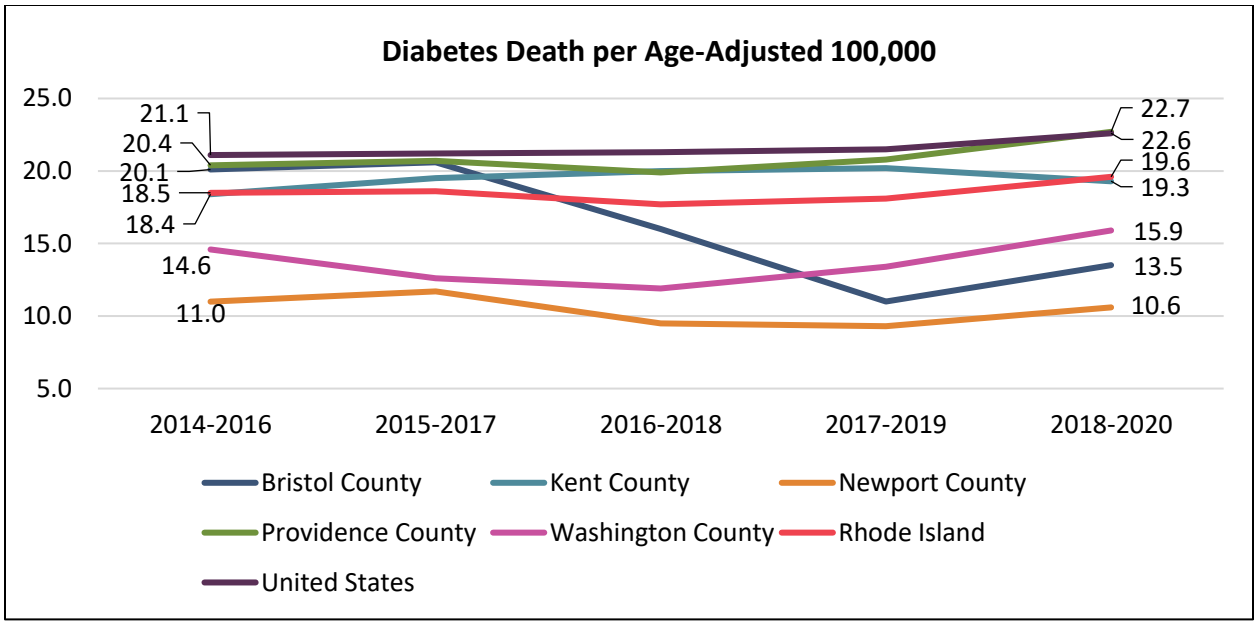


Source: Centers for Disease Control and Prevention

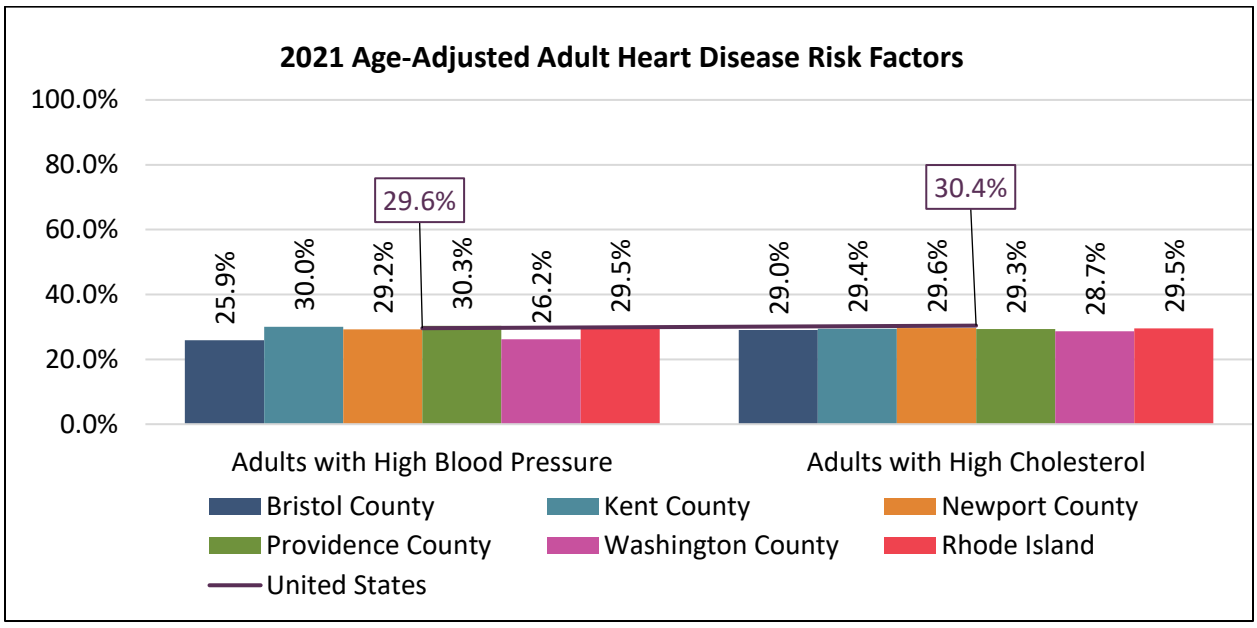
2022 Adults with Diabetes by Zip Code



Source: Centers for Disease Control and Prevention

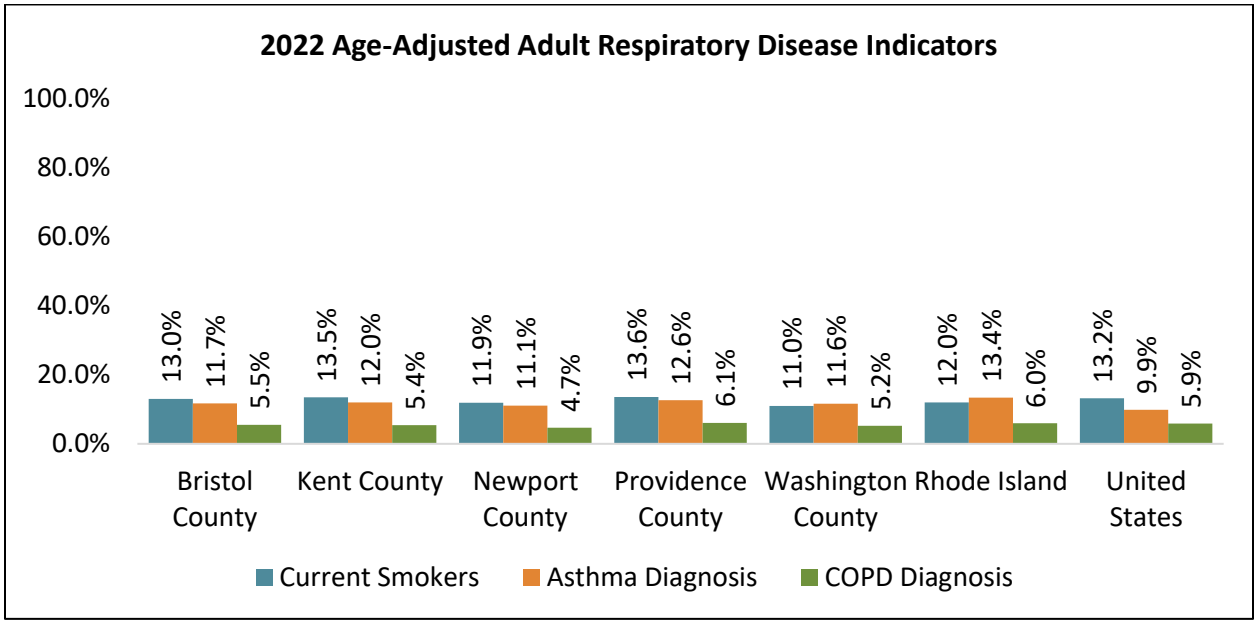


Source: Centers for Disease Control and Prevention



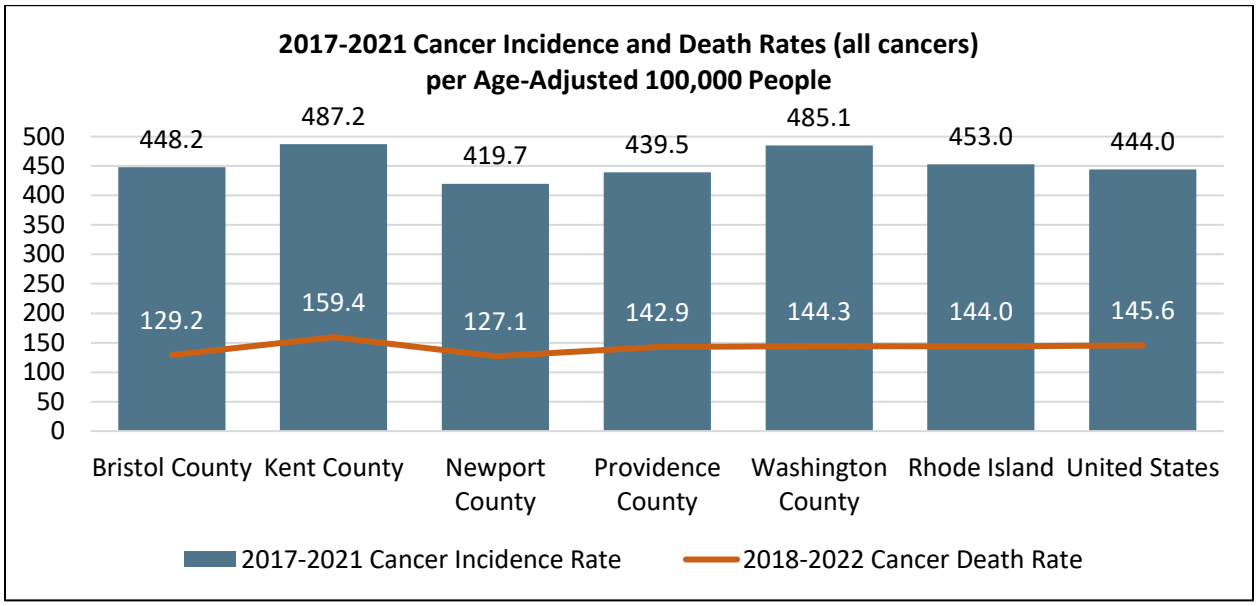
Source: Centers for Disease Control and Prevention

