BROWN Health UNIVERSITY

The Miriam Hospital

2025 Community Health Needs Assessment

September 2025

About Brown University Health and the 2025 CHNA

Formed in 1994, Brown University Health is a not-for-profit health system based in Providence, Rhode Island comprising three teaching hospitals of The Warren Alpert Medical School of Brown University: Rhode Island Hospital and its Hasbro Children's; The Miriam Hospital; and Bradley Hospital, the nation's first psychiatric hospital for children; Newport Hospital, Saint Anne's Hospital, and Morton Hospital, community hospitals offering a broad range of health services; Gateway Healthcare, the state's largest provider of community behavioral healthcare; and Brown Health Medical Group, the largest multi-specialty practice in Rhode Island.

Delivering health with care, Brown University Health is committed to restoring people's health and strengthening and supporting the health of the communities it serves. We are a cherished community asset, synonymous with the highest quality, most compassionate, and most patient-centered healthcare anyone needs, at any age and at any time of life. That goal extends beyond the health system into schools, workplaces, and neighborhoods. Across the system we all share a commitment to put the patient at the center of everything. That commitment is realized through investments in charity care, in-kind and subsidized health services, research, provider education, and community initiatives.

Brown University Health coordinates hundreds of programs, events, and community service activities that serve between 25,000 and 30,000 southern New Englanders annually. Programs are provided through partner hospitals and are often offered free or at a reduced cost to the community.

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

Brown University Health 2025 CHNA Leadership

Kevin Bickerstaff, CPA/MST, Director of Finance, Brown University Health

Carrie Bridges, MPH, Vice President of Community Health, Brown University Health

Teresa Gerety Ibbotson, MEd, Administrative Director of Community Health Benefits, Saint Anne's Hospital, Brown University Health

Katherine Kiser, Manager of Tax Compliance, Brown University Health,

Julie Masci, Senior Director of Marketing, Community Relations & Support Services, Morton Hospital, Brown University Health

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The 2025 Community Health Needs Assessment

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

CHNA Study Objectives:

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

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

We thank you for partnering with us in this effort. We invite our community partners to learn more about the CHNA and opportunities for collaboration to address identified health needs. Please visit our website at https://www.brownhealth.org/centers-services/community-health-institute or contact us at cbridges@brownhealth.org.

Research Partner

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

2025 CHNA Leadership and Oversight

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

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

HARI 2025 CHNA Partners and Steering Committee Members

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

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

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

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

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

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

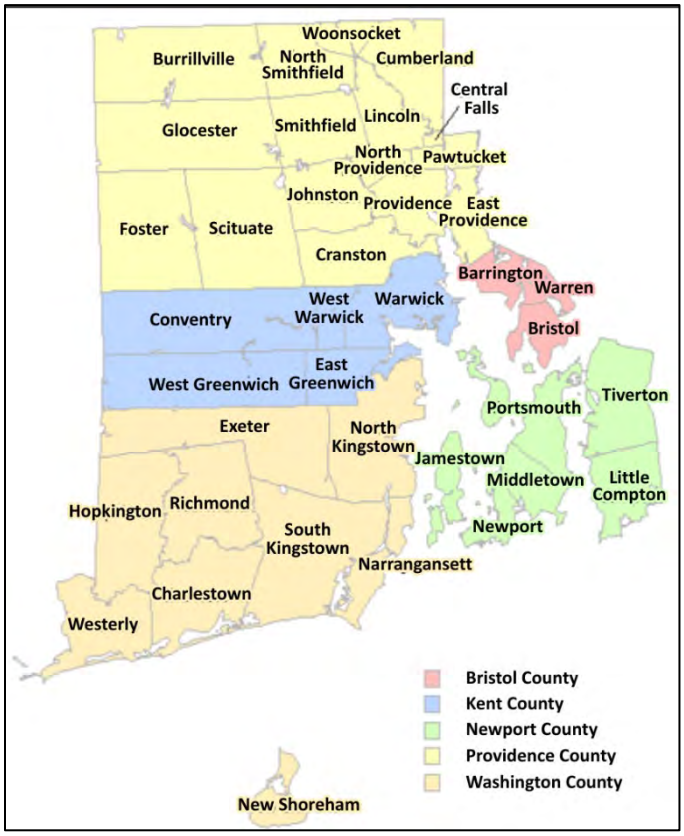
South County Health
Lynne Driscoll, *Assistant Vice President Community Health*
Holly Fuscaldo, *Clinical Medical Social Worker and Wellness Lead*
Nina Laing, *Manager Case Management*

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

2025 CHNA Study Area

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

Rhode Island Counties and Communities



HARI 2025 CHNA Participating Member Hospitals and Locations

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

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

The hospital is staffed by more than 816 physicians, approximately 50 full-time house staff (medical school graduates), a nursing staff of 650 and more than 2,800 employees. The Miriam is a major teaching affiliate of The Warren Alpert Medical School of Brown University and is committed to being at the forefront of medical research. The Miriam Hospital identified its primary service area as 24 zip codes, largely located within the northeast portion of Providence County. The Miriam Hospital's primary service area also includes a portion of Attleboro in Massachusetts; for purposes of the CHNA, the hospital focused reporting on its Rhode Island service area.

The Miriam Hospital Primary Service Area

Research Methods

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

Primary Research and Community Engagement

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

Key Stakeholder Survey

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

Community Conversations and Engagement

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

2025 CHNA Community Engagement Partners and Events

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

Secondary Data Analysis

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

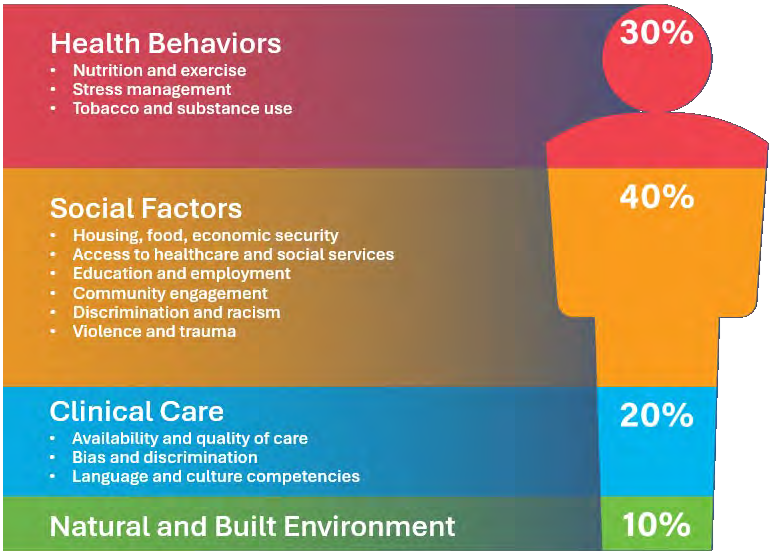
Social Drivers of Health

Where we live impacts choices available to us

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

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

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



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

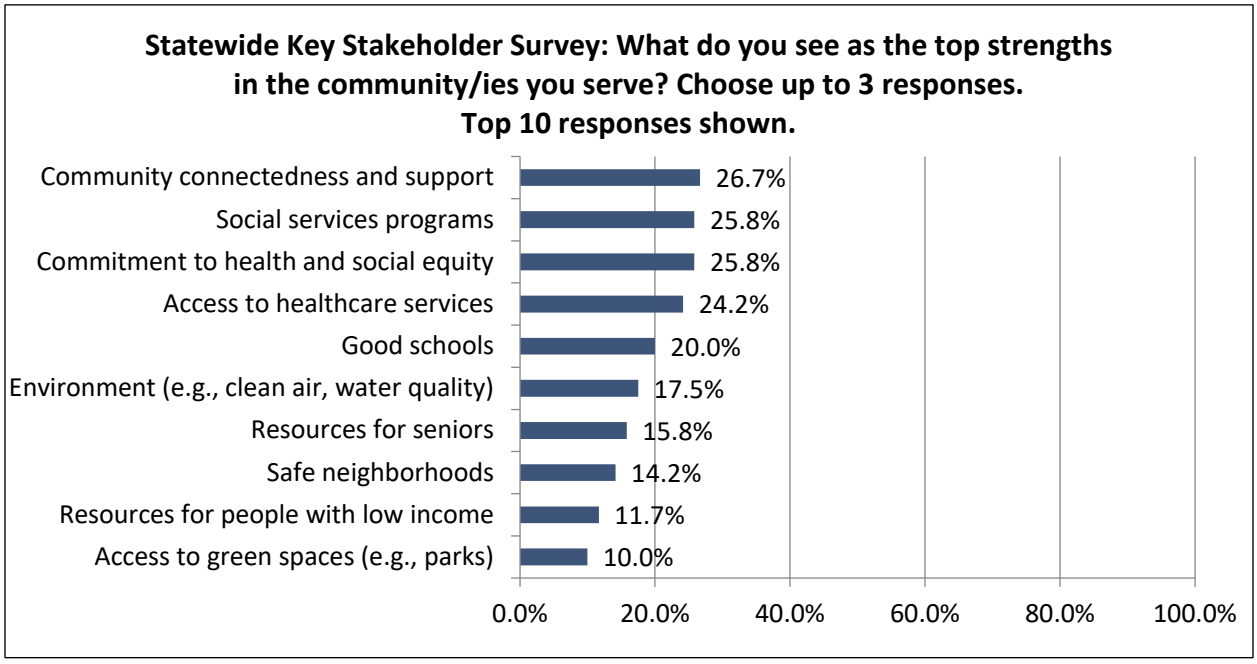
Only 20% of health outcomes are attributed to clinical care.

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

Our Strengths and Opportunities

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

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

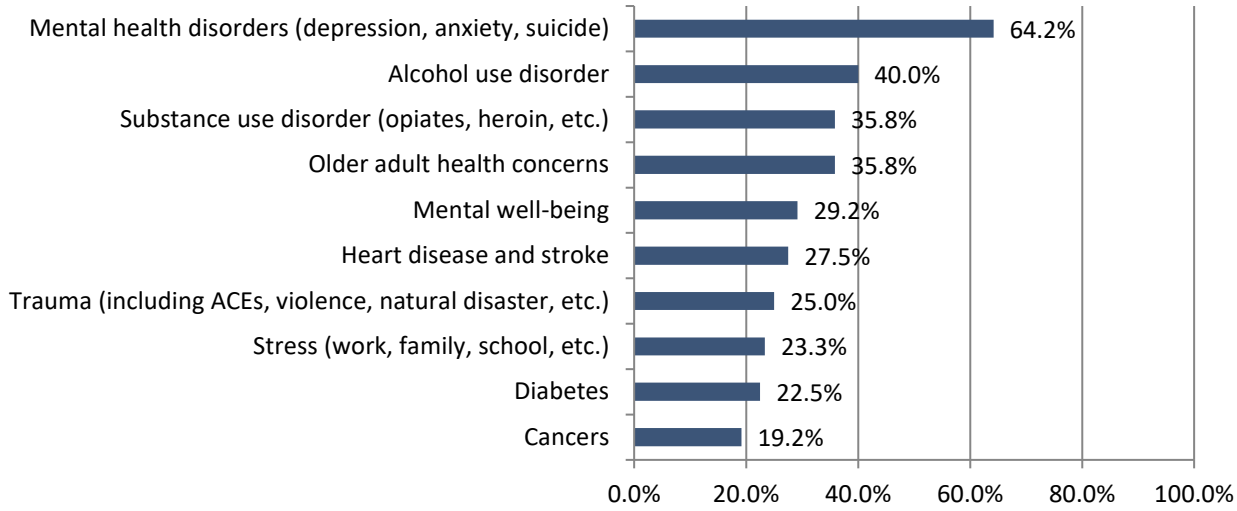


Community Strengths

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

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

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



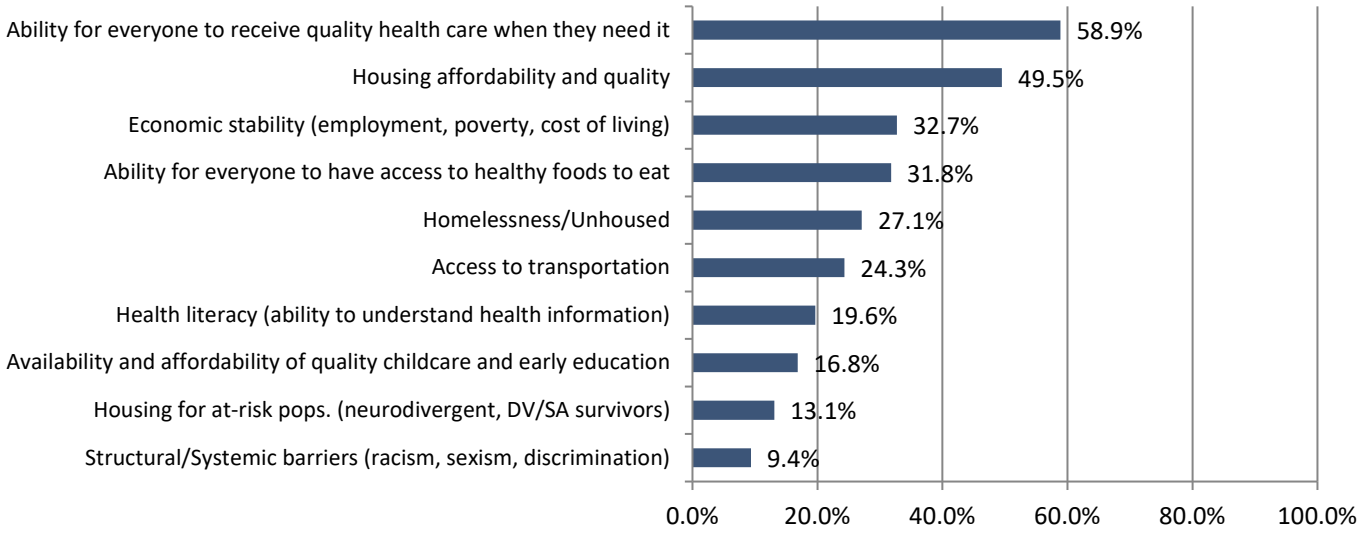
Community perception and public health data suggest that many of the identified health concerns worsened in recent years due to the lingering impact of the COVID-19 pandemic (e.g., isolation, delayed healthcare, developmental delays) and underlying SDoH factors, including rising cost of living, housing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

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

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

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

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



Community Challenges

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

Determining Community Health Priorities

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

Brown University Health applied the following rationale and criteria to define priorities:

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

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

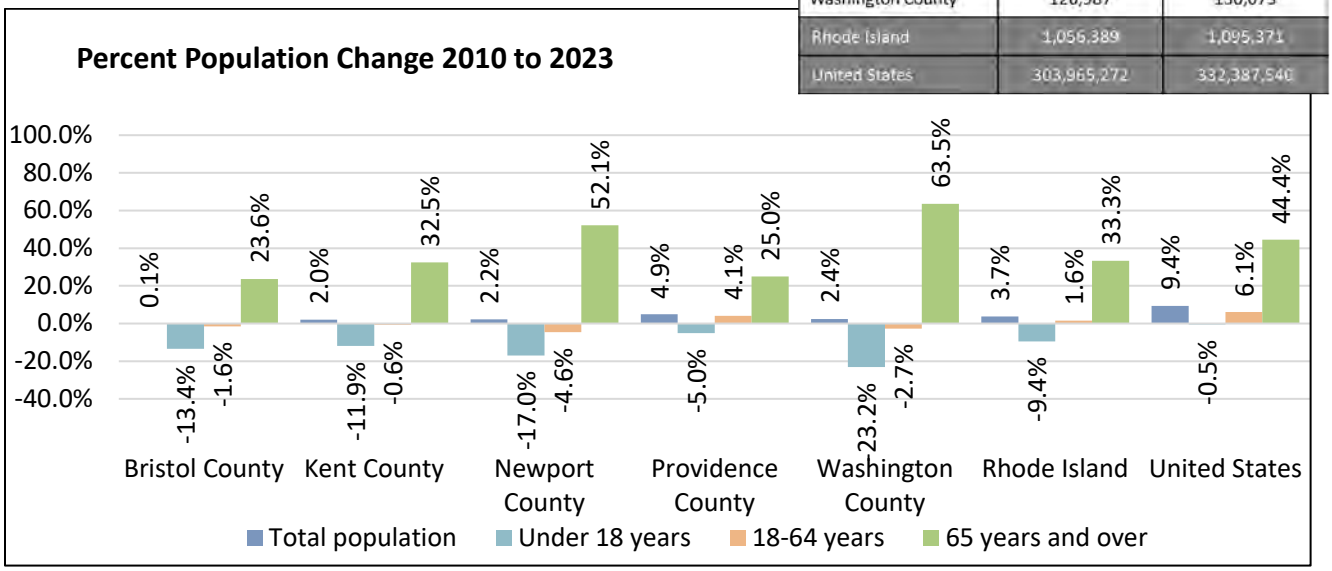
Other health issues identified as significant health needs for the state include affordable housing, maternal and child health, and older adult health and wellbeing. While these areas are not named priorities for Brown University Health due to the need to prioritize resources, the system is committed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

