City of Providence – Healthy Communities Office

2020 Providence Public School District School Health Needs Assessment

June 2020

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Contents

Introduction

Providence Healthy Communities Office

Improving Health of Providence Residents Through
POLICY I PROMOTION I PREVENTION I ADVOCACY

The Healthy Communities Office (HCO) is the City's lead agency for health policy, health promotion, and substance abuse prevention, with significant focus on youth, families, and health equity. The HCO works to ensure that Providence residents have equitable access to the resources they need to lead healthy lives.

The year 2020 marks the eighth year since the HCO was established. Our growth during this time has allowed us to position the City of Providence as a leader in public health policy, systems, and environmental changes. Providence is recognized locally, regionally, and nationally for our chronic-disease prevention efforts, particularly around tobacco, nutrition, agriculture, and physical activity. We look forward to continuing this work in years to come.

A primary function of the HCO is to support the Providence Public School District (PPSD) to implement the School Wellness Policy, create opportunities for healthy, positive behaviors, and promote a healthy and equitable school environment for all students. In 2020, the HCO initiated a School Health Needs Assessment for the PPSD with the goal of determining health and support service needs among students and to inform the development of a more coordinated, efficient, and effective system for addressing student health. The findings of the assessment will be used to guide key priorities, funding, and other opportunities for the HCO. The assessment will also serve as a community resource for grant-making and advocacy, and to support the many programs provided by our community health and social service partners.

We encourage you to visit providenceri.gov/healthy-communities to learn more about HCO's work to improve the health of our community. Questions or comments about the School Health needs Assessment can be directed to Ellen Cynar, Office Director, ecynar@providenceri.gov.

Providence Public School District

The Providence Public School District (PPSD) serves nearly 24,000 students across 41 schools, including 22 elementary schools, seven middle schools, 10 high schools, and two public district charter schools. Of the more than 3,200 professionals who work in PPSD, approximately 2,000 are educators and more than 600 others directly support students and families in schools.

	Enrollment by Grade Level
Preschool	334
Elementary	10,452
Middle	5,605
High	7,445
Total	23,955

Source: Rhode Island Department of Education, October 1, 2019

Providence Public Schools are diverse learning communities with 67% of students identifying as Latinx and 16% of students identifying as Black/African American. Approximately 29% of students are multilingual learners. Combined, PPSD students and families speak 55 different languages and hail from 91 countries of origin.

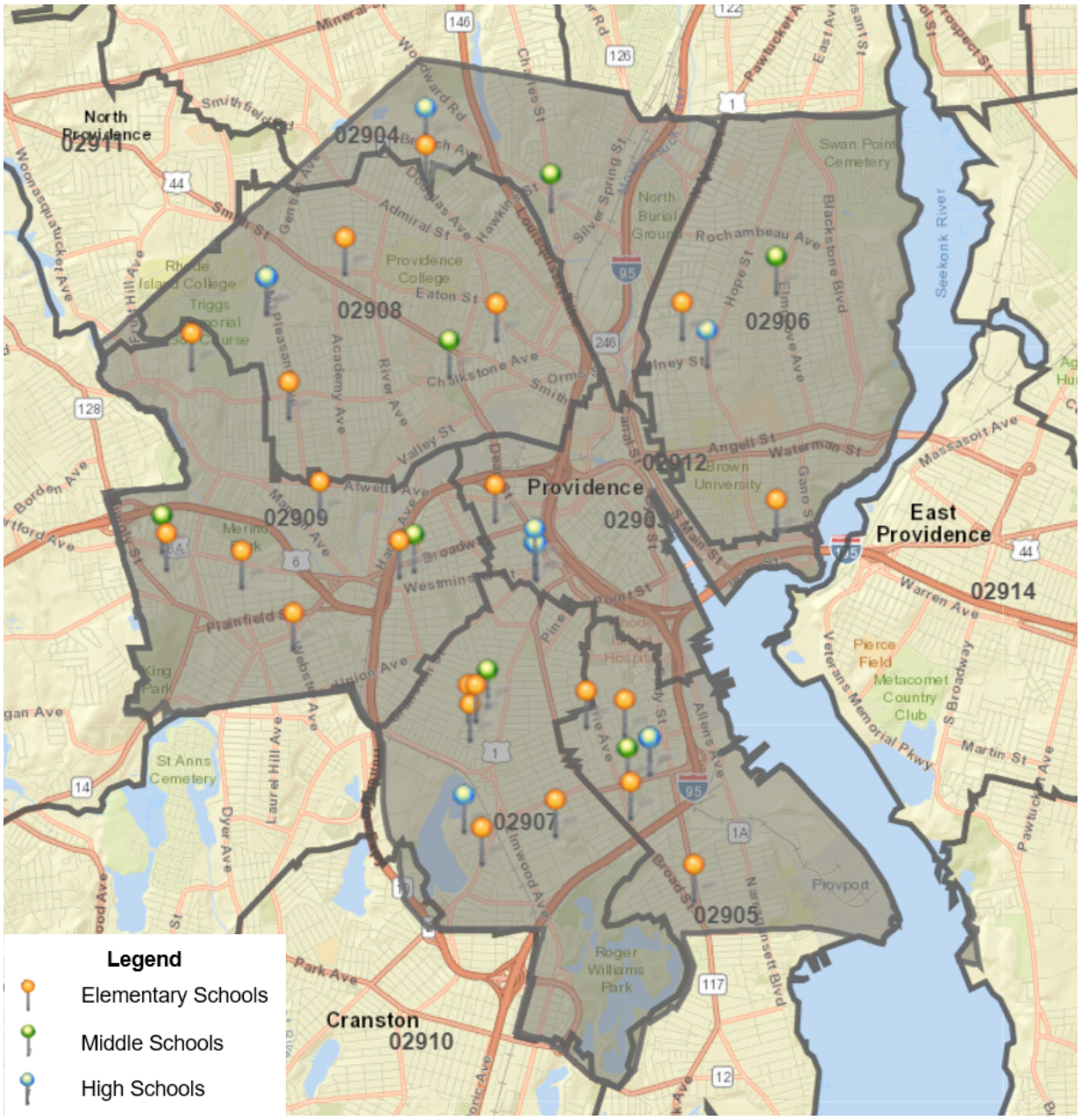
The following table depicts PPSD enrollment by race and ethnicity compared to enrollment across Rhode Island and the four core cities. The core cities include Central Falls, Pawtucket, Providence, and Woonsocket in Providence County. Residents of the core cities generally experience greater economic distress and potential for health inequity than residents in other communities, including cyclical poverty, trauma, and higher disease morbidity. Benchmark comparisons for the core cities are provided as available throughout the report.

Enrollment by Race and Ethnicity

	PPSD	Four Core Cities	Remainder of State	Rhode Island
White	8%	19%	76%	55%
Black/African American	16%	18%	4%	9%
Native American	1%	1%	1%	1%
Asian/Pacific Islander	4%	3%	4%	3%
Multiracial	4%	5%	5%	5%
Hispanic/Latinx	67%	53%	12%	27%

Source: Rhode Island Department of Education, October 1, 2019

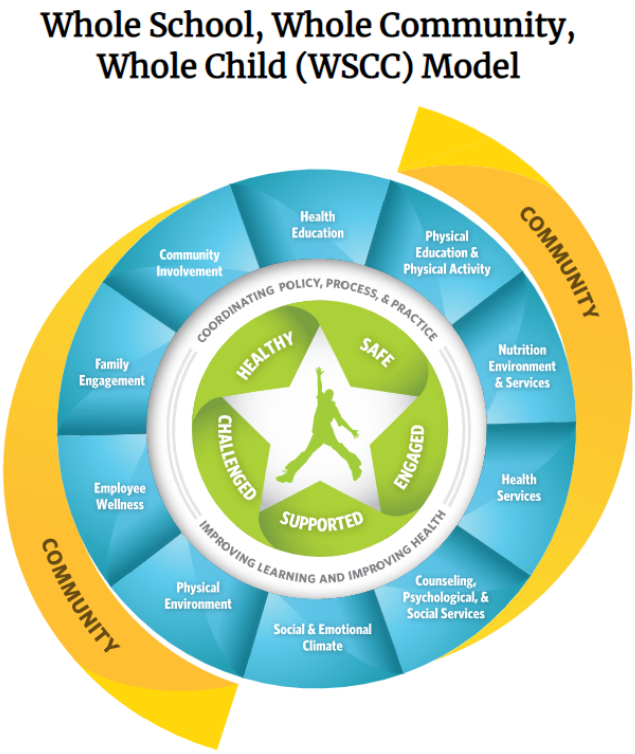
City of Providence and
Providence Public School Locations



Whole School, Whole Community, Whole Child

The HCO used the Centers for Disease Control and Prevention (CDC), Whole School, Whole Community, Whole Child, or WSCC model, to guide both the school health assessment and planning for future school health and wellness initiatives. The WSCC model is student-centered and emphasizes the role of the community in supporting the school, the connections between health and academic achievement, and the importance of evidence-based school policies and practices. The WSCC model has 10 components:

1. Physical education and physical activity.
2. Nutrition environment and services.
3. Health education.
4. Social and emotional school climate.
5. Physical environment.
6. Health services.
7. Counseling, psychological and social services.
8. Employee wellness.
9. Community involvement.
10. Family engagement.



The CDC's Whole School, Whole Community, Whole Child (WSCC) model was central to the HCO's approach for assessing and addressing school health needs within PPSD.

Executive Summary

Background

The City of Providence Healthy Communities Office undertook a School Health Needs Assessment of the PPSD from March to June 2020. The goal of the assessment was to determine health and support service needs among students and to inform the development of a more coordinated, efficient, and effective system for addressing student health.

The School Health Needs Assessment was led by the HCO in partnership with representatives from the PPSD Wellness Committee and the Providence *By All Means* Cabinet. The HCO engaged community research consultants to assist with the needs assessment including project management, data collection and analysis, and report writing.

The findings of the assessment will be used to guide key priorities, funding, and other opportunities. The assessment will also serve as a community resource for grant-making and advocacy, and to support the many programs provided by health and social service partners.

Methodology

The School Health Needs Assessment included quantitative and qualitative research methods to determine health trends and disparities among PPSD students. Primary study methods were used to solicit input from key stakeholders representing the broad interests of the community. Secondary study methods were used to identify and analyze demographic, socioeconomic, and student health trends, incorporating benchmarking and trending as available.

School Health Needs Assessment Methodology

- **Secondary data analysis**, including demographic, socioeconomic, and related health indicators, and compiled from sources including the RIDOH, Rhode Island KIDS COUNT, CDC, and the US Census, among others
- **Key Informant Interviews** with PPSD family members and individuals representing health and social service organizations; youth and family advocates; and civic leaders to gain insight on health issues, community infrastructure, and recommendations for improvement
- **Student Health and Wellness Survey** distributed to middle and high school students within Providence to collect student perspectives on health and wellness needs
- **Best practice recommendations** for improved student health based on priority health needs and peer school models
- **Review of research findings and action planning** to be developed and presented to the assessment partners, PPSD students and families, community partners, and other stakeholders for review and input to finalize a plan for student health and wellness

Community Engagement

Community engagement was an integral part of the school health needs assessment. The HCO solicited and received input from persons who represent the broad interests of the community, including underserved, priority, or minority populations. Through this input, the HCO received wide perspectives on health trends, expertise about existing community resources and gaps in services, and insights about issues that contribute to health disparities.

Representatives from the following organizations participated in the School Health Needs Assessment to provide insights, expertise, and perspectives. A list of individual participants is included in Appendix A.