Traditional cigarette use (not including e-cigarettes, cigars, etc.) declined statewide and nationally over the last few decades. Rhode Island adults are less likely to smoke than their peers nationally, although prevalence is slightly higher in Kent and Providence counties compared to other communities. Chronic conditions like asthma and chronic obstructive pulmonary disorder (COPD) are strongly linked to cigarette use, as well as environmental factors like older housing stock. More Rhode Island residents have been diagnosed with asthma as compared to their peers nationally.



Source: Centers for Disease Control and Prevention

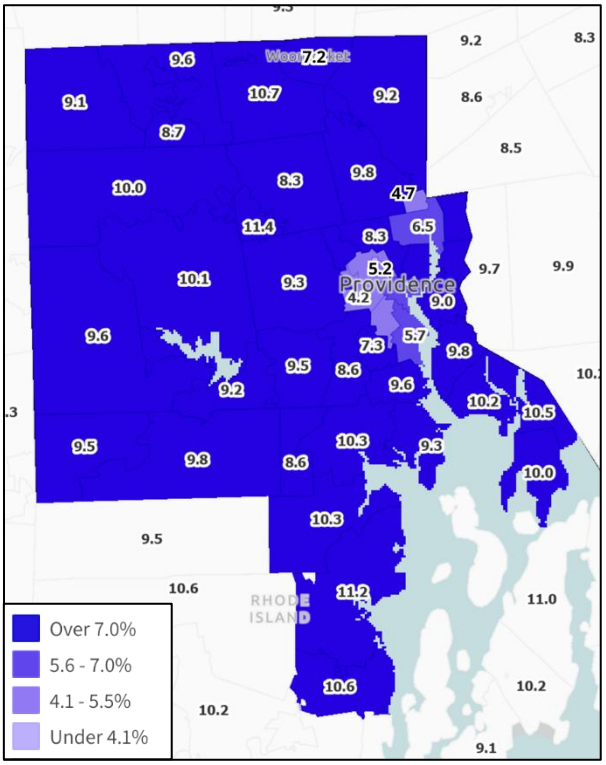
Rhode Island as a whole has similar incidence and death rates due to cancer as the nation, but experiences vary across the state with higher reported death rates in Kent and Providence counties. Across Women & Infants Hospital service area zip codes, approximately 1 in 10 adults have been diagnosed with cancer.



Source: Centers for Disease Control and Prevention

*Cancer incidence data lag and are reported for most recent years available.

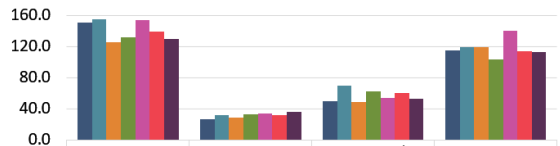
2022 Adults with Cancer, (non-skin) or Melanoma, by Zip Code



Source: Centers for Disease Control and Prevention

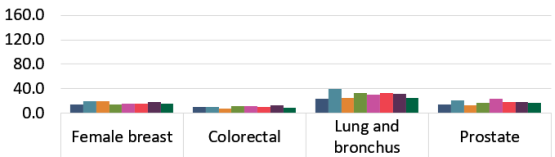
The top four cancer types are female breast, colorectal, lung and bronchus, and prostate cancers. Statewide, residents have a higher incidence of female breast cancer, but a lower death rate due to female breast cancer, a trend that typically reflects better screening practices for early detection and treatment. Opportunity exists to address community-level disparities in cancer outcomes, including higher female breast cancer death in Kent and Newport counties, higher lung cancer incidence and death in Kent County, and higher prostate cancer death in Kent and Washington counties. Poorer health outcomes related to cancer in these areas may indicate the need for additional screenings and access to treatment as well as addressing social drivers that contribute to health disparities.

2017-2021 Cancer Incidence per Age-Adjusted 100,000 People



	Female breast	Colorectal	Lung and bronchus	Prostate
Bristol County	150.3	26.4	49.7	114.5
Kent County	155.0	31.9	69.9	119.2
Newport County	125.6	29.0	48.1	118.7
Providence County	132.1	32.9	61.8	103.5
Washington County	154.1	33.4	53.6	140.3
Rhode Island	139.0	32.0	60.0	114.0
United States	129.8	36.4	53.1	113.2

2018-2022 Cancer Death per Age-Adjusted 100,000 People



	Female breast	Colorectal	Lung and bronchus	Prostate
Bristol County	14.4	10.5	23.7	14.1
Kent County	19.6	11.0	40.6	21.3
Newport County	19.5	7.9	25.8	12.7
Providence County	14.9	11.7	33.9	17.2
Washington County	15.8	11.3	31.0	24.3
Rhode Island	16.0	11.0	33.0	18
United States	19.2	13.1	32.3	18.6
HP2030	15.3	8.9	25.1	16.9

Source: Centers for Disease Control and Prevention
Note: Years reported differ for incidence and death rate; data are reported for most recent years available.

Advocates working to reduce cancer in Rhode Island said that cost is a primary barrier for residents seeking preventive screenings and holistic cancer care. They noted that outside of the prevention schedule, insurance does not typically cover screenings (i.e., for lung cancer) at the patient's request. Out-of-pocket costs for nutrition and other holistic support are also not covered by insurance programs. Copays and other costs can keep people with limited resources from accessing primary care to increase early detection of disease. Primary care shortages in Rhode Island have also created a backlog for screenings and prompted some patients to travel to neighboring states where they perceive there is more comprehensive support.

Challenges and Solutions as defined by health and human service professionals identified the following key drivers that impact effective chronic disease prevention and management:

- Declining access to primary care providers and specialized healthcare
- Health literacy among patients, including lack of understanding their insurance benefits
- "Silos" among health and social service providers, prompted by fear of losing resources or market share, which reduces effective collaboration and resource sharing
- Lack of transportation options to get to medical appointments
- Limited support for disease management (e.g., medication management and cost assistance)
- Need for more social workers to help patients and their families navigate the healthcare system and receive social supports

Community recommendations to improve chronic disease healthcare and outcomes:

- More clinical sites and mobile options to provide local care and education (e.g., Blue Cross Blue Shield Blue Bus/Blue Store)
- Centralized public communication hub for community and health resource information
- Better reimbursements and incentives for doctors and other providers to stay in state
- Expanded use of Nurse Practitioners and other advanced practitioners to augment physicians
- Adoption of asynchronous visits using text messaging communications with patients
- Respite care and expanded support for caregivers
- More programs to address food security and nutrition like the *Food as Medicine* program

Housing

More than 70% of Key Stakeholder Survey participants rated housing affordability and availability as "poor." Participant feedback highlighted rising housing prices, a shortage of available and planned affordable housing across the state, and strong local NIMBY (not in my backyard) opponents to affordable housing development. Gentrification within communities and short-term and vacation rental properties were seen as contributing to affordability challenges. Housing has been treated as a commodity, a source of wealth accumulation and investment, harming residents and making it hard to advocate for housing needs.