Our Community and Residents

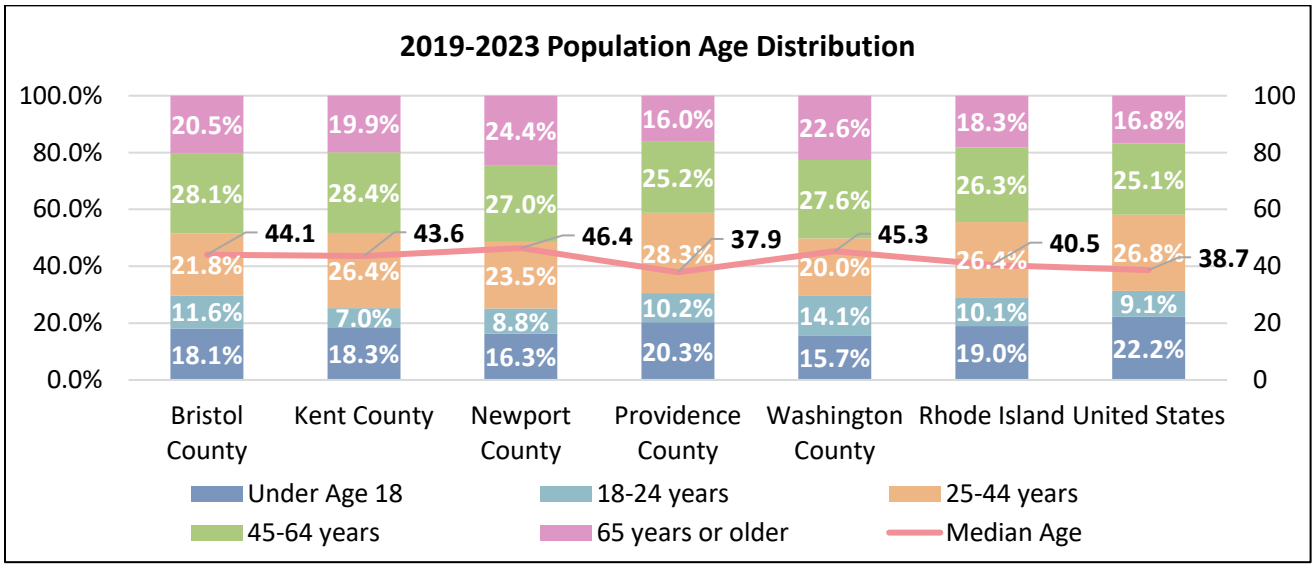
Rhode Island had a total population of 1,095,371 people in 2023 and overall population growth of approximately 3.7% from 2010 to 2023. The total population of Rhode Island and its counties is growing at a slower rate than the nation. However, the state saw a 33.3% increase in older adults aged 65 from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

Total Population by Year

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



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

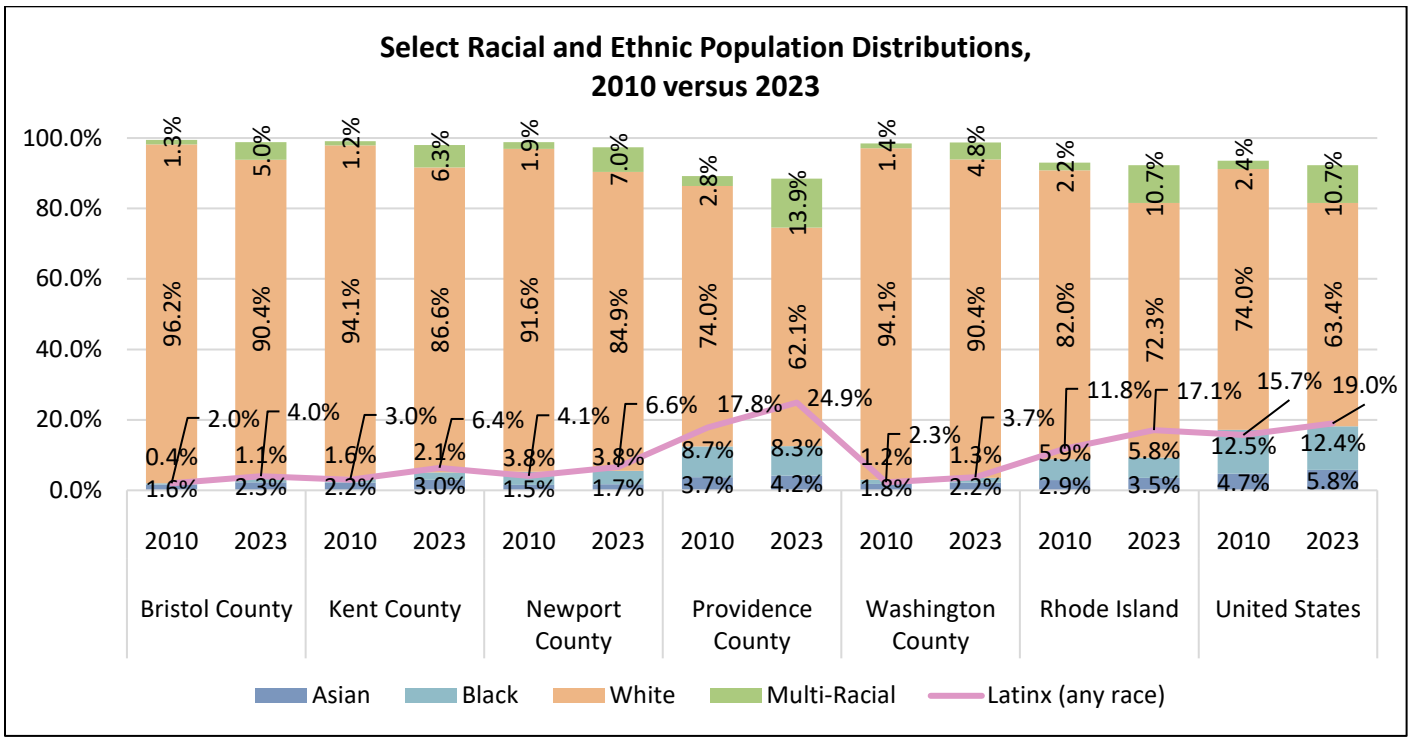
Disability is a physical or mental condition that limits a person's movements, senses, or activities. Across the US, 13% of the population and about 33% of older adults live with a disability. Rhode Island state averages are in line with the nation. Experiences of disability, particularly among older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

2019-2023 Population with a Disability

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

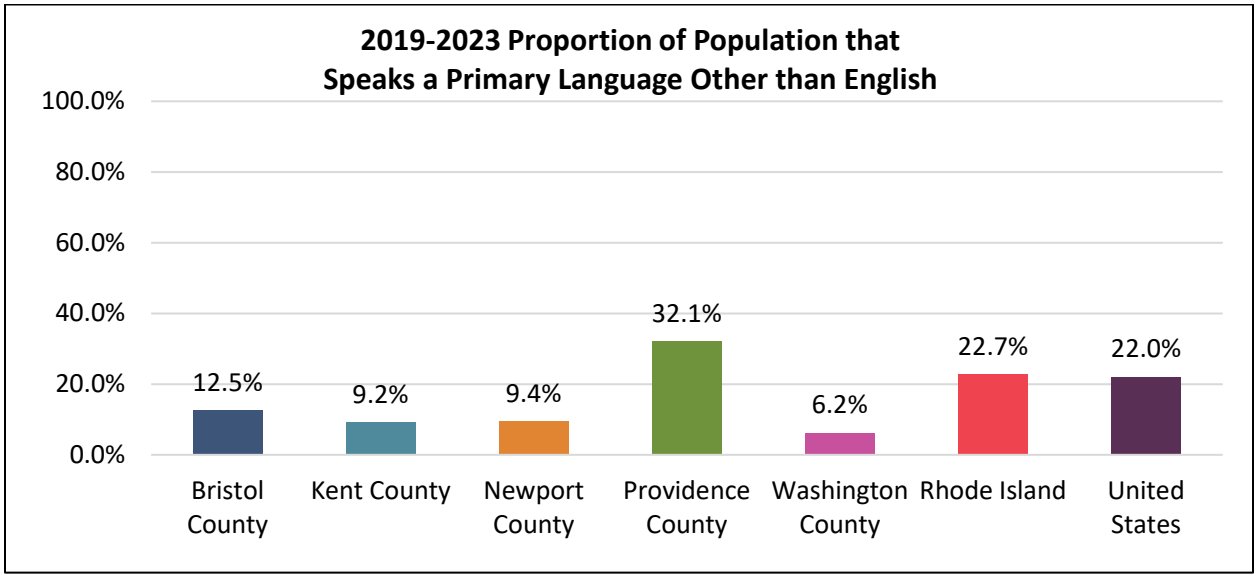
Source: US Census Bureau, American Community Survey

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



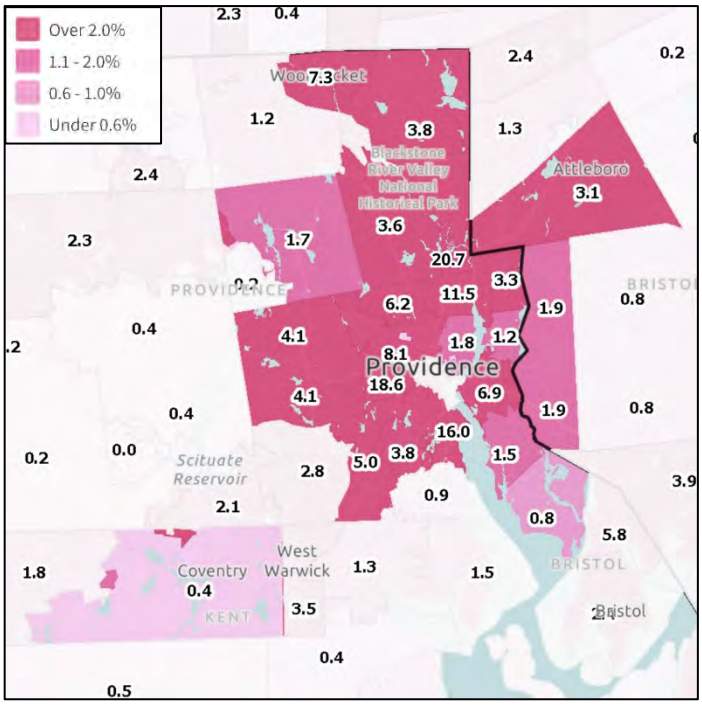
Source: US Census Bureau, American Community Survey

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



Source: US Census Bureau, American Community Survey

2019-2023 Linguistically Isolated Households by Zip Code^



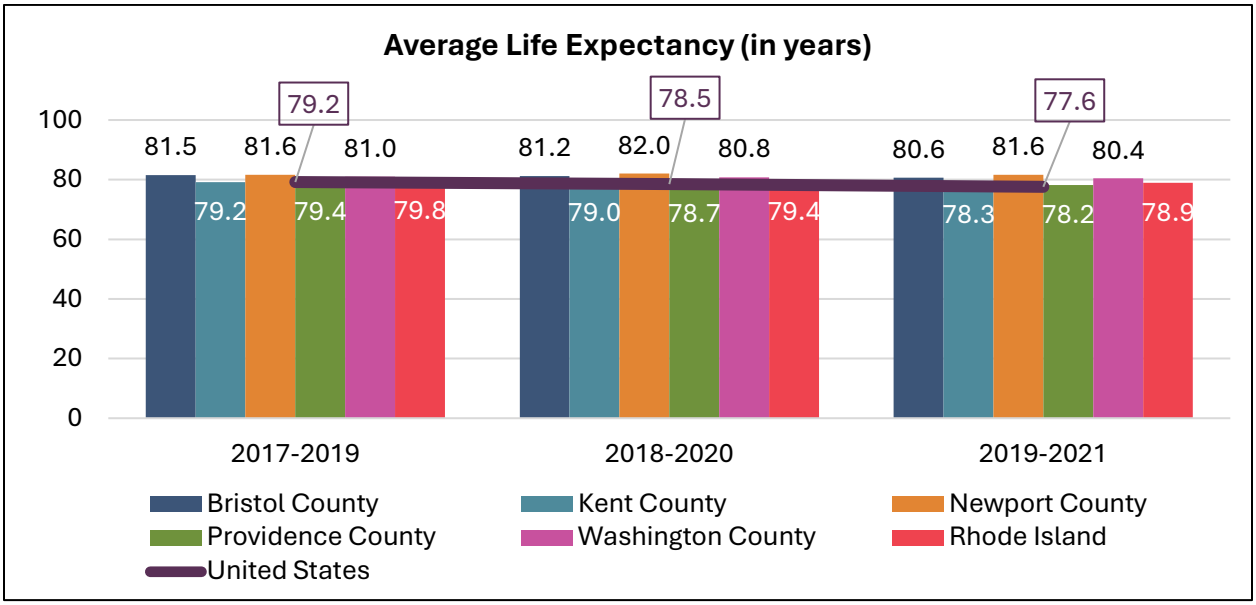
Source: US Census Bureau, American Community Survey

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

Measuring Health in Our Community

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

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



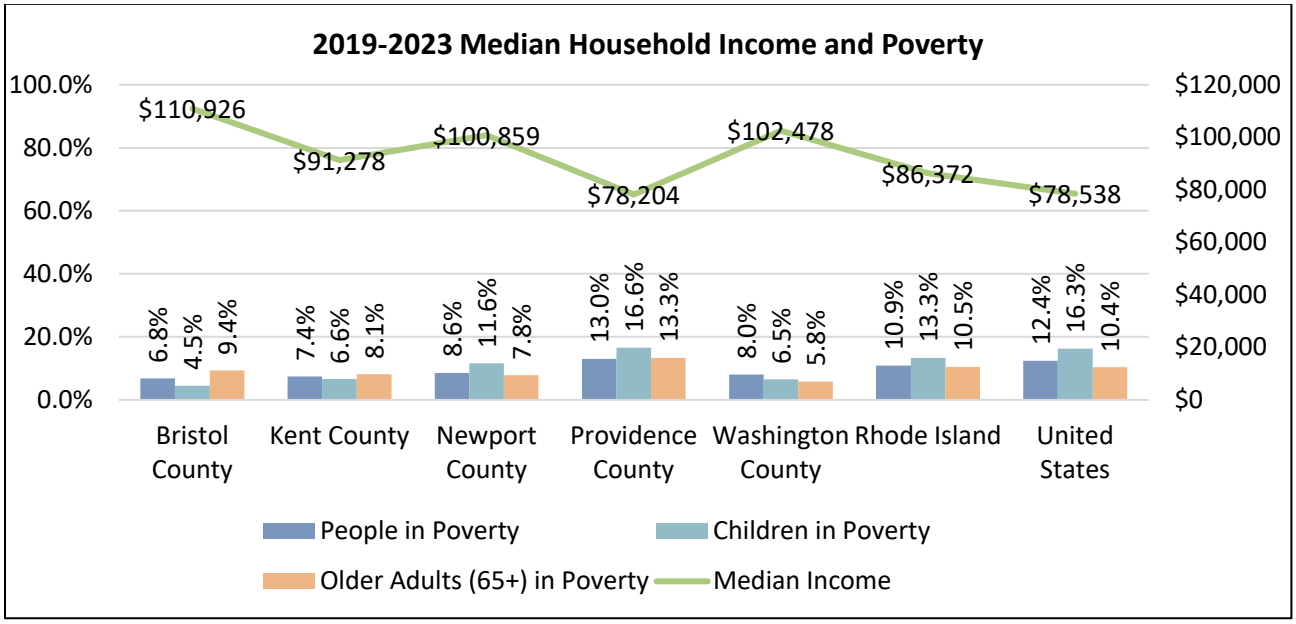
Source: Centers for Disease Control and Prevention

