DIVERSITY,
EQUITY
& INCLUSION
at Care New England

Advancing Excellence in HEALTH EQUITY

2025

care new england

On Tuesday, March 25th at 10:59 am, April Elvannia da Rocha Oliveira was the first delivery in the new Brown University Labor and Delivery Center at Women & Infants Hospital, weighing 6 pounds, 11 ounces. Proud mother, Ana Iza Macedo Da Rocha, and father, Arsenio Oliveira, of Pawtucket, were overjoyed.

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About the Care New England Health System

Care New England Health System (CNE) is a trusted, integrated health care organization that fuels the latest advances in medical research, attracts the nation's top specialty-trained doctors, hones innovative services and programs, and engages in the important discussions people need to have about their health and end-of-life wishes. Care New England is helping to transform the future of health care, providing a leading voice in the ongoing effort to ensure the health of patients and the community in all its endeavors. As a healthcare system, CNE works to improve medical research, hire highly-trained doctors, offer trusted services, and create new programs to help patients. CNE is strong because its hospitals and programs work well together, each bringing special skills and services. Care New England serves many communities in southeastern New England and helps families get connected, complete healthcare services.

Care New England Health System includes the following hospitals and organizations:

- Butler Hospital is Rhode Island's premier treatment, teaching, and research hospital for psychiatric, movement, and memory disorders.
- Kent Hospital provides high-quality, compassionate, and personalized healthcare delivered in an interdisciplinary model that involves all members of the healthcare team.
- Women & Infants Hospital is the region's premier hospital for women and newborn children. It operates one of the nation's largest single-family room neonatal intensive care units.
- The Providence Center helps adults, adolescents, and children affected by psychiatric illnesses, emotional problems, and addictions by providing treatment and supportive services within a community setting.
- VNA Home Health and Hospice provides a broad spectrum of home health and hospice services for adults and the terminally ill.
- Care New England Medical Group has over 500 physicians and advanced practitioners, offering primary care and specialty services in offices throughout Rhode Island and Southeastern Massachusetts.
- Integra Community Care Network is an Accountable Care Organization comprised of a community of doctors, nurses, social workers, pharmacists, community health workers, and patients working together to improve the health and well-being of the community.

Our Commitment

At Care New England, we remain committed to fostering an environment where all patients, guests, community members, care teams, and staff are treated with dignity, respect, and fairness. We recognize and celebrate the varying backgrounds, identities, life experiences, and belief systems of the communities we serve. This commitment is guided by our system's values of accountability, caring, and teamwork. Together, we are creating an innovative environment to provide high quality patient care and a welcoming workplace that values every individual and our collective goals.

Care New England can be reached at (401) 227-3669, or with the Send Us A Message page. Our office is at 10 Charles Street, Suite 220, Providence RI, 02904.

Why We Created This Report

Everyone deserves an equal opportunity to be healthy. At Care New England we look to see where people we care for are left behind, and we act to improve the conditions that keep communities from being as healthy as possible. It's our job to make sure healthcare is fair, and to partner with patients and communities to improve health where it begins. This is health equity.

We created this report to share our health equity work with our teams and our communities.

In this report, you will see concrete ways we are advancing excellence in equity across the Care New England system. For example:

This report is also an invitation. We can all play a role in understanding the challenges and working together to address them.

CNE's **Office of Community and Social Impact (OCSI)** coordinates health equity, diversity, community engagement across the system. You can reach **OCSI at healthequity@carene.org.**

To learn more about community engagement at Care New England, visit: **https://www.carenewengland.org/community-engagement**

To learn more about community giving at CNE, see **https://www.carenewengland.org/community-giving**

If you'd like to learn more about the Community Health Needs Assessment at CNE, see **https://www.carenewengland.org/community-health-needs-assessment**

To learn more about the health-related social needs in our communities, see **healthequity.carene.org**

If your organization would like to explore partnership with CNE to advance shared equity priorities, email **healthequity@carene.org**

Executive Summary

Care New England's Advancing Excellence in Health Equity: 2025 report describes how projects across our health system are working to ensure that everyone has a fair chance to be healthy, regardless of race, language, income, insurance, or neighborhood. Across Rhode Island and Southeastern Massachusetts, teams are screening patients for health-related social needs such as food insecurity, housing instability, and transportation barriers; partnering with community organizations to address the root causes of poor health; and redesigning care to reduce disparities in outcomes. This year's work reflects our commitment to identifying inequities, testing solutions, measuring results, and building changes into everyday practice.

Butler Hospital focused on strengthening fair and consistent care for patients with mental health and substance use disorders. Teams examined whether people leaving the hospital had equal access to life-saving medications for opioid and alcohol use disorders, closely reviewed how medications for agitation are used during crises, and continued improving the accuracy of race and ethnicity data so disparities can be identified and addressed. In 2025, Butler reached its goal of having nearly all patients self-identify their race and ethnicity at registration, providing a stronger foundation for equity work going forward.

Integra Community Care Network and Care New England Medical Group concentrated on closing gaps in preventive care for people with Medicaid, especially breast and colorectal cancer screening. After finding that Medicaid patients were screened at much lower rates than commercially insured patients, teams launched targeted outreach, expanded radiology access, reduced referral delays, and used patient and nurse navigators to help with transportation, scheduling, and language needs. Screening rates improved across all patients in 2025, with faster gains among Medicaid members, narrowing—but not yet eliminating—the gap. Integra also continued holding itself to high-quality standards for Medicaid populations, matching commercial "four-star" benchmarks on several measures such as diabetes and blood pressure control. In 2026, efforts will continue to close remaining screening gaps and expand equity work to diabetes-related kidney disease.

Kent Hospital advanced equity through several projects focused on social needs, maternal care, emergency department operations, and cancer screening. More than three-quarters of inpatients were screened for housing, food, transportation, and utility challenges, and social workers helped connect those who wanted assistance to community resources. In maternity care, Kent reviewed cesarean birth rates by race and ethnicity, strengthened labor-support practices, and added new technologies and pain-management options to promote patient-centered births. In the Emergency Department, Kent achieved large reductions in the number of patients who left before being seen, while adding multilingual signage and interpreter tools to improve experiences for patients with limited English proficiency. The hospital also launched a lung cancer screening program designed to prevent patients from being lost to follow-up and to guide outreach using disparity data. New priorities for 2026 include analyzing restraint use in the Emergency Department, expanding lung cancer screening equity efforts, and strengthening connections to community resources.

VNA Home Health and Hospice worked to improve equity in home health, hospice, and community nutrition programs. Home Health teams strengthened the collection of race and ethnicity information, added Spanish-language written materials, and built monitoring processes into routine operations. Hospice programs increased outreach in underserved communities and trained staff to provide culturally and spiritually responsive care, with plans to create individualized care plans in the coming year. VNA also partnered with Blackstone Health meal sites to survey food insecurity among community members who receive more than 120,000 meals each year; results will guide new referral pathways to dietitians, community health workers, and social services in 2026. Across programs, VNA is focusing on transportation barriers, food insecurity, and personalized hospice care as part of its multi-year equity strategy.

Women & Infants Hospital continued to prioritize equitable maternal health, especially for patients affected by hypertensive disorders of pregnancy. Teams reviewed every severe maternal morbidity case related to preeclampsia to identify opportunities for improvement, strengthened data systems after changes in national reporting partners, and expanded a postpartum hypertension program that provides home blood-pressure monitors, education, nurse practitioner oversight, and support from community health workers. More than 1,200

patients joined the program in 2025, including families from many different races and languages. Women & Infants also launched the regional RI-SPHERES remote monitoring program in partnership with other hospitals, extending hypertension care to patients across the state. Beyond blood-pressure initiatives, the hospital has expanded community-based services, mobile health clinics, and inpatient community health worker roles to address mental health needs, social drivers of health, and safe transitions home after birth.

Looking Ahead

Care New England's 2025 work shows how data, community partnerships, and frontline teams can come together to reduce inequities and redesign care. While progress is clear—especially in preventive screenings, emergency department operations, postpartum care, and social-needs screening—leaders recognize that health equity requires sustained effort over many years. The system remains committed to transparency, continuous improvement, and collaboration with patients and community organizations so that where someone lives, what language they speak, or what insurance they carry does not determine the quality of care they receive. This report is both a record of progress and an invitation for partners across Rhode Island to work together toward healthier, more equitable communities for all.

Acknowledgments

Many people and organizations dedicate countless time, talent, and passion to advance health equity at Care New England. Most of these individuals work within the system, but this work would not be possible without dedicated partners who advocate for community wellness, fund initiatives and research, and hold the system accountable to a higher standard.

Butler Hospital

Mary Marran, President, and Chief Operating Officer

Carolyn Walsh, Director of Social Services and Care Management

Diane Block, Director of Quality and Patient Experience

Kevin Baill, Medical Director of Outpatient Services

G. Mustafa Surti, Chief Medical Officer

Diane Ferreira, Senior Vice President and Chief Nursing Officer

Women & Infants Hospital

Method Tuuli, Chief of Obstetrics and Gynecology

Heather Smith, Academic Generalist Division

Denise Henry, Director of Quality Management

Mariel Aleman, Health Equity Program Manager

Kent Hospital

Jennifer La Luz, Executive Director of Operations

Brydie Thomasian, Director of Behavioral Health & Clinical Social Work

Sherri Sprague, Senior Vice President, and Chief Nursing Officer

Care New England Medial Group

Roger Mitty, President, and Chief Operating Officer

Claire Mathews, Executive Director Clinical Operations and Quality

The Providence Center

Linda Dewey, Vice President of Clinical Services

Donna Bagdasarian, Director, Quality Improvement

Ben Isaiah, Chief Operating Officer

Jillian Roy, Chief Nursing Officer, and Vice President of Clinical Services

Integra Community Care

Jalyn Alzate, Patient Care Navigator

Pam Costello, Senior Director of Quality and Primary Care

Andrea Detora, Nurse Navigator

Brady Dunklee, Manager of Community Partnerships & Health Equity

Joseph Diaz, Chief Health Equity Officer, Medical Director for Medicaid Accountable Entity program

Martha Gutierrez, Patient Care Navigator

VNA Home Health and Hospice

Jane Pike-Benton, President

Katie Ganusko, Director of Hospice and Palliative Care

Lois Hamilton, Director of Home Health

Kelley Munroe, Director of Organizational Excellence

Paula Foster, Manager of Organizational Excellence

Care New England Corporate

Joseph Diaz, Chief Health Equity Officer

Kevin K. Martins, Vice President, and Chief Diversity Officer

Robin Neale, Vice President for Quality and Clinical Effectiveness

Dear Colleagues and Community Partners,

In last year's Health Equity Report, Care New England reaffirmed our core belief that healthcare is a universal right. As we reflect on the progress achieved over the past twelve months, we continue to stand firm in that conviction. We have not only identified barriers to better health outcomes; we are actively working to remove them.