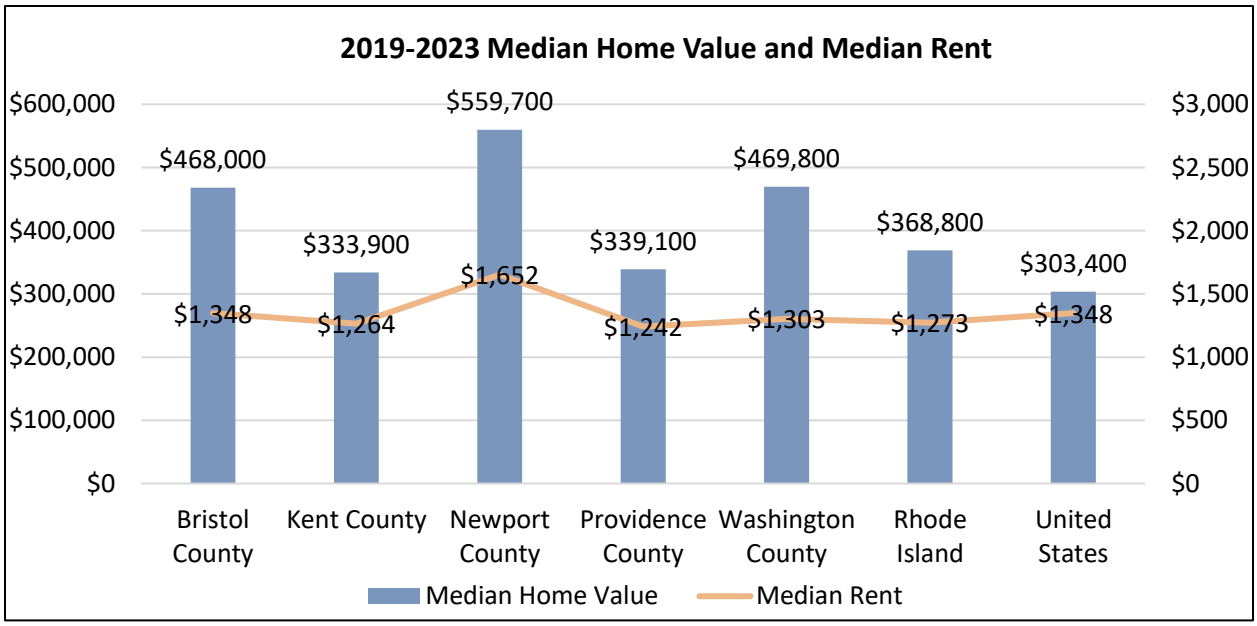
> *"The prevalence of economic disparity between those with much and those with not enough is growing greater every day. […] Ironically, some of the housing scarcity comes from the development of more arts and related businesses in the downtown area which has come at the expense of what used to be affordable housing apartments. Additionally, the over development of the short-term rental market has also removed housing stock from circulation even as it has contributed to summer over-crowding issues. Also, the political will of the NIMBY group here is quite tangible. Those who already have much are getting even more. Those without enough to live comfortably are being made more uncomfortable by the moment. The disparity is not sustainable." (Key Stakeholder Survey)*

Health and human service professionals were concerned that while there has been more state-level support and funding for housing initiatives, programs are not being implemented effectively at the local level due to NIMBY mentality. For some communities, housing insecurity is seen as an issue affecting "outsiders" and not neighbors and long-time residents. Professionals were frustrated by the overall lack of change in housing affordability, citing the need for a comprehensive statewide plan and long-term housing solutions.

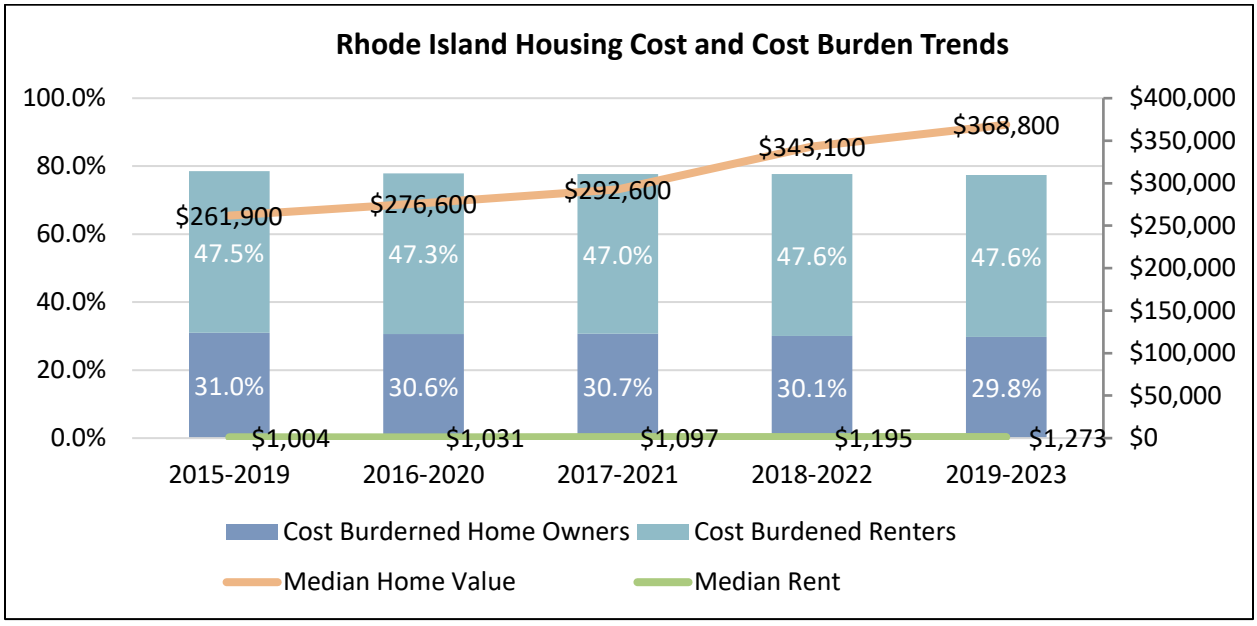
> *"They don't think they're serving their own community." (Partner Forum Participant)*
>
> *"What if we said each town will build 250 units and 75% of them will be filled by people from the area?" (Key Stakeholder Survey)*
>
> *"We have been having these conversations for years now." (Key Stakeholder Survey)*

Populations historically placed at risk for housing insecurity, including people with behavioral health conditions, justice-involved people, older adults, and survivors of domestic violence, face significant barriers to securing stable and appropriate housing. Recovery housing is limited, often requiring people to move out of their community and making long-term stability more challenging. Current policies exclude many people with a criminal record from affordable housing eligibility, disproportionately affecting those impacted by the opioid epidemic. Partners reported a lack of assisted living beds available for older adults, especially those experiencing cognitive disabilities. Poor oversight in some affordable housing facilities endangers residents, with reports of domestic violence survivors being housed alongside individuals with sex-related offenses.

Housing costs increased nationally and across Rhode Island. From 2019 to 2023, statewide median home value rose 41% and median rent rose 27%. The National Low Income Housing Coalition estimated that in 2023 the hourly wage a full-time worker needed to earn to afford a two-bedroom rental home at fair market rent in Rhode Island was $33.20. In that year, the state minimum wage was $14.00. Approximately 30% of homeowners and 48% of renters are considered cost burdened, spending 30% or more of their household income on mortgage or rent expenses alone. The proportion of cost burdened households is consistent across Rhode Island counties.



Source: US Census Bureau, American Community Survey

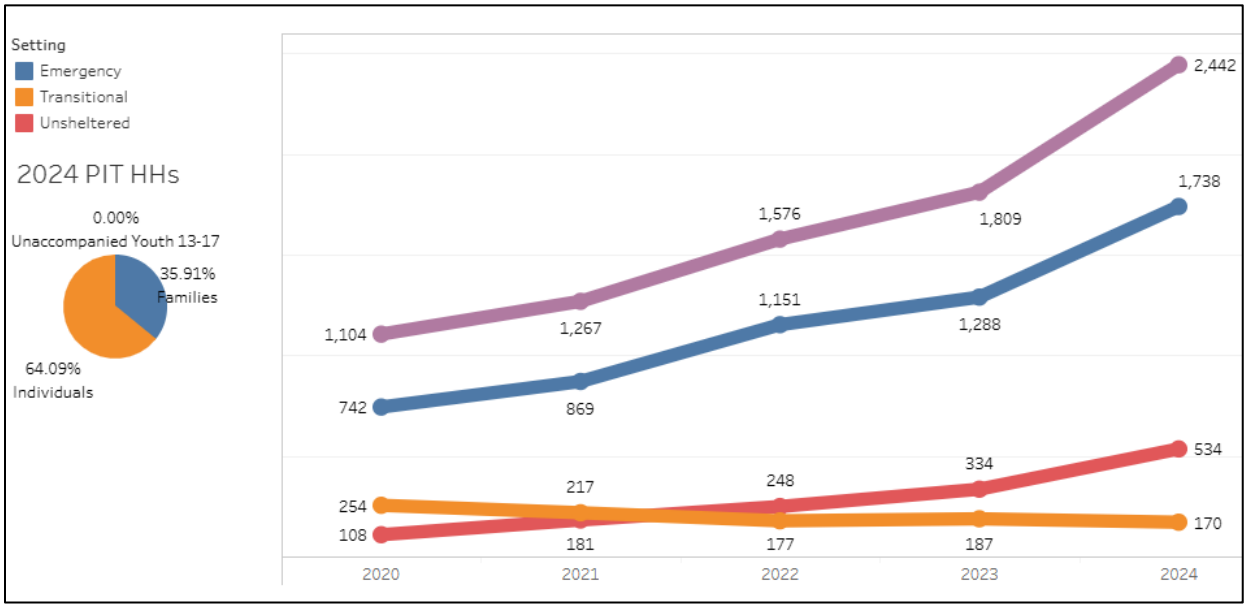


Source: US Census Bureau, American Community Survey

HousingWorks RI at Roger Williams University reports annually on housing affordability data for Rhode Island. In 2024, HousingWorks RI—for the first time—found no Rhode Island municipality where a household with an income under $100,000 could affordably buy. The lowest calculated income required to buy was in Woonsocket at $119,123. HousingWorks RI determined that Burrillville was the only municipality where the state's median renter household income of $45,560 was sufficient to affordably rent the average-priced two-bedroom apartment.

Rising housing costs have contributed to more people experiencing homelessness. The Point-in-Time (PIT) count is a nationwide count of sheltered and unsheltered people experiencing homelessness. The most recent count conducted in 2024 found that there were 2,442 unhoused Rhode Islanders, a 35% increase from 2023 and more than 120% increase from 2020.