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

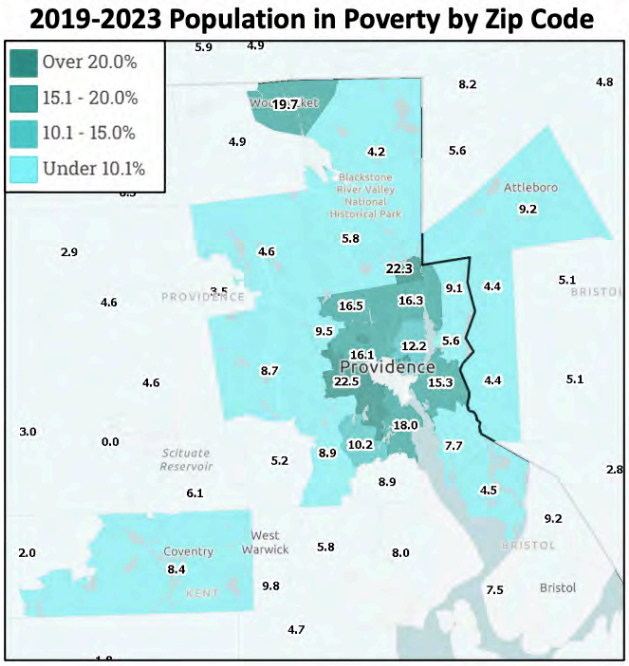
Resident Insights:

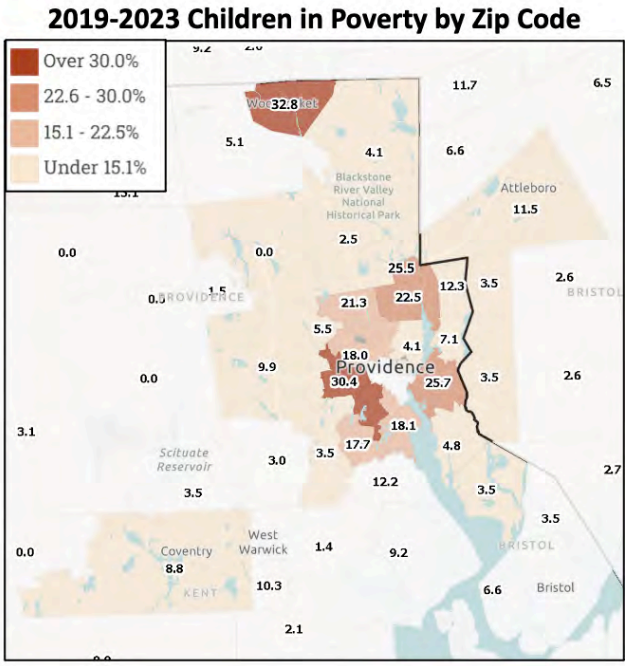
> *"[There are] grassroots efforts to ensure community members have the opportunity to participate in voting and have access to education. [There are] people wanting to make sure their communities are empowered."*
>
> *"In general, Rhode Island is a civic-minded state and promotes diverse thinking."*
>
> *"[We have] strong community values and leadership in protecting the special places and scenic areas of our state, including beaches, forests, ponds, parks, etc."*

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



Source: US Census Bureau, American Community Survey





Source: US Census Bureau, American Community Survey

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

In The Miriam Hospital's service area, there is 79-point difference between zip codes with the highest and lowest UNS value, demonstrating community-level health and social disparities. The hospital's service area zip codes with a UNS value exceeding 50 are depicted below, along with select SDoH indicators.

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

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

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

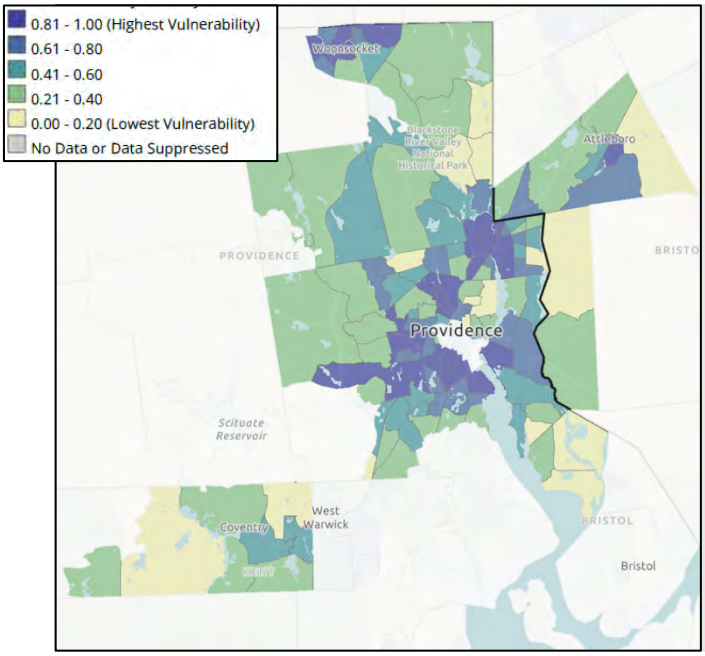
The Social Vulnerability Index (SVI) goes a level deeper than the UNS to demonstrate vulnerability to health disparities at a census tract-level.

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

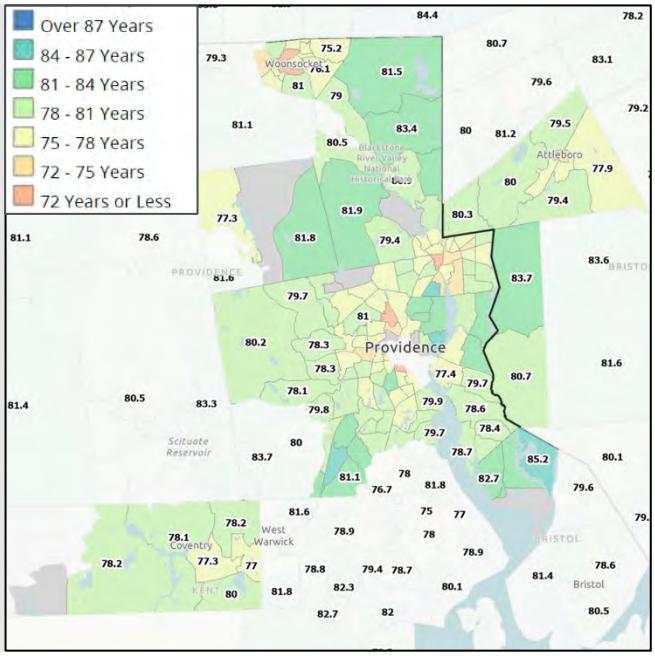
The SVI scores census tracts on a scale from 0.0 (lowest) to 1.0 (highest) vulnerability based on factors like poverty, lack of transportation, and overcrowded housing.

Examining the SVI in conjunction with average life expectancy demonstrates how SDoH impact health outcomes. Within The Miriam Hospital service area, historical data indicates potential for a more than 13-year difference in average life expectancy between communities with the lowest and highest averages. Affected areas, including Central Falls, Cranston, Pawtucket, Providence, and Woonsocket, also have SVI values of 0.81 or higher out of a maximum score of 1.0, reported as recently as 2022.

2022 Social Vulnerability Index by Census Tract



2010-2015 Life Expectancy by Census Tract



Source: Centers for Disease Control and Prevention

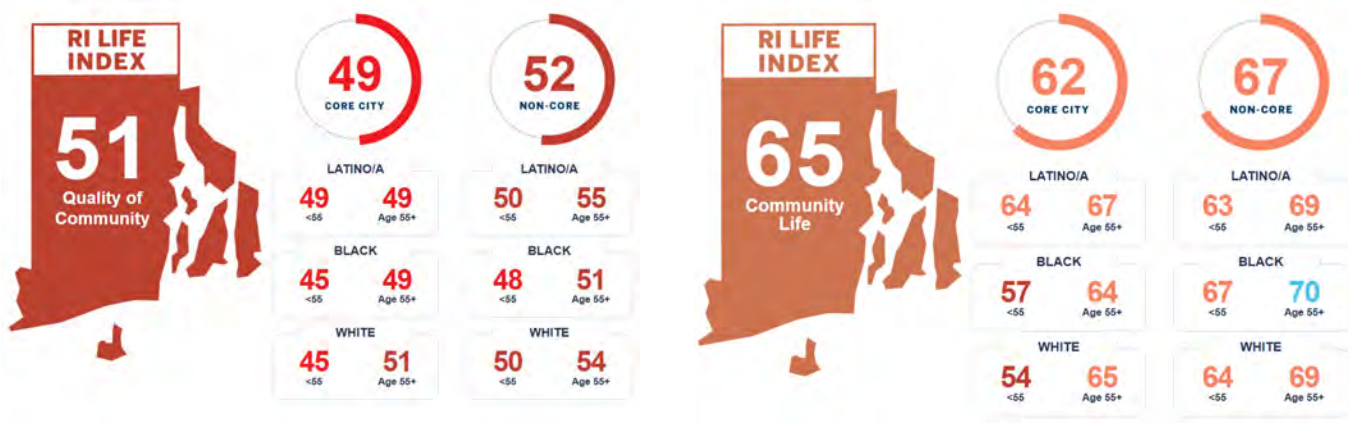
Blue Cross & Blue Shield of Rhode Island (BCBSRI) and the Brown University School of Public Health have produced the RI Life Index each year since 2019 to capture Rhode Islanders' perceptions of SDoH and wellbeing, including quality of community and quality of life. Scores are presented in aggregate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

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

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

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

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



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

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

Community Health Needs

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

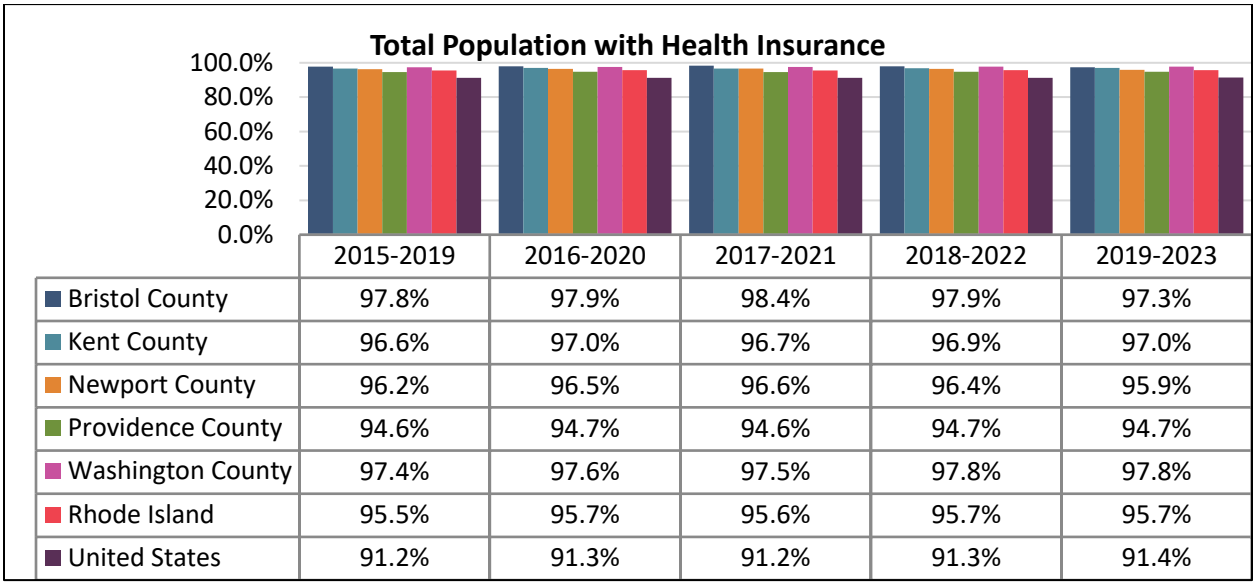
A full summary of secondary data findings is also provided on Brown University Health's website and available to our community partners as a resource to support their many programs and services.

Access to Care and Services

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

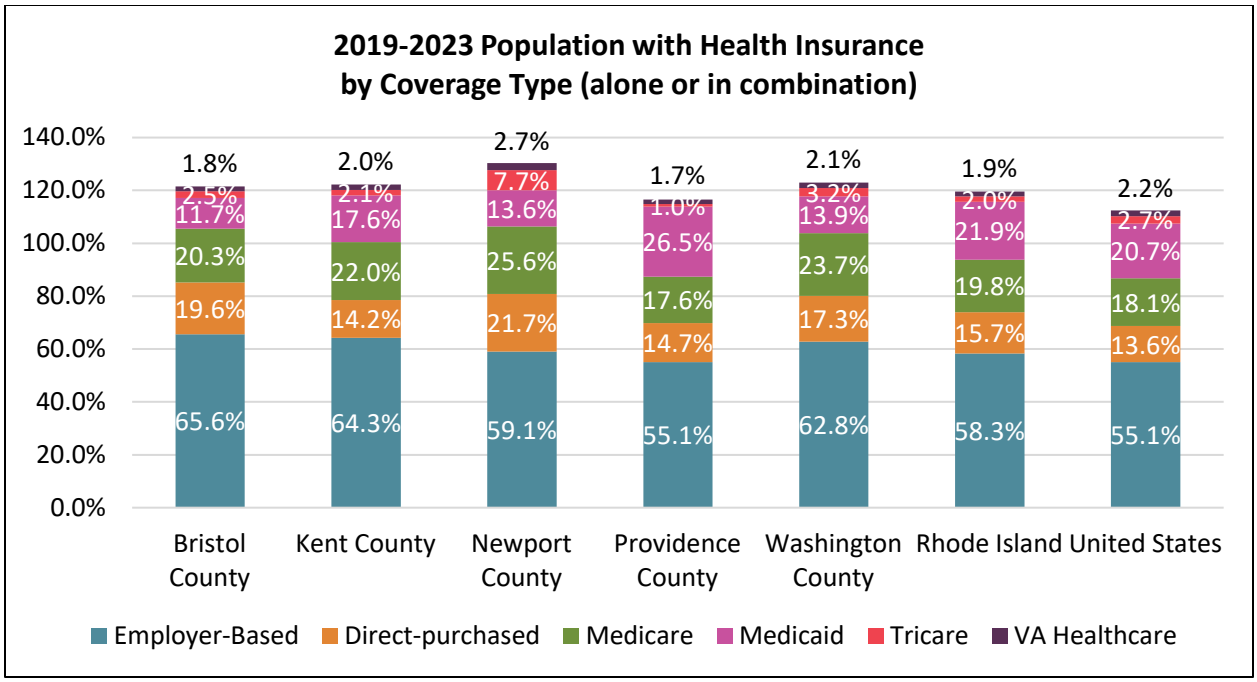
Health insurance coverage among Rhode Island residents has been consistently high with 95.7% of residents covered in 2023 compared to 91.4% of residents nationally. Statewide, a high proportion of insured residents obtain their insurance through an employer (58.3%), providing cost-sharing benefits and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