Although disparities in transportation, insurance coverage, and language access continue to pose substantial challenges, our approach has become more targeted and proactive. We have moved beyond merely acknowledging the impact of social drivers of health—such as housing instability and food insecurity—to making social needs screening a vital sign for assessing a patient's overall well-being. By connecting clinical care with social support, we are shifting our focus from reactive treatment to holistic empowerment.

We recognize that achieving true health equity is a marathon, not a sprint. While we have advanced beyond the initial phases of this work, we remain mindful of the challenges that still lie ahead. This year's report highlights not only our successes, but also our commitment to transparency and innovation as we refine our strategies to better serve every resident of our state.

I extend my deepest gratitude to our frontline teams, health equity specialists, and community partners. Through your dedication, thousands of our neighbors are being seen, heard, and supported in ways that reach far beyond the walls of our exam rooms. Your efforts continue to have a tremendous impact on the lives of those we serve.

Our commitment to access and health equity remains a core pillar of our strategic vision. It shapes the partnerships we form, our engagement with the communities we serve, and every patient interaction we facilitate. We will continue to build a healthcare system where your zip code, language, or background never determines the quality of your care or the length of your life.

Thank you for joining us on this essential mission.

Sincerely,

Michael E. Wagner, MD
President & CEO
Care New England Health System

Dear Colleagues and Community Partners,

The past year has marked continued evolution in how Care New England integrates equity into the fabric of our daily operations. While our previous report established a necessary foundation, this 2025 Health Equity Report reflects a system-wide momentum driven by dedicated individuals in every corner of our organization. This work is not the product of a single department; rather, it is a collective expression of our mission to provide exceptional care with kindness and compassion to every person who walks through our doors.

In 2023–2024, we focused on refining data collection and stratification across our organizations to accurately identify disparities. By leveraging this data, we transitioned into a structured framework of action planning, goal definition, and progress monitoring. Entering 2025, we scaled our efforts by launching additional projects at each organization and extending project timelines for deeper impact. These projects include collecting information, putting plans into action, checking results, and making lasting changes. By setting clear goals, tracking our progress, and working with partners, we are building strong systems that support long-term success. This progress is a direct result of the foundational commitment developed several years ago and the continued leadership across our health system.

A cornerstone of our transparency efforts is the launch of a new public-facing Social Drivers of Health (SDoH) website in 2026. This platform is designed to provide community access to the data we collect, summarizing SDoH trends within communities served by Care New England and our partners. By offering interactive visualizations of social needs, geographic trends, and demographic insights, we are providing a tool that supports not only our own clinical care but also the vital work of community stakeholders across Rhode Island. We believe that sharing this information is essential for fostering the collective action needed to improve the social conditions that impact health.

We recognize that the path to health equity requires persistent and evolving effort. As we move forward, we remain dedicated to refining our strategies and expanding our reach to ensure that every person we serve receives the highest quality of care. Our commitment to this mission remains a core pillar of our strategic vision as we lead the way in anticipating and meeting the needs of our patients, team members, and the communities we serve. Guided by our values of accountability, caring, and teamwork, we will continue to ensure that those who seek our help receive the very best quality medical care in a way that communicates respect every step of the way.

Thank you for your ongoing commitment to this vital work.

Sincerely,

Kevin Keith Martins, Ed.D., MBA
Vice President and Chief Diversity Officer
Care New England

J.A. Diaz, MD, MPH
Chief Health Equity Officer
Care New England

Screening for Health-Related Social Needs

Social Drivers of Health (SDoH) are the conditions where people live, work, learn, and play. These conditions often affect health more than medical care or personal choices. Recognizing this important impact, Care New England has increasingly implemented universal screenings to identify patients' unmet health-related social needs (HRSNs), such as food insecurity, housing instability, financial strain, transportation barriers, and safety concerns, across both inpatient and outpatient settings. Initiated in 2021 by Integra Community Care Network within its primary care offices, including the Care New England Medical Group, this universal screening program expanded system-wide to inpatient units in 2023, with 2024 marking its first full year of implementation. In the 2025 fiscal year, more than 17,000 patients were screened for health-related social needs in Care New England inpatient settings. Between 2021 and 2025, more than 50,000 people were screened for health-related social needs in Care New England Medical Group and other ambulatory care settings. The table below shows how many people were screened and how many said they needed help in each area.

Inpatient Screening for Health-Related Social Needs: 2024 Butler Hospital, Kent Hospital, and Women & Infants Hospital

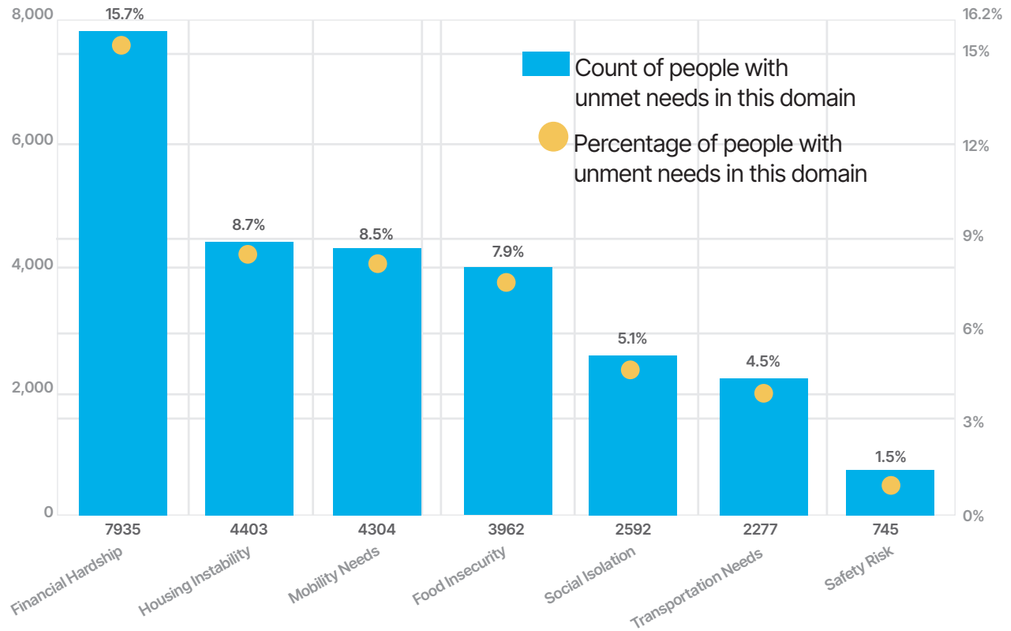
Screening and Positivity Rates FY2025	Butler	Kent	WIH
Unique Discharges	3697	9388	8842
Declined to answer*	320	375	104
Numerator = Number screened for 5 required HRSNs	3377	6699	7104
Denominator = Number unique admissions choosing to respond	3108	9013	8738
% of unique discharges screened for all 5 HRSNs	92%	78%	82%
% of patients who screened positive for housing instability	30%	6%	3%
% of patients who screened positive for food insecurity	29%	5%	5%
% of patients who screened positive for trouble paying utilities	27%	4%	3%
% of patients who screened positive for lack of reliable transportation	31%	5%	3%
% of patients who screened positive for interpersonal violence	8%	<1%	<1%

*Declined to answer shows the number of people who answered between 1–4 of the 5 questions on the screener (i.e., partially completed it).

Ambulatory Screening for Health-Related Social Needs: Care New England Medical Group (CNEMG) and other Care New England ambulatory settings.

HRSN Screening and Positivity Rates, 2021 – 2025	People	Percentage
Unique individuals screened	50,394	100%
Patients who screened positive for any need	13,739	27.3%
Patients who screened positive for housing instability	4,403	8.7%
Patients who screened positive for food insecurity	3,962	7.9%
Patients who screened positive for financial hardship	7,935	15.7%
Patients who screened positive for lack of reliable transportation	2,277	4.5%
Patients who screened positive for mobility needs	4,304	8.5%
Patients who screened positive for safety risk	745	1.5%
Patients who screened positive for social isolation	2,592	5.1%

Source: healthequity.carene.org, Jan. 29, 2026



Patients who screen positive for health-related social needs (HRSNs) and express that they would like support are connected with Social Work, Case Management, and/or Community Health Workers (CHWs). These teams facilitate referrals to essential resources such as safe housing, local food banks, and medical transportation. When a patient screens positive for Interpersonal Violence (IPV) in an outpatient practice setting, the electronic health record system, Epic, automatically flags this result. This flag presents as a Best Practice Advisory (BPA) that requires the healthcare provider to stop and respond to the concern before moving forward. The BPA also provides the hotline number for the RI Coalition Against Domestic Violence as a resource. Providers are guided by established protocols to manage the concern in real time, with social work services engaged as indicated by these protocols or the patient's needs.

Care New England also utilizes integra.findhelp.org, a comprehensive database of local community resources, and includes this information in discharge paperwork.

While these efforts provide a foundational approach to addressing identified social needs, we continue to explore the ways in which we, as a health system, can intervene in the root causes of these needs and lessen the harm they do to the health of our communities.

Sharing Data on Social Drivers to Promote Community Health

Where we live, work, learn, and play affects our health. We ask our patients questions about their social and economic needs to help take care of them, using screening questionnaires that are entered into the electronic medical record. These needs are called Health-Related Social Needs (HRSN). Taken as a whole, the data can give a picture of HRSN at the population level in Rhode Island.