Organizations that Participated in the School Health Needs Assessment
Brown University
Children & Youth Cabinet of Rhode Island
City of Providence
EduLeaders of Color Rhode Island
Lifespan Community Health Institute
Parents Leading Educational Equity
Providence Public School District
Rhode Island Behavioral Healthcare, Development Disabilities and Hospitals
Rhode Island Healthy Schools Coalition
Rhode Island KIDS COUNT
Rhode Island Department of Elementary and Secondary Education (RIDE)
Rhode Island Department of Health (RIDOH)
The Providence Center
Young Voices

Priorities for Student Health and Recommendations

The following summary highlights key findings related to student health priorities and recommendations for improvement, as identified by the school health needs assessment.

Priorities for Student Health

Student health and wellness, socioeconomics, and academic performance are inextricably intertwined.

- The median income for Providence families with children is nearly $35,000 less than the state; and 34% of children live in poverty, almost double the state average. Within Providence, individuals living in census tracts with a greater proportion of impoverished households generally have lower life expectancy and a higher prevalence of chronic disease, including youth asthma.
- While Providence residents of all racial and ethnic groups experience greater poverty in comparison to the state and nation, wide disparities exist among residents of color. Youth of color also experience notable health disparities, including obesity, asthma hospitalizations and ED visits, behavioral health conditions, and dating and sexual health risk factors.
- The percentage of Providence students missing 18 or more days of school in a single year is approximately double state averages, and higher than other core cities. Chronic absence is more pronounced in high school, where 48% of PPSD students miss 18 or more days.
- Approximately 75% of PPSD students graduate from high school with four years, a similar percentage to other core cities, but 13 percentage points lower than the remainder of RI.
- PPSD students of all racial and ethnic groups demonstrate lower academic proficiency in comparison to peer sites, but students of color are disproportionately impacted with lower proficiency than White students and declining proficiency from elementary to middle school.

Providence students experience more chronic health conditions than other students statewide. Students of color experience more health disparities than their White peers.

Asthma

- Providence has one of the highest youth asthma prevalence rates in Rhode Island, particularly for youth in Medicaid. Older schools and housing stock, poverty conditions, and/or poor housing conditions likely contribute to asthma rates among students.
- The asthma ED visit rate for Providence children under age 18 is triple the rate for Rhode Island as a whole, indicating barriers for disease management. Across Rhode Island, children of color are more likely to visit the ED for asthma than their White peers.

Overweight and Obesity

- Overweight and obesity is declining among Providence children. However, Nearly 1 in 4 Hispanic/Latinx and Black/African American students across Rhode Island are obese.
- Food insecurity among Providence County youth is declining. Still, nearly 1 in 5 youth are food insecure, a higher proportion than the state and nation.

- Physical activity is declining across the Rhode Island youth population; students of color are also less likely to report being physically active.

Risk Behaviors

- While traditional tobacco use is declining among Rhode Island youth, e-cigarette use is increasing rapidly, particularly among high school students. In 2019, 30% of high school students reported current use of e-cigarettes, a 10-point increase from 2018. White students and females were the most likely to report using e-cigarettes.
- School actions to suspend students caught vaping do not treat the underlying health issue or treatment needs. E-cigarette and vaping education needs to be included in health education curriculum.
- Alcohol use is declining among Rhode Island students, while substance use, including marijuana and prescription pain medication, has been generally stable. High school students are the most likely to report alcohol or substance use.
- Across Rhode Island, the percentage of sexually active high school students is increasing. Within Providence, the teen birth rate is more than 2.5 times higher than the state, excluding core cities.

Behavioral health conditions—particularly anxiety—are prevalent among students. Childhood trauma is a significant health issue for PPSD students.

- Based on the results of a recent Cognitive Behavioral Interventions for Trauma in Schools (CBITS) assessment, it is estimated that 80-90% of PPSD students have experienced trauma.
- Student behavioral health conditions are often complex and a result of multiple factors that may cause trauma, including bullying, poverty, food insecurity, housing quality or homelessness, fear for undocumented family members, language barriers, violence, drugs and alcohol use, and other individual influences.
- School policy is often aimed at disciplinary action for misbehavior, not treating the underlying behavioral health need; i.e. trauma.
- Across Rhode Island in 2019, 33% of high school students reported feelings of depression and 15% attempted suicide, an increase from 25% and 9% respectively in 2011. Among Providence Youth age 0-17 in 2019, there were 1,124 ED visits and 422 hospitalizations for a behavioral health diagnosis. Nearly 60% of the youth hospitalized were uninsured compared to 12% of ED visits for uninsured youth, indicating a lack of adequate care for uninsured youth, increasing the risk for hospitalization.
- Social and emotion learning programs are a key need for students, but vary greatly across schools, with inconsistent support and training among staff and teachers.
- Among Student Health and Wellbeing Survey respondents, mental health was identified as the biggest health issue among youth. When asked to rate their own mental health, 47% of respondents rated it as “fair” or “poor.”

Existing school services are positive and effective; expansion is needed to promote reach throughout the district.

- Examples of existing services include the Healthy Communities Office, Familias Unidas, Project Aware, Project Success, The Providence Center, PPSD school nurses, and Young Voices, among others.
- Challenges include the need for additional staff, including social workers, counselors, and administrative support at each school to assist with paperwork and follow-up with families and community partners; office space for external program providers to meet with students; and access for external partners to technical equipment including internet and printers.
- Required and recommended health and wellness visits including immunizations, well-child visits, and dental visits are typically on-track for elementary age students and begin to taper off as students age.
- Language barriers, lack of a primary care provider (PCP), family moves/school transfers, and undocumented status increase challenges and reduce compliance for required health documentation, which can keep children from being allowed to attend school.
- School nurses spend significant administrative time checking records and sending multiple communications to students' homes. Administrative support has improved the process flow, but additional support is needed to allow nurses to focus on student health needs and coordinating services with primary care providers and community partners.
- Student health records captured during school health visits may be a useful tool to determine and address top health needs among students, augment primary care, or guide health education topics. Analysis of these records for trends is recommended.

Centralized public health leadership with district-wide oversight for determining health policies, soliciting and approving school-community partnerships, and advancing health programming is needed.

- Health and wellbeing programs vary greatly among schools. Successful school-based health programs are not "scaled up" to serve all district students. Lack of consistent funding and turnover in school leadership contribute to discontinued programs.
- Schools that have available resources—including funding and partners—in combination with motivation and cooperation from individual school leaders have more health and wellbeing programs for their students.
- A district-wide committee with oversight and coordination responsibility for local school health committees was recommended.
- A district-wide, public health approach to student health promotion is needed to increase awareness and support for priority needs and streamline initiatives.
- Community-based health and social service organizations find it difficult to partner with PPSD due to delays in paperwork and lack of communication from the central office.

School nutrition has improved through recent initiatives. Continued progress is needed to improve quality of food and nutrition habits of students. A recognition of the connection between student nutrition and school achievement is under-emphasized.

- Actions to improve school nutrition including healthier vending options, school/ community gardens, improved meal preparation, etc. have been recognized as steps in the right direction. Nutrition education for students and families, food distribution, and related recreation activities should be continued and expanded to include all schools.
- All PPSD students are eligible for the free and reduced meal program, but many students forgo school meals because they are unappealing to them. Quality of food, taste, temperature, and cultural familiarity were noted issues that reduce appeal.
- Budget and space constraints impact the quality of food. Title 1 funding does not provide for “best foods.” School meals are prepared offsite and delivered to schools. Delivery time can impact temperature and reduce presentation and appeal of food to students.
- To compensate for distaste of school meals, and “healthy vending” at schools, students often stop at bodegas or corner stores on the way to school, and purchase snacks, sodas, and less healthy foods for lunch.
- A partnership with food vendor Sodexo is aimed at improving nutrition and reflecting the cultural cuisine of students. Sodexo has contributed funds toward community efforts to improve food security and discussion for future initiatives is ongoing.
- The COVID-19 health crisis has highlighted the need for year-round food security programs. There is opportunity for more outreach to improve food security, coupled with nutrition education. Current initiatives include food distribution, school/community gardens, Farm Fresh RI, URI SNAP-ED, and food justice education.

Health education curriculum is outdated and lacks content.

- Health curriculum is outdated both in content and mode of delivery. Some content is delivered via VHS tape.
- Students describe health class as disengaging and not relatable to their experiences. They report that instructors seem uncomfortable or unfamiliar with the subject matter, which diminishes the content, even when it is current.
- Partnerships with health and human service providers like Sojourner House have been successful in providing health education to students on specific topics.
- PPSD is “surrounded by health expertise” (Brown University, Care New England, Lifespan, University of Rhode Island, etc.) that could provide competent, relevant, and current health information.
- Students may not receive accurate or comprehensive sexual health information at home, increasing the need for comprehensive health education at school.
- Parents do not feel informed about the health education being offered to students.

Language barriers reduce effective communication between school and home. Approximately 50% of students come from homes where English is not the primary language spoken. Combined, students and families speak 55 different languages and hail from 91 countries of origin.

- PPSD has a high rate of new and transitioning students and multilingual learners, making it harder to inform families of school policies and direct families to resources, and general communication.
- Students are often expected to translate for parents, at times for sensitive information, which may not be properly conveyed.
- English as a Second Language class size and teachers vary throughout the school year and among schools, which negatively impacts learning for students.
- Health promotion services and programs–including communication about school meals–need to be culturally specific and relevant and offered in multiple languages. Few programs are offered in languages other than English or Spanish.
- Distance learning due to the COVID-19 health crisis has highlighted disparities in communication among parents who do not have computer or internet experience.

Students of color make up more than 90% of the student body. There is a long-standing (40+ years) history of bias and disenfranchisement of families of color, which impacts engagement and relationships among families and school leaders.

- Families of color feel “unheard and underrepresented” in school decisions. There is both perceived and experienced bias toward families of color.
- Teacher and staff training doesn’t always include capacity for engaging with parents or context for why it is important.
- The perception that East Side schools “get more” is reinforced through those school communities’ ability to raise funds and influence how funds are spent.
- Key stakeholders provided the following comments. “We need to change the narrative about what PPSD schools are. We need to change what people expect, and what they have come to think they deserve.” “As a parent, it’s hard to believe the district is sincere about engaging the community when there is no formal process or structure in place.”

School culture and climate is seen as a top issue among students, families, and teachers and impacts the learning environment. There is a prevailing message that “school is failing” in every aspect.

- There are dedicated adults and students within every school and they are succeeding at making small differences, but culture change needs to be embraced by the whole district, not just a committed group.
- High turnover in teachers, staff, and administrators impacts consistency in policies and ability to carry through with initiatives, and changes priorities.

- Violence, bullying, fights, and disrespectful behavior is common in schools and creates a hostile environment where the wellbeing of students and staff is not prioritized.
- Initiatives like Young Voices provide student-led opportunities for empowerment and advocacy to improve school community and policy and should be expanded.
- There is an opportunity to change the narrative to celebrate successes and what is going well to rebuild pride and momentum.
- School facilities do not support health due to physical structural issues and unsafe outdoor environments.
- Teachers and staff do not reflect the student population. There is a lack of understanding and acceptance of cultural differences and challenges that students face at home and in community. In the community's eyes, recommendations for anti-bias training for teachers have not been acted upon in tangible ways.
- PPSD administration is limited by the teacher union collective bargaining agreement to take disciplinary actions against teachers who break school policies and to mandate additional professional development days for anti-bias or other trainings.