Five-Year Trends in Rhode Islanders Experiencing Homelessness



Source: The Rhode Island Coalition to End Homelessness

Community recommendations to improve housing:

- Advocate for a comprehensive statewide housing plan with local level accountability
- Explore development of a medical shelter or other care continuum facility that can receive and care for chronically ill unhoused people upon hospital discharge
- Explore alternative approaches to affordable housing development, including acquiring/using abandoned housing
- Provide education like estate planning, financial literacy, etc. to help people pass housing to the next generation (e.g., RI Families-First Model)
- Provide more expungement services to help individuals with criminal records qualify for housing

Maternal and Child Health

Births have declined for most of the past decade, both nationally and in Rhode Island. National research suggests that the general decline in fertility is due to women delaying childbearing and having fewer total children. Rhode Island had the second lowest fertility rate among US states, and the number of babies born to mothers living in Rhode Island declined 18% between 2002 and 2022, from 12,375 to 10,115.

Rhode Island overall reports more positive pregnancy and birth outcomes than the nation. The statewide teen birth rate declined 58% between 2009-2013 and 2018-2022, from 21.0 births per 1,000 teen girls to 8.9 per 1,000. Across the state and all counties, people are more likely to receive early prenatal care and fewer babies are born preterm and/or with low birth weight compared to national averages. However, significant differences in these outcomes are seen between counties population groups. Black people and babies continue to be placed at risk for many of these factors, with only slight improvements from the 2022 CHNA.

2018-2022 Maternal and Infant Health Indicators

	Teen Birth Rate (per 1,000 Ages 15-19)	First Trimester Prenatal Care	Preterm Births	Low Birth Weight Births	Breastfeeding at Time of Birth
Bristol County	NA	84.3%	8.1%	6.8%	83.0%
Kent County	NA	87.8%	8.6%	7.0%	79.0%
Newport County	NA	87.4%	7.5%	6.7%	85.0%
Providence County	NA	82.3%	9.6%	8.2%	73.0%
Washington County	NA	90.0%	8.3%	5.9%	81.0%
Rhode Island	8.9	84.2%	9.2%	7.7%	76.0%
Asian, Non-Hispanic	3.3	83.7%	8.8%	8.9%	82.0%
Black or African American, Non-Hispanic	9.8	78.3%	11.4%	11.4%	69.0%
White, Non-Hispanic	3.7	87.1%	8.4%	6.6%	79.0%
Hispanic or Latina (any race)	24.3	81.8%	10.2%	8.3%	70.0%
HP2030 Goal	NA	80.5%	9.4%	NA	NA

Source: Rhode Island KIDS COUNT Factbook

Pregnancy and birth disparities are evident in Providence County and largely experienced by people living in the core cities. While the teen birth rate for the core cities declined at a similar rate as the state overall, it remains more than three times higher than the remainder of the state. The proportion of people residing in the core cities and receiving early prenatal care improved from the 2022 CHNA (79.5%

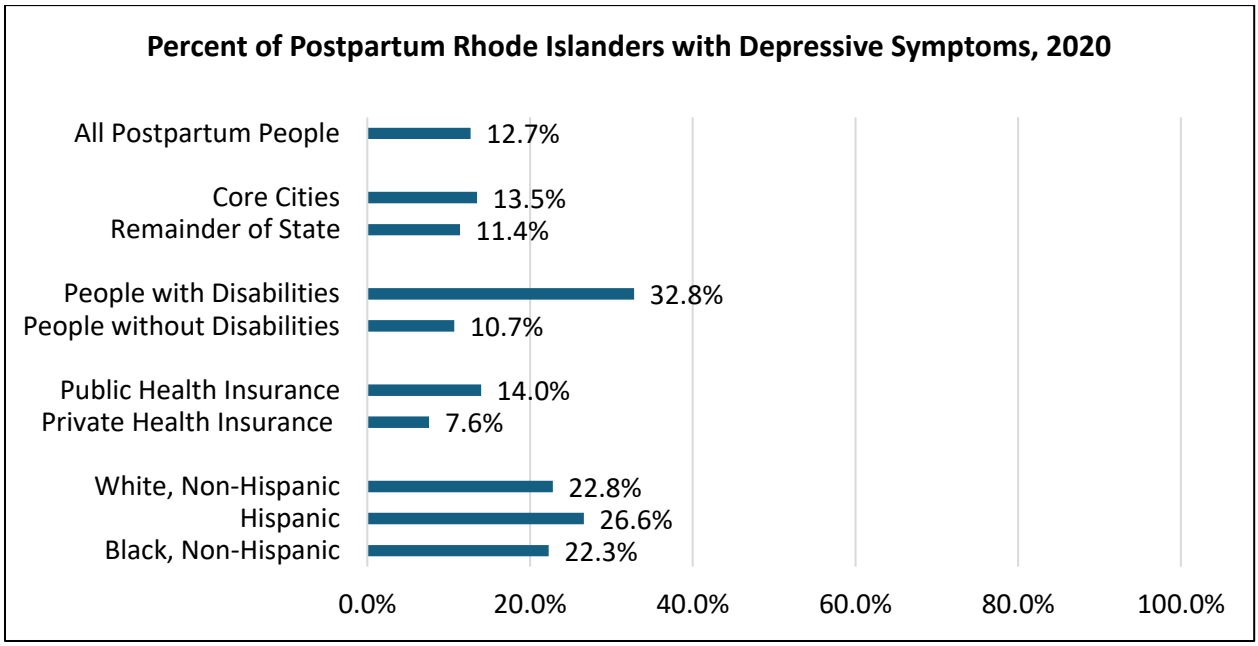
to 80.4%), but preterm and low birth weight births are persistently high. The core cities saw improvement in breastfeeding at time of birth from the 2022 CHNA (63% to 68%).

2018-2022 Maternal and Infant Health Indicators for Core Cities

	Teen Birth Rate (per 1,000 Ages 15-19)	First Trimester Prenatal Care	Preterm Births	Low Birth Weight Births	Breastfeeding at Time of Birth
Central Falls	21.3	77.9%	11.8%	8.3%	67.0%
Pawtucket	19.0	81.9%	9.9%	9.2%	70.0%
Providence	15.5	79.9%	10.1%	8.8%	68.0%
Woonsocket	25.5	81.9%	10.3%	8.8%	66.0%
Four Core Cities	17.3	80.4%	10.2%	8.8%	68.0%
Remainer of Rhode Island	4.5	86.5%	8.5%	7.0%	81.0%
Rhode Island (all)	8.9	84.2%	9.2%	7.7%	76.0%
HP2030 Goal	NA	80.5%	9.4%	NA	NA

Source: Rhode Island KIDS COUNT Factbook

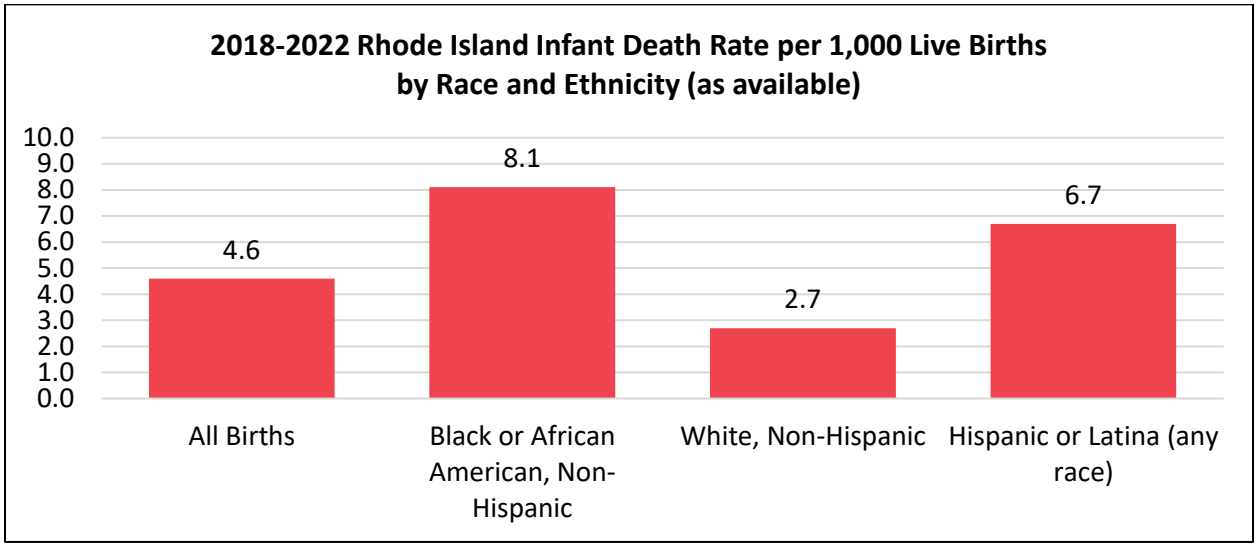
A pregnant person's body and mind go through many changes during and after pregnancy. Postpartum depression is a severe, long-lasting form of depression that happens after having a baby. It may involve strong feelings of sadness, anxiety (worry), and tiredness. In 2020, about 13% of all postpartum people in Rhode Island experienced depressive symptoms, a similar proportion as in prior years. Prevalence of depressive symptoms varied greatly by socioeconomic and community experiences.