With generous support from Amazon Web Services, Care New England has created a website at healthequity.carene.org, to share aggregated HRSN data in an anonymous, secure way, to help improve the health of our communities.

Many people are working every day to improve the social and economic conditions that affect health in our communities. Advocates, nonprofits, social service agencies, researchers, philanthropy, community health workers, students, and regular people can use this website to strengthen their work. Having data on social needs can inform strategies to address them, attract resources, facilitate partnerships, and help people ask new questions.

Take a look at healthequity.carene.org to see the data and learn more.

What is Health Equity?

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

–Robert Wood Johnson Foundation

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BUTLER HOSPITAL

In 2025, Butler Hospital deepened its commitment to driving equity in our patient care by focusing on three key projects: improving access to medication-assisted treatment for people struggling with opioid and alcohol addiction, examining medication use for agitation to ensure fair treatment practices, and improving the collection of race and ethnicity data during registration. Together, these efforts strengthen our ability to identify disparities, understand their causes, and guide change that supports every patient we serve.

Improving Access to Medication Assisted Treatment

Medication Assisted Treatment (MAT)—the use of FDA approved medications to treat opioid and alcohol use disorders—is an underutilized treatment that can reduce mortality in individuals with these disorders. The use of MAT for Alcohol Use Disorders lags its use for Opioid Use Disorders. Recent research demonstrates that the use of MAT for alcohol use disorders can be improved with changes to prescribing processes in hospitals and educational interventions to prescribers.

National research has identified that Black patients often do not receive MAT at comparable rates to White patients. Our goal was to understand whether all patients at Butler have equitable access to these treatments when they leave the hospital after an inpatient stay. We reviewed data for all 2025 discharges, comparing who received MAT based on race, ethnicity, language, insurance type, and town of residence.

Our early review of the data shows patients with commercial insurance may have greater access to MAT for individuals with AUD. Our data thus far is inconclusive on the impact of insurance for individuals with OUD. We did not have any findings on the use of MAT based on town of residence. In other words, we are unable to address higher overdose rates noted in specific towns in RI because we have equal variation in the rates of patients leaving with MAT to towns throughout the state.

Due to very small sample sizes, we are continuing to examine the rates of MAT use for individuals based on race, primary language, and insurance status. We will add additional individual-level variables, such as whether the patient agreed to the necessary lab work that is required before starting these medications, and whether they were offered the medications but refused them. Our goal is to ensure that all patients that are discharged with these disorders have equal access to these evidence-based medications and that we can help address disparities reported in national data.

Equitable Use of Medication for Agitation

The second project focused on the hospital's use of as needed medications for agitation or high anxiety. These medications can play an important role in managing acute periods of distress. National research has identified that Black patients often receive more PRN medications or different medications than White patients. Butler wanted to understand whether this pattern was occurring in our own settings.

In 2025 we explored the use of medications used at the time of a crisis and examined individual variables such as race, ethnicity, primary language and insurance status. We have too few cases yet to draw any conclusions but we will continue to monitor each case. Additionally, we will look for patterns regarding medication education for all patients. Our aim is to ensure that patient care in times of crisis is both equitable and informed by best practice.

Strengthening Race and Ethnicity Data Collection

To identify and address disparities effectively, we first need accurate information about who our patients are. In 2025, Butler continued its multiyear effort to improve how patients' race and ethnicity are recorded at registration. Accurate, self identified data allows us to analyze outcomes fairly and direct equity efforts where they are most needed.

In 2025, we achieved our goal: 96% of patients had self identified race and ethnicity documented, with only 2.1% listed as "unknown." This success followed targeted training for registration staff in specialty outpatient areas, ensuring consistent processes campus wide.

As we transition fully to our new electronic health record system in 2026, we will continue to track this measure to maintain and strengthen data quality. This foundational work is essential, because equitable care depends on understanding and honoring the identity and experiences of every patient.

Plans for 2026

Equity is not a single project but an ongoing commitment. Through careful measurement and transparent reporting, Butler Hospital is learning where disparities exist, engaging staff at every level, and taking concrete steps to close those gaps. In 2026, this work will continue—guided by data, patient experience, and our shared belief that every person deserves care that is fair, compassionate, and equitable. Butler has three health equity goals for 2026:

- **Measure the percent of patients that are discharged on Medication-Assisted Treatment (MAT)** for Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD). Break down the results by race, primary language and insurance type, and investigate context for patients not receiving MAT.
- **Examine the use and type of medication given at the time of a psychiatric crisis** looking at factors including patient race and primary language. Ensure that medication education has been completed within 3 days of an inpatient admission.
- **Maintain performance in collection of self-identified race and ethnicity during transition to Epic**, by maintaining the rate of unknown race < 5%, and self-identified race > 93%.

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INTEGRA COMMUNITY CARE NETWORK

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MEDICAL GROUP

Equitable care for people with Medicaid

Screening for breast cancer and colorectal cancer can lead to better outcomes through prevention and early detection. In 2025, Care New England Medical Group (CNEMG) and Integra determined that Medicaid beneficiaries had a 17% lower screening rate for both mammography and colorectal cancer screening compared to commercially insured patients. In order to ensure equitable access to cancer screenings for all patients, they set a goal to reduce this gap by 50% in 2025 and achieve equal screening rates by the end of 2026. The aim is to ensure that all eligible patients, regardless of insurance type, receive timely breast and colorectal cancer screenings.

At the same time, Integra maintained its goal to meet or exceed the 4-star Commercial quality standard for Medicaid measures in at least 4 of quality measures. Insurers measure the performance of Accountable Care Organizations (ACOs), like Integra, using quality measures for their populations. Insurers set lower goals for ACOs for their Medicaid patients than they do for their commercially insured patients. Integra, with its mission to deliver equitable population health, set itself a higher bar. In 2023 and 2024, the health equity goal was to meet or exceed the 4-star Commercial standard for Medicaid measures in at least 4 of the quality measures. Integra met this goal in both years. In 2025, Commercial 4-star targets increased, but Integra maintained the goal of achieving these quality measures for the Medicaid population Specifically, these measures are rates of breast cancer screening, colon cancer screening, diabetes A1c management, diabetes eye exam, and hypertension blood pressure control.

Planning and action to improve preventive health for Medicaid members

To address disparities in breast and colorectal cancer screening in the Medicaid population, Integra and Care New England Medical Group began using a method called a Plan-Do-Study-Act (PDSA) cycle. In the first half of 2025, the Plan phase included a detailed review to understand why the gap exists, review best practices, and develop an action plan with measurable targets and a data monitoring process. The Do phase began in July of 2025 and continued for the rest of the calendar year, with Integra and CNEMG implementing the action plan.

Action steps to close the cancer screening gap included interventions to increase demand for screenings, reduce barriers to access, increase the number of screenings delivered. For example, Integra and CNEMG continued their partnership with tech-enabled outreach platform HealthHelper to conduct a campaign to connect with Medicaid members due for mammograms, and schedule appointments with them. CNE's Radiology Department added diagnostic mammograms at its Pawtucket location, and developed strategies to increase accessibility at this location, that serves a high volume of people with Medicaid. The project also connected CNEMG primary care providers with CNE GI specialists who perform colonoscopies, helping to make appointments more efficient and reduce wait times.

In all 13 CNEMG primary care office locations, Integra's patient navigators and nurse navigator assisted patients with barriers to care related to transportation, scheduling, and language access to ensure they could overcome those barriers to close screening and care gaps. Integra and CNEMG also continued to partner with HealthHelper to help close gaps in preventive care include breast and colorectal cancer screening, as well as quality measures like diabetes and hypertension management. These strategies increased performance on quality measures for preventive health overall, and for the Medicaid population in particular.

Measuring progress

In order to measure cancer screening rates, the first step is to count how many people are eligible to be screened based on factors like their age, gender and medical history. The next step is to determine how many of these people got their screening within the appropriate timeframe. For example, most people with average risk who are eligible for colorectal cancer screening should be screened every ten years if they get a colonoscopy, or more often if they use another method. Most people who need breast cancer screening should get it every two years. Data from the electronic medical record shows the rate of people who are up to date on their screenings at a given time.

For its goal to attain four-star ratings, Integra tracks clinical quality measures using national healthcare standards, such as a system called HEDIS, which are specified by health insurers. Clinical quality measures were tracked in breast cancer screening, colon cancer screening, diabetes A1c management, diabetes eye exam, and hypertension blood pressure control. Integra compares the quality metric outcomes by payer, helping to focus on disparities between population, and guide strategies to improve equitable outcomes.

Outcomes

Screening rates for breast cancer and colorectal cancer increased in 2025 in Care New England Medical Group's primary care population. Overall screening rates for breast cancer among eligible people increased by 4 percentage points from 73% in January, to 77% in December. For colorectal cancer, overall rates also increased by 4 percentage points, from 72% in December to 76% in January.

Medicaid rates improved at a faster rate, growing by 7 percentage points for both breast and colorectal cancer screening between December and January.

Our aim was to reduce the gap in screening rates between people with Medicaid and people with employer-sponsored (commercial) health insurance. That gap at the January 2025 baseline was 17 percentage points less for both breast cancer screening (75% commercial vs. 58% Medicaid) and colorectal cancer screening (72% commercial vs. 52% Medicaid). Our goal was to cut this gap in half in 2025, and go on to eliminate it in 2026.

Commercial screening rates improved this year, but we managed to increase Medicaid rates at a faster pace, narrowing the gap even as the target moved. As of December, 2025, there is a 16% gap between Medicaid and commercial in breast cancer screening, and a 15% gap for colorectal cancer screening. These measures show that screening rates are improving overall, improving at a faster pace among the group with the largest disparity, and that there is still work to do to make sure everyone gets the preventive care they need.

As a result of our efforts to improve quality and equity, **Integra and CNEMG had the best screening rates for breast cancer and colorectal cancer among Medicaid programs** for both Neighborhood Health Plan and UnitedHealthCare in 2025. Integra also achieved its goal of attaining quality measures in the Medicaid population that were as high as four-star ratings for commercial insurance plans.