Recommendations to Improve Student Health and Wellbeing

1. **Address the school environment to remove health hazards and prioritize health as a key factor in education achievement.**
   - Develop a feasible timeline and secure budget for school renovations.
   - Revise the school health meal program with input from students, nutritionists and clinicians, food vendors, and others to develop healthful, appetizing meals.
   - Explore partnerships with the Providence Career and Technology Academy (PCTA) and other culinary teaching programs to augment school meals.
   - Assess strategies to maximize opportunities for school breakfast in classrooms, targeting middle and high schools.
   - Collaborate with community-based organizations, Health Equity Zones, or other partners to address food insecurity, duplicate successful school/community gardens.
   - Reflect social and emotional learning objectives within the physical environment including wellness center/school-based health center, counseling center, physical fitness equipment, gender neutral restrooms, community meeting rooms, cafeteria with food preparation kitchen, green schoolyards, etc.

2. **Incorporate district-wide health and wellbeing education for students and staff to support social and emotion learning, advance cultural competencies, cultivate understanding, and provide resources to restore a sense of pride and value for individuals and the school community.**
    - Leverage public health expertise from health systems, universities and colleges, and health and human service providers to develop, deliver, and/or augment programming with oversight by the district and local health advisory committees.
    - Incorporate social emotional learning into curriculum and programming at all grade levels to build cultural competencies and understanding among teachers, staff, and students. Provide staff professional development for integrating health into learning.
    - Encourage family engagement, celebration of culture, and school and community activities to reflect the local community and reinforce the school as a community resource.

3. **Explore opportunities to restructure the district wellness committee to have direct oversight and accountability for developing health policy and ensuring implementation across schools. Develop local school subcommittees to oversee local-level implementation of health policy and programming.**
    - District-level wellness committee should develop policy and programming and have oversight responsibility of local school subcommittees to ensure comprehensive, equitable health services across the district.
    - The district-level wellness committee will approve local health initiatives, seek to leverage best practices across all schools.
    - Wellness committees should include PPSD administration and teachers, child and adolescent health experts, students, and family members.
    - Local school subcommittees should serve as liaisons to district-level committee with elected or appointed local chairperson serving on the district-level advisory committee.
    - Leverage the School Wellness Coordinator to coordinate activities of the committees, and serve as a liaison to the Healthy Communities Office.

4. **Develop a district-wide plan for defining and promoting equitable student health with consistent objectives and services across grade levels.**
    - Develop and communicate comprehensive district-wide plan with goals, objectives, strategies, action steps, and measurements.
    - Identify a common language for defining student health that is consistent across the school district, and advances the Whole School, Whole Community, Whole Child Model for integrated health (e.g. physical, nutrition, SEL, behavioral).
    - Define roles of administrators, teachers, staff, and partners in supporting student health.

- Reduce disparities in programming, service gaps, and ensure accurate and age appropriate curriculum across population groups and schools.
- Coordinate district-wide partnerships with health and human service providers to augment health education or services.
- Review current capacity of school-based behavioral health resources, increase school-based or partner-based resources to increase access to services for students.
- Outline the policy and process for approvals of additional activities or partnerships.
- Leverage the School Wellness Coordinator to oversee the plan, and serve as a liaison to the Healthy Community Office.

5. **Update health education curriculum and augment instruction with topical experts to provide current, relevant, age appropriate education for students.**
   - Curriculum should include physical health and nutrition; behavioral health and wellbeing; healthy relationships, sexuality, gender identity, and hygiene; social and emotional learning; drug, alcohol, and tobacco use; risk factors and chronic disease; among other topics requested by the student body or otherwise deemed relevant.
   - Leverage public health expertise from health systems, universities and colleges, and health and human service providers to develop, deliver, and/or augment programming with oversight by the district-level and local health advisory committees.
   - In coordination with classroom learning, provide access to menstrual hygiene products (MHPs), condoms, sexual education literature, and referral resources.
   - Review best practice student health programming recommendations provided within this report for topic-specific interventions (e.g. community partnering, obesity, trauma, sexual health education, bias training, etc.).

6. **Develop consistent metrics and oversight to monitor and assess student health and wellness goals.**
   - Leverage existing tools, such as the Behavior Intervention Monitoring Assessment System (BIMAS-2), to initiate universal screening for student needs across schools and community partners, and to develop active communication channels and defined response or safety net protocols.
   - Leverage PPSD's Multi-Tiered System of Supports (MTSS) framework to establish and communicate a central, unified message for student health, and to potentially serve as the backbone infrastructure for student health initiatives. Consider a cross-sector MTSS team at each school to be responsive to local student needs, with accountability to a collective, district-wide MTSS team.
   - Provide administrative support for health services to assist with mandatory health record keeping, data analyses, and reporting to monitor student health.

- Coordinate student health surveys and data collection across the district and with other statewide initiatives to allow for benchmarking and consistent outcomes measurement. Explore opportunities to oversample PPSD youth as part of the Youth Risk Behavior Survey to allow for district-specific findings.

Next Steps

Research findings were reviewed with members of the HCO, RIDE, RIDOH, PPSD, and the City of Providence Mayor's Office to determine action planning to address needs identified in the assessment. Planning included a review of existing initiatives and community partners; ways to eliminate disparities in health and wellness needs among school communities; viability of replicating program models from other communities; potential opportunities for collaboration; expansion of successful programs; and process mapping for district-wide oversight and approval of initiatives.

A recommended action plan will be developed and presented to the assessment partners, PPSD students and families, community partners and other stakeholders for review and input to finalize a plan for student health and wellness.

Demographic and Socioeconomic Data Analysis

Analyses of demographic and socioeconomic data are essential in understanding health trends and determining key drivers of health status. Socioeconomic indicators play a significant role in community and individual health. Known as **social determinants of health**, they are defined as factors within the environment in which people live, work, and play that can affect health and quality of life. Social determinants of health are often the root causes of health disparities.

A full analysis of demographic and socioeconomic data for Providence and PPSD youth follows the key findings highlighted below.

Demographic and Socioeconomic Key Findings

- Providence youth are younger and more diverse than youth across Rhode Island and the nation. Nearly 30% of youth are under age 5 compared to 26% statewide and 27% nationally. Approximately 60% of youth are Hispanic/Latinx and 50% speak Spanish as their primary language compared to 16-17% across Rhode Island and the nation.
- Providence youth are more likely to have a diagnosed disability compared to the state and nation, most commonly a cognitive disability.
- Families with children comprise 30% of all Providence households. While the majority of family households are married couples, the percentage of single female householders is nearly double state and national averages. Single female householders have the lowest median income and greatest potential for poverty in comparison to other family types.
- Grandparents raising grandchildren can contribute to social, emotional, and financial stress for families. Providence youth are less likely to be raised by a grandparent, with 22% of grandparents responsible for grandchildren compared to 30% statewide and 35% nationally.
- Poverty among Providence youth is declining, but remains a significant concern. The median income for families with children is nearly $35,000 less than the state; and 34% of children live in poverty, almost double the state average. Approximately 46% of households with children receive the Supplemental Nutrition Assistance Program compared to 41% statewide, and 8% of children live in families with cash assistance versus 3% statewide.
- Poverty is a social determinant of health and indicator of life expectancy. Within Providence, individuals living in census tracts with a greater proportion of impoverished households generally have lower life expectancy.
- While Providence residents of all racial and ethnic groups experience greater poverty in comparison to the state and nation, wide disparities exist among groups. The percentage of White residents living in poverty is 10 points lower than for Hispanic/Latinx residents and half the percentage for multi-racial or American Indian/Alaska Native residents.
- Approximately 57% of Women, Infants, and Children (WIC) eligible families are actively enrolled in the program, a higher percentage than the state overall (47%). While higher enrollment is a positive finding, it is noteworthy that 43% of eligible families are not enrolled.

- More Providence families with children rent their home compared to the state overall, and average rent costs are higher in Providence despite lower reported incomes than the state. Very-low income Providence families are projected to spend 58% of their income on a two-bedroom apartment; families in poverty are projected to spend 100% of their income.
- Nearly 1.2% or 300 youth enrolled in PPSD were identified as homeless during the 2018-2019 school year, a two-fold increase from the 2015-2016 school year.

Providence Youth and Families Overview

Youth Population Characteristics

	City of Providence	Rhode Island	United States
Age			
Under 18 years	40,473	208,128	73,309,412
Under 5 years	29.2%	26.2%	27.1%
5 – 9 years	27.9%	27.6%	27.7%
10 – 14 years	26.2%	28.3%	28.4%
15 – 18 years	16.7%	17.8%	16.8%
Gender			
Male	49.6%	51.2%	51.1%
Female	50.4%	48.8%	48.9%
Race			
White	43.7%	72.0%	67.1%
Some other race	24.6%	8.0%	6.4%
Black or African American	19.2%	9.0%	14.0%
Two or more races	7.1%	6.8%	6.5%
Asian	3.8%	3.5%	4.8%
American Indian/Alaska Native	1.3%	0.6%	1.0%
Native Hawaiian/Other Pacific Islander	0.2%	0.1%	0.2%
Ethnicity			
Hispanic or Latinx (any race)	60.3%	24.6%	25.0%
Language Spoken at Home (5 to 17 years old)			
Spanish	50.3%	16.6%	16.0%
Only English	43.0%	77.1%	77.8%
Other Indo-European languages	3.5%	4.1%	2.8%
Asian and Pacific Island languages	2.2%	1.5%	2.4%
Other languages	1.0%	0.6%	1.1%

Source: US Census Bureau, 2014-2018

Youth Disability Status

	City of Providence	Rhode Island	United States
With any disability	5.5%	4.9%	4.2%
Cognitive difficulty	6.5%	5.2%	4.2%
Self-care difficulty	1.8%	1.3%	1.0%
Ambulatory difficulty	1.0%	0.7%	0.6%
Hearing difficulty	0.5%	0.6%	0.6%
Vision difficulty	0.5%	0.7%	0.8%

Source: US Census Bureau, 2014-2018

Providence Families

Households with Children Under 18 by Type

	City of Providence	Rhode Island	United States
Total households	61,638	410,885	119,730,128
Households with children under 18	33.4%	28.7%	31.4%
Family households* with own children under 18	30.2%	25.8%	27.9%
Married-couple family	15.1%	16.5%	19.0%
Male householder, no wife	2.9%	2.1%	2.3%
Female householder, no husband	12.1%	7.2%	6.7%

Source: US Census Bureau, 2014-2018
*Defined as a group of two or more people related by birth, marriage, or adoption and residing together.