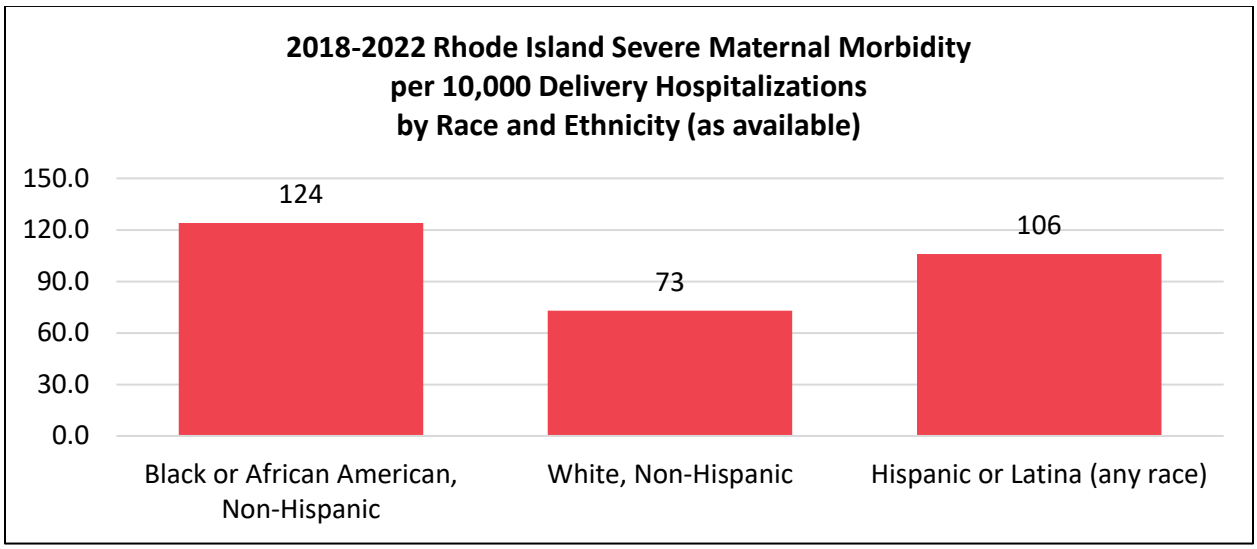
Source: Rhode Island Department of Health

The infant death rate is widely used as a key indicator of community health because it reflects not only the health of infants but also the overall health and wellbeing of a population. It serves as an overall indication of factors like access to healthcare, socioeconomic conditions, and the quality of the environment.

The five-year aggregate (2018-2022) infant death rate for Rhode Island meets the Healthy People 2030 target of 5.0 per 1,000 live births, but disparities by race and ethnicity are indicative of the social and environmental stresses experienced by people of color. Across Rhode Island, the infant death rate for non-Hispanic Black and Hispanic and/or Latinx infants is 2.5-3 times higher than the death rate for white infants. Similarly, the prevalence of severe maternal morbidity, defined as unintended outcomes of labor and delivery that result in significant consequences to a woman's health, is significantly higher for Black and Hispanic and/or Latina women.



Source: Rhode Island KIDS COUNT Factbook

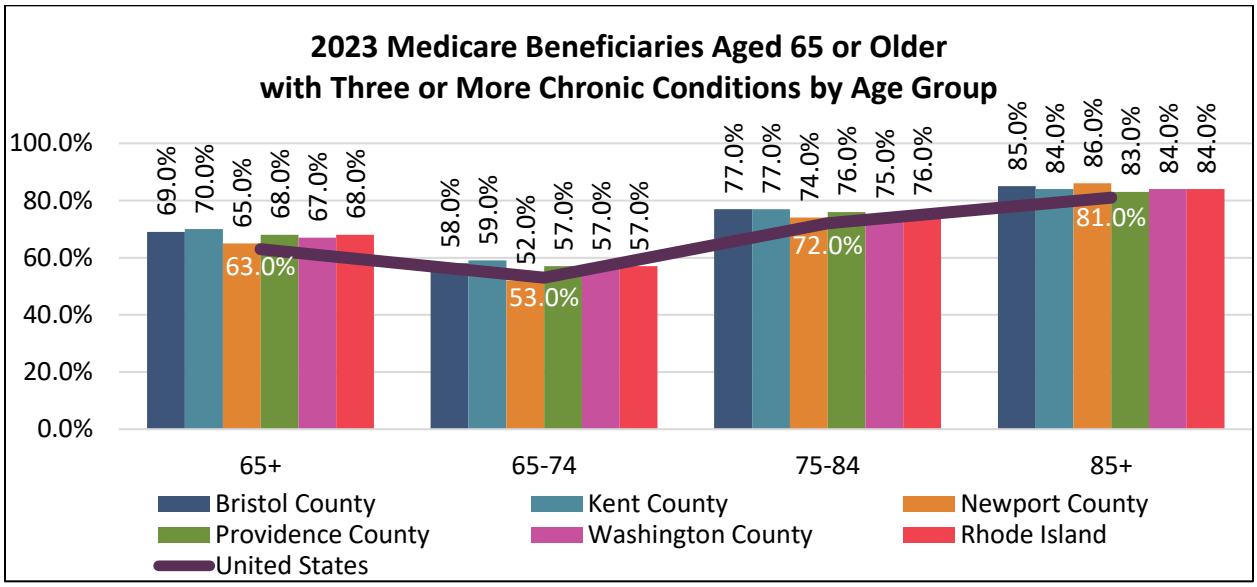


Source: Rhode Island KIDS COUNT Factbook

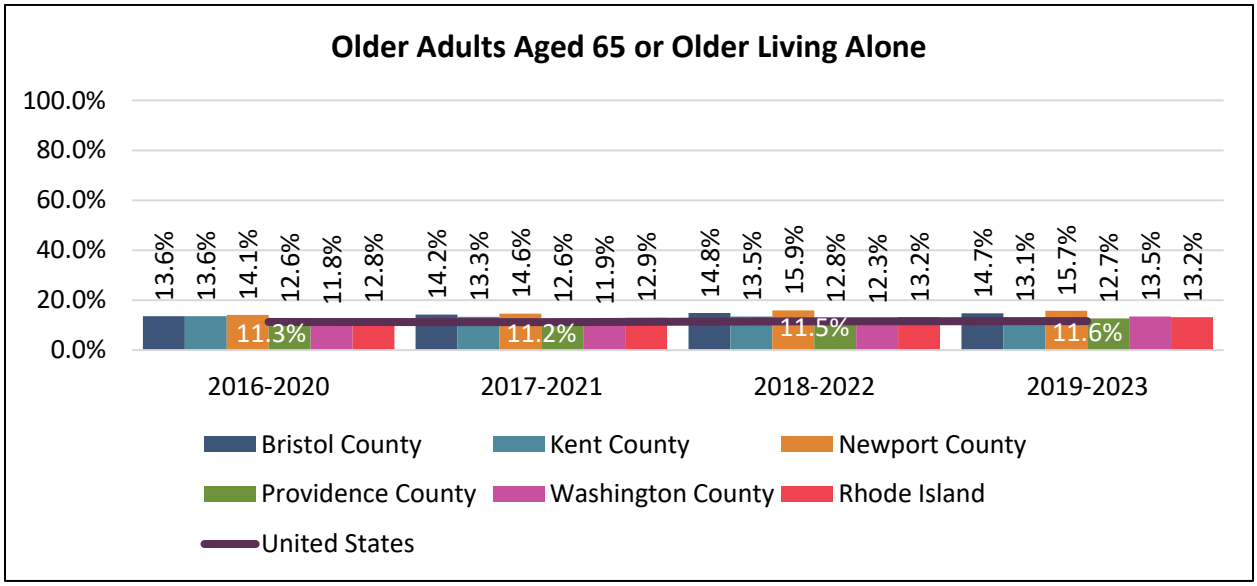
Older Adult Health and Wellbeing

Rhode Island's population is rapidly aging. From 2010 to 2023, the number of adult residents aged 65 or older grew 33.3% statewide and by as much as 50%-60% in Newport and Washington counties.

Older adults are more at risk for chronic disease, as well as factors that impede disease management, including economic insecurity, social isolation, and access barriers (e.g., transportation, digital literacy). In 2023, 68% of Rhode Island Medicare beneficiaries aged 65 or older managed three or more chronic conditions, most commonly high cholesterol (72%), high blood pressure (70%), rheumatoid arthritis (37%), diabetes (27%), and depression (21%). An increasing percentage of older adults live alone, estimated at 13% in 2023.