Plans for 2026

In 2026, Integra and Care New England Medical group will continue their efforts to close gaps in cancer screening. The goals are to **1) Close gaps between Medicaid and commercial patients for breast cancer screening,** and **2) Close gaps between Medicaid and commercial patients for colorectal cancer screening.**

In 2026, Integra and CNEMG have adopted a third goal, to **3) Determine gaps in equitable care for individuals with diabetes, and create an action plan to improve kidney disease screening and care.** Chronic Kidney Disease (CKD) is a risk for people living with diabetes, and regular screening and referral to care can improve outcomes. But there are gaps in access to needed screening and care, and disparities in the burden of diabetic illness among populations. Integra and CNEMG will begin a process to understand and intervene to improve these health equity concerns.

From 2023 through 2025, Integra had a goal to achieve commercial four-star ratings for preventive health quality measures in our Medicaid population. After three years of achieving this goal, it is now a part of standard operating procedures and "hardwired" as part of the core approach to equitable population health.

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KENT HOSPITAL

Overview

Over the past year, Kent Hospital has continued to expand its health equity capacity and initiatives. Starting with the expansion of inpatient screening for health-related social needs (HRSNs), the hospital is now gathering data about patient needs beyond healthcare. Two of our projects, Primary Cesarean Section Rates and Emergency Department Left Without Being Seen completed the third and final year of the cycle. Kent's project related to Health-Related Social Needs completed its second year and a new project was launched for lung cancer screening.

Health-Related Social needs

Kent Hospital in collaboration with other Care New England Health System Hospitals, developed a screening tool to learn about patients' health-related social needs (HRSNs). This tool asks about housing, food, transportation, utilities, and safety concerns, which are important factors impacting patients' health and wellness. The tool was successfully deployed at Kent Hospital in October of 2023, and the Health Equity Team has continued to support clinical staff in removing barriers to collecting this important data.

Kent's Social Work team follows up with patients with identified needs and a willingness to accept support. During these consultations, social workers assist patients with referrals for services such as safe housing, connections to local food banks, and medical transportation. Additionally, Care New England utilizes FindHelp.com, a database of local organizations and programs who provide resources for community members, and it is included in discharge paperwork for all patients as a bridge to the resources needed. In 2025 we focused on building our screening tool in our new electronic medical record. We also focused on workflows and referral processes to support patients with identified needs, adding these tools and resources into our regular daily work.

In the 2025 fiscal year, 78% of Kent Hospital patients (6,699 individuals) were screened for health-related social needs. Of these, **5% said that they had food insecurity, 6% housing insecurity, 5% unmet transportation needs, and 4% difficulty paying for utilities.**

Primary Cesarean Section Rate by Race/Ethnicity

Across the country, there are known differences in birth outcomes among racial and ethnic groups. To address this, Kent Hospital partnered with the experts and leaders within the CNE system to identify and implement strategies to improve birth outcomes for all patients. Continuing the work from 2024, Kent Hospital monitored outcomes related to racial and ethnic disparities in many key areas. Kent Hospital delivers approximately 500 babies annually, representing about of 5% births in Rhode Island.

While Cesarean sections are sometimes medically necessary and may even be requested by a birthing person, a high number of first-time C-sections is usually not considered best practice. C-sections carry inherent risks for both the birthing patient and baby, including increased risk of infection, bleeding, and potential complications in future pregnancies.

The Women's Care department, continually evaluates best practices to assure policies and procedures are carried out which support the safety of the patient with care taken to review cases to identify any issues in practice and make improvements as needed.

Kent Hospital performance for C-section rates varied over time and were not consistent across all racial and ethnic classifications. The largest gap observed was between Black and White patients as documented in the table below, however, the differences in outcomes across race were not large enough to show a clear pattern. This measure will continue to be monitored. The Women's Care leaders have taken the task of addressing potential disparities seriously and reducing any bias in their care by following consistent care steps and continually raising awareness regarding the individual needs of patients when planning their care.

Racial and Ethnic Disparities

Kent Hospital observed variability in C-section rates across racial and ethnic groups. The largest numerical difference appeared between Black and White patients; however, because the number of deliveries among Black patients is very small, even one additional C-section can dramatically shift percentages.

FY2025 Data	Black	White
Numerator (Number of C-Sections)	**4**	**61**
Denominator (Number of Births)	11	193

For example, if only two Black women deliver in a given period and one has a C-section → the rate appears as 50%. Statistical analysis showed no significant difference in event rates:

This means that because the number of births and C-sections was small, there was no statistically significant difference between C-section rates for Black and White birthing people at Kent in 2025. Fisher's exact p = 0.746, showed no meaningful difference in this data.

Actions to Improve C-Section Rates and Promote Equity

Although statistical disparities were not identified, Kent Hospital is committed to advancing maternal equity, improving birth outcomes, and reducing unnecessary cesarean sections.

In FY2025, Kent Women's Care made several changes to support natural, or vaginal births when it is safe, strengthen labor support, and reduce unnecessary primary cesareans. These efforts included reinforcing one-to-one labor support when feasible, standardizing nursing practices that promote maternal mobility and position changes (including peanut ball use and upright/lateral positioning), and supporting consistent, respectful, patient-centered communication and shared decision-making throughout labor. We also strengthened interdisciplinary communication through structured team huddles and continued following national best practice guidelines for labor care to support consistent decision-making related to labor progress and indications for cesarean delivery.

In addition, we implemented two key practice enhancements to support patient-centered labor care:

- Novii Wireless Monitoring: We introduced the Novii wireless fetal monitoring system, which allows staff to monitor the baby's heartbeat and contractions while the mother can still move freely. This reduces restrictive belts/leads and supports upright positioning, ambulation, use of birthing balls, and comfort measures such as showering. Overall, this promotes patient satisfaction and better supports individualized birth plans.
- Nitrous Oxide for Labor Analgesia: We also introduced nitrous oxide as an additional pain management option to help reduce pain and anxiety. This has expanded patient choice, particularly for those who prefer an alternative to epidural anesthesia.

In FY2025, Kent Women's Care collaborated with Rhode Island AIM (RI AIM) and the Rhode Island Department of Health (RIDOH) to support maternal quality improvement efforts and advance equitable birth outcomes.

Kent Hospital Women's Care remains committed to advancing equitable outcomes through strengthened data collection, multidisciplinary collaboration, and continuous improvement. Although differences in rates of Cesarean births across racial groups are not statistically significant due to small patient volumes, the Women's Care Unit continues to prioritize safe, respectful, and evidence-based care for all birthing patients. In 2026, Women's Care will support continued monitoring of maternal equity measures and leveraging improved Epic reporting capabilities to strengthen data-driven interventions and sustain improvements.

Emergency Patients Leaving Without Being Seen

"Left Without Being Seen" (LWBS) means a patient leaves the Emergency Department before being checked by a physician or other qualified healthcare provider. Hospitals aim to decrease this number to 0, as the goal is to assess and care for all community patients. In 2024, the State of Rhode Island changed policy for hospital emergency departments to require them not to divert patients to other hospitals during times when they are experiencing high volumes. As a result, Kent Hospital worked to put lasting changes in place to assure patients received prompt treatment in FY2025.

Kent Hospital continued a 2-year trend to significantly reduce rates with a 20% reduction in FY2024 and an additional 18% reduction in FY2025, improving from a FY2024 baseline of 5.8% to 3.36% in FY2025. Throughput initiatives in the Emergency Department as well as on the inpatient units to improve efficiencies supported this achievement:

- Implementing a multi-disciplinary throughput task force to coordinate improvements across the hospital.
- Using a fast-track system to shorten wait times for patients with less serious conditions.
- Expediting timely discharge of patients to open capacity in the Emergency Department by improving efficiency with treatment orders, mobility protocols and daily communication with team members.

Based on a concern from the FY2024 analysis which demonstrated that Black patients leave the Kent ED without being seen at statistically higher rates than White patients; and Hispanic patients leave the Kent ED at higher rates than non-Hispanic patients, showing a possible meaningful difference. Kent Hospital implemented key strategies to reduce disparities:

- Improving access to language interpreters through the deployment of additional virtual interpreter devices in the ED
- Improving signage in multiple languages within the ED waiting room to inform patients about the processes. Signage was intentionally designed to be welcoming and inclusive.

Observations and Outcomes

Measures	Baseline FY2024	Threshold	Target	FY25Q1 Oct – Dec	FY25Q2 Jan – Mar	FY25Q3 Apr – Jun	FY25Q4 Jul – Sep	FY2025
ED Left Without Being Seen OP-22	4.1%	4.00%	2.00%	**3.54%**	**3.55%**	**2.83%**	**3.53%**	**3.36%**
Black	4.6%			3.90%	2.45%	3.34%	2.49%	3.05%
White	3.7%			3.19%	3.02%	2.49%	3.28%	3.00%
Asian	1.9%			2.90%	2.13%	1.50%	1.43%	1.99%
Hispanic	4.6%			4.91%	4.55%	3.17%	3.47%	4.01%
Non-Hispanic	3.6%			3.21%	3.10%	2.46%	3.27%	3.01%
English-speaking	3.9%			3.39%	3.24%	2.59%	3.33%	3.14%
Limited English Proficiency	2.2%			3.19%	3.02%	2.33%	1.41%	2.48%

FY2025 LWBS	FY2024 Numerator	FY2024 Denominator	FY2025 Numerator	FY2025 Denominator
Black	**106**	**2296**	**76**	**2489**
White	1864	50384	1537	51296
Asian	10	540	11	552
Hispanic	96	2098	92	2297
Non-Hispanic	1907	50958	1543	51286
English-speaking	2197	55809	1780	56774
Limited English Proficiency	35	1591	42	1694

LWBS rates have dropped significantly at Kent Hospital's ED (P< 0.001) within the fiscal years of 2024 and 2025.

Looking within the three overall categories of race, ethnicity, and language by which we stratified the data, additional conclusions can be made:

Race: Asians have an overall significantly lower LWBS rate than both Black and White races (p<0.08-0.02) . LWBS rates for Black and White races do not significantly differ from each other (p> 0.01)

Ethnicity: non-Hispanics have an overall significantly lower LWBS rate than Hispanics (p<0.001)

Language: ED visits by non-English speaking patients have an overall significantly lower LWBS rate than those that speak English (P<0.01)

In conclusion, in FY2026 Kent Hospital was successful in reducing ED Left Without Being Seen (LWBS) rates for all patients, and reducing disparities for Hispanic patients. Leaders will continue to monitor LWBS rates to assure improvements are hardwired and outcomes are sustained in the coming years.