Relationship to Householder for Children Under 18

	City of Providence	Rhode Island	United States
Own child	89.3%	89.9%	88.0%
Grandchild	6.1%	6.9%	7.9%
Other relatives	3.0%	1.7%	2.4%
Foster child or other unrelated child	1.6%	1.5%	1.7%

Source: US Census Bureau, 2014-2018

Grandparents Responsible for Grandchildren Under 18 by Years Responsible

	City of Providence	Rhode Island	United States
Grandparents responsible for grandchildren	22.4%	30.4%	34.8%
Less than 1 year	5.5%	7.1%	6.6%
1 – 2 years	3.6%	5.3%	7.5%
3 – 4 years	2.7%	5.0%	5.7%
5 or more years	10.6%	13.0%	15.0%

Source: US Census Bureau, 2014-2018

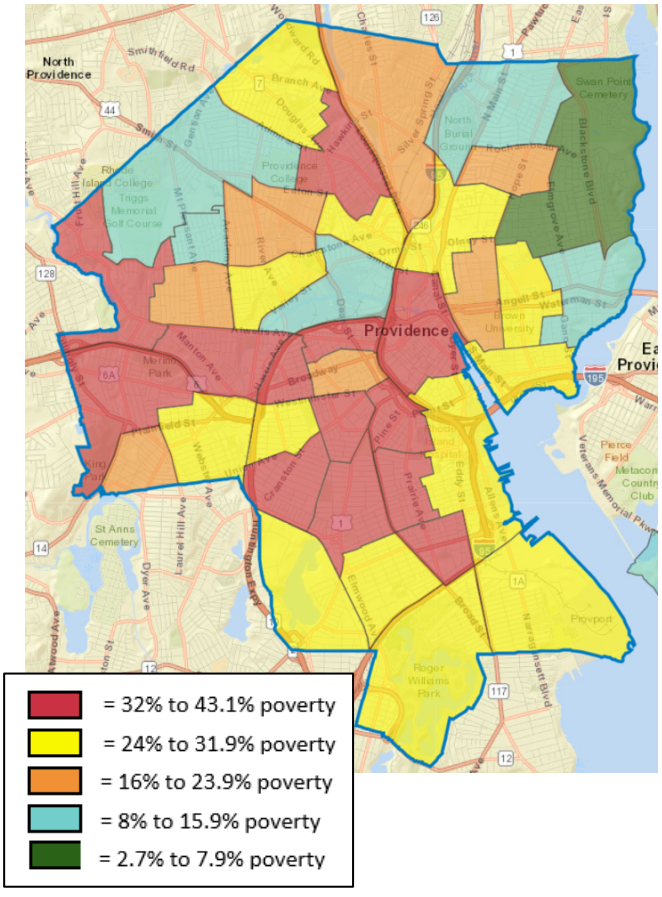
Income and Poverty

Median Income by Household Type

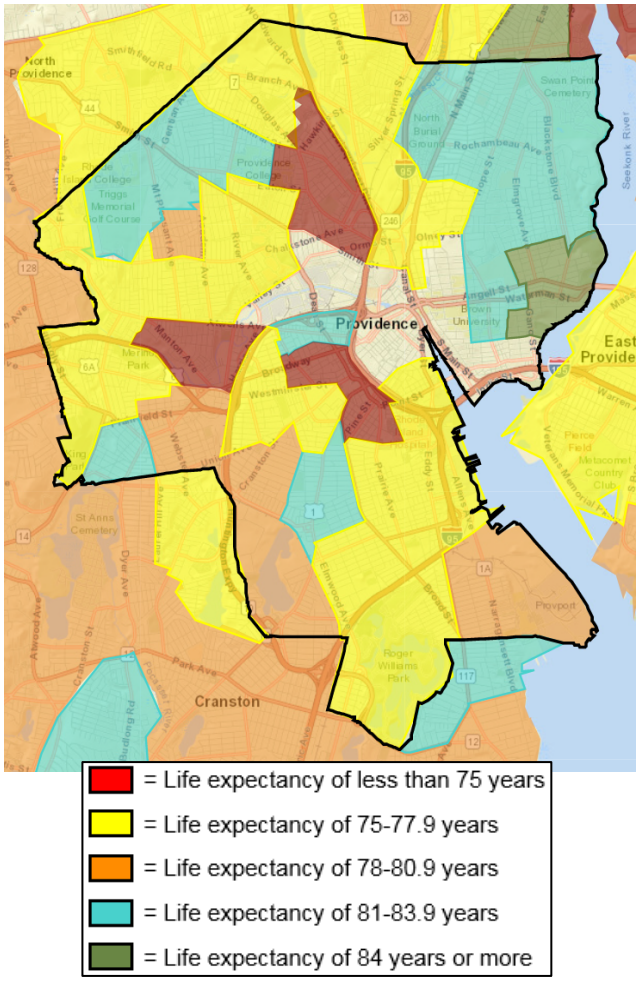
	City of Providence	Rhode Island	United States
All households	$42,158	$63,296	$60,293
All families	$49,743	$81,822	$73,965
Families with own children under 18	$40,497	$74,540	$71,048
Married-couple family	$69,094	$105,323	$95,854
Male householder, no wife	$28,068	$45,491	$42,637
Female householder, no husband	$22,621	$28,585	$27,335

Source: US Census Bureau, 2014-2018

City of Providence
Households in Poverty by Census Tract



City of Providence
Life Expectancy by Census Tract

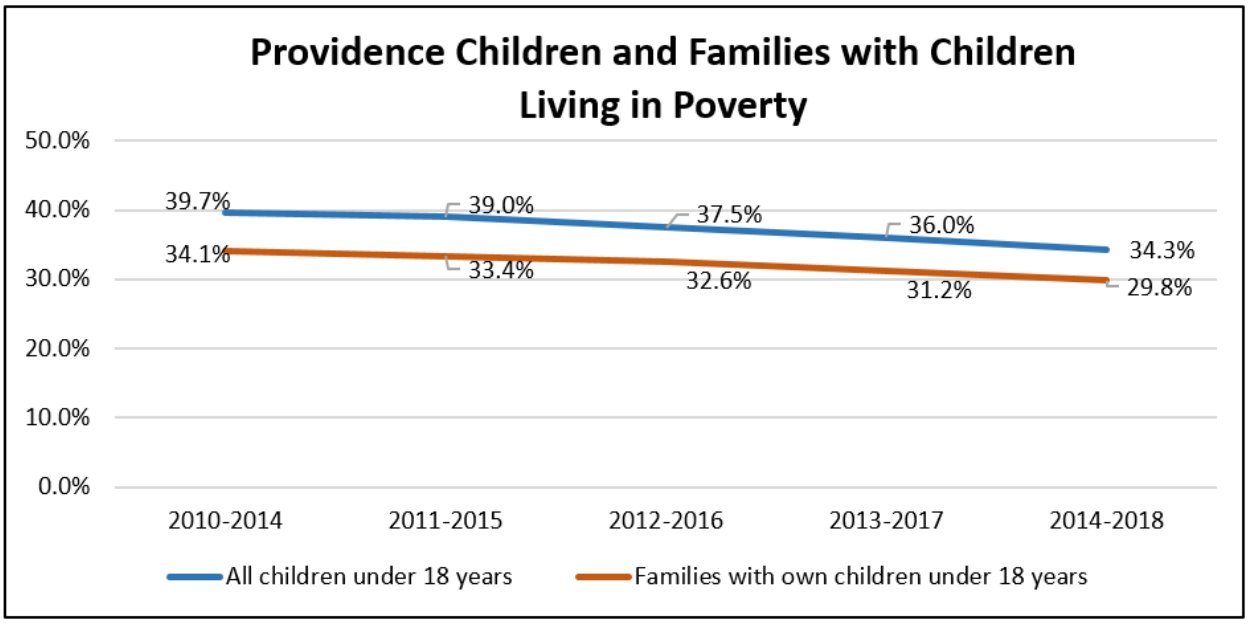


Children and Families with Children Living in Poverty*

	City of Providence	Rhode Island	United States
All children under 18 years	34.3%	18.2%	19.5%
Under 5 years	33.5%	20.1%	21.5%
5 – 17 years	34.6%	17.5%	18.8%
Families with own children under 18 years	29.8%	15.5%	15.9%
With own children under 5	24.8%	15.0%	15.3%
With own children 5 to 17	29.0%	13.9%	13.6%

Source: US Census Bureau, 2014-2018

*Children may live in family (two or more related people) or non-family households. Reported poverty levels reflect all children, regardless of household type, and families with children.



Source: US Census Bureau

Families Below Poverty Level by Race/Ethnicity Of Householder

	City of Providence	Rhode Island	United States
Two or more races	37.5%	23.0%	14.3%
American Indian/Alaska Native	36.2%	22.9%	21.4%
Hispanic or Latinx (any race)	28.4%	25.5%	18.6%
Asian	27.2%	10.9%	8.1%
Some other race	26.6%	25.4%	20.5%
Black or African American	23.2%	19.6%	20.3%
White	18.2%	7.0%	7.9%

Source: US Census Bureau, 2014-2018

Children Participating in Low-Cost or Free School Breakfast Program

	PPSD	Four Core Cities*	Remainder of State	Rhode Island
Average daily participation	11,431	17,875	10,073	31,368
Percent of all children participating	50%	44%	11%	22%

Source: Rhode Island Department of Education, October 2019

*The core cities include Central Falls, Pawtucket, Providence, and Woonsocket in Providence County.

Households with Children Receiving Supplemental Nutrition Assistance Program (SNAP)

	City of Providence	Rhode Island	United States
All households with children under 18	46.0%	40.5%	51.3%
Married-couple family	13.4%	11.6%	17.7%
Male householder, no wife	4.8%	4.4%	5.4%
Female householder, no husband	27.4%	24.2%	27.4%

Source: US Census Bureau, 2014-2018

Families with Cash Assistance or Enrolled in Women, Infants, and Children (WIC)

	City of Providence	Four Core Cities	Remainder of State	Rhode Island
Children in families with cash assistance	3,142	4,855	2,007	6,884
Percent of children with cash assistance	8%	7%	1%	3%
Estimated WIC eligible	14,369	24,432	19,138	43,570
Percent of WIC eligible enrolled	57%	55%	37%	47%

Source: Rhode Island Department of Human Services & Rhode Island Department of Health, 2019

Housing

Housing Occupancy for Families with Related Children under 18

	City of Providence	Rhode Island	United States
Total family occupied housing	20,442	116,358	37,070,782
Owner occupied	35.5%	59.8%	61.8%
Renter occupied	64.5%	40.2%	38.2%

Source: US Census Bureau, 2014-2018

Low and Moderate Income Housing (LMIH) Family Housing Units

	Total Housing Units	Total LMIH Units	LMIH Family Units
Providence	71,168	10,643	5,277 (50%)
Rhode Island	445,902	37,157	13,726 (37%)

Source: State of Rhode Island Office of Housing and Community Development, 2017

Cost of Housing for Family with Very Low-Income or Living in Poverty

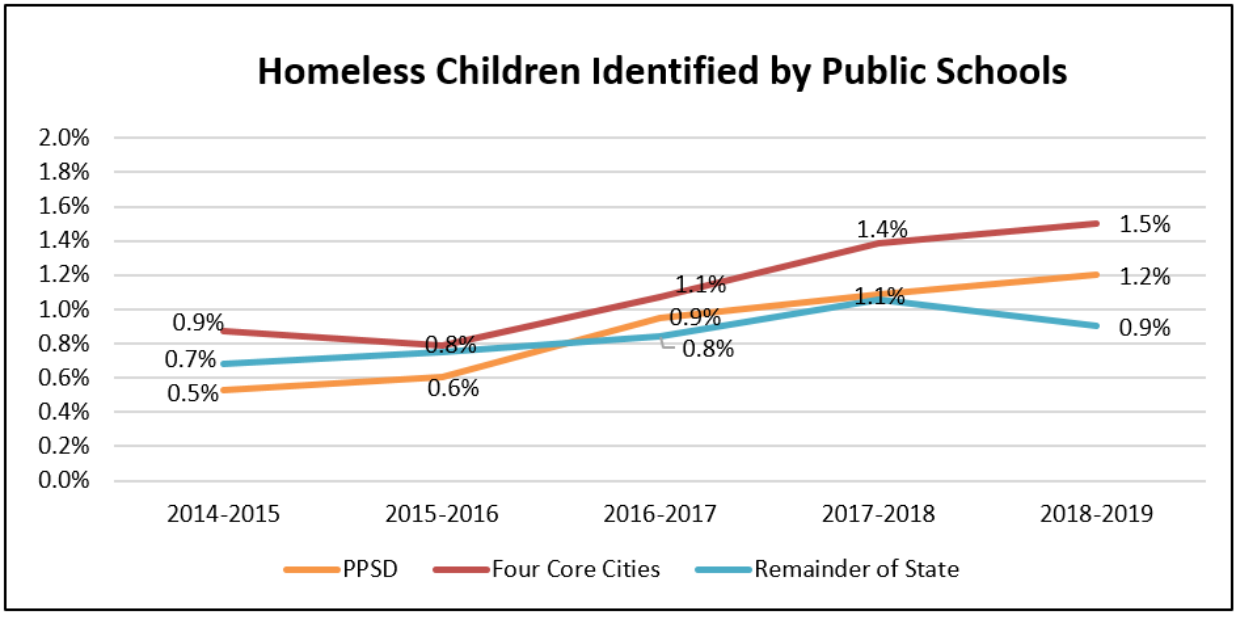
	City of Providence	Four Core Cities	Remainder of State	Rhode Island
Very low-income for family of three*	$36,900	$36,900	$37,470	$37,250
Poverty income for family of three	$21,330			
Homeownership Costs				
Typical monthly housing payment	$1,504	$1,556	$2,681	$2,063
Percent of income needed for housing payment (very low-income family)	49%	51%	86%	66%
Rental Costs				
Average rent for 2 bedroom apartment	$1,779	$1,656	$1,645	$1,651
Percent of income needed for rent (very low-income family)	58%	54%	53%	53%
Percent of income needed for rent (family of three living in poverty)	100%	93%	93%	93%

Source: Rhode Island Housing Rent Survey & HousingWorks RI, 2019
*A very low-income family is a three-person family with income 50% of the Area Median Income and is defined separately for each of the three metropolitan areas comprising the state and for the state overall.