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



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

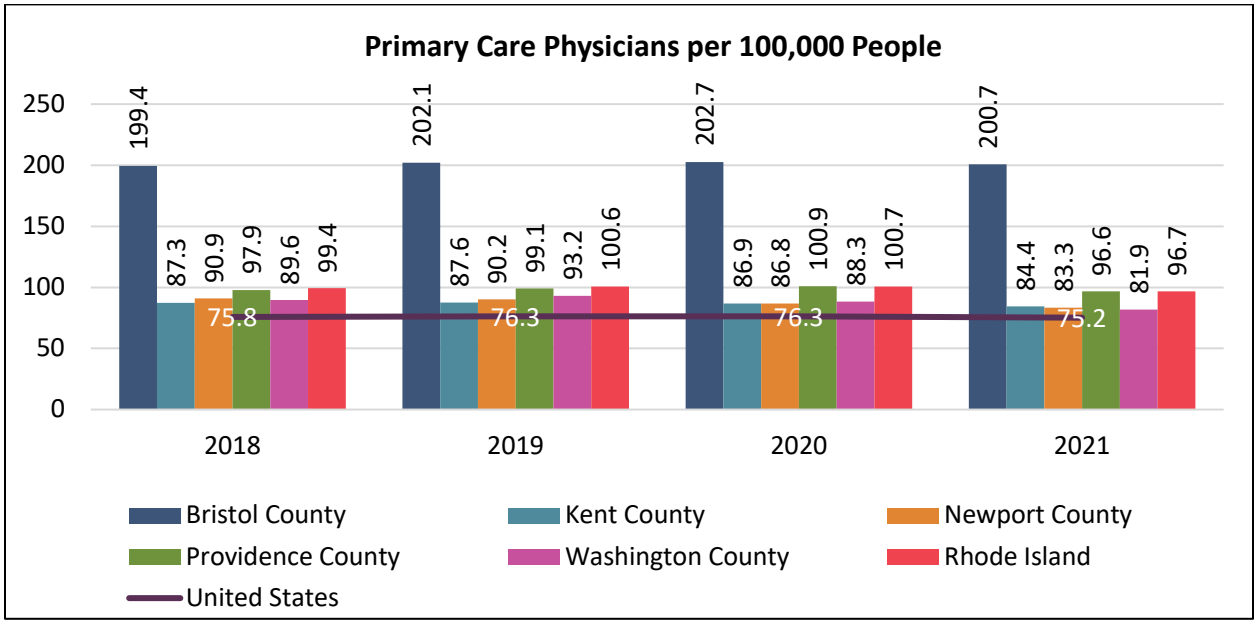
Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

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

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



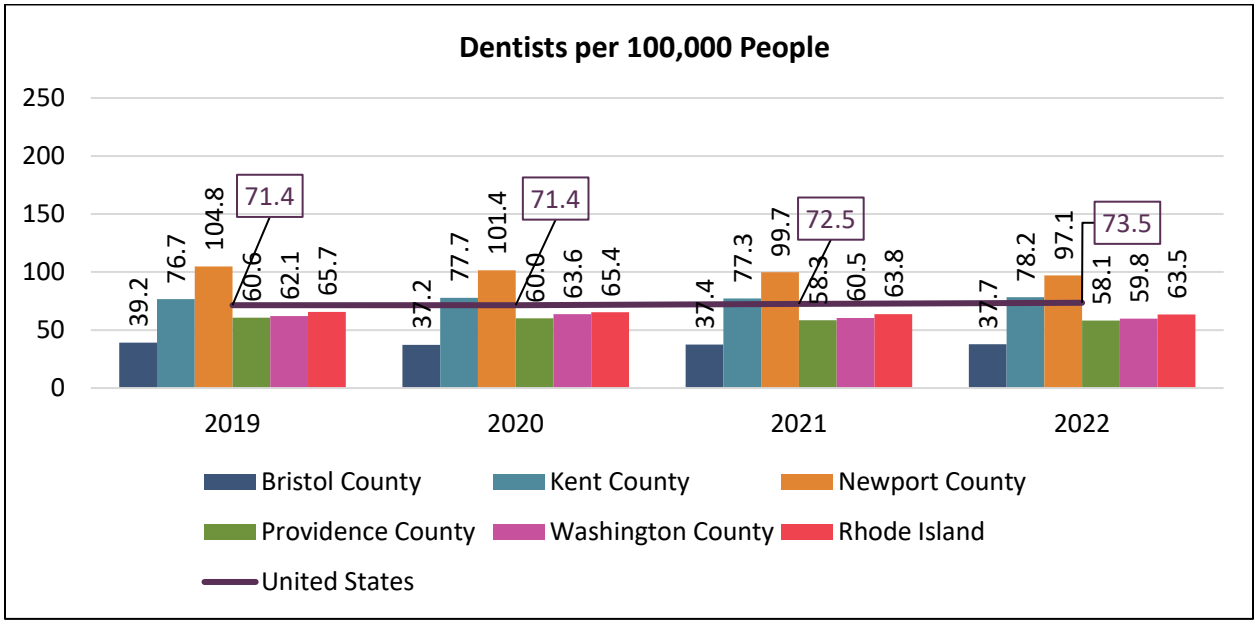
Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services

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

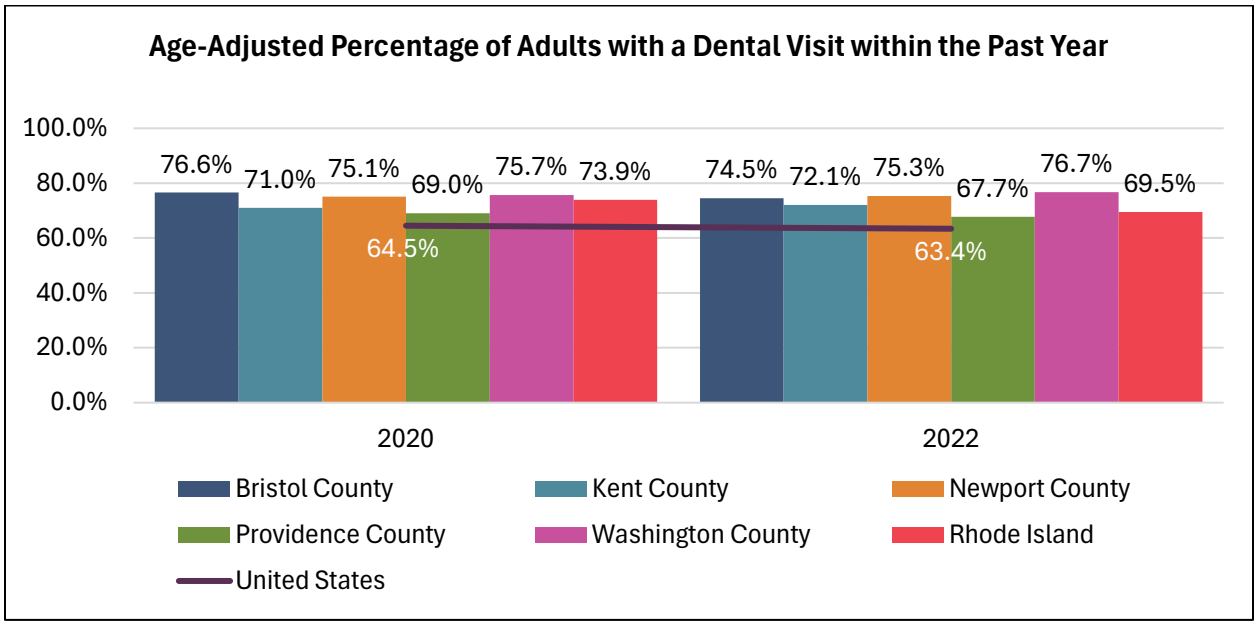
Primary Care Strengths and Challenges in Rhode Island (as reported by OHIC)

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

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



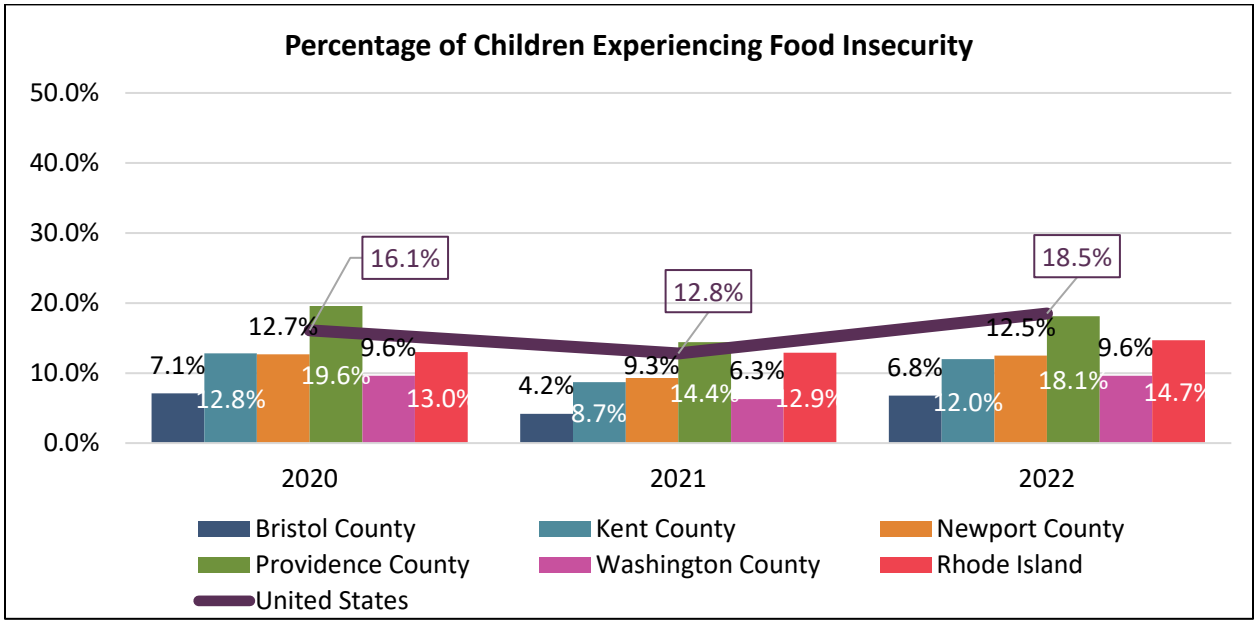
Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services



Source: Centers for Disease Control and Prevention

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

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



Source: Feeding America

Childcare Availability and Affordability

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

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

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

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

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

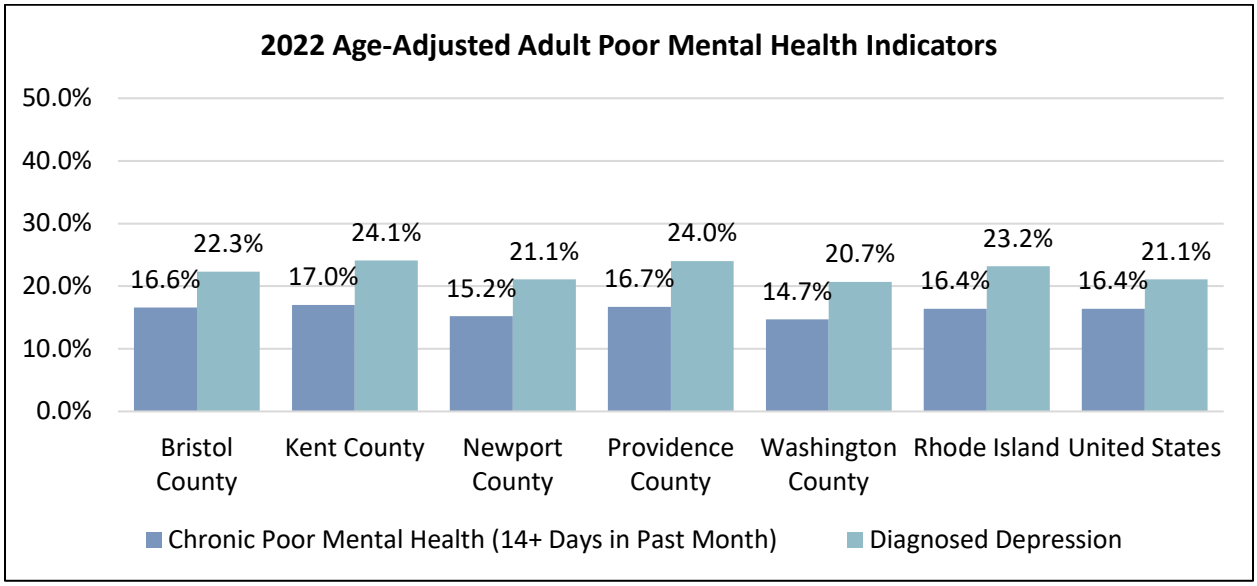
Key stakeholders recognized that groups who have been historically marginalized were more likely to experience health disparities. These underserved communities—including those that identify as people of color and/or people with disabilities—are more likely to face economic insecurity and have cultural and language barriers.

Stakeholders underscored the importance of staff and provider training in cultural competency and humility and increased health education materials that reflect the language and culture of communities. They also advocated for the presence of people with lived experience in developing community solutions.

> *"[They] keep cancelling appointments due to not enough interpreters available, or the doctor office didn't call until last minute."*
>
> *"The top health concerns for the Deaf community include limited access to healthcare services that are linguistically and culturally competent, with providers fluent in ASL or supported by qualified interpreters."*
>
> *"There are system and structural barriers that prevent certain populations from accessing the care they need and resources to live a comfortable life. We need to work together to identify these barriers and make changes."*

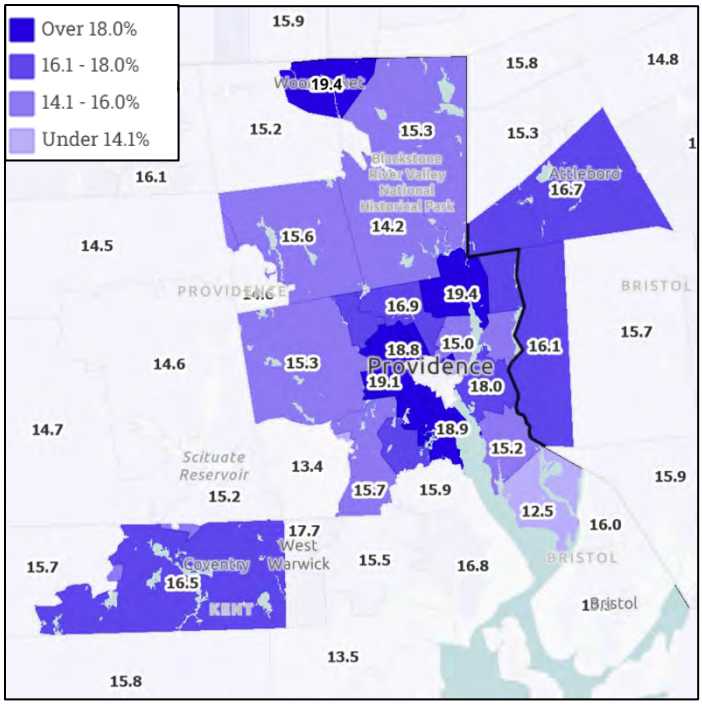
Behavioral Health

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



Source: Centers for Disease Control and Prevention

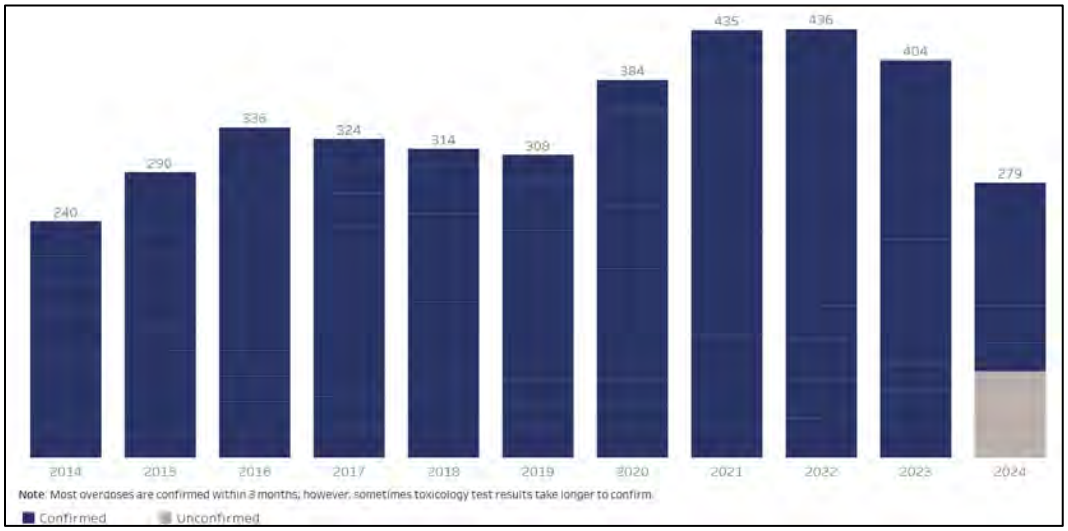
2022 Adults with Chronic Poor Mental Health by Zip Code