Lung Cancer Screening

In Fiscal Year 2025, the hospital launched a strategic initiative to enhance equity in lung cancer screening and reduce gaps in follow-up care. This project aims to ensure that all patients receiving lung cancer screening have timely, comprehensive follow-up and that outreach efforts are informed by analysis of health disparities.

During the first year, the team focused on creating the systems needed to support a strong lung cancer screening program focused on patients. A key component was the implementation of a software solution integrated with our imaging platform (PACS) to create a dynamic, real-time patient registry. This registry helps identify lung nodules and unexpected findings on chest CT scans—early signs of potential cancer – and ensures that patients are tracked and managed appropriately. The build was completed by the end of the fiscal year, and the system successfully launched on October 4, 2025.

The hospital adopted Nuance PowerScribe Lung Screening Follow-Up Manager to strengthen continuity of care and make sure patients do not miss needed follow-up care—similar to the processes in place for mammography screening. This technology supports comprehensive management of lung cancer screening patients and facilitates proactive communication.

Next Steps:

The program will now include structured follow-up processes, patient outreach, and notification letters for individuals undergoing lung cancer screening. Central to the program values, the initiative incorporates analysis of health disparities and Health-Related Social Needs (HRSN) to guide outreach strategies and ensure equitable care delivery.

Plans for 2026

While FY2025 saw an improvement in some measures, the disparities continued to persist. Kent leaders will have the benefit of additional data analytic tools within the newly implemented Epic electronic medical record and the imaging software programs to improve understanding and take focused action to reduce health gaps. Programmatic priorities for FY2026 will include:

Year 1:
Emergency Department Restraint Usage: We review how often restraints are used for patients receiving care in our Emergency Department by race, ethnicity and language to identify disparities and facilitate action planning, with a target of having an initial action plan ready to implement by end of this fiscal year.

Year 2:
Lung Cancer Screening: We will utilize analysis of the lung cancer screening rates to identify targeted outreach strategies to address disparities with specific outreach activities piloted by the end of the fiscal year.

Year 3:
Health-Related Social Needs: We will further explore options to utilize the analysis of the health-related social needs to connect patient to community resources to address identified disparities. Our goal is to make screening and connecting patients to resources a regular part of care, while continuing to check for unfair differences as part of our daily work across hospital settings.

care new england
THE PROVIDENCE CENTER

Overview

The Providence Center, located in Providence, Rhode Island, is a leading provider of mental health and substance use treatment services. Since its establishment in 1969, it has been dedicated to offering comprehensive care to housed and unhoused adults, adolescents, and children affected by psychiatric illnesses, emotional problems, and addictions. The Center provides a wide range of services, including outpatient care, crisis stabilization, and community-based support. The Center also offers wraparound services such as food and housing assistance, job training, legal services, primary health care, and wellness activities. The Providence Center focuses on helping people recover, reach their goals, and improve their overall well-being. In December 2014, The Providence Center became an affiliate of the Care New England Health System, further expanding its reach and resources. In October 2024, The Providence Center became a Certified Community Behavioral Healthcare Clinic (CCBHC) designed to serve anyone who walks through the doors, regardless of age, diagnosis, or insurance status with a goal to improve community health outcomes, reduce health disparities, and support providers in delivering higher quality, more sustainable services. These services are supported by the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Client Population

In FY2025, The Providence Center served 8,245 individual clients. The following data provide additional context to the client population:

Diagnoses:

- 40% presented with a mental health diagnosis only.
- 28% were diagnosed with both a mental health condition and a substance use disorder.
- 2% presented with a substance use diagnosis only.
- 1% had no diagnosis recorded in the State's Behavioral Health On-Line Database (BHOLD) system.

Demographics:

- 48% identified as female, 51% as male, and 0% had an unknown gender.
- 43% were aged 41–65, 31% were aged 18–40, 15% were aged 6–17, 9% were aged 66–85, and 2% were aged 0–5. Fifteen clients (0.2%) were over the age of 86.
- 47% of clients identified as White, 26% as Hispanic/Latino, 20% as Black/African American, and 1% identified as Native American or Alaskan.
- 58% were non-Hispanic/Latino, 39% were Hispanic/Latino, and 3% had unknown ethnicity.
- 80% of clients preferred English, 18% preferred Spanish, and 1% preferred Cambodian.

Socioeconomic Factors:

- 59% of clients resided in Providence, 13% in Pawtucket, and 4% in Cranston.
- 32% of clients identified as disabled, 16% were unemployed, and 10% were students.
- 2% of clients were incarcerated.

Connecting Black Male Patients with a Primary Care Provider

In 2024, TPC identified a large gap: 37% of Black male clients did not have a primary care provider (PCP). Through a focused action plan, this gap was significantly reduced, and in FY2025 the rates had nearly equalized—81% of White male clients and 80% of Black male clients were connected with a PCP.

This progress was achieved through several coordinated strategies:

- **Staff education and engagement:** Staff were trained on the importance of PCP connection and how to effectively communicate this to clients.
- **Client education:** Clients were given clear, supportive information on why having a PCP is crucial for preventive care and overall health.
- **Proactive linkage to available providers:** Staff used updated lists of PCPs accepting new patients—such as from Care New England and Providence Community Health Centers—to help clients make appointments.
- **Targeted outreach:** Staff received regularly refreshed lists of Black male clients without a PCP, enabling focused follow-up.
- **Ongoing monitoring:** Monthly tracking of PCP connection rates kept efforts guided and accountable.

Now that TPC has closed this racial gap, we will make these successful practices a regular part of care, sustaining the equitable outcomes achieved, and driving up overall rates for all our clientele.

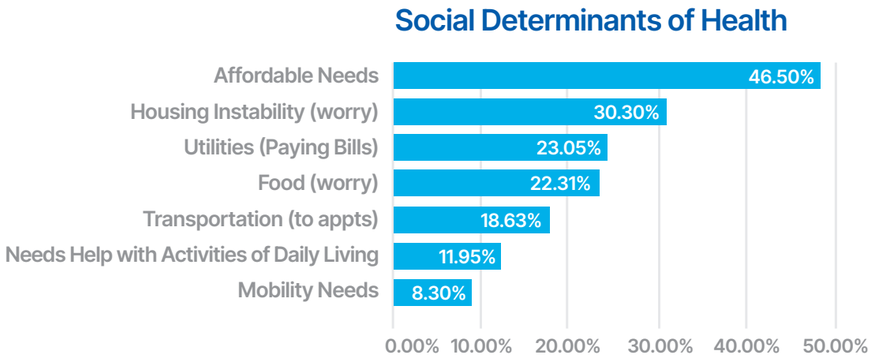
Social Determinants of Health Screening

The Providence Center set a goal for this year to improve the collection rate of screening for health-related social needs to examine those data for potential inequities. In Oct 2024, TPC began tracking the percentage of clients screened per month. The baseline rate of screening that month was 49.5%, and this rate improved to 77.8% in September, 2025. Altogether, in January–September 2025, we screened 45.5% of all clients aged 18 and older.

As a Certified Community Behavioral Health Center (CCBHC), The Providence Center must track and report how many clients are screened for health-related social needs. When we analyzed the data by ethnicity, comparing Not Hispanic or Latino, Hispanic or Latino, and Unknown, we found no significant disparity. When we analyzed the data by race, we found that Asian clients showed the largest deviation compared to overall and White populations; however, the number of clients in this group is small, which makes the results harder to interpret. The following data table illustrates TPC's screening rates for January–September, 2025:

Measure	Numerator	Denominator	Rate (Percentage)
Medicaid	1760	3934	44.7%
Non-Medicaid (including dually eligible for Medicare and Medicaid)	817	1725	47.4%
Total Eligible Population	2577	5659	45.5%
Stratification by Ethnicity (Hispanic or Latino) and Total Eligible Population			
Measure	Numerator	Denominator	Rate (Percentage)
Not Hispanic or Latino	1192	2576	46.3%
Hispanic or Latino	919	2037	45.1%
Unknown	466	1046	44.6%
Total Eligible Population:	2577	5659	45.5%
Stratification by Race and Total Eligible Population			
Measure	Numerator	Denominator	Rate (Percentage)
White or Caucasian	1181	2603	45.4%
Black or African American	1250	541	44.3%
American Indian or Alaska Native	32	69	46.4%
Asian	63	110	57.3%
Native Hawaiian or Other Pacific Islander	9	23	39.1%
More than one race	657	1425	46.1%
Unknown	85	188	45.2%
Total Eligible Population:	2577	5659	45.5%

The Providence Center's client population experiences a high burden of unmet health-related needs, also known as social drivers of health (SDOH). The following chart illustrates the percentage of people screened who responded that they had unmet social needs:



In order to respond to these needs, teams at The Providence Center routinely link clients to necessary external resources (housing assistance agencies, food pantries, transportation services, employment programs, etc). TPC provided staff training this year in workflows in screening for SDOH. The client's needs are added to their care plan and recorded in their medical record. TPC also engages with community organizations to support access to services that address social needs. TPC hosted a Summer Community Resource Fair in June 2025 for staff and clients to connect with community partners and organizations, learn more about local services and resources. Some attendees included the RI Community Food Bank, and the United Way of RI.

care new england
VNA HOME HEALTH & HOSPICE

Home Health

In the first year of the project in 2023, the VNA health equity team identified improvements in data collection were needed to better identify disparities in healthcare. We had challenges using our electronic medical record system. Processes were developed to enable clinicians to document racial and ethnic data. Managers used daily reports to quickly follow up and coach staff when needed. In the last two quarters of 2024, compliance was 100% for staff collecting race and ethnicity data. The results of the daily monitoring of admissions for missing data in 2024 has now changed to weekly monitoring to help maintain progress over time.