Source: Centers for Medicare and Medicaid Services

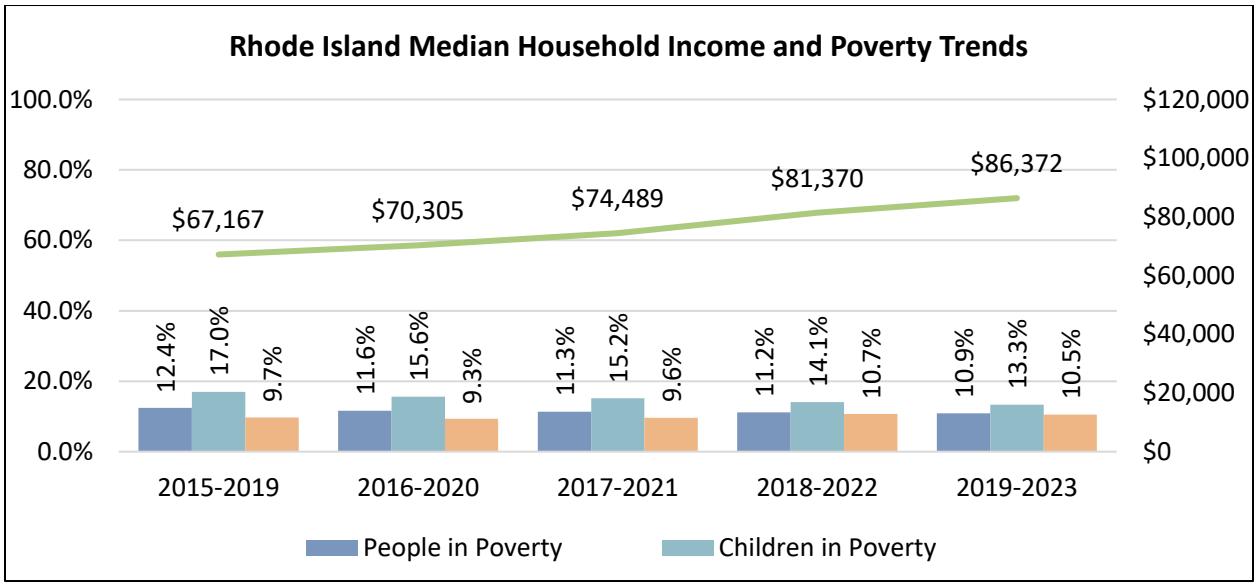


Source: US Census Bureau, American Community Survey

Health and human service professionals shared that more older adults are experiencing mental health challenges, often rooted in loneliness and isolation. While socialization opportunities for older adults have improved (e.g., senior centers, volunteering, intergenerational college classes), more is needed to intentionally engage this population. Professionals recommended more direct communication, noting that older adults are increasingly opting in to text messages as a primary form of communication. They also recommended a centralized database for older adult events and information, leveraging organizations like Age Friendly Rhode Island to assist with implementation.

Older adults typically live on a fixed income and have been disproportionately affected by the rising cost of living. While the proportion of all Rhode Island residents and children living in poverty declined, the proportion of older adults living in poverty increased in recent years. More older adults were perceived to struggle with homelessness, food insecurity, and medication costs, among other concerns. Health and human service professionals noted that despite rising financial concerns, many older adults are either not aware of the services available to them or are uncomfortable asking for help.

> *"More seniors are homeless. Many can't afford their basic needs and may be too prideful to ask for help." (Partner Forum Participant)*



Source: US Census Bureau, American Community Survey

Other primary barriers for older adults to maintain their health are a lack of caregiver support and Medicare insurance gaps. Caregivers were seen as overburdened by their responsibilities, with both limited options for respite care and limited awareness of the community resources that are available to support them. Medicare insurance gaps included high costs of supplemental insurance, lack of home care and home modification coverage, and a potential end to telehealth reimbursement.

> *"Caregivers don't know where to go. Trying to get information to them is hard. They don't come [to events]. They have children and parents to take care of." (Partner Forum Participant)*

Our Response to The Community's Needs

In 2022, CNE conducted a similar CHNA and developed a supporting three-year Community Health Improvement Plan (CHIP). Based on the CHNA findings, CNE leadership identified three priority areas:

- Behavioral Health
- Chronic Disease
- Maternal and Child Health

CNE invested in internal population health management strategies and partnered with diverse community agencies across Rhode Island to fund programs and initiatives aimed at addressing the identified priority areas. The system measured contributions and community impact from these investments, as outlined in the following sections.

Our Impact in Numbers

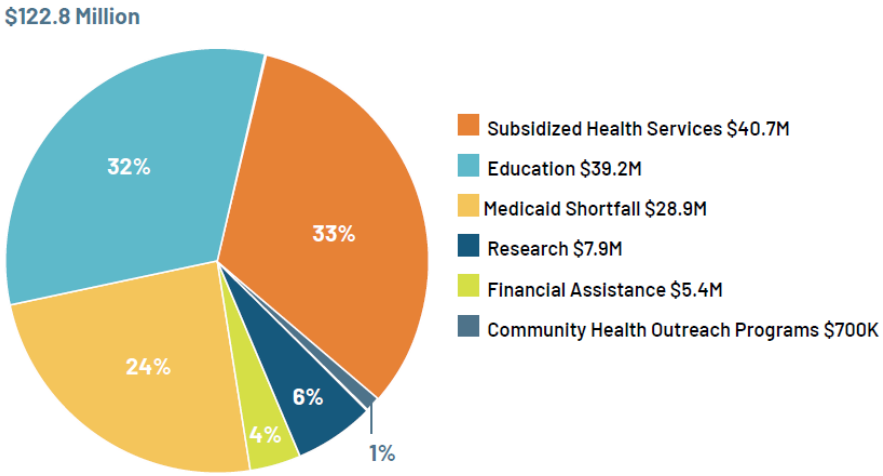
CNE community engagement professionals participated in community events organized by local organizations and coordinated with community organizations to create impactful events. Each operation unit within the CNE health system participated in a number of community engagement events which were recorded in our internal Community Engagement calendar. **In 2024 alone, over 300 events were recorded on the community engagement calendar.**

Community Collaborations

- Community College of Rhode Island
- Refugee Dream Center
- Progreso Latino, Inc
- United Way of Rhode Island
- New Briges for Haitian Success
- Big Brothers Big Sisters of Rhode Island
- Rhode Island's Health Equity Zones
- The Metropolitan Regional Career and Technical Center
- North Providence High School CTE Pathways
- Central RI Chamber of Commerce
- Westbay Community Action
- Latino Cancer Control Task Force
- Rhode Island Foundation
- Southside Community Land Trust
- House of Hope CDC
- Rhode Island Coalition to End Homelessness
- Oasis International, Inc
- Smith Hill Library
- Fox Point Neighborhood Association
- Saint Elizabeth Community
- Newport Alzheimer's Taskforce
- Ministers Alliance of Rhode Island
- St. Martin de Porres Center
- Rhode Island Pride
- Cranston Senior Enrichment Center
- Latino Policy Institute
- American Parkinson Disease Association
- Rhode Island Chapter
- Clinica Esperanza/Hope Clinic
- Leon Mathieu Senior Center
- Providence Community Health Centers
- West End Community Center
- Samuel Slater Middle School
- Temple Emanu-El
- Mt. Pleasant Library
- BRAIN WAVES Rhode Island
- Elmwood Adult Day Health Care
- The University of Rhode Island
- Rhode Island College
- National Alliance on Mental illness (NAMI)
- The Warren Alpert Medical School of
- Brown University
- Amos House
- American Heart Association
- Executive Office of Health and Human
- Services
- JuneteenthRI
- Youth Pride, Inc
- Blue Cross Blue Shield of Rhode Island
- Johnston Housing Authority
- The Autism Project
- American Cancer Society in Rhode Island
- Women's Fund of Rhode Island
- Rhode Island Trans Health Conference
- Nonviolence Institute
- Rhode Island Free Clinic

And many more!

Care New England is proud to contribute to community wellness through a holistic approach. **The following community benefit activities represent our contributions from 2022, the most recent fiscal year for which data are available.**



Source: Care New England 2022 Schedule H Form 990

Financial Assistance

CNE is committed to providing high-quality care to all patients, regardless of their ability to pay, through a robust financial assistance program. This program offers free or discounted care to patients with incomes up to 300% of the federal poverty level, with consideration for family size.

Medicaid Shortfall

Medicaid provides health coverage for low-income individuals and families with limited resources but often falls short in covering the full cost of care. This Medicaid shortfall occurs when payments for beneficiaries are less than the actual costs of their care, a challenge seen in many states, including Rhode Island.

Subsidized Health Services

Subsidized health services address community needs even when they operate at a financial loss, ensuring access to essential care. CNE provides critical services like neonatal intensive care, inpatient psychiatric care, chronic disease management, emergency and trauma services, and home health programs to meet these needs.

Community Health Outreach Programs

CNE dedicates thousands of hours annually to outreach programs, addressing the needs of at-risk populations and breaking barriers to better health. These programs focus on improving access to healthcare, promoting public health, and raising awareness about specific conditions or treatments.

Education

CNE is committed to training the next generation of caregivers while delivering excellent clinical care to communities. Through partnerships with The Warren Alpert Medical School of Brown University and other medical programs, medical students gain hands-on experience and mentorship in patient care, research, and education.

Research

Advancing patient care at CNE is deeply influenced by ongoing clinical research, conducted with the courage and hope of patients who contribute to studies aiming to improve their lives and future treatments for others. This report highlights research efforts, including basic, clinical, and community health studies, carried out at CNE's major teaching hospitals—Butler, Kent, and Women & Infants—affiliated with Alpert Medical School.

Spotlight on Our Impact: Behavioral Health

Events and programs focused on behavioral health address the prevention, diagnosis, and treatment of mental health conditions and substance use disorders, aiming to improve overall wellbeing.

Strategy: Collaborate with community-based providers to assess BH needs, facilitate service referrals, and coordinate care.