Source: Centers for Disease Control and Prevention

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

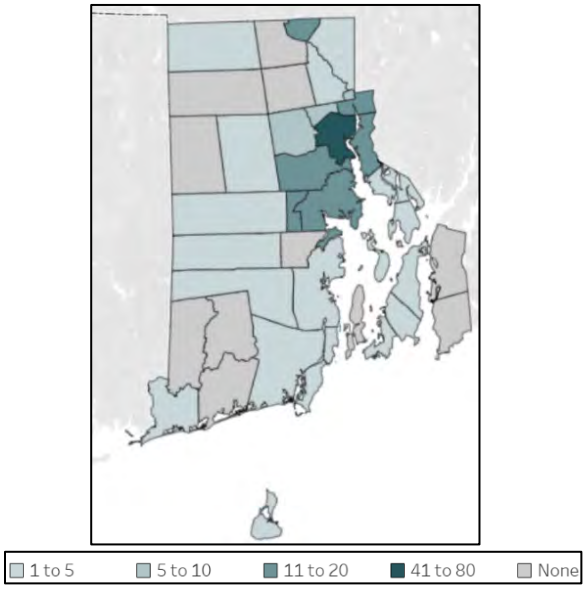
Rhode Island State Number of Drug Overdose-Related Deaths, 2014-2024



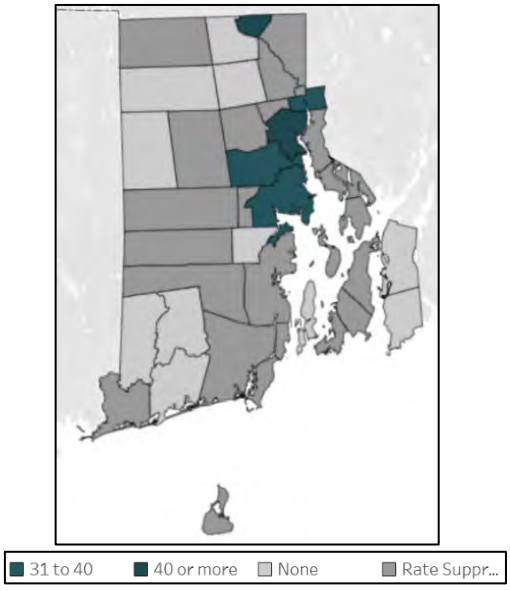
Source: Prevent Overdose RI

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

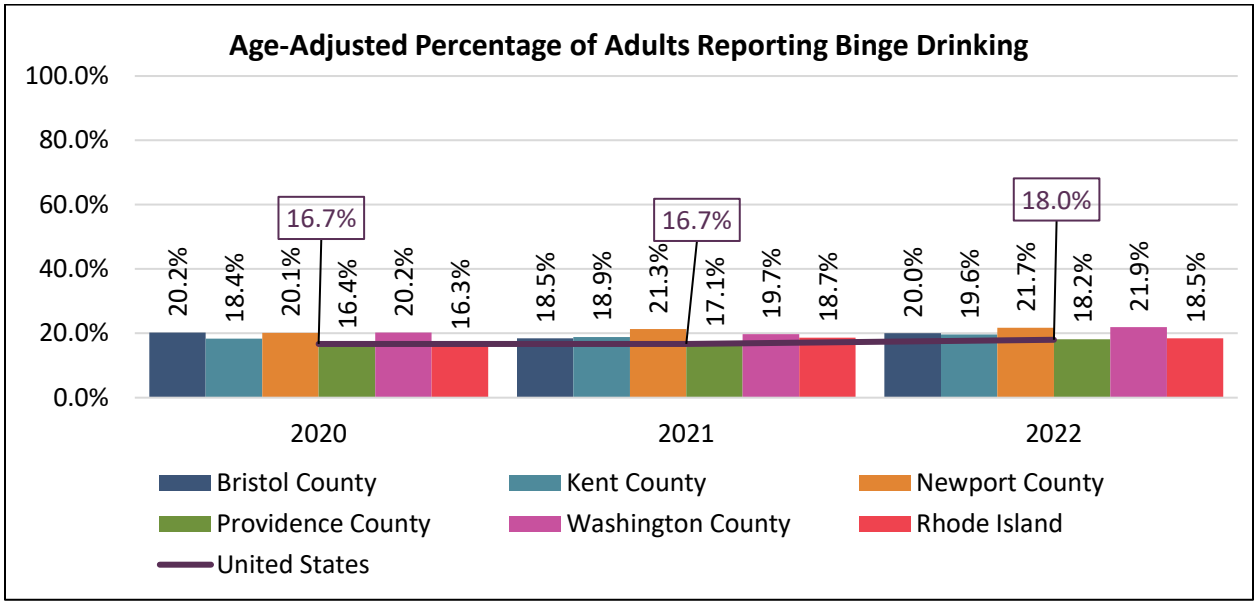
2024 Overdose Deaths by City/Town (counts)



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

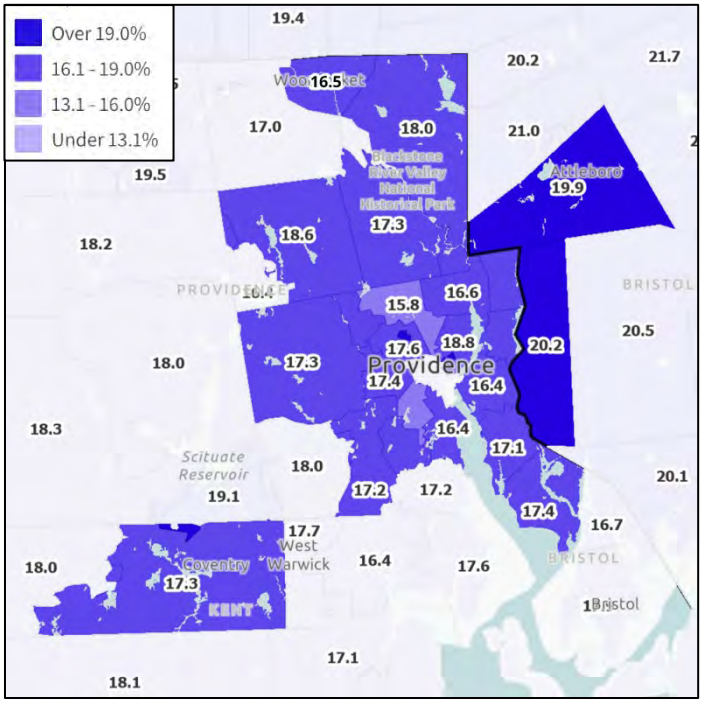


Alcohol use disorder is a growing concern nationally and for Rhode Island residents. Nearly 1 in 5 Rhode Island adults reported excessive alcohol use, with recent increases in all counties except Bristol. Zip code-level analysis shows that excessive alcohol use is prevalent across communities.



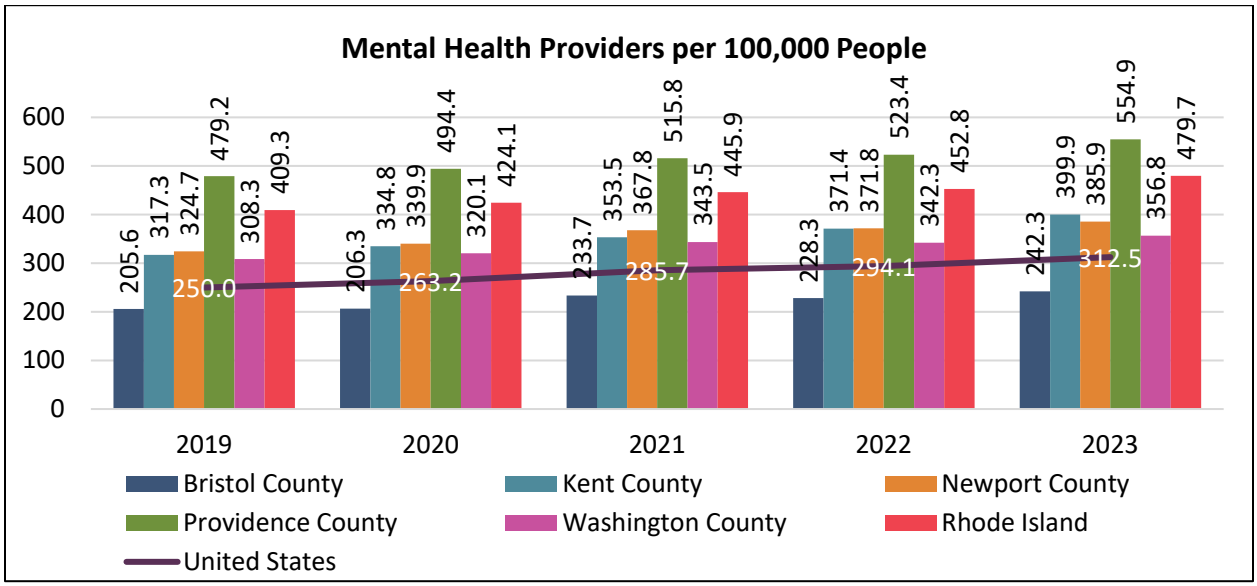
Source: Centers for Disease Control and Prevention

2022 Adults who Self-Report Binge Drinking by Zip Code



Source: Centers for Disease Control and Prevention

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



Source: Centers for Medicare and Medicaid Services

*Mental health providers include those specializing in psychiatry, psychology, mental health, addiction or substance use disorders, or counselling.

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

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

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

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

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

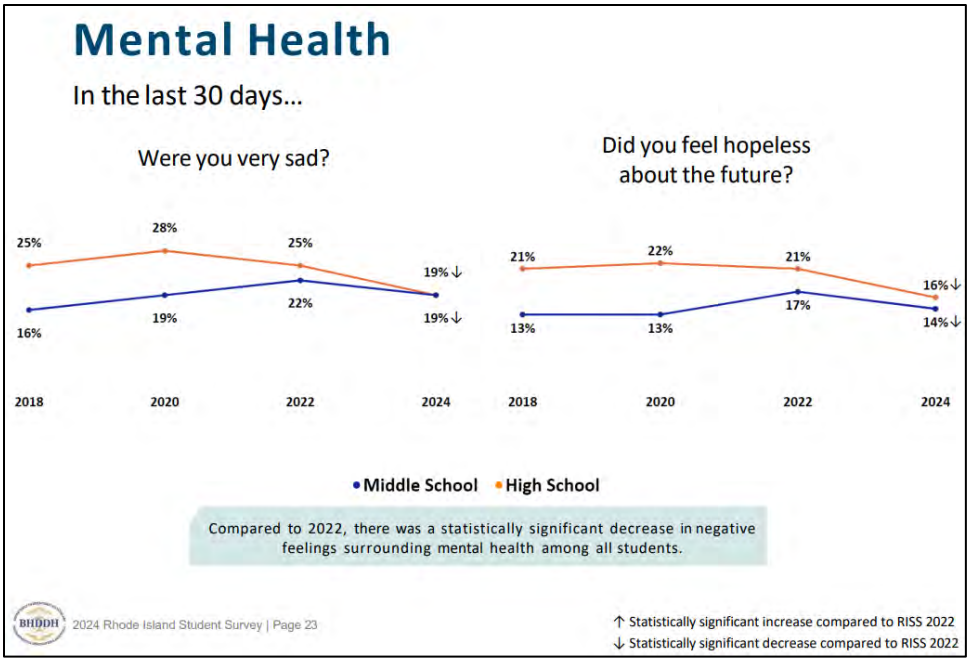
> *"The community's concern is that they will be stigmatized because of use, they will not be supported in safe use, or that they will not be supported in the 50th attempt to cut down."*
>
> *"[There is] stigma surrounding alcoholism and dependence - social expectation in the area is to drink, not abstain."*

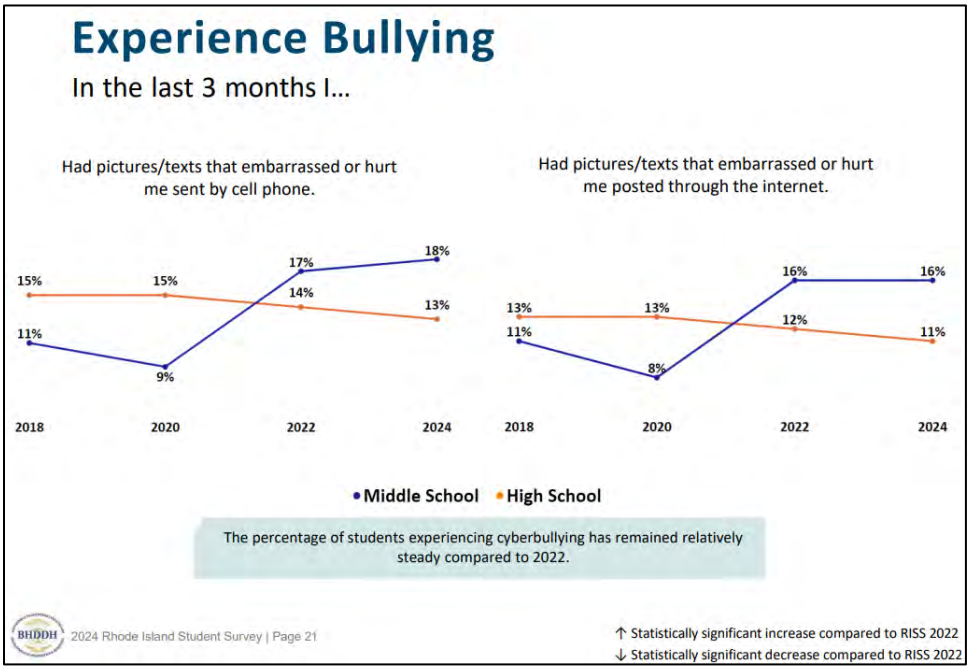
Health and human service professionals noted an increase in mental health and substance use concerns among youth, often rooted in adverse childhood experiences (ACEs) like living in poverty and exposure to violence. Isolation and developmental delays from the COVID-19 pandemic also have had lingering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