Homeless Children Identified by Public Schools

	PPSD	Four Core Cities	Remainder of State	Rhode Island
Number of children identified as homeless	298	608	830	1,475
Percent of children identified as homeless	1.2%	1.5%	0.9%	1.0%

Source: Rhode Island Department of Education, 2018-2019 School Year



Source: Rhode Island Department of Education

Academic Performance and Achievement

The following section outlines academic performance and achievement factors for all PPSD students. Findings specific to each PPSD school are included in Appendix C to assist in identifying targeted areas for improvement. Data are primarily provided by the Rhode Island Department of Education, with summary analyses included from the June 2019 PPSD review by the Johns Hopkins Institute for Education Policy.

Academic Performance and Achievement Key Findings

- Student enrollment at PPSD reflects the demographics of the larger community, with 66% of students identifying as Hispanic/Latinx and 29% of students receiving multilingual learner services. The diversity of students is not reflected in PPSD educators, with less than 10% of educators identifying as Hispanic/Latinx. This finding will continue to present a challenge as student diversity and the proportion of multilingual learners continues to grow.
- Approximately 15% of PPSD students receive special education services due to a disability, similar to the state overall and consistent with prior years. The most common disabilities among students receiving services are learning disabilities, followed by a health impairment.
- Chronic absence of students from school is a common issue across grade levels. The percentage of students missing 18 or more days of school in a single year is approximately double state averages, and higher than other core cities. Chronic absence is more pronounced in high school, where 48% of PPSD students miss 18 or more days.
- Suspension is a widely used disciplinary technique for schools despite lack of evidence for productive outcomes. Across PPSD grade levels, the rate of out-of-school suspensions is consistent with other core cities, but nearly double the rate for the remainder of the state.
- As reported in the Johns Hopkins report, Providence students achieve academic proficiency at substantially lower rates than their peers across Rhode Island and in peer cities like Worcester, Massachusetts. Proficiency rates decline notably from 5th to 8th grade.
- While PPSD students of all racial and ethnic groups demonstrate lower academic proficiency in comparison to peer sites, wide disparities exist among student populations. The percentage of White students who are academically proficient is higher than for Black/African American or Hispanic/Latinx students. White students demonstrate consistent proficiency from 3rd to 8th grade, while students of color experience notable declines.
- Approximately 75% of PPSD students graduate from high school with four years, a similar percentage to other core cities, but 13 percentage points lower than the remainder of the state. Greater disparity in graduation rates is seen among American Indian/Alaska Native students (44%), followed by homeless students (52%) and multilingual learners (65%). Of note, American Indian/Alaska Native residents are also the most likely to live in poverty.
- Approximately 58% of PPSD students participate in postsecondary education, with wide differences among population groups. Multilingual learners are the least likely to participate in postsecondary education (41%).

School Enrollment

Providence Public School District Student Enrollment and Educator Demographics

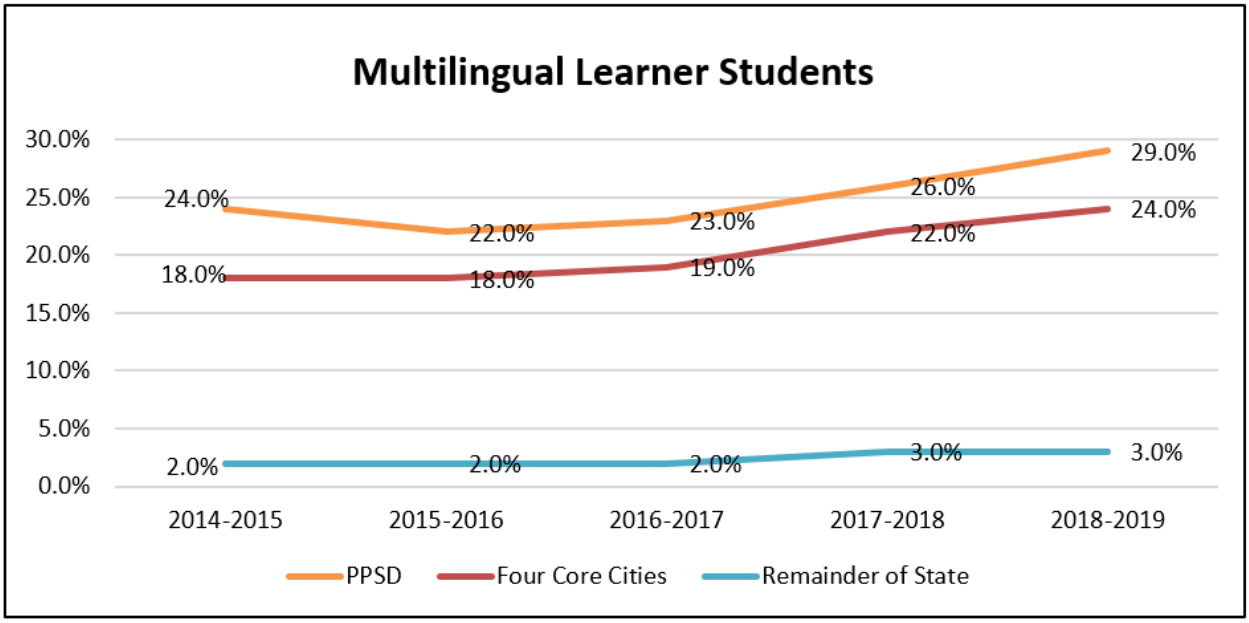
	Students	Educators
Total	23,955	2,150
Race and Ethnicity		
Hispanic or Latinx	15,705 (65.7%)	203 (9.4%)
Black or African American	3,884 (16.2%)	145 (6.7%)
White	2,058 (8.6%)	1,637 (76.1%)
Asian	1,027 (4.3%)	50 (2.3%)
Two or more races	1,014 (4.2%)	20 (0.9%)
American Indian/Alaska Native	231 (1.0%)	10 (0.5%)
Native Hawaiian/Other Pacific Islander	36 (0.2%)	1 (0.05%)
Race not reported	NA	282 (13.1%)

Source: Rhode Island Department of Education, 2018-2019 School Year

Multilingual Learner (MLL) Students

	PPSD	Four Core Cities	Remainder of State	Rhode Island
Elementary	3,574	5,238	1,578	7,775
Middle	1,285	1,959	417	2,483
High	2,024	2,824	446	3,533
Total MLL learners	6,883	10,022	2,441	13,792
Percent of Total District	29%	24%	3%	10%

Source: Rhode Island Department of Education, 2018-2019 School Year



Source: Rhode Island Department of Education

Students Ages 6-21 Receiving Special Education Services by Type of Disability

	PPSD	Four Core Cities	Remainder of State	Rhode Island
Learning disability	1,483	2,756	4,527	7,867
Health impairment*	562	1,273	2,540	4,092
Speech/language impairment	470	892	1,509	2,594
Emotional disturbance	311	576	1,030	1,700
Developmental delay	299	577	863	1,508
Autism spectrum disorder	272	628	1,805	2,534
Intellectual disability	200	360	512	899
Other	108	180	420	674
All students receiving services	3,705 (15%)	7,242 (17%)	13,206 (15%)	21,868 (15%)

Source: Rhode Island Department of Education, June 2019
*Health impairment includes a number of medical conditions, including ADD/ADHD, diabetes, epilepsy, hemophilia, heart conditions, lead poisoning, and leukemia, among others.

Chronic Absence

	PPSD	Four Core Cities	Remainder of State	Rhode Island
Grades K-3				
% Absent 0-5 days	23%	26%	38%	35%
% Absent 6-11 days	27%	28%	37%	34%
% Absent 12-17 days	20%	19%	16%	17%
% Absent 18+ days	29%	26%	9%	14%
Middle School (Grades 6-8)				
% Absent 12-17 days	18%	18%	16%	16%
% Absent 18+ days	35%	31%	12%	17%
High School (Grades 9-12)				
% Absent 12-17 days	15%	15%	15%	15%
% Absent 18+ days	48%	45%	19%	26%

Source: Rhode Island Department of Education, 2018-2019 School Year

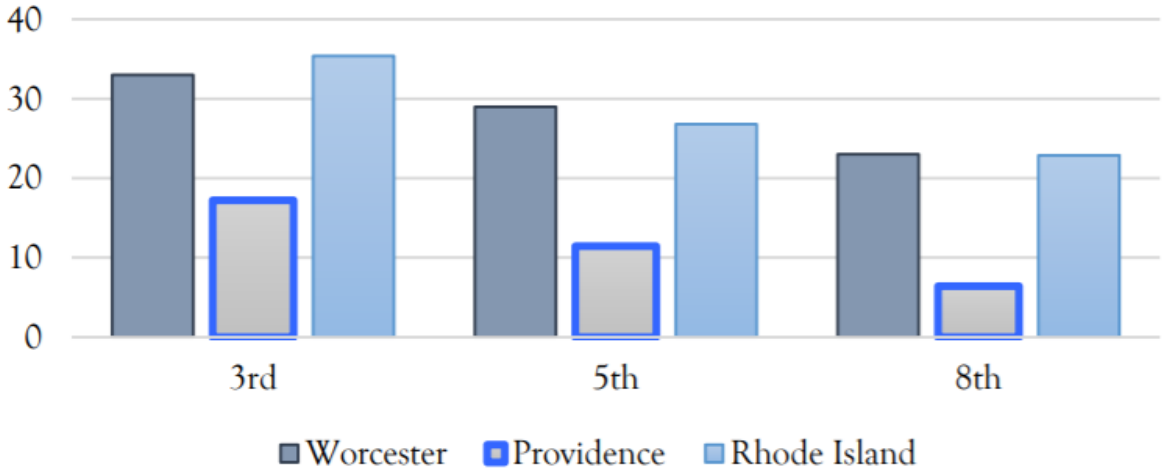
Disciplinary Actions

	PPSD	Four Core Cities	Remainder of State	Rhode Island
Students suspended out-of-school	2,364	4,339	5,158	9,981
Rate of suspensions per 100 students	10	10	6	7
Students suspended in- or out-of-school	3,055	7,453	13,355	21,562
Rate of suspension per 100 students	13	18	15	15