Data collection continued for FY 2025 for all admissions, and a new report to identify race/ethnicity is in use. Identified issues of concerns of inaccurate documentation are flagged for review with the clinical team.

In FY2025, the Home Health program began to produce appropriate Spanish written materials with the assistance of Horton services for translation.

Following three years, we will sunset this goal in 2026, and continue collecting race and ethnicity data as part of our standard processes. We will continue to review these data for underlying patterns or trends, and to identify inaccurate documentation of concern and reviewing with clinical team.

Hospice

In 2024, the Health Equity Team also set a goal for the Hospice Program to increase the number of referrals from underserved communities. In the first year, we built multifaceted relationships. The team enhanced community engagement through attendance at a variety of community events. We reviewed where patients live to guide our outreach and education efforts. Three physician offices serving diverse communities were outreached for staff education.

In 2025, VNA focused on education to better prepare the Hospice team to give care to diverse populations, particularly those from diverse religious backgrounds. The Hospice Alliance provided VNA with staff training videos on religion, which all Hospice staff were trained on. We plan to share these videos with all VNA staff in the coming year to increase their capacity with diverse populations.

In 2026, our Year 2 goal will be to create culture- and religion-specific care plans to tailor Hospice services to each patient. We will continue expanding learning opportunities that enhance cultural competency around diverse religious beliefs and practices, both for Hospice and Home Health programs. We will participate in community events to increase diversity in patient population served, particularly in the northern part of the state.

New Horizon Daycare Center/Blackstone Health Meal Sites

In 2025, we developed our first project with Blackstone Health meal sites. Our aim was to evaluate the presence of food insecurity for community members attending Blackstone Health, Inc. meal sites. **Our 16 meal site programs serve 120,000 meals per year.** In 2025, we designed and administered an extensive survey to understand food and nutrition for our clients. We received 262 responses.

In 2026, we will review the surveys closely, research our resources, and develop an action plan based on our findings. We will aim to provide connections to available community services such as dietitians, community health workers, and social service programs, based on what we learn.

Plans for 2026

The VNA Home Health and Hospice has adopted the following goals for the coming year:

Year 1:
Home Health: Strengthen equitable access to care by reliably identifying transportation barriers using OASIS E item A1250 (Transportation) at Start of Care (SOC) and ensuring timely follow up actions for patients who screen positive.

Year 2:
Blackstone Health Meal site: Develop and implement an action plan to respond to food insecurity at Blackstone Health Meal sites, based on analysis of 2025 survey.

Year 3:
Hospice: Implement individualized care plans for each patient, including a spiritual and cultural care component, with assistance of Chaplaincy. Continue staff training for cultural competency training.

care new england
WOMEN & INFANTS HOSPITAL

Overview

Throughout FY2025, Women & Infants Hospital reaffirmed its commitment to improving equitable maternal health outcomes by addressing high blood pressure during and after pregnancy. Building on earlier identification of inequities in postpartum readmissions among Black patients, the Health Equity Team collaborated with clinical, operational, and community stakeholders to put into place plans based on data to improve hypertension-related care and address social determinants of health across the perinatal and postpartum continuum.

Aligned with national trends showing a higher burden of hypertensive disorders of pregnancy among Black women, our teams closely monitored internal performance metrics and national benchmark data to understand the impact of these conditions within the Women & Infants patient population. This ongoing review highlighted persistent inequities in severe maternal morbidity associated with preeclampsia, reinforcing hypertension as a critical driver of adverse maternal outcomes and underscoring the importance of sustained, equity-focused interventions.

In response, Women & Infants continued to invest in and expand programs and services designed to promote early identification, effective clinical management, and continuity of care for patients affected by hypertensive disorders of pregnancy or facing other inequities that may pose barriers to optimal health outcomes. Through coordinated efforts across inpatient and outpatient settings, these initiatives emphasize preventive care, timely intervention, and enhanced postpartum follow-up to support patients throughout pregnancy and beyond. Collectively, these efforts reflect Women & Infants' ongoing dedication to reducing serious health problems and improving maternal health outcomes by proactively addressing inequities in prenatal and postpartum care.

The sections that follow highlight key initiatives currently in place, demonstrating how multidisciplinary teams are actively delivering equitable, patient-centered care to support improved outcomes during the prenatal and postpartum periods.

On Tuesday, March 25th at 10:59 am, April Elvannia da Rocha Oliveira was the first delivery in the new Brown University Labor and Delivery Center at Women & Infants Hospital, weighing 6 pounds, 11 ounces. Proud mother, Ana Iza Macedo Da Rocha, and father, Arsenio Oliveira, of Pawtucket, were overjoyed.

Severe Maternal Morbidity and Readmissions

Equity Goal #1

Number of Patients enrolled in the Postpartum Hypertension Equity Program

Baseline (FY24): 1000

Threshold: 1170

Target: 1250 (about 75% of eligible patients)

- Aligns with CNE Goal for FY2025

Equity Goal #2

SMM PEC Full Interdisciplinary Chart Review

Baseline (FY24): n/a

Threshold: 90%

Target: 100%

- Cases are obtained from Quality Analytics
- Action planning will be completed for defects found in SMM PEC case reviews
- Continue to report NPIC data for informational purposes—lagging data

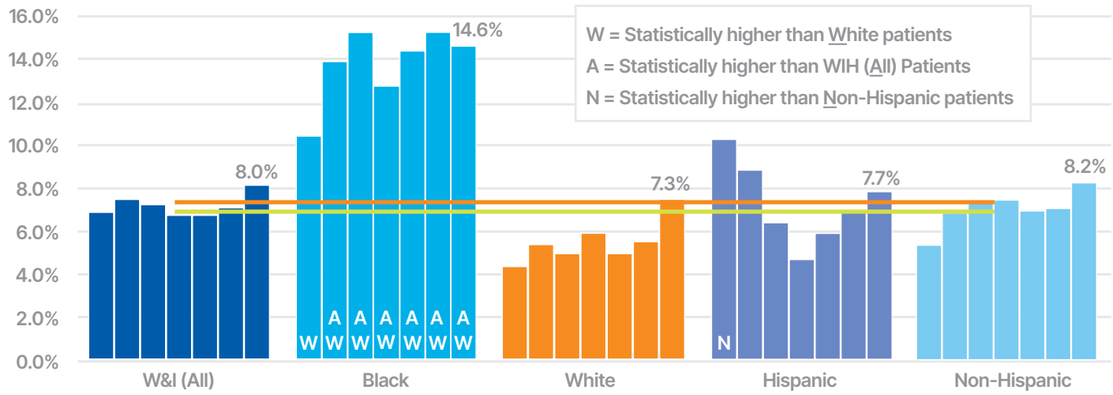
Regarding equity goal #2:

Throughout FY2025, the Women & Infants SMM Task Force reviewed each case of Severe Maternal Morbidity (SMM) among patients with Preeclampsia (PEC) for intervenable opportunities at the individual and systems levels. Reviewers used a modified version of the SMM review form produced by the Alliance for Innovation on Maternal Health (AIM) which included fields like race, ethnicity, preferred language, and if an interpreter was appropriately utilized. The case reviews were led by Dr. Heather Smith and Dr. Victoria Adewale, then presented for analysis within the multidisciplinary task force. The team discussed any problems that could have been prevented and made plans to improve care.

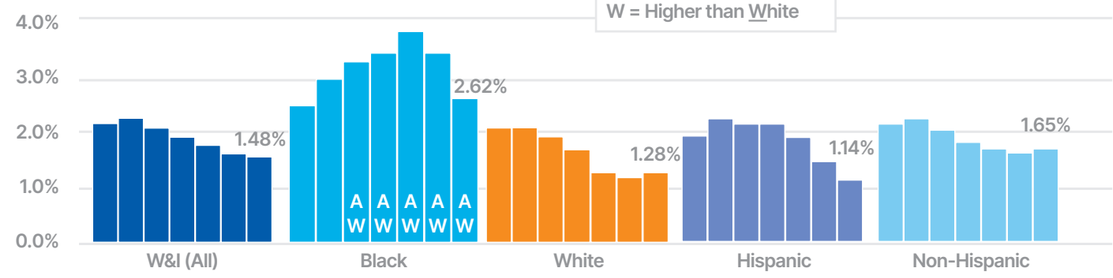
Regarding Data in general:

Our main perinatal data partner, the National Perinatal Information Center (NPIC) closed on June 30, 2025. Our final data update through NPIC finished off the calendar year 2024. In the wake of this closure, the Quality team worked to identify new data sources to continue monitoring not only our health equity work, but perinatal data reporting in general. An alternate data source for SMM PEC and Postpartum Readmissions was quickly identified, and case reviews were able to continue. However, this data source did not yet include race and ethnicity. Thankfully, in May 2025, this vendor introduced race and ethnicity into their reporting. The Quality team is eager to utilize and validate the new data to continue to inform W&I's health equity work.

SMM PEC CY23 Q2– CY23 Q4 Rolling 12-Month Rate by Quarter



W&I: PP Readmissions 42 Days CY23 Q2– CY23 Q4



Postpartum Hypertension Program

Equity Goal #1

Number of Patients enrolled in the Postpartum Hypertension Equity Program

Baseline (FY24): 1000

Threshold: 1170

Target: 1250 (about 75% of eligible patients)

- Aligns with CNE Goal for FY2025

Equity Goal #2

SMM PEC Full Interdisciplinary Chart Review

Baseline (FY24): n/a

Threshold: 90%

Target: 100%

- Cases are obtained from Quality Analytics
- Action planning will be completed for defects found in SMM PEC case reviews
- Continue to report NPIC data for informational purposes—lagging data

Since November 2022, the Hypertension Equity Program at Women & Infants Hospital (WIH) has aimed to reduce maternal morbidity and hospital readmissions related to postpartum hypertension, while promoting health equity among patients with hypertension. The program provides patients with blood pressure cuffs and comprehensive education on how to monitor their blood pressure at home.

Program Goals:

- Detect postpartum hypertension early and start treatment quickly to prevent worsening morbidity and hospital readmissions.
- Reduce barriers to postpartum care and follow-up.