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

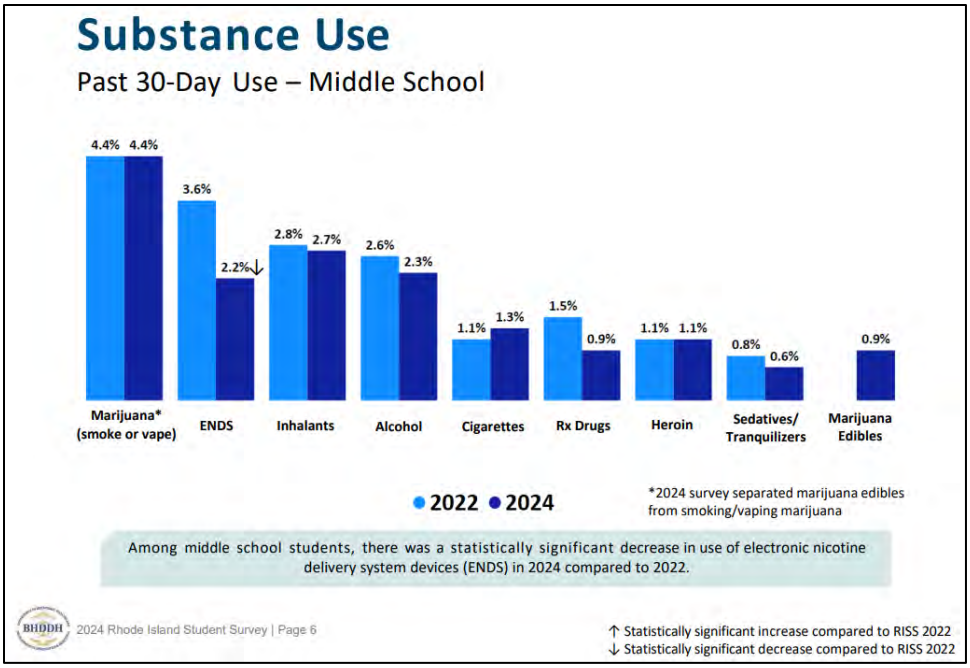
> *"The legalization of marijuana [during] COVID caused increases to an already growing problem that lacked resources. Specifically, we have many addicted students that need in-patient or intense treatment."*
>
> *"Treatment options for youth (12-18 y.o.) need to be identified and shored up. While the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

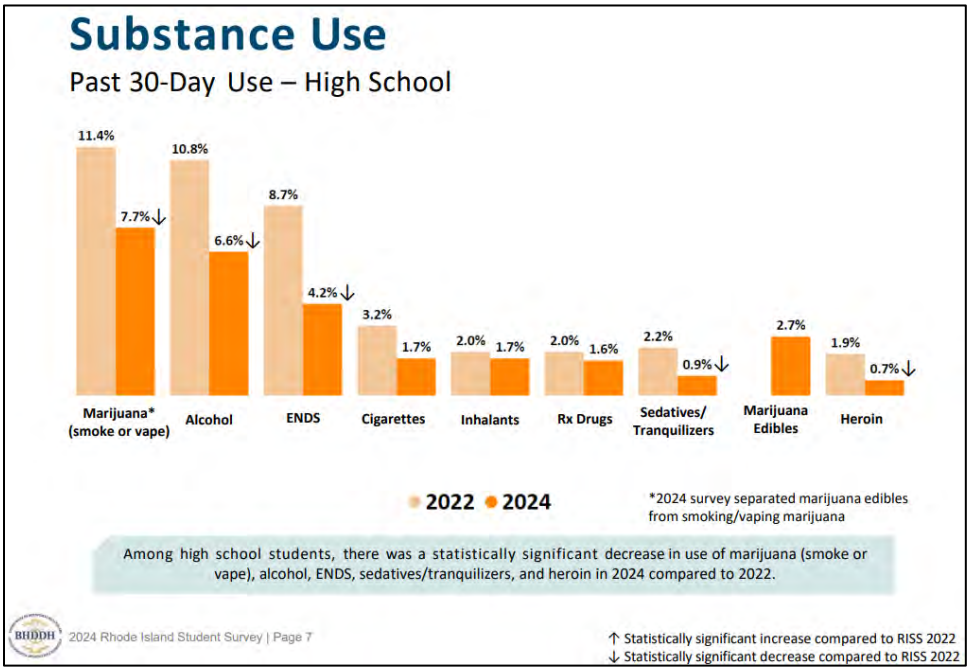
The Rhode Island Student Survey is a statewide survey administered every other year and examines the risk and prevalence of substance use, bullying, depression, suicide, and violence among Rhode Island youth in middle (MS) and high (HS) schools. The most recent survey administered in 2024 found significant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





Source: Rhode Island Student Survey





Source: Rhode Island Student Survey

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

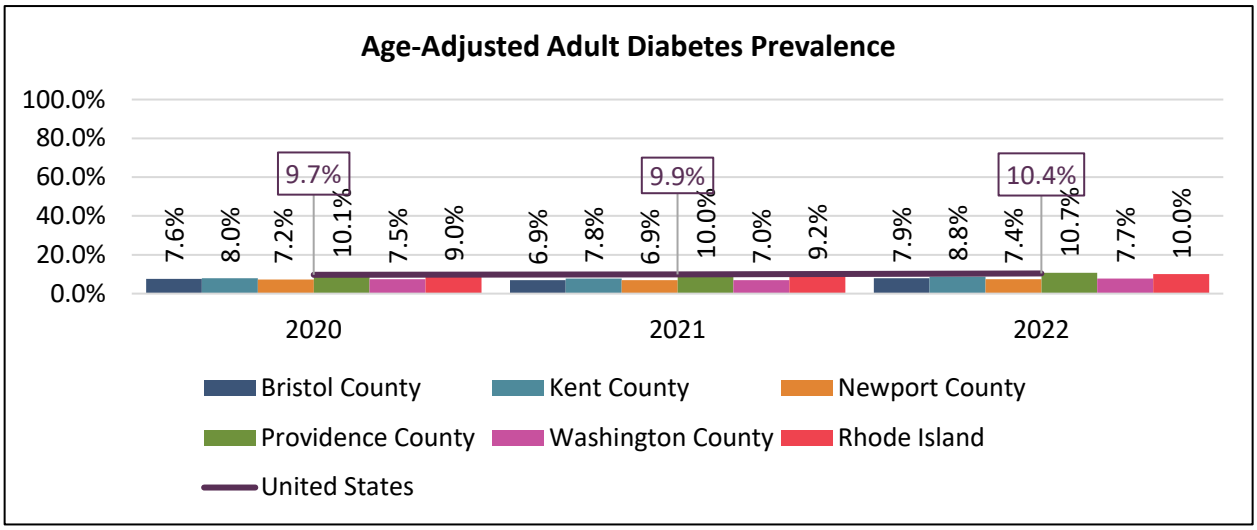
Concerted efforts to address increasing behavioral health needs have led to progress in improving community awareness and access to services. Health and human service professionals named the following successes within Rhode Island:

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

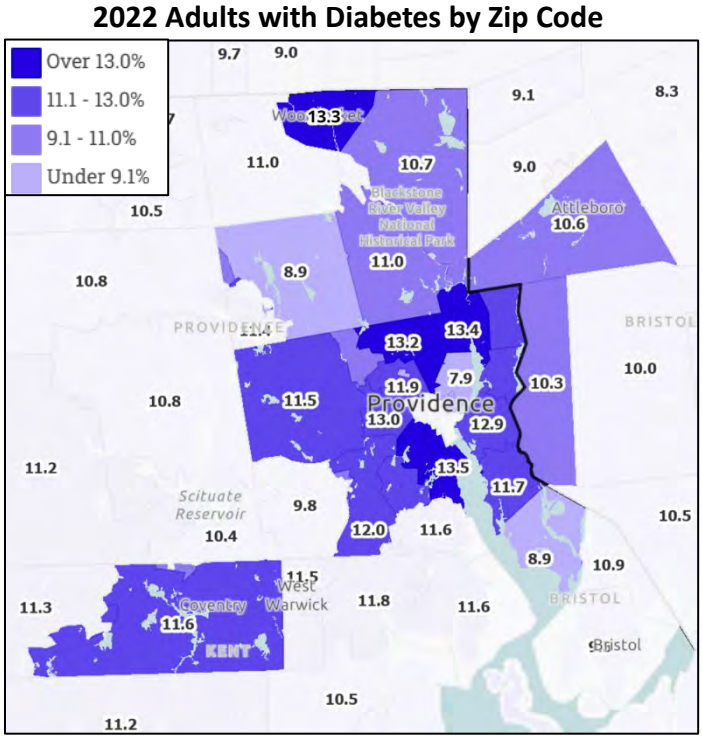
Chronic Diseases: Leading Causes of Death and Disease

The following section focuses on the leading causes of disease burden and death, and management and prevention efforts.

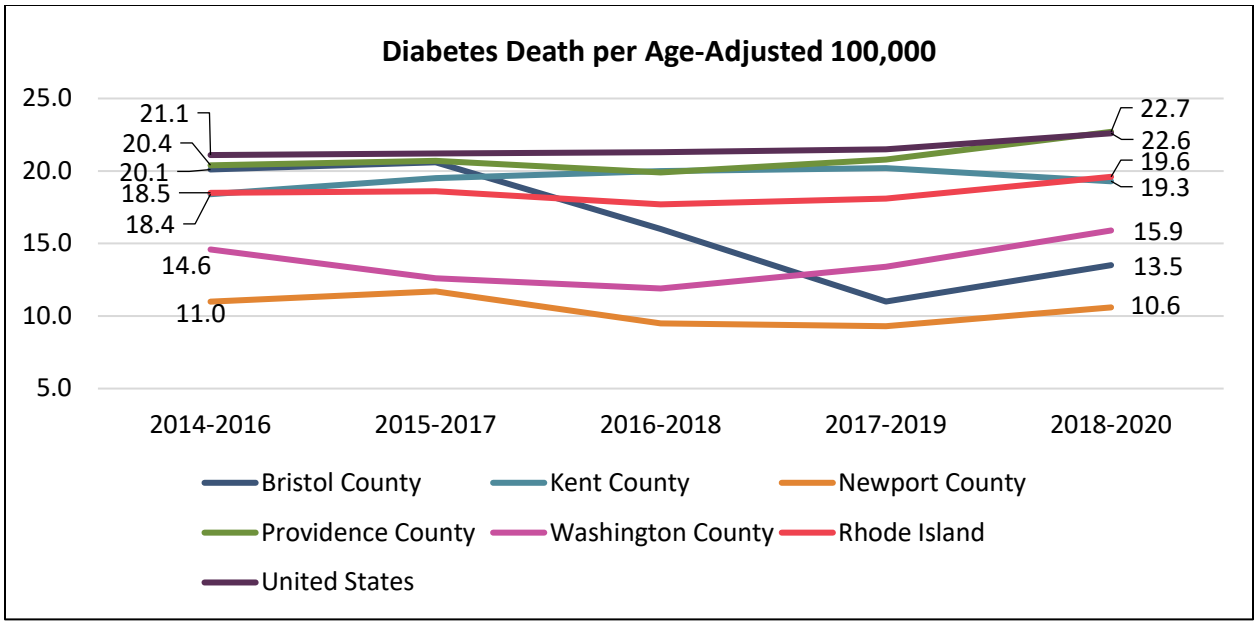
Diabetes and heart disease are among the top causes of death for residents in Rhode Island. The proportion of adults in Rhode Island that are diagnosed with diabetes has increased since 2020 to approximately 1 in 10 adults. More than one-quarter of adults have high blood pressure and/or high cholesterol.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



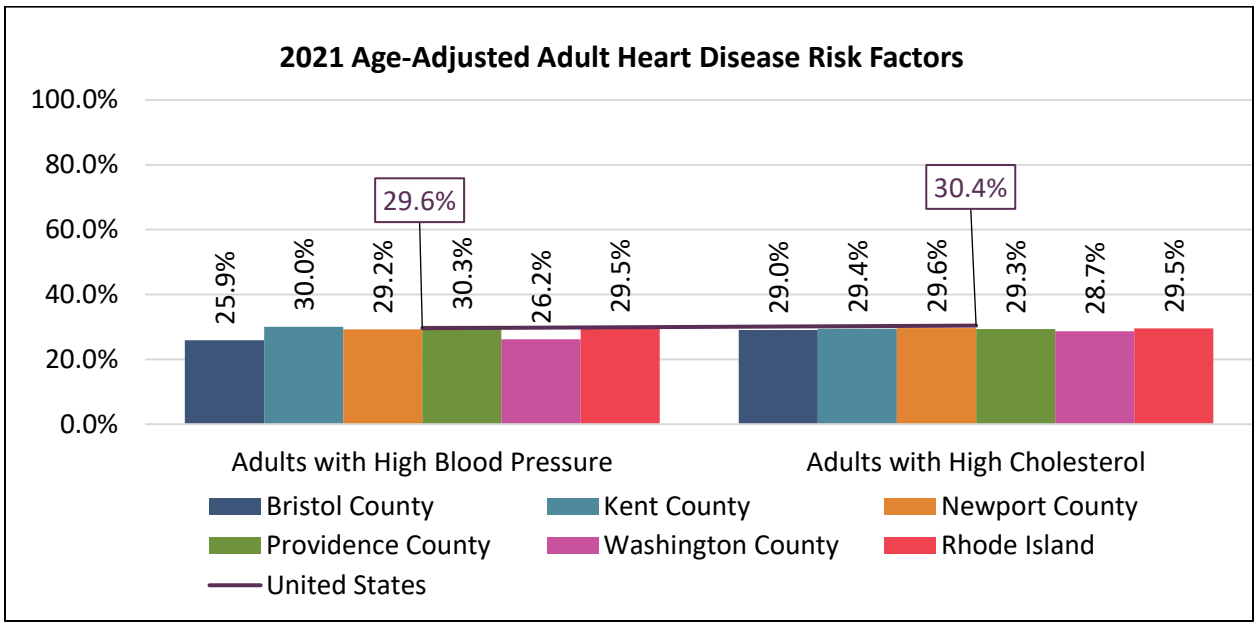
Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