Source: Rhode Island Department of Education, 2018-2019 School Year

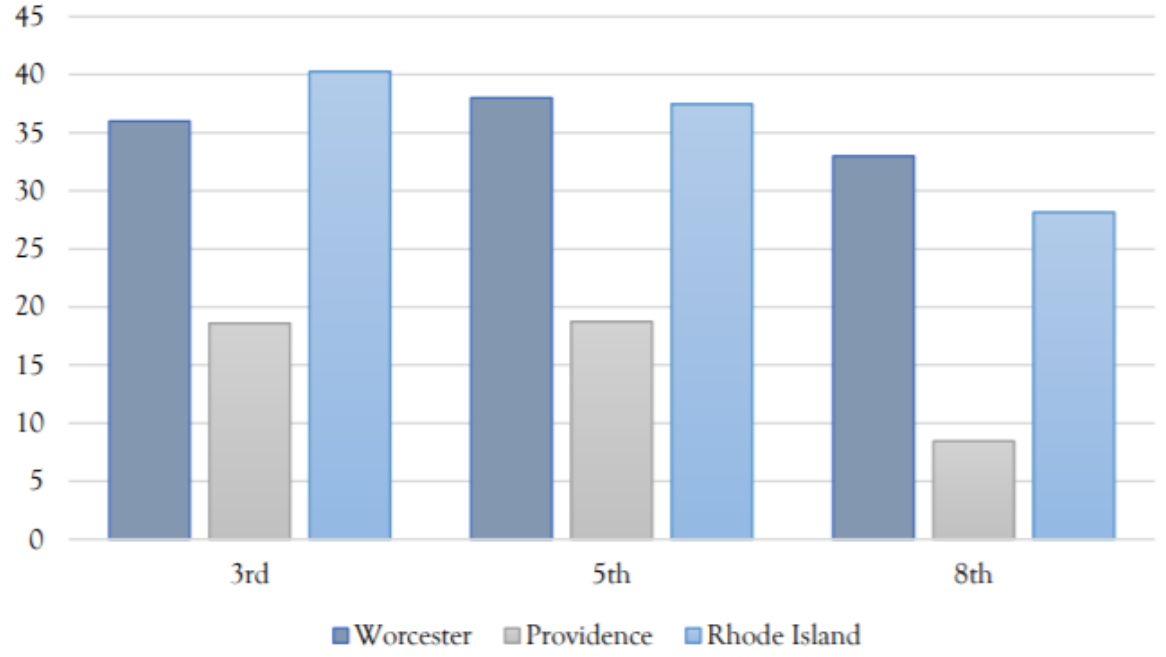
Academic Proficiencies

Rhode Island Comprehensive Assessment System (RICAS)
Math Proficiencies by Grade, All Students, 2018*



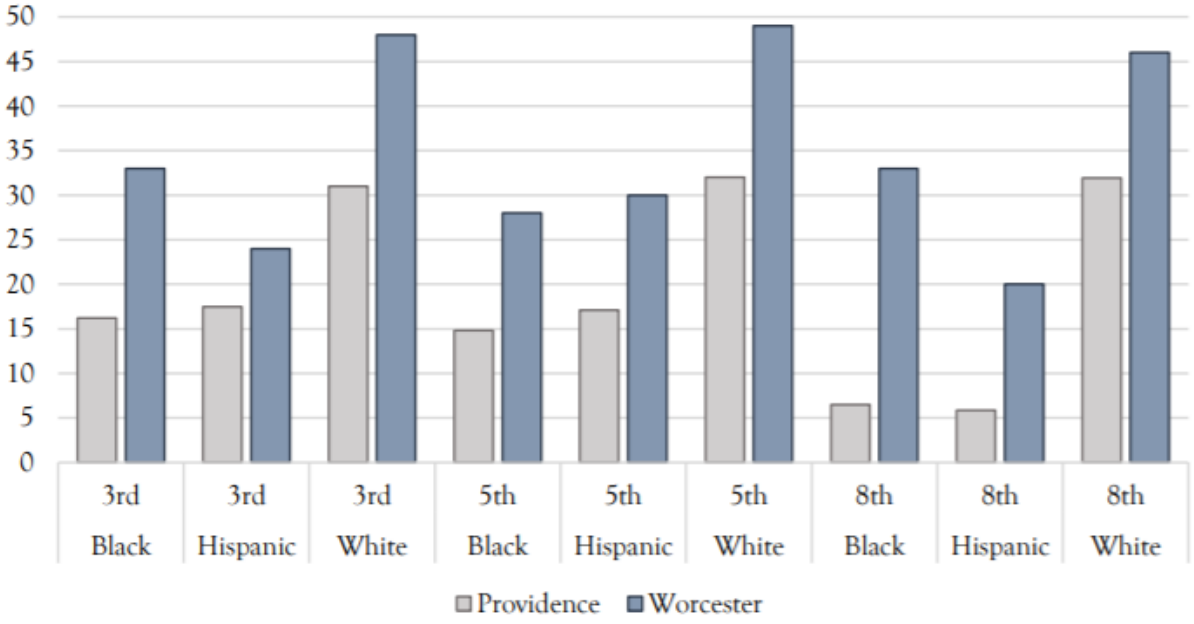
Source: Johns Hopkins Institute for Education Policy, 2019
*Worcester, Massachusetts shown as a comparison site based on comparable student demographics and assessments.

Rhode Island Comprehensive Assessment System (RICAS)
English Language Arts Proficiencies by Grade, All Students, 2018



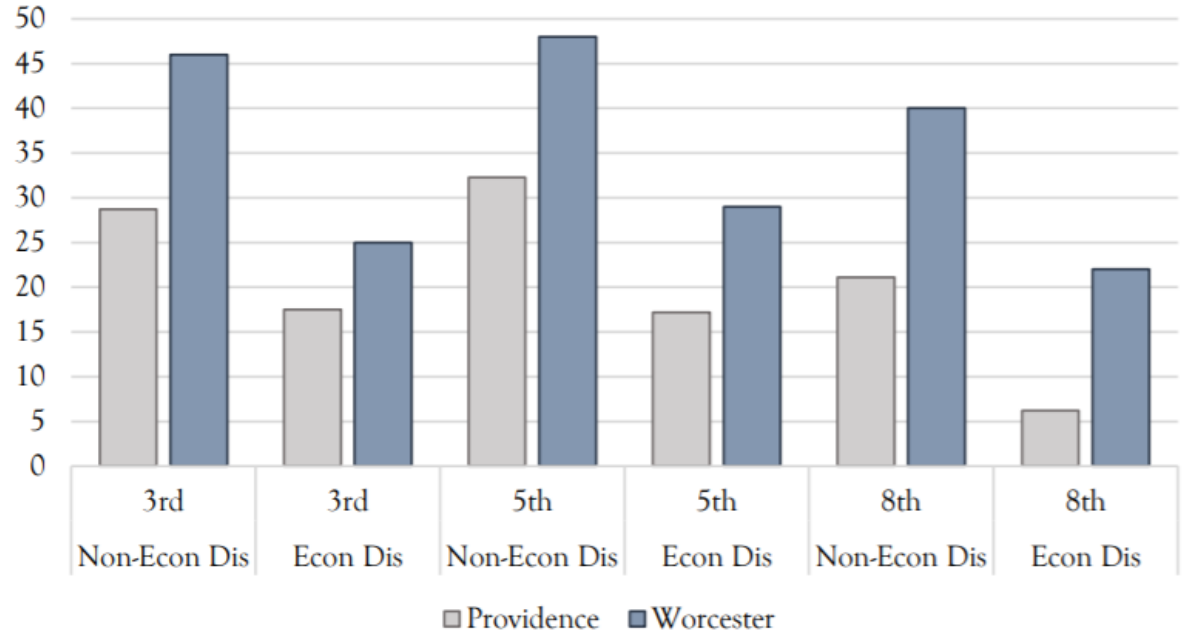
Source: Johns Hopkins Institute for Education Policy, 2019
*Worcester, Massachusetts shown as a comparison site based on comparable student demographics and assessments.

English Language Arts Proficiencies by Race/Ethnicity, by Grade, 2017-2018



Source: Johns Hopkins Institute for Education Policy, 2019
*Worcester, Massachusetts shown as a comparison site based on comparable student demographics and assessments.

English Language Arts Proficiencies by Economic Disadvantage, by Grade, 2017-2018



Source: Johns Hopkins Institute for Education Policy, 2019
*Worcester, Massachusetts shown as a comparison site based on comparable student demographics and assessments.

Academic Achievement

Providence Public School District Graduation Rates

	Percent Graduated within Four Years
All students	74.9%
Asian	89.3%
Black or African American	79.5%
Hispanic or Latinx	74.0%
White	71.9%
Two or more races	67.4%
American Indian/Alaska Native	44.4%
Economically disadvantaged	75.4%
Multilingual learners	64.8%
Homeless	52.2%
Four Core Cities (all students)	75.0%
Remainder of State (all students)	88.0%
Rhode Island (all students)	84.0%

Source: Rhode Island Department of Education, 2017-2018 School Year

Providence Public School District Postsecondary Rates by Type

	Not Enrolled	RI Public School	RI Private School	Out of State
All students	42.3%	44.6%	4.6%	8.4%
Hispanic or Latinx	45.4%	45.5%	4.6%	4.5%
Two or more races	44.1%	41.2%	2.9%	11.8%
White	40.7%	28.1%	6.7%	24.4%
American Indian or Alaska Native	37.5%	50.0%	0.0%	12.5%
Black or African American	35.0%	46.3%	4.1%	14.6%
Asian	29.9%	58.2%	4.5%	7.5%
Economically disadvantaged	43.1%	45.5%	4.7%	6.7%
Multilingual learners	59.4%	35.6%	3.4%	1.6%

Source: Rhode Island Department of Education, 2017-2018 School Year

Student Health Trends and Outcomes

Student health indicators were analyzed for Providence youth to better understand community drivers of health status, health trends, and emerging health needs. Data were compared to the four core cities, state, and national benchmarks, as available, to identify areas of strength and opportunity. Key data findings are highlighted specific to each student health topic area.

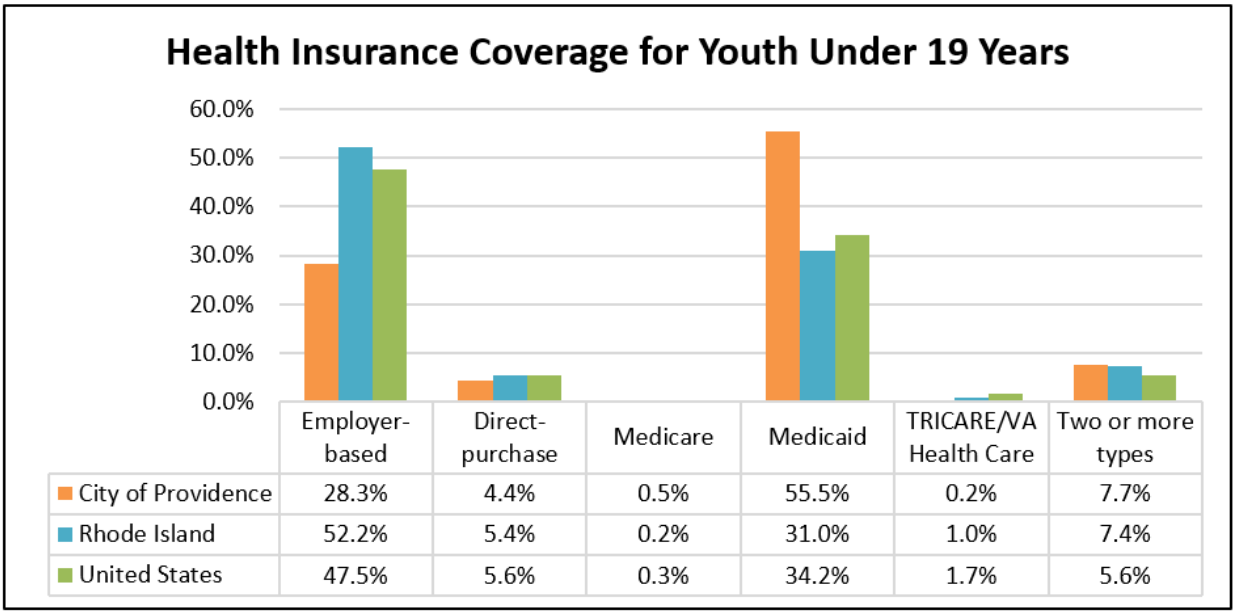
Student health indicators were analyzed for a number of health issues, including access to care, health risk factors, disease conditions, mental health and substance use, and sexual health. Data were compiled from secondary sources including the Rhode Island Department of Health, Rhode Island KIDS COUNT, Youth Risk Behavioral Survey (YRBS), SurveyWorks, among other sources. A comprehensive list of data sources can be found in Appendix B.