Patient Eligibility Criteria for Enrollment:

- Patients diagnosed with gestational hypertension
- Patients diagnosed with chronic hypertension
- Patients diagnosed with pre-eclampsia

Enrollment and Patient Education

Eligible patients are enrolled prior to hospital discharge. Each participant receives:

- A blood pressure cuff for home monitoring
- Training on how to measure and report blood pressure daily
- Education on warning signs and guidance on when to contact the program for abnormal readings

Program Staffing:

- Nurse Practitioner: Monitors and tracks patient blood pressure results, adjusts or prescribes medications as needed, and works closely with doctors to make sure patients continue to receive care.
- Community Health Worker: Partners with the program coordinator to support patient engagement, address social determinants of health (e.g., transportation, housing stability, food security, access to community resources), and provide culturally responsive care.

Program Enrollment (FY 2025)

Postpartum Hypertension Program Enrollment	October '24 – December '24	January '25 – March '25	April '25 – June '25	July '25 – September '25	Cumulative
# Patients Enrolled in the Program Overall	269	300	339	345	1253

With the addition of new team members of a Nurse Practitioner and Community Health Worker who join the team in FY 2024, the program was able to increase enrollment from around 71% of eligible patients in Q1 to 91% in Q4.

Patient[AM1.1][AM1.2][DB1.3] Enrollment by Race	October '24 – December '24	January '25 – March '25	April '25 – June '25	July '25 – September '25	Cumulative
American Indian or Alaska Native	11	4	9	20	44
Asian	9	8	9	9	35
Black or African American	44	53	38	57	192
Native Hawaiian or Other Pacific Islander	6	7	5	7	25
White or Caucasian	138	167	212	188	705
Other	56	55	59	57	227
Prefer not to answer	5	4	4	4	17
Unavailable	0	2	3	3	8

Patient Enrollment by Ethnicity	October '24 – December '24	January '25 – March '25	April '25 – June '25	July '25 – September '25	Cumulative
Yes, Hispanic	98	110	108	115	431
No, Not Hispanic	170	189	229	230	818
Prefer not to answer	1	0	1	0	2
Unavailable	0	1	1	0	2
White or Caucasian	138	167	212	188	705
Other	56	55	59	57	227
Prefer not to answer	5	4	4	4	17
Unavailable	0	2	3	3	8

RI- SPHERES Program

The RI-SPHERES Program offers a regional remote blood pressure (BP) monitoring service for patients with elevated blood pressure or a diagnosis of hypertension who receive care at hospitals outside of Women & Infants Hospital (WIH), including Landmark, Newport, and Kent hospitals. This collaborative initiative will expand our reach beyond the WIH system, allowing us to reach more patients with high blood pressure, many of whom may also face significant social determinants of health (SDOH) challenges. By working collaboratively across these institutions, the RI Sphere Program team can provide more comprehensive and equitable care that addresses the full spectrum of patient needs. This innovative program has received funding from the National Institute of Child Health and Human Development.

Led by its principal investigator, Adam K. Lewkowitz, MD, MPHS, Assistant Professor of Obstetrics & Gynecology at Alpert Medical School of Brown University and Director of Maternal-Fetal Medicine Research. The multidisciplinary team also includes Venus Ramos, FNP, Nurse Practitioner, who supports clinical oversight and patient engagement; Stephanie Nunez, Research Coordinator, who manages study operations, regulatory compliance, and cross-team coordination; and Lindsay Spratt, Research Assistant, who supports data collection, participant follow-up, and day-to-day research activities.

Since its launch in spring 2025, the RI Spheres program has successfully enrolled 304 patients, providing ongoing remote monitoring and support to improve blood pressure management and maternal health outcomes.

Current demographics of enrolled patients as of December 2025 highlight the program's reach:

- Language: 87.3% English, 11.8% Spanish, 1.0% Haitian Creole
- Ethnicity: 33% Hispanic, 66.7% non-Hispanic, 0.3% unknown
- Race: 17.4% African American/Black, 61.1% White, 1.4% American Indian/Alaskan Native, 2.4% Asian, 19.4% Other, 1.0% Unknown

These data show that the program is reaching patients from many language and racial backgrounds and helping improve equitable maternal health outcomes.

Health Equity Initiatives Beyond Postpartum Hypertension

The following section highlights key programs and initiatives that reflect Women & Infants Hospital's comprehensive approach to caring for birthing people and their newborns throughout pregnancy, birth, and after delivery. From state-of-the-art labor and delivery services to expanded community-based care through the newly launched Community Mobile Health Clinic, these efforts demonstrate our commitment to meeting families where they are. This work is further strengthened by the integration of a Community Health Worker (CHW), who supports patients within our inpatient postpartum units, works collaboratively with the Postpartum Hypertension Programs, and conducts outreach through the mobile clinic helping to improve outcomes for birthing people and their babies.

In addition, this section highlights programs and initiatives that provide coordinated, whole-person care for birthing individuals, with a focus on addressing mental health needs, social determinants of health, and other factors that impact maternal and infant outcomes. It also describes how our hospital integrates community partners into care delivery to ensure patients are connected to essential resources at the time of discharge and beyond.

It is important to note that this section does not capture all research studies, programs, or initiatives currently underway at Women & Infants Hospital, nor does it reflect those anticipated to launch in FY 2026. Certain programs are not included due to grant-related restrictions that limit the information teams are able to share at their current stage of implementation. Additionally, this report focuses on initiatives for which data and outcomes can be reported within the current reporting period. We acknowledge that our health equity efforts extend well beyond the programs highlighted in this and the following sections, and we look forward to including additional initiatives in future reports. Doing so will further illustrate how teams across Women & Infants are advancing women's health at all ages, beyond pregnancy and childbirth.

Postpartum Inpatient Community Health Worker

Community Health Workers are trusted, frontline public health workers who share lived experiences with the people that they serve. Women & Infants Hospital (WIH) currently employs one Community Health Worker (CHW) who supports both the postpartum inpatient units and the Community Mobile Health Clinic. The inpatient CHW provides culturally responsive, trauma-informed support to birthing individuals and families across the perinatal and postpartum continuum. Serving as a critical bridge between clinical care and community-based resources, the CHW plays a key role in advancing maternal and infant health equity. Our CHW's core responsibilities include the following:

- Inpatient and Postpartum Unit Support
- Conduct social determinants of health screenings using validated assessment tools.
- Serve as a liaison between patients and the healthcare system to reduce barriers to care.
- Connect patients to essential services, including food assistance, housing support, behavioral health care, transportation, and early intervention programs.
- Provide culturally responsive referrals through established community partnerships.
- Collaborate closely with providers, nurses, case managers, and interdisciplinary teams to support safe discharge planning and effective care transitions.
- Community Mobile Health Clinic and Outreach
- Support patient engagement during mobile clinic visits in priority communities.
- Conduct social determinants of health screenings in community-based settings.
- Provide social needs navigation and follow-up support.
- Serve as a mobile clinic driver, as needed.

Inpatient Community Health Worker Impact

From October 1, 2024, through September 30, 2025, the Community Health Worker completed over 600 inpatient patient interactions. These interactions included patient education; referrals to postpartum doula services; connections to safe sleep resources and car seats, when applicable; and assistance with applications for programs such as SNAP, WIC, TDI/TCI, and non-emergency medical transportation through Medical Transportation Management (MTM). Through this work, our inpatient CHW supported continuity of care, reduced access barriers, and strengthened patients' connections to critical community resources.

Expanding Access to Maternal Care with the Community Mobile Health Clinic

The Community Mobile Health Clinic is a vital extension of Women & Infants Hospital's commitment to health equity and patient-centered care. This mobile unit brings essential postpartum services, including screenings for depression and hypertension, contraceptive counseling, and breastfeeding support, directly to communities across Rhode Island. By eliminating transportation barriers, the clinic ensures families receive high-quality care where and when they need it. This innovative program is supported by the CVS Health Foundation.

The Community Mobile Health Clinic is designed to address both medical and social needs that impact wellness. Services include:

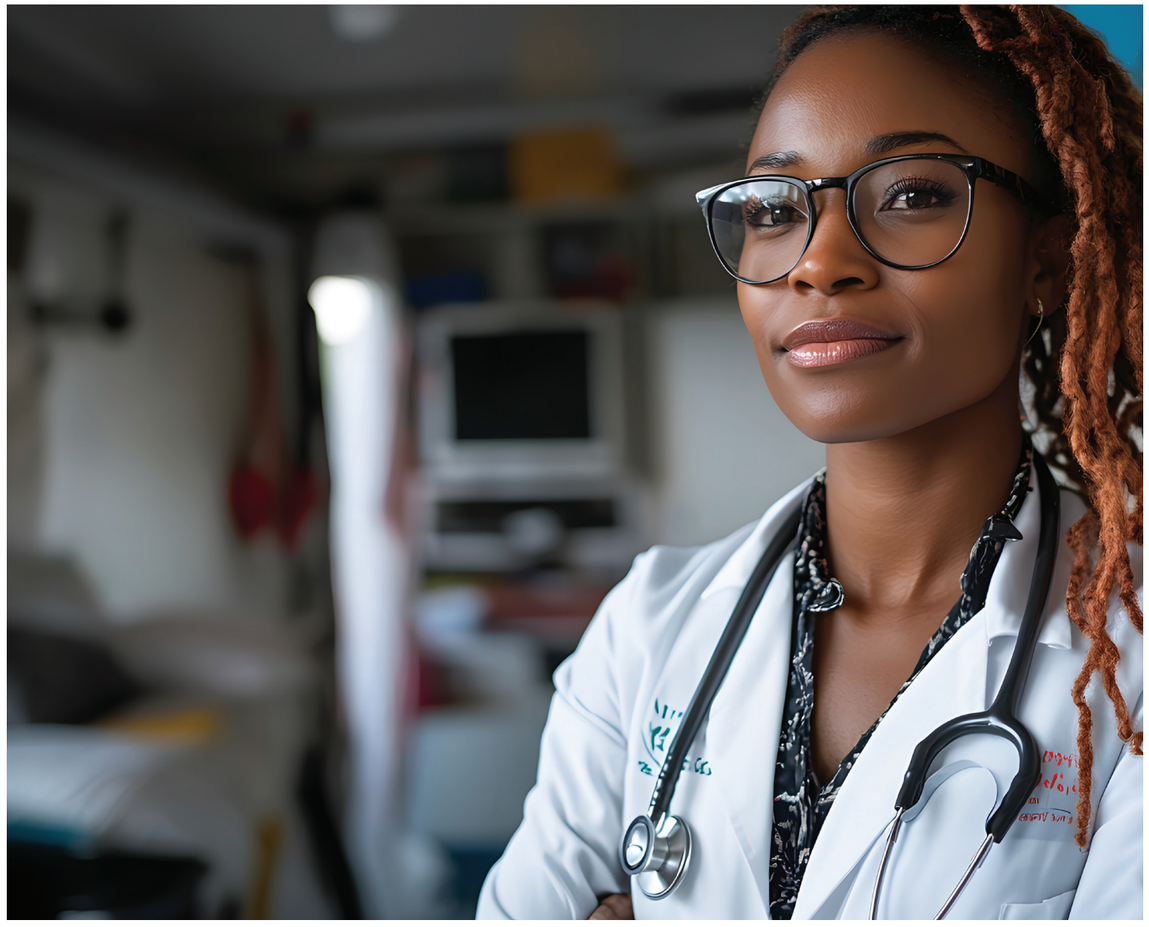
- Postpartum Hypertension Screenings
- We offer screenings to monitor blood pressure in the postpartum period.
- Postpartum Mental Health Screening and Support
- Tailored mental health services are provided for postpartum patients, including screenings to identify and address symptoms of postpartum depression.
- Lactation Support
- Our team provides physical assessments to address any medical concerns related to lactation and breastfeeding. As needed, we connect patients with lactation specialists who offer personalized education, hands-on support, and compassionate care to promote successful breastfeeding experiences.
- Contraceptive Counseling and Care
- We provide accessible and confidential family planning education and contraceptive options, based on each patient's needs and preferences.
- Navigating Social Drivers of Health
- We recognize the profound influence of non-medical factors on health. Our team will help individuals navigate connections to vital community resources addressing needs such as, but not limited to, transportation barriers, housing instability, food insecurity, access to local programs and social supports.
- Infant & Toddler Oral Health Support
- In partnership with Delta Dental of Rhode Island, our mobile clinic provides Infant & Toddler Oral Health Kits to families with young children. These kits are designed to promote healthy oral hygiene habits from the very beginning of life. Each kit includes:
- An infant and toddler toothbrush
- Two-minute brushing timer
- Educational materials to support parents and caregivers in caring for their child's teeth and gums

Community Partnerships and Impact

The mobile clinic operates in close collaboration with community partners to expand healthcare access, reduce disparities, and support healthier families. Staff provide care with dignity, compassion, and cultural responsiveness.

During its soft launch from summer through fall 2025, the mobile clinic served postpartum individuals in Central Fall, Providence, and Warwick through partnerships with Children's Friend, Refugee Dream Center, and community events such as the Promise Walk for Preeclampsia and the South Providence Health Equity Zone Maternal Health Fair.

Looking ahead to 2026, the mobile clinic will expand services across additional partner sites and communities throughout Rhode Island.



The Rhode Island Community-based Maternal Support Services Bundle (RI CoMSS)

The Rhode Island Community-Based Maternal Support Services (RI COMSS) project aims to improve perinatal health outcomes by adding community support services into regular healthcare visits. In collaboration with the COMPASS+ initiative through the Hassenfeld Institute at Brown University, Women & Infants Hospital (WIH) has embarked on a collaborative care model that brings together physicians, Care Managers, Community Health Workers (CHWs), doulas, and community-based organizations. This approach brings people together to better coordinate care and addresses the critical social determinants of health (SDoH) that impact maternal and child well-being. Beginning in February 2025, the WIH-led team implemented the COMSS model across six obstetric and gynecological sites, including Care New England Medical Group in Warwick, Providence Community Health Centers, the Obstetrics and Gynecology Care Center (OGCC), Women's Care, and Brown University Health Women's Medicine Collaborative. This implementation encompasses care coordination, doula services, and referrals to community-based organizations that address critical SDoH such as food security, housing stability, and transportation. To facilitate these connections, the project uses a special system to make referrals for resources easier and faster, and help to address social needs directly.

RI CoMSS uses three main steps:

1. Routine screening of pregnant individuals for key SDOH indicators through the ITO Health platform,

2. Immediate intervention by linking participants to resources and support systems tailored to their unique needs, and

3. Partnerships with community-based organizations for provision of SDOH support.

RI CoMSS continues to work to improve perinatal health outcomes amongst pregnant and postpartum patients who screen positive for health-related social needs (food, housing, transportation) with the support of community health workers, and through partnerships with community-based organizations and doulas. These partnerships include Meals on Wheels of Rhode Island, Amos House, and Community Servings. In addition, with the use of a specially designed social needs navigation platform, ITO Health, community health workers have been able to make sure referrals to community-based organizations, and to state and federal programs are completed and patients receive services. Thus, increasing the likelihood that patients will resources and supports to help them attain good health.

It also continues to collaborate with care managers through the COMPASS+ program that employs that collaborative care model to address perinatal mental health. This partnership has deployed a large-scale perinatal health equity initiative that encompasses the intersection between mental health and social needs.

In February 2025, the RI CoMSS program began implementation at Providence Community Health Centers—Central (PCHC Central). Due to the stepped-wedge, randomized nature of this program, six months later, the program was launched at Brown University Health OBGYN in Providence, Rhode Island. The program is now preparing to implement the RI CoMSS model at its first Care New England site, CNE Warwick OGBYN, for January 2026.

Current enrollment data shows that of patients enrolled in the program at PCHC Central and Brown University Health:

- 75% screened positive for food insecurity
- 38% screened positive for housing insecurity
- 21% screened positive for transportation insecurity

To address this, throughout the course of the program the team will continue to engage community organizations with plans to support and leverage their programs and initiatives to provide wrap-around services to patients experiencing health-related social needs and improve maternal health outcomes for birthing patients in Rhode Island.

Lastly, this program encourages continuous training of program staff, collaboration with community-based organizations, and sharing the RI CoMSS model with others. Collaborative Care Model for Perinatal Wellness Support Services—Population-level Equity-Centered Solutions (COMPASS+)

Collaborative Care Model for Perinatal Wellness Support Services—Population-level Equity-Centered Solutions (COMPASS+) is a grant-funded initiative that aims to integrate mental health care into pregnancy and postpartum care across 6 perinatal clinics in Rhode Island. COMPASS+ is co-designed with the input of a community action and advisory board comprised of birth workers and people with lived experience.

Patients in COMPASS+ have the support of a care manager a mental health professional who has the ability to monitor patients' mental health symptoms via a patient registry, provide short-term therapy, support medication management, and connect patients to other community resources. The care manager also participates in weekly meetings with an obstetric provider and a perinatal psychiatrist to talk through modifications to treatment plans that are required to achieve full remission of mental health symptoms. The care manager is available to support patients throughout pregnancy and up to 1 year postpartum. The care manager also collaborates with a community health worker (CHW) to connect patients with identified health related social needs to community resources. Together, the care manager and CHW work together to provide coordinated care that addresses both the mental health and material needs of patients. To date, approximately 130 patients are receiving COMPASS+ across two clinics. The third COMPASS+ site will launch in January 2026.

WIC Enrollment Support Program Led by WIH Community Health Workers

In partnership with WIC, Dr. Rahul Vanjani, Founder & CEO of ITO Health, and Women & Infants Hospital, have launched an initiative to address the social needs of women during the prenatal and postpartum periods. As part of this initiative, Community Health Workers (CHWs) at Women & Infants will ask questions focused on finding helpful solutions to new mothers the day after they give birth.

A key component of this process includes screening for food insecurity, with a particular focus on WIC as a potential solution. During our pilot project, CHWs will verify WIC income eligibility and complete intake questions at the bedside using the attached intake form. CHWs will administer a solutions-based questionnaire to postpartum patients at bedside. If a patient is eligible for WIC but not enrolled, CHWs will help them complete the WIC application process before discharge, helping to remove barriers and expedite benefits. Once completed, the form will be emailed to RIDOH WIC staff for entry into the Crossroads system, helping families get benefits faster.

Additionally, if the participant provides consent, the CHW will be authorized to pick up the eWIC card from the Women & Infants WIC clinic, ensuring that the family has access to their benefits upon discharge.

Because this initiative is a pilot program that was implemented midway through FY 2025, and due to the federal government shutdown that occurred during the first quarter of FY 2026, our teams and external partners are not able to share program data at this time. As implementation and data collection continue, we anticipate being able to report outcomes and key findings in next year's report.

Family Visiting Programs Teams Onsite at WIH

In partnership with Women & Infants Hospital (WIH) Patient Experience and Family-Centered Care, WIH has established an onsite collaboration with Family Service of Rhode Island and Children's Friend to support enrollment into Family Visiting Programs. This partnership promotes direct patient engagement and strengthens access to evidence-based home visiting services for families during the perinatal period.

Program Purpose

The purpose of this workflow is to ensure a seamless, effective, and respectful integration of Family Visiting Program staff into the hospital setting, enabling timely connections to supportive home visiting services for eligible families.

Onsite Location and Coordination

During designated onsite days, Family Visiting Program team members are stationed in the Antenatal Care Unit (ACU), located on the 4th Floor, South Pavilion. This location supports early engagement with patients prior to delivery, with the goal of enrolling families and scheduling initial Family Visiting Program appointments before hospital discharge.

Patient Referral and Engagement Process

Family Visiting Program team members may engage patients upon receipt of a signed consent form from any of the following WIH staff:

- Social Workers
- Case Managers
- Nurses
- Physicians
- Patient Experience and Community Health Advisory staff
- Community Health Workers

Occasionally, referrals may also originate from the Postpartum Unit. In these cases, once a signed consent form is received, Family Visiting Program staff are authorized to engage patients directly in that unit.

Program Implementation and Reach

The pilot program launched in spring 2025. To date, our 40 families have been referred, enrolled, and successfully connected to a Family Visiting Program, supporting early intervention and ongoing family support.

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