Initiatives:

- **Neighborhood Health Plan (NHP) of Rhode Island Behavioral Health Focus Group.** The focus group identified areas of improvement including NHP clinical processes, access to care for NHP members, health outcomes and quality of care for NHP members, and investment in workforce development. CNE continued to collaborate around innovative payment models to expand access to needed services including exploration of case management funding for the Transitional Outpatient Program.
- **Serving local colleges and universities.** Butler Hospital maintained active collaboration with colleges and universities to facilitate priority ambulatory program access and evaluation in the Inpatient Assessment Center to improve coordination of care for students.
- **Treatment needs for immigrants served by the Refugee Dream Center.** Work is ongoing to develop and implement a unique workflow to include immediate involvement of a clinical leader in the Inpatient Assessment Center when a Refugee Dream Center member is brought in for treatment.
- **Memory and Aging Program / Black and Aging Event (2023 and 2024).** The event was dedicated to supporting the health and wellbeing of Black seniors and their caregivers. Attendees connected with a wide range of community organizations and public agencies offering valuable wellness resources, health screenings, and information on food insecurity and health insurance programs. The fair created an inclusive space for education, support, and empowerment, highlighting the importance of accessible and culturally responsive care for aging Black communities.

Strategy: Provide and expand culturally competent and sensitive behavioral healthcare services.

Initiatives:

- **LGBTQ+ Safe Zone Program.** The LGBTQ+ Safe Zone Program certifies healthcare organizations that identify themselves as supporters of the LGBTQ+ community. Certification requirements reflect policies, procedures, and physical space related to equity and inclusion for LGBTQ+ patients. The following programs and departments at Butler Hospital have applied and been recognized as meeting certification requirements: Young adult ambulatory programs; adolescent ambulatory programs; the Transcranial Magnetic Stimulation (TMS) program; the Memory and Aging Program; the Women's Partial Program; BRAin Interventional Psychiatry.
- **Memory and Aging Program / Community Memory Screenings.** Since 2024, the outreach team has been conducting memory screenings and referrals in the community. While these screenings are not solely focused on mental health, they offer an important service to individuals in underserved areas who may not otherwise have access to this type of assessment. They also provide community members the opportunity to engage with trained professionals who specialize in memory concerns and can identify potential underlying mental health issues.

Strategy: Conduct community behavioral health trainings and programs to empower residents to seek services and reduce associated stigma and fear.

Initiatives:

- **Butler Memory and Aging Program (MAP) Community Advisory Board (CAB).** The CAB is a multi-stakeholder cooperative dedicated to real solutions, impactful change, and meaningful diversity. The cohort champions people-centric organizations and contributes to research, outreach, educational efforts, and activities of all institutions represented in the CAB. The CAB supports a reparational framework and relationship-focused engagement model to support the universal promotion and advancement of underrepresented communities through the lens of health and equity.
- **Brain Health Room at Progreso Latino.** Butler used a diversity grant to create the Brain Health Room at Progreso Latino, where doctors and community members can have one-on-one conversations about their memory concerns and research opportunities. Progreso Latino serves the Hispanic and Latino population of Central Falls.
- **Butler Hospital inpatient and ambulatory program education.** Program education was provided at multiple community events that target individuals at risk for suicide and other mental health problems. These include events hosted by the American Foundation for Suicide Prevention, PRIDE Fest, local college/university mental health awareness groups, and select primary care offices.
- **Brain Research and Interventional Neurotherapeutics Program and Memory and Aging Program education**. Education about research studies and treatment options are on display at two community events annually, open to and well attended by the public in Providence and Pawtucket.

Strategy: Invest in workforce recruitment and retention of BH professionals.

Initiatives:

- **Nurse Graduate Residency Program.** The program provides structured support for newly graduated nurses as they transition to psychiatric nursing behavioral healthcare and take permanent positions at the hospital at the end of the program. Roughly 12 nurse graduate residents are trained per year.

Spotlight on Our Impact: Chronic Disease

Events and programs focused on chronic disease management provide strategies and interventions to help individuals effectively manage long-term health conditions, such as diabetes, hypertension, and heart disease.

Strategy: Invest in community services and programs that address equity in health and healthcare.

Initiatives:

- **Nutrition security.** CNE is a member of Integra Community Care Network, an Accountable Care Organization (ACO) dedicated to providing coordinated high-quality care for patients. Integra has organized and invested in several community partnerships to promote nutrition security, including a prescription produce program and a Food Ambassador program to improve diet-related contributors to chronic illness. 695 individuals, comprising 292 households, received food assistance in 2022-2025; 4,747 shares/bags of food assistance were provided to participants.

- **Homelessness and housing conditions.** Integra has established and invested in community partnerships that reduce homelessness and improve housing conditions. Participants in the homelessness case management program are adult patients; between 2022 and 2025, approximately 35 patients were housed. Healthy Homes participants are children with asthma; environmental interventions were provided for 8 households, and asthma control scores were improved.

Strategy: Provide and expand healthcare services that enhance access to care for historically underserved populations and promote whole-patient care.

Initiatives:

- **Health services for refugees.** In 2024 CNE Medical Group's Family Care Center started a new clinic serving recently arrived refugees with required health screenings and established a primary care relationship with patients. To date, 14 individuals (7 families) have been screened, ranging in age from 18-42 years. Patients were provided referrals for behavioral health, nutrition, diabetes, and physical therapy services. They received required screenings, preventive health screenings, and immunizations. All patients benefited from in-person interpreter services for their first visits and video interpretation services for follow-up care.
- **Medicaid Quality of Care.** Beginning in 2023, Integra established a health equity goal to achieve commercial four-star quality measures for Medicaid populations. These measures include screening and chronic disease management, such as diabetic A1c control. In 2023, Integra achieved commercial four-star targets for 3 of 5 quality metrics in the Medicaid population. In 2024, Integra achieved targets for 4 of 5 quality metrics. In 2025, Integra will aim for 5 of 5 quality metrics.

Spotlight on Our Impact: Maternal and Child Health

Events and programs focused on Maternal and Child Health aimed to provide comprehensive care, education, and support to promote healthy outcomes for both mothers and children.

Strategy: Advocate for equitable birth outcomes for Black women and babies.

Initiatives:

- **Advocacy.** Successfully advocated for an increase in Medicaid reimbursements for births (doubled). Successfully advocated for the Doula bill requiring insurance companies to pay for doula services.
- **Women and Infants Hospital Community Advisory Board (CAB).** The CAB includes broad representation of communities and community-based organizations and was established to provide input into hospital programs.
- **Black Maternity Health Week.** This event is celebrated annually at Women and Infants Hospital to raise awareness of birth initiatives.
- **NICU Transition Home Program.** The program provides support for any family in the NICU experiencing complex infant discharge and/or social barriers that challenge care for a newborn. The program was the first of its in kind in the nation. Other NICUs, both regionally and nationally, are following CNE's lead and recapitulating its approach.

- **Community-partnered bilingual and culturally concordant doula care for NICU families.** The new program will launch soon under the leadership of Dr. Rimi Sen to better support non-English speaking families and families who do not have the resources for ongoing support and visitation during the NICU stay.

Strategy: Provide and expand culturally competent and sensitive maternal and child health services.

Initiatives:

- **Clinical Improvements.** CNE operationalized doula access for patients, increased translation services, expanded low intervention birth options, and incorporated community health workers to screen patients for health-related social needs and connect them with resources.
- **Clinical Expansion.** A new labor and delivery center was completed featuring larger rooms, a window in each room, and mobile bathtubs to support low- to high-risk deliveries. $1.8 million in additional funding was secured to build a dedicated midwifery unit.
- **March of Dimes Partnership.** A full-time March of Dimes employee provides support for all families in the NICU, connecting them with essential services.
- **Refugee Dream Center cultural competency training.** Women & Infants Hospital and Integra partnered with Refugee Dream Center to produce a series of videos on healthcare needs and cultural attunement for refugee communities, to be used for staff training and systems alignment efforts. Video series production was completed in 2025 with staff training to follow.
- **DULCE Program.** CNE Medical Group's Family Care Center implemented the DULCE program for families with newborns, providing community health worker and legal support to promote healthy starts and reduce risk of adverse childhood experiences (ACEs). Dulce is a universal model for pregnancy and newborn care up to 6 months. The service is available to all families and encouraged for families with complexities of social determinants of health. Dulce recruited 52 participants in year 1 and 120 participants in year 2. Families in Dulce have a higher well-child visit adherence rate than the general clinic population, lower rates of ED usage, and 100% screening for postpartum depression and linkages to community services. Postpartum visit adherence for Dulce families was also higher than the general clinic population. Most importantly, all families involved have provided positive feedback about their involvement in the program and feeling supported.

Next Steps and Board Approval

Thank you to our community partners that provided guidance, expertise, and ongoing collaboration to inform the 2025 CHNA and foster collective impact in improving the health and wellbeing of Rhode Island residents.

The CHNA was approved by the Care New England Board of Directors in September 2025. Following the Board's approval, the CHNA report was made widely available to the public via our website at https://www.carenewengland.org/community-health-needs-assessment**.**

A full summary of secondary data findings for Rhode Island and its counties is also provided on the website and available to our community partners to serve as a resource for grant making, advocacy, and to support their many programs and services.

We value your input on our CHNA and CHIP. To contact us, please visit our website or contact Aleyra Lamarche Baez, DEI Community Engagement Liaison at ALamarchebaez@CareNE.org.

Appendix A: Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

The following is a list of represented community organizations and the participants' respective title, as provided.