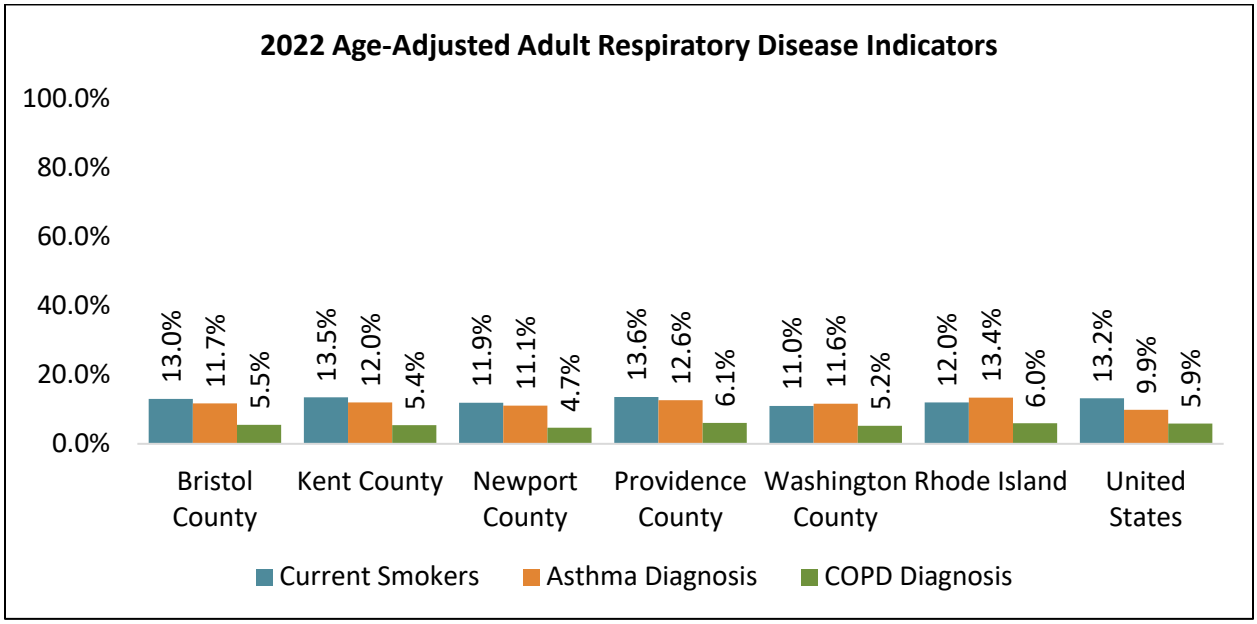


Source: Centers for Disease Control and Prevention



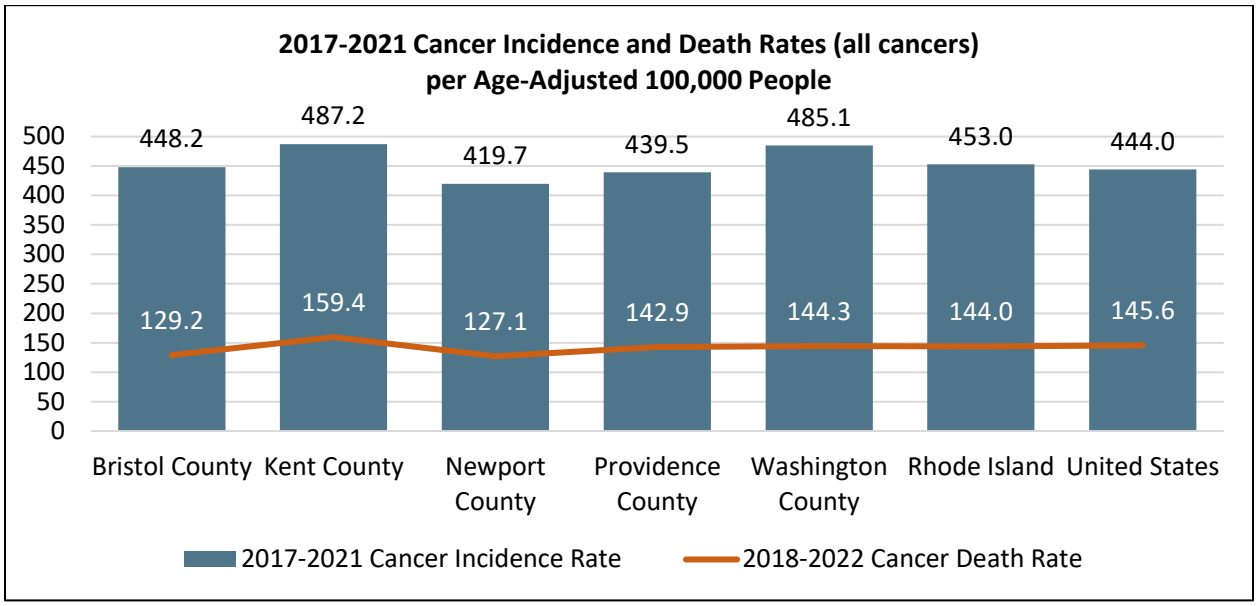
Source: Centers for Disease Control and Prevention

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



Source: Centers for Disease Control and Prevention

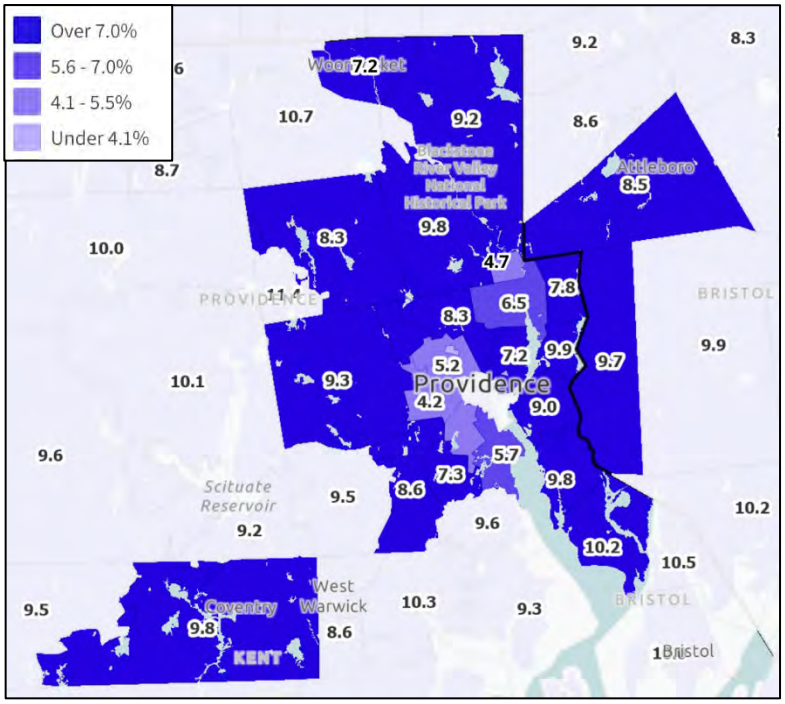
Rhode Island as a whole has similar incidence and death rates due to cancer as the nation, but experiences vary across the state with higher reported death rates in Kent and Providence counties. Across The Miriam Hospital's service area zip codes, approximately 1 in 10 adults have been diagnosed with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



Source: Centers for Disease Control and Prevention

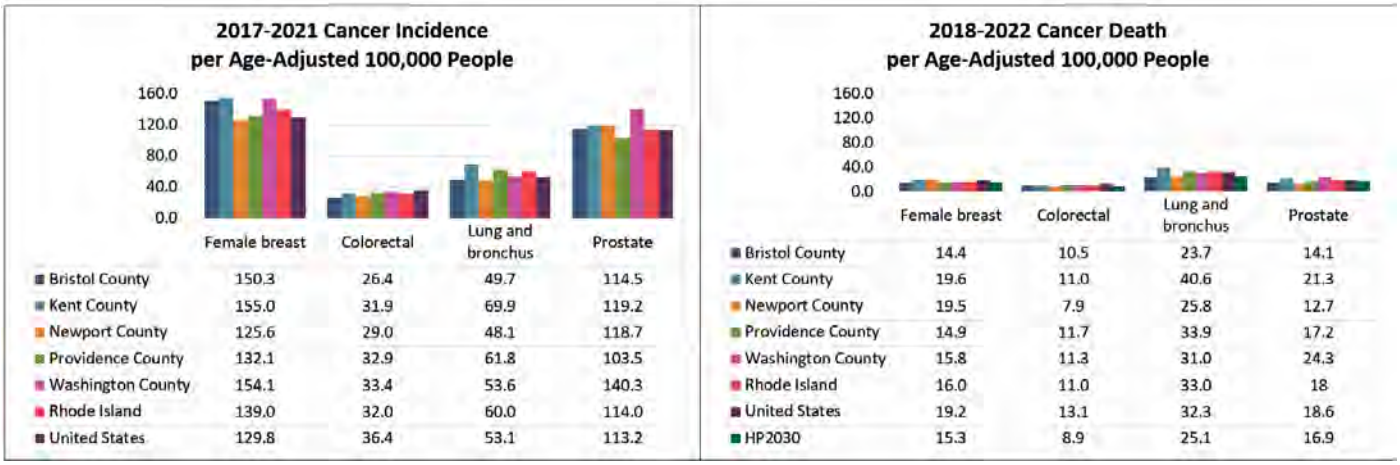
*Cancer incidence data lag and are reported for most recent years available.

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



Source: Centers for Disease Control and Prevention

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



Source: Centers for Disease Control and Prevention

Note: Years reported differ for incidence and death rate; data are reported for most recent years available.

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

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

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

Recommendations to improve chronic disease healthcare and outcomes:

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

Housing

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

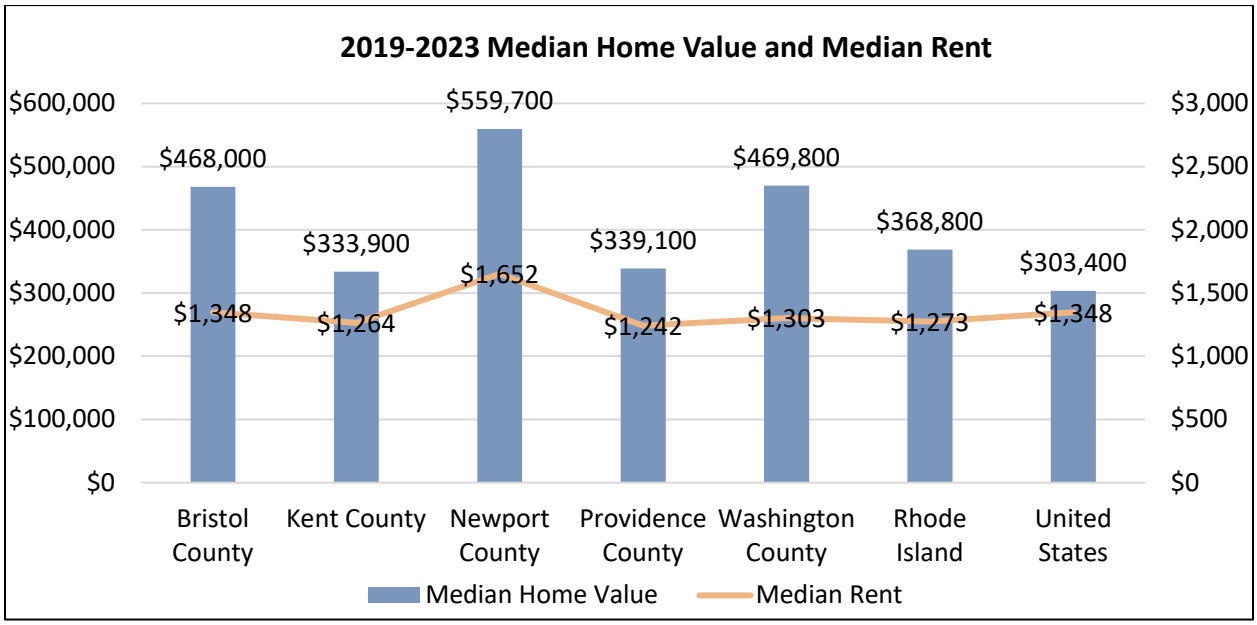
> *"The prevalence of economic disparity between those with much and those with not enough is growing greater every day. […] Ironically, some of the housing scarcity comes from the development of more arts and related businesses in the downtown area which has come at the expense of what used to be affordable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

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

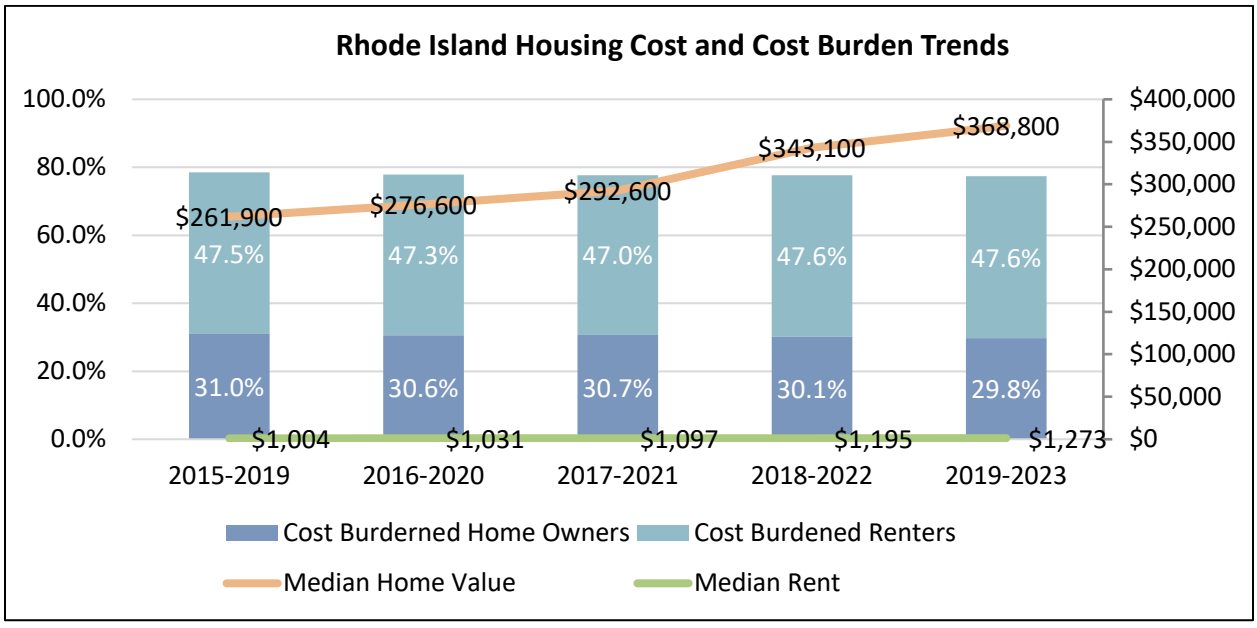
> *"They don't think they're serving their own community."*
>
> *"What if we said each town will build 250 units and 75% of them will be filled by people from the area?"*
>
> *"We have been having these conversations for years now."*

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

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



Source: US Census Bureau, American Community Survey

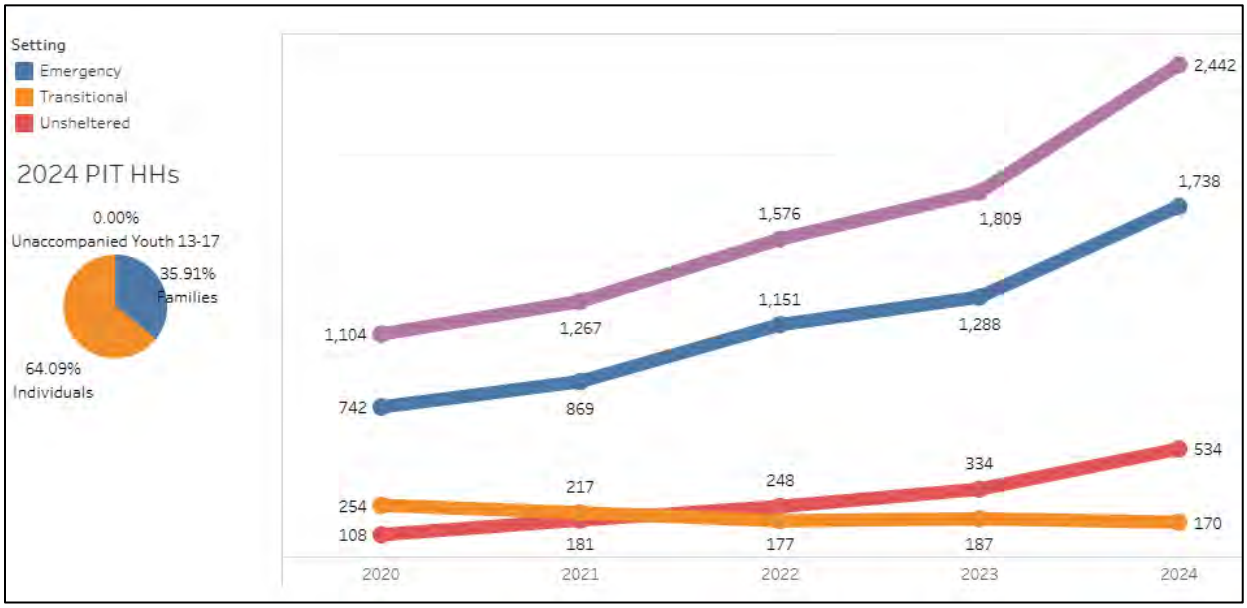


Source: US Census Bureau, American Community Survey

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

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

Five-Year Trends in Rhode Islanders Experiencing Homelessness



Source: The Rhode Island Coalition to End Homelessness

Health and human service professionals identified the following recommendations to improve housing:

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

Maternal and Child Health

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

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

2018-2022 Maternal and Infant Health Indicators

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

Source: Rhode Island KIDS COUNT Factbook

Pregnancy and birth disparities are evident in Providence County and largely experienced by people living in the core cities. While the teen birth rate for the core cities declined at a similar rate as the state overall, it remains more than three times higher than the remainder of the state. The proportion of people residing in the core cities and receiving early prenatal care improved from the 2022 CHNA (79.5% to 80.4%), but preterm and low birth weight births are persistently high. The core cities saw improvement in the proportion of people breastfeeding at time of birth from the 2022 CHNA (63% to 68%).