The YRBS is a school-based survey conducted every other odd year by the CDC to monitor priority health risk behaviors among youth. YRBS findings are reported for youth in middle school and high school, and reflect all Rhode Island youth in aggregate. Data are not presented for Providence due to availability.

SurveyWorks is a statewide survey conducted by the Rhode Island Department of Education to gain feedback from residents about their experience with the state's public schools. Feedback is gathered from students in grades 3-5 and 6-12.

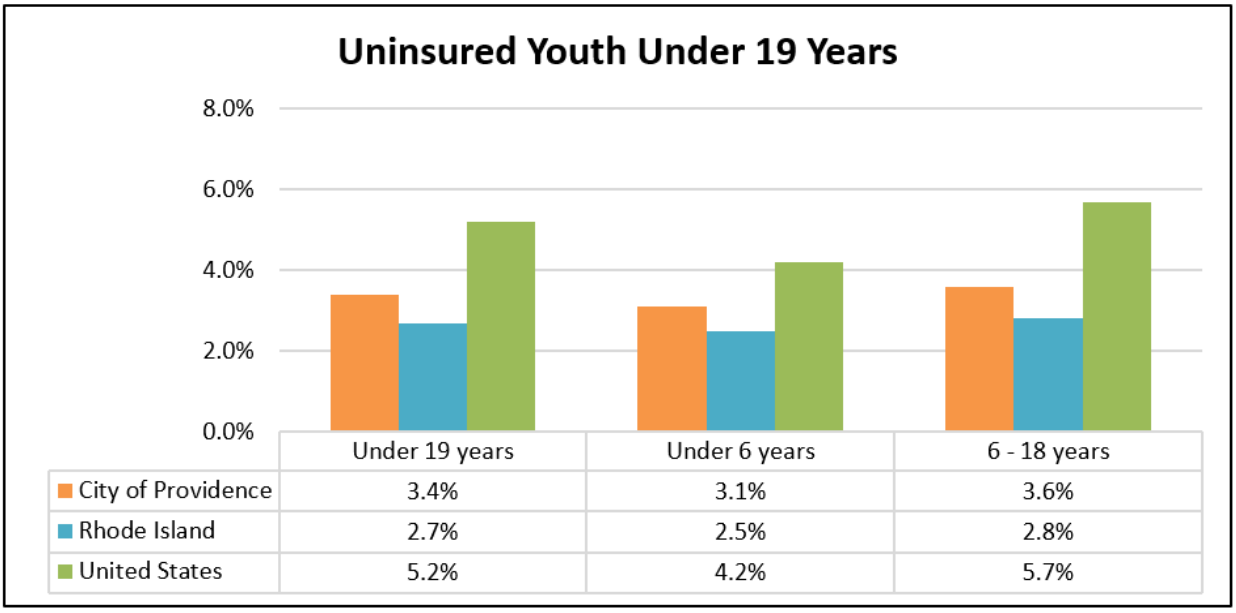
Health Care Access Key Findings & Supporting Data

- The Rhode Island Executive Office of Health and Human Services estimates that as of December 2019, 36,625 youth under age 19 in Providence receive Medicaid (RIte Care). The proportion of Providence youth with Medicaid is more than 50% higher than for Rhode Island or the nation overall.
- Consistent with the state and nation, the proportion of uninsured Providence youth is declining. The current percentage is consistent with the state and lower than the nation, although Asian youth are disproportionately uninsured (10.8%) in comparison to their peers.
- During the 2018-2019 school year, approximately two-thirds of kindergarten and third grade PPSD students received a dental screening from a school nurse. Among screened youth, approximately 20% needed follow-up dental care. An additional 33% of third grade students required sealants, a coating to prevent tooth decay.
- Providence Public School District elementary school students are more likely to be fully vaccinated than their peers statewide. However, the percentage of vaccinated students declines in higher grade levels and is lower than state averages.



	Employer-based	Direct-purchase	Medicare	Medicaid	TRICARE/VA Health Care	Two or more types
City of Providence	28.3%	4.4%	0.5%	55.5%	0.2%	7.7%
Rhode Island	52.2%	5.4%	0.2%	31.0%	1.0%	7.4%
United States	47.5%	5.6%	0.3%	34.2%	1.7%	5.6%

Source: US Census Bureau, 2014-2018



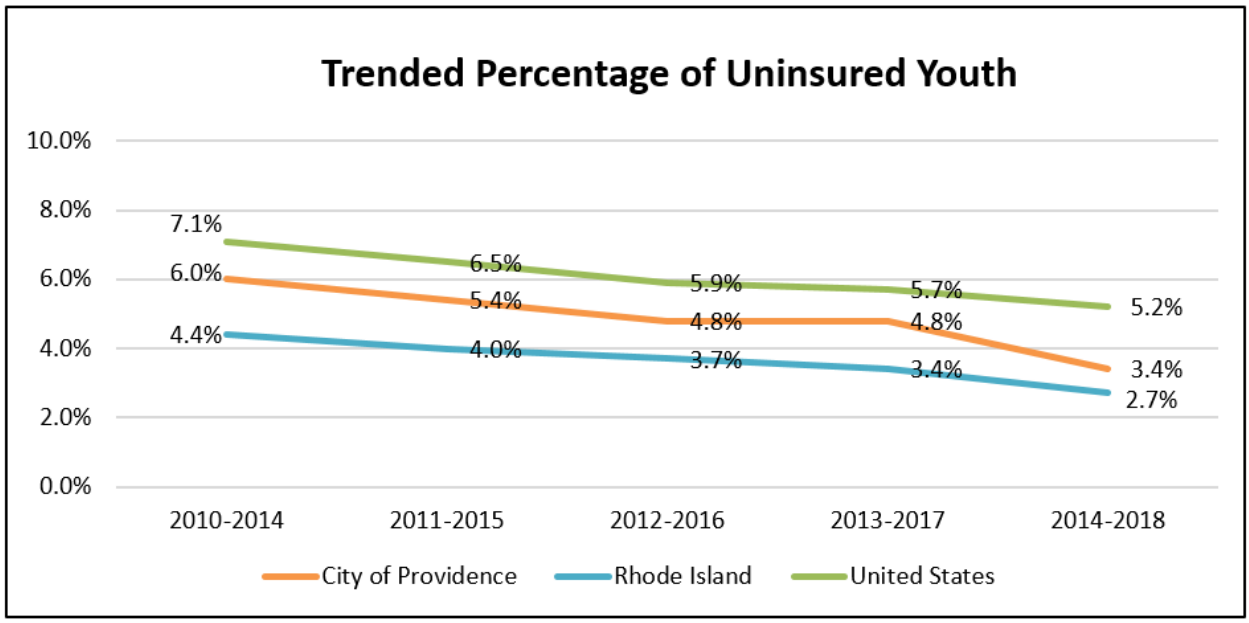
	Under 19 years	Under 6 years	6 - 18 years
City of Providence	3.4%	3.1%	3.6%
Rhode Island	2.7%	2.5%	2.8%
United States	5.2%	4.2%	5.7%

Source: US Census Bureau, 2014-2018

Providence Uninsured Youth Under 19 Years by Race and Ethnicity

	Asian	White	Hispanic or Latinx	Black or African American	Other Race
No health insurance	289	681	648	0	0
Percent uninsured	10.8%	2.9%	2.6%	0.0%	0.0%

Source: US Census Bureau, 2018



Source: US Census Bureau

*Note: Prior to 2013-2017, uninsured youth was calculated for youth under 18. In 2013-2017 the measure was refined to include youth under 19.

Providence Public School District Dental Screenings Conducted by School Nurses

	Kindergarten	Third Grade
Student Enrollment	1,396	1,503
Screened for Dental Care	922 (66.0%)	1,074 (71.5%)
Needing dental care	252 (18.1%)	295 (19.6%)
Needing sealants*	NA	490 (32.6%)

Source: Rhode Island Department of Health, 2018-2019 School Year

*Protective coating to prevent tooth decay.

Providence Public School District Students Fully Immunized*

	Providence	Rhode Island
Kindergarten	96.4%	95.8%
7th Grade	80.5%	75.3%
8th Grade	73.7%	75.7%
9th Grade	78.9%	81.3%
12th Grade	83.3%	84.8%

Source: Rhode Island Department of Health, 2018-2019 School Year

*Data include the number of students assessed, fully immunized, without an immunization record, and with an exemption certificate on file. Students' immunization status is assessed as of December 3.

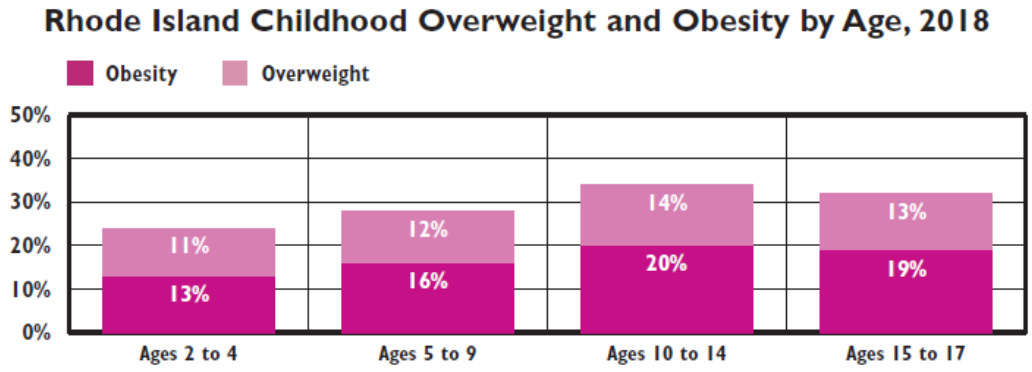
Health Risk Factors Key Findings & Supporting Data

- The percentage of overweight or obese youth in Providence declined 11 percentage points from 2016 to 2018. The current percentage is lower when compared to other core cities, but exceeds the rest of Rhode Island.
- In general, older students and students of color have higher rates of obesity. Nearly 1 in 4 Hispanic/Latinx and Black/African American students across Rhode Island are obese. Students of color are also less likely to report being physically active, although physical activity is declining across the youth population.
- Food insecurity is closely associated with obesity. While food insecurity among Providence County youth is declining, nearly 1 in 5 youth are food insecure, a higher proportion than the state and nation.
- Traditional cigarette use is declining among Rhode Island youth, but e-cigarette use is increasing rapidly, particularly among high school students. In 2019, 30% of high school students reported current use of e-cigarettes, a 10-point increase from 2018. Among racial groups, White students were the most likely to report using e-cigarettes. Females are also more likely than males to report using e-cigarettes.
- LGBTQ+ students experience notable health disparities, including the highest percentage of reported physical inactivity of any student group and the highest reported use of e-cigarettes.