Organization	Title/Role
Acoustic Neuroma Assoc Support Group - Southeast New England Chapter	Moderator
Alzheimer's Association RI Chapter	Executive Director
Big Brothers Big Sisters of RI	Director of Program Growth and Impact
Boys & Girls Clubs of Northern RI (BGCNRI)	Director of Family & Community Engagement
Bradley Hospital	Family Liaison Program Manager
Brown Health Medical Group Primary Care- formerly Coastal Medical	Chief of Primary Care
Brown University Health	Case Management
Brown University Health	Director of Discharge Planning
Brown University Health	VP, Care Coordination
Brown University Health Transitions Clinic	Americorp VISTA member
Brown University Health (RIH, TMH and NPH)	Director of Social Work
Butler Hospital / CNE	Butler Hospital / CNE
Care New England	Vice President and Chief Diversity Officer
Care New England	Director Revenue Finance
Care New England / The Warren Alpert Medical School	Primary Care Physician / Chief Health Equity Officer / Associate Dean
Comprehensive Community Action Plan	Education Coordinator
Chariho Regional School District	Director of Development and Sustainability
Charter Care/Roger Williams Medical Center	Manager of Case Management
CharterCARE health partners	CharterCARE health partners
Coastline EAP/RI Student Assistance Services	CEO
East Bay Community Action Plan	Community Health Worker, Transgender Whole Healthcare
Eleanor Slater Hospital	Chief Executive Officer
Eleanor Slater Hospital	Associate Director of LTACH Admissions/ Community Relations Liaison
Eleanor Slater Hospital BHDDH	Administration
Emma Pendleton Bradley Hospital	President
Family Service of Rhode Island	Chief of Behavioral Health
Hospital Association of RI/Health Care Coalition Rhode Island	Director
Harris House Apartments	Harris House Apartments
Healthcentric Advisors	CEO
HousingWorks RI	Executive Director
Juneteenth RI	President
Kent Hospital	Kent Hospital
Landmark Medical Center	Administration
Leadership RI	Fellow
LISC- Pawtucket Central Falls Health Equity Zones	Program Officer
Ministers Alliance of Rhode Island	Treasurer
National Alliance on Mental Illness Rhode Island	Executive Director
North Kingstown Fire Department	Assistant Fire Chief/EMS Chief

Organization	Title/Role
North Providence Fire Department	EMS Chief
Ocean Community YMCA - Westerly	Health & Wellness Director
Office of the Health Insurance Commission, Yale New Haven Health Systems	Suicide Prevention Coordinator
PACE-RI Elderly Services	Chief of External Affairs
Partnership to Reduce Cancer in Rhode Island	Coalition Coordinator
Partnership to Reduce Cancer in Rhode Island	Executive Director
Perspectives Corporation	Director
Portsmouth Middle School	School Counselor
Providence Public School District	Social worker
Pride in Aging RI	Volunteer
Prime Healthcare	Corporate Regional Director of Case Management
Providence Career and Technical Academy	Providence Career and Technical Academy
Providence Community Health Centers	AVP, Site Operations
Rhode Island Coalition to End Homelessness	Community Programs Manager
PACE-RI Elderly Services	Chief of External Affairs
Partnership to Reduce Cancer in Rhode Island	Coalition Coordinator
Partnership to Reduce Cancer in Rhode Island	Executive Director
Perspectives Corporation	Director
Portsmouth Middle School	School Counselor
Providence Public School District	Social worker
Pride in Aging RI	Volunteer
Prime Healthcare	Corporate Regional Director of Case Management
Providence Career and Technical Academy	Providence Career and Technical Academy
Providence Community Health Centers	AVP, Site Operations
Rhode Island Coalition to End Homelessness	Community Programs Manager
Rhode Island College	Interim Dean, Onanian School of Nursing
Rhode Island Commission on the Deaf and Hard of Hearing	Deaf community member
Rhode Island Community Food Bank	CEO
Rhode Island Health Care Association (RIHCA)	President & CEO
Rhode Island KIDS COUNT	Director of Early Childhood Policy and Strategy
RI Deaf Senior Citizens	President
RI Certified School Nurse Association	President
RI Coalition for Elder Justice	Healthcare EM Director
RI Legal Services	Social Worker, BSW
RI legislature	NA
RI Coalition Against Domestic Violence	Executive Director
RI Department of Health	Epidemiologist
RIPIN	Resource Coordinator Office of Special Needs (RIDOH)
RIPIN	Family Support Specialist
Saint Elizabeth Haven for Elder Justice	Elder Justice Advocate
South County Health	CMO
South County Health	South County Health
South County Health	Team Leader
South County Health	Manager
South County Health	Administrative Director of Nursing Operations
South County Health	Director of Revenue Cycle Management

Organization	Title/Role
South County Health	South County Health
South County Health	South County Health
South County Health	South County Health
South County Health	Case Manager
South County Health	VP Strategy
South County Health	Clinical Leader Respiratory Therapy, EKG, EEG
South County Health	AVP Community Health
South County Home Health, HCO-ID 65237 (Wakefield, RI)	Director
South County Hospital	Nurse
South County Hospital	Director Emergency Services
South County Hospital	South County Hospital
South County Hospital	South County Hospital
South County Hospital	nursing director
South County Hospital	Clinical Leader
South County hospital Case Manager Department	CM /RN
South County Hospital Health Care System	South County Hospital Health Care System
South County Hospital	Pharmacy Manager
St. Thomas	Pastor
The Miriam Hospital	Manager of Case Management
The Providence Center	The Providence Center
The Rhode Island Department of Elementary and Secondary Education	The Rhode Island Department of Elementary and Secondary Education
Town of Richmond	Human Services
Town of Westerly	Assistant Town Manager
Tri County Community Action Agency HEZ	Tri County Community Action Agency HEZ
United Congregational Church of Westerly, United Church of Christ	Pastor
United Way of Rhode Island	Chief Impact and Equity Officer
Washington County Coalition for Children	Director
West Elmwood Housing	02907 HEZ Program Director
West Elmwood Housing / 02907 Hez	Community Health Worker
West Warwick Police Department	Chief of Police

Appendix C: Partner Forum Participants

The following is a list of community representatives and their respective organization, as provided.

Warwick Partner Forum

Organization	Name
Boys and Girls Clubs of Warwick	Jo-Ann Schofield
Elizabeth Buffum Chace Center	Stefanie Curran
Kent Hospital	Emily Angelo
Kent Hospital	Jenny Laluz
Kent Hospital	Kayla Goncalves
Kent Hospital	Tiffany Belcher
Mothers Against Drunk Driving	Jenn O'Neil
Thrive BH	Brooke Myers
Thrive BH	Dawn Allen
Tides Family Services	Meredith Correia
Warwick HEZ	Deidre Jones
Warwick HEZ	Michael Fratus
WIC	Chantelle Dos Remedios

Washington County Partner Forum

Organization	Name
Alzheimer's Association - Rhode Island Chapter	Jennifer Finley
Brown Health - Gateway	Danielle Stewart
Chestnut Court Tenant Association	Charlene Fry
Gateway Healthcare	Susan Stevenson
Healthy Bodies Healthy Minds Washington County HEZ	Kristen Frady
Oakley Home Access	Justin Oakley
Ocean Community YMCA - Westerly	Janine Parkins
Society of Saint Vincent de Paul - Rhode Island Southern District	Joan Gradilone
South County Health	Lynne Driscoll
South County Health	Holly Fuscaldo
South County Home Health	Elaine Irby
South County Home Health	Kelly Pucino
South County Hospital	Alyssa Marciniak
South County Hospital	Nina Laing
South County Mobile Integrated Health	Kevin McEnery
South Kingstown Police Department	Matthew Moynihan
Town of Exeter	Jessica DeMartino
Wellbeing Collaborative	Dan Fitzgerald
Wood River Health	Christine King
Wood River Health	Frank Hopkins
Wood River Health	Kat Miller
Wood River Health	Sarah Channing
Yale New Haven Hospital	Shanthi Mogali
Yale New Haven Hospital	Rob Harrison, MD
Resident-at-Large	Maxine Mae Hutchins

Woonsocket Partner Forum

Organization	Name
Blackstone Valley Prevention Coalition	Lisa Carcifero
City of Woonsocket	Margaux Morisseau
Community Care Alliance	Bette Gallogly
Community Care Alliance	Mark Cote
Community Care Alliance	Christa Thomas-Sowers
Community Care Alliance	Jessica Jones
Connecting for Children & Families	Felix ColÓn
Connecting for Children & Families	Erin Spaulding
Crisis Intervention Teams of Rhode Island	Sarah Begin
Discovery House of Woonsocket Comprehensive Treatment Center	Kar Wilson
Eleanor Slater Hospital	Hector Guerreiro
Hospital Association of Rhode Island	Lisa Tomasso
Landmark Medical Center	Deb Hansen
Landmark Medical Center	Carolyn Kyle
Landmark Medical Center	Daniel Quinn
Providence Revolving Fund	Veronicka Vega
The Autism Project	Linda Brunetti
Tides Family Services	Meredith Correia
Woonsocket City Council	Kristina Contreras Fox
Woonsocket Comprehensive Treatment Center	Matthew Rogalski
Woonsocket Head Start Child Development Association	Jody Ragosta
Woonsocket Health Equity Zone	Ana Antonopoulos
Woonsocket Health Equity Zone	Kwang Baek
Woonsocket Health Equity Zone	Tara Cimini
Woonsocket Health Equity Zone	Shelly Hyson
Woonsocket Health Equity Zone	Boonie Piekarski