2018-2022 Maternal and Infant Health Indicators for Core Cities

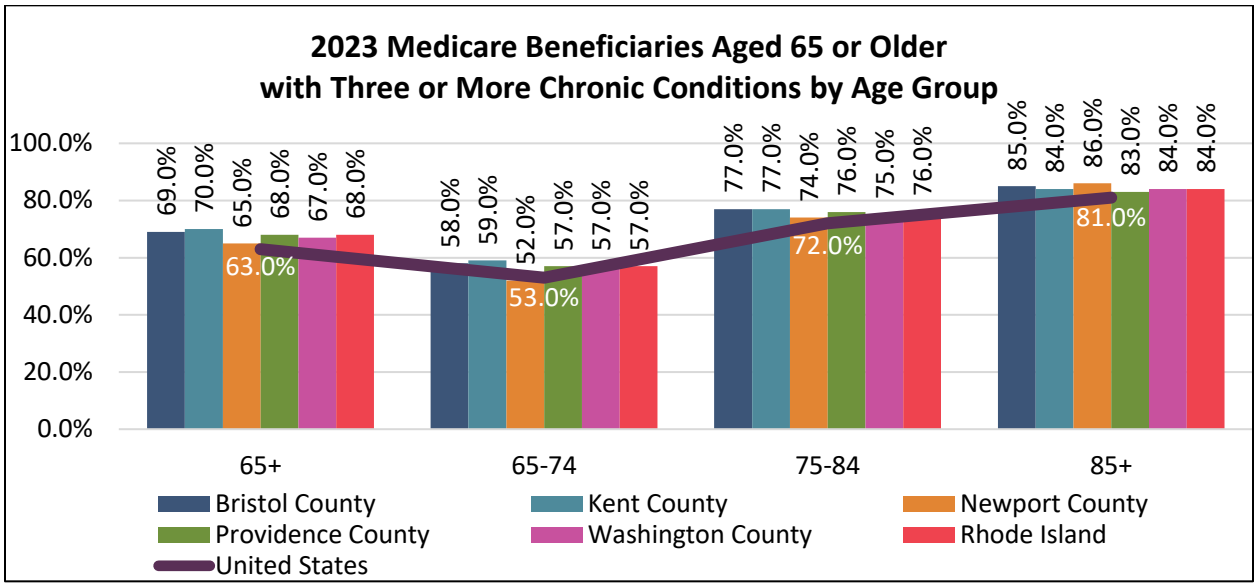
	Teen Birth Rate (per 1,000 Ages 15-19)	First Trimester Prenatal Care	Preterm Births	Low Birth Weight Births	Breastfeeding at Time of Birth
Central Falls	21.3	77.9%	11.8%	8.3%	67.0%
Pawtucket	19.0	81.9%	9.9%	9.2%	70.0%
Providence	15.5	79.9%	10.1%	8.8%	68.0%
Woonsocket	25.5	81.9%	10.3%	8.8%	66.0%
Four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

Source: Rhode Island KIDS COUNT Factbook

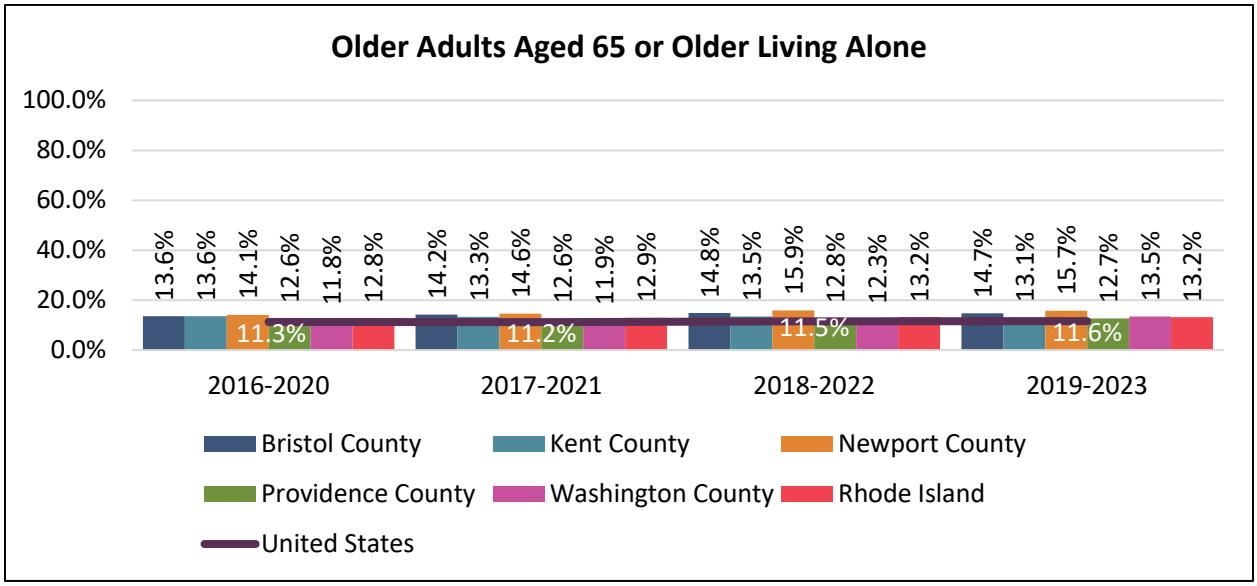
Older Adult Health and Wellbeing

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

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



Source: Centers for Medicare and Medicaid Services

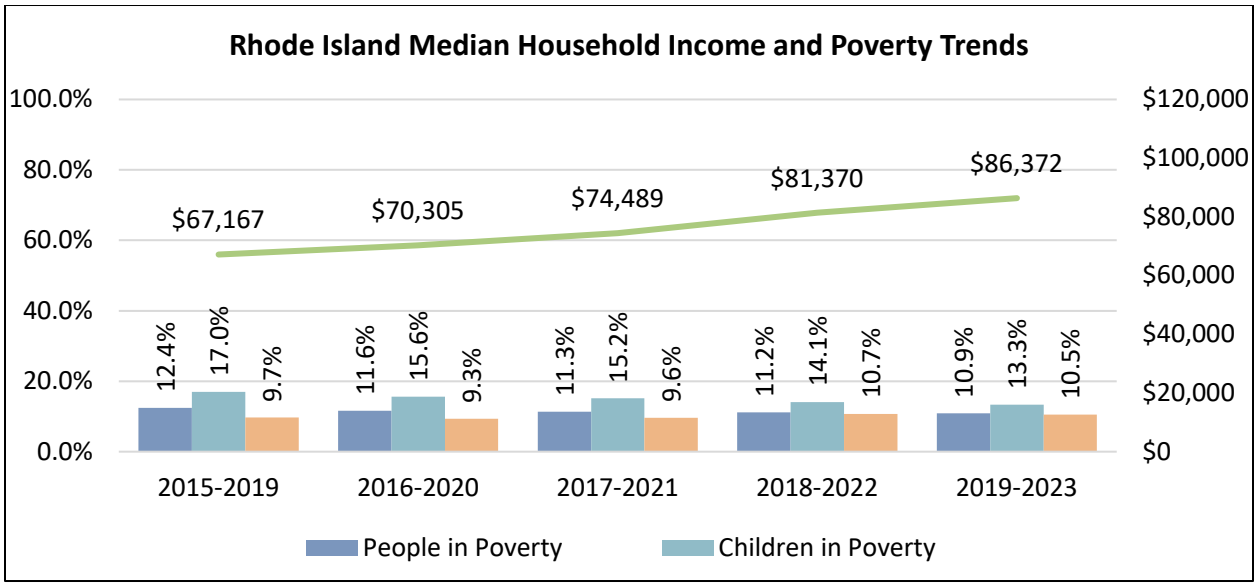


Source: US Census Bureau, American Community Survey

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

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

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



Source: US Census Bureau, American Community Survey

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

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

Our Response to The Community's Needs

In 2022, Brown University Health and The Miriam Hospital (TMH) conducted a similar CHNA and developed a supporting three-year Community Health Improvement Plan. Based on the CHNA findings, TMH leadership identified six priority areas:

- Access to Healthcare Services
- Chronic Disease Management
- Mental and Behavioral Health Services for Patients and Caregivers
- Grow and Diversify the Workforce
- Community-based Access to Health Information
- Navigation Supports in Hospital and Community Settings

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

Key Accomplishments: Access to Healthcare Services

- Provided transportation assistance to medical appointments; RoundTrip ride scheduling is available to all departments through LifeChart.
- Added Community Health Workers (CHWs) in key service lines to improve continuity of care and availability.
    - Between FY2023 and FY2024, 10 CHW positions were hired at TMH, including within Social Work and Emergency Department sectors.
- Offered free skin cancer screenings at diverse locations:
    - FY2023 - Two new skin cancer screening sites/partners added - Women in Agriculture Conference (19 screened) and RI Pride (49 screened).
    - FY2024 - Six (6) Skin Check Screenings held with 385 people served.
- Offered blood pressure and glucose screenings to 3,380 people in community settings between FY2023 and FY2024 through a total of 230 screening events.
- Held 76 flu clinics and vaccinated 1,243 people between FY2023 and FY2024.
- Hospital Operations led the effort to create a PowerBI dashboard to track key hospital metrics for emergency department flow and wait times and overall patient experience in real time.
    - Emergency department improvements from September 2023 to October 2024:
        - Median door to doctor wait time decreased from 121 minutes to 57 minutes
        - Active care time increased from 187 to 194 minutes
        - Disposition to departure was stable (28 to 27 minutes)
    - Patient experience Net Promoter Score is tracked monthly and identified five focus areas with providers: transparency, education, improvement, research, and recognition.

Key Accomplishments: Chronic Disease Management

- Offered annual breast and cervical cancer screening for uninsured and low-income residents with 101 women screened in FY2023 and FY2024.
- Explored enhanced referral mapping to streamline referrals from primary care providers to specialty care services, ensuring referrals reach the department and are acted on in a timely manner.
- Opened advanced cardiac care center (January 2023) and advanced heart failure clinical spaces in East Providence and at RIH main campus in order to serve more patients.
- Partnered with HopeHealth in FY2023 to integrate palliative care early in the care of cardiac patients; a vendor for future care needs is being assessed.
- Assessed social determinants of health among patients in the Heart Failure clinic:
    - Partnered with Connect for Health program to refer up to five patients at a time from the Hearts at Home program for social needs supports.
    - Completed referrals to Mom's Meals, paid for by CMS, for disease-specific diets.
- Launched smoking cessation and Dean Ornish weight loss programs at cardiac rehabilitation.

Key Accomplishments: Mental and Behavioral Health Services for Patients and Caregivers

- Offered community Mental Health First Aid (MHFA) training:
    - The Bradley MHFA team taught a total of 88 classes (44 adult, 40 youth, and 4 teen) between FY2023 and FY2024.
    - A total of 1,210 Mental Health First Aiders were trained: 672 in adult, 491 in youth, and 47 in teen.
- Worked with the addiction medicine team at RIH on prevention and outreach to reduce racial and ethnic differences in overdose rates and fatalities:
    - The Addiction Care Today (ACT) clinic opened at RIH in March of 2024 and provides urgent substance use disorder treatment, including medications, on a walk-in basis:
        - ACT's mission is to ensure high-quality, evidence-based addiction care is easy to access for everyone. The clinic accepts all patients, no matter what substances they use and whether their goal is to stop drug use, decrease use, or to use more safely.
        - Since opening, ACT has provided care to pregnant women, adolescents, patients who are unhoused, patients who have moved from out of state, and patients who do not meet requirements for other addiction treatment programs in the state.
- Adopted NRC Survey as a tool to measure patient experiences in psychiatric services.
- Recruited a new provider at the Transitions Clinic and Recovery Clinic at RIH to increase access and better manage addiction disorders among the adult population transitioning out of incarceration. The Center for Health and Justice Transformation was awarded the medical discharge planning contract from the RI Department of Corrections.

- Contributed research and policy leadership to statewide initiatives to reduce opioid overdose and fatality rates:
    - The VP of Community Health & Equity continued to serve as Chair of the statewide Opioid Settlement Advisory Committee.
    - Drs. Jody Rich and Tracy Greene continued to lead the Center of Biomedical Research Excellence on Opioids and Overdose (COBRE) at RIH, the first of its kind center in the nation to focus on collaboratively addressing the opioid epidemic. In FY23, the COBRE received a second, five-year grant award of $12 million from the National Institute of General Medical Sciences to cultivate skilled researchers who specialize in opioid use disorders.
    - Brown University Health) leads the nation in correctional health research; we host multiple NIH-funded grants, including the largest NIH R25 educational research program dedicated to this topic: the "Collaborative Justice-Involved Research and Training Program on Substance Use and HIV at Brown University Health."
- Participated on the Governor's Overdose Task Force and Opioid Settlement Advisory Committee, which allocated $30.3 million between FY2023 and FY2024 for family- and community-based strategies that address social drivers of health, prevention, harm reduction, treatment, and recovery.

Key Accomplishments: Grow and Diversify the Workforce

- Added Community Health Workers (CHWs) in key service lines to improve continuity of care and availability.
    - Between FY2023 and FY2024, 10 CHW positions were hired at TMH, including within Social Work and Emergency Department sectors.
- Created opportunities for employees to participate in community health improvement activities by inviting TMH employees to participate in Team Brown Health volunteerism and to volunteer directly with the Community Health Institute through intranet promotions.
- Provided job shadow and mentoring opportunities to primary and secondary school youth in the service area:
    - Five Brown University Health volunteers offered half hour reading and mentoring Power Lunch sessions to 11 students weekly at the Martin Luther King Jr. Elementary School.
    - Initiated planning process to develop Job Shadow Day at Martin Luther King Jr. Elementary School in Providence.
    - Students from 3 area high schools participated in the Brown University Community Institute Health Mentoring Program that matched students 1:1 with mentors to provide academic reinforcement, professional exposure, and social support.
- In FY2023, 59 students were onboarded as interns at TMH.

Key Accomplishments: Community-Based Access to Health Information

- Delivered healthy living and healthy eating programs in community settings in FY2023 and FY2024:
    - Monthly Community Health Ambassador workshops delivered to 565 participants; topics generated by community partners.
    - 20 conferences and workshops on topics requested by the community delivered to 605 participants.
    - 1,449 people participated in food demonstrations, Food is Medicine, A Taste of African Heritage, and food and nutrition education programs.
- Offered 32 hands-only CPR classes with 282 participants trained.
- Offered the Diabetes Prevention Program with seven cohorts and 116 people enrolled in FY2023 and FY2024.
- Provided Tar Wars programming for youth with 11 sessions held with 465 students in FY2023 and FY2024.
- Provided 68 Safe Sitter classes with 638 students in FY2023 and FY2024.

Key Accomplishments: Navigation Supports in Hospital and Community Settings

- Implemented a LifeChart alert for patients with qualifying criteria for a community health referral.
- Explored patient experience strategies including creating and posting FAQs and resources on the website for patients and caregivers to prepare for hospital care and discharge (planned for FY2025).
- Explored expansion of Connect for Heath to the adult primary care clinic (planned for FY2025).
- Renewed contract with Unite Us in FY2024, offering patient referrals to community-based services and supports. Unite Us onboarded users from TMH Social Work and Emergency Department.

Next Steps and Board Approval

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

Following approval from the Brown University Health Board of Directors, the CHNA report will be posted for public review on our website at https://www.brownhealth.org/centers-services/community-health-institute/reports-and-resources .

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

We value your input on our CHNA and the subsequent Community Health Improvement Plan. To contact us, please visit our website or contact Carrie Bridges, Vice President for Community Health at cbridges@brownhealth.org or 401-444-8009.

Appendix A: Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

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

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

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

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

Appendix C: Partner Forum Participants

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

Warwick Partner Forum

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

Washington County Partner Forum

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

Woonsocket Partner Forum

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