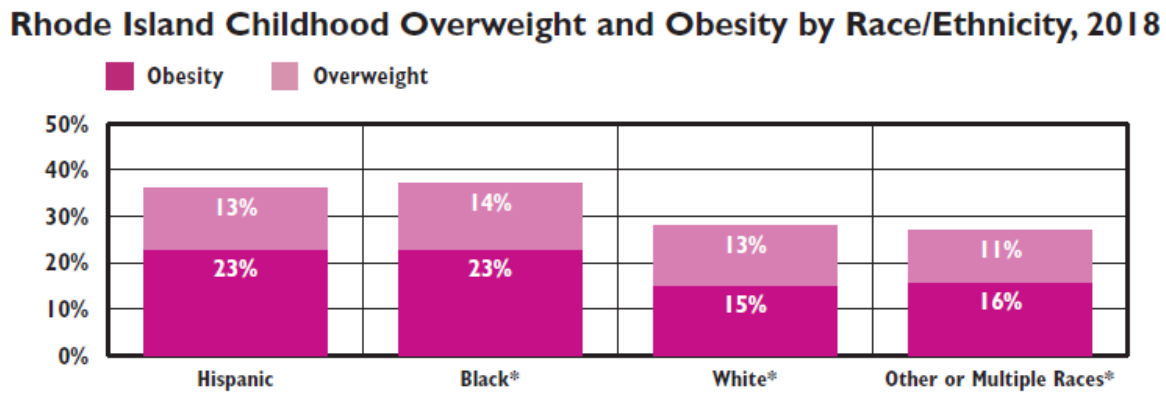
Unhealthy Weight in Children Ages 2 to 17

	City of Providence	Four Core Cities	Remainder of State	Rhode Island
2018 Overweight or obese	32%	36%	27%	30%
Overweight	12%	13%	13%	13%
Obese	20%	23%	14%	17%
2016 Overweight or obese	43%	43%	30%	35%
Overweight	17%	17%	14%	15%
Obese	26%	26%	16%	20%

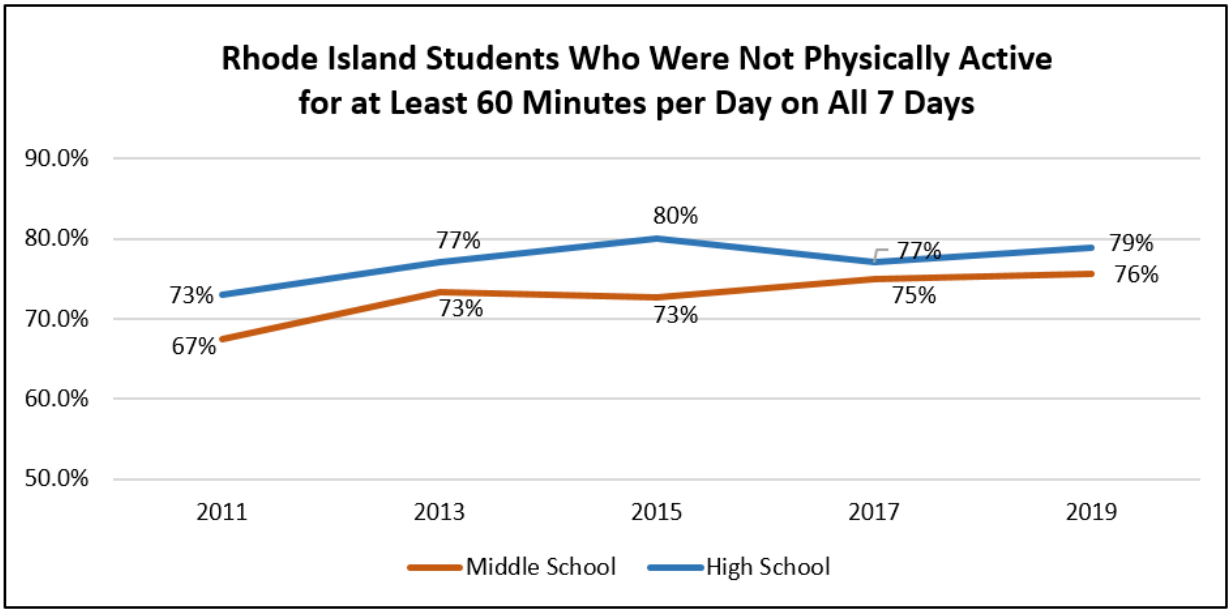
Source: Hassenfeld Child Health Innovation Institute, 2018



Source: Hassenfeld Child Health Innovation Institute, 2018



Source: Hassenfeld Child Health Innovation Institute, 2018

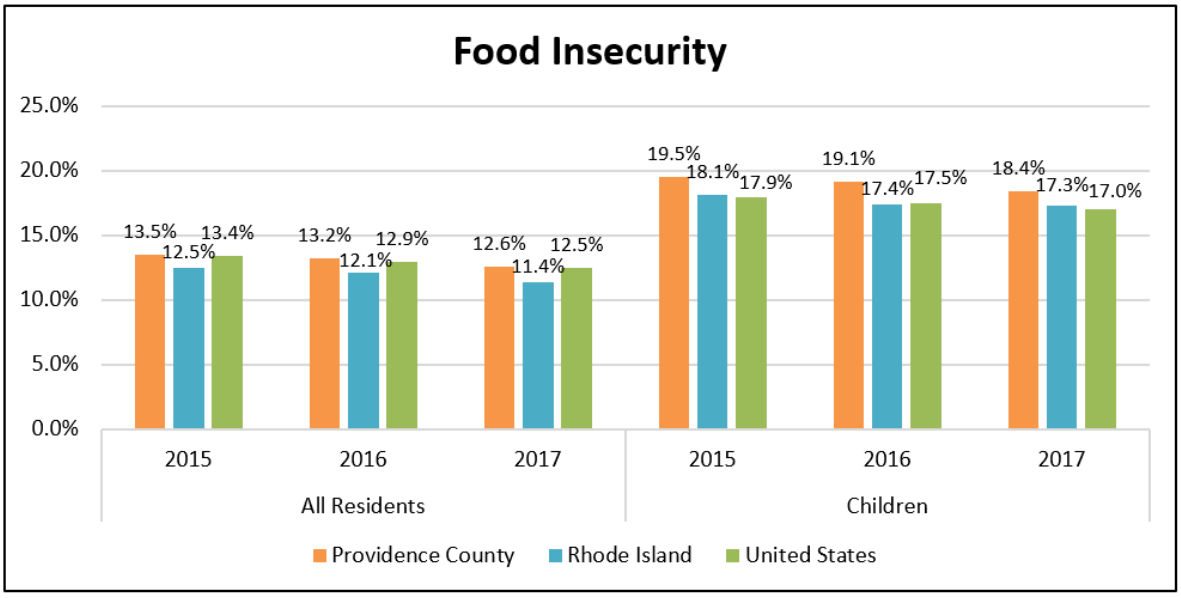


Source: Youth Risk Behavior Survey

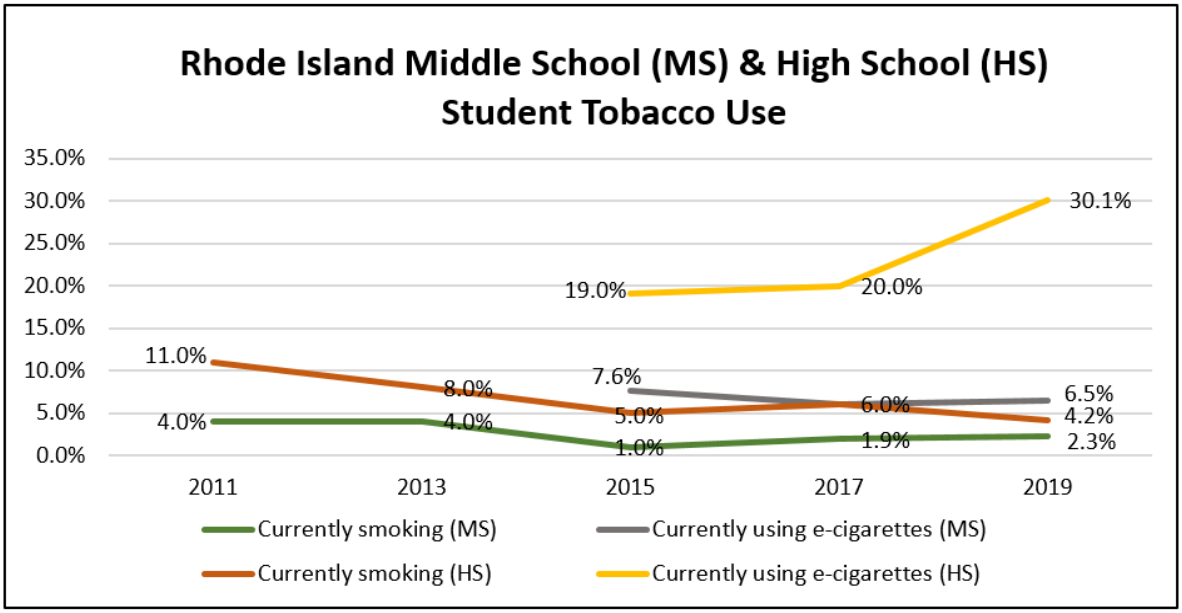
Rhode Island High School Students Who Were Not Physically Active for at Least 60 Minutes per Day on All 7 Days by Demographic Group

Hispanic	Black	White	Male	Female	LGBTQ+	Straight	Disability
85.6%	79.4%	76.3%	72.3%	85.3%	89.8%	77.2%	87.3%

Source: Youth Risk Behavior Survey, 2019



Source: Feeding America



Source: Youth Risk Behavior Survey

Rhode Island High School Student E-Cigarette Use by Demographic Group

	Hispanic	Black	White	Male	Female	LGBTQ +	Straight	Disability
Ever used e-cigarettes	42.2%	42.4%	53.4%	46.0%	51.5%	56.3%	49.6%	47.6%
Currently use e-cigarettes	20.1%	18.0%	36.4%	28.4%	31.2%	37.3%	30.1%	28.3%

Source: Youth Risk Behavior Survey, 2019

Disease Conditions Key Findings & Supporting Data

- Rhode Island has the highest percentage of low-income children and the second highest percentage of children of all incomes living in older housing in the nation. This finding is of particular concern in Providence, where 86% of houses were built before 1980, a higher proportion than even the state. Older housing stock presents potential youth health challenges, including respiratory infections and lead poisoning.
- Asthma is the most common chronic condition among youth. Diabetes is less common than asthma among youth, but still one of the top conditions. Among PPSD students, approximately 1 in 10 have an asthma diagnosis, with the highest percentage among middle school students. Less than 1% of students at PPSD have diabetes, but the percentage increases from elementary to middle to high school.
- Providence has one of the highest youth asthma prevalence rates in Rhode Island, particularly for youth in Medicaid. Nearly all of the Providence census tracts with a higher prevalence of youth asthma are hot spots for poverty and lower life expectancy.
- Inadequate asthma management can result in emergency department (ED) visits. While the rate of child ED visits due to asthma is declining, Providence has the highest rate in the state. The ED visit rate for Providence children under 18 is triple the rate for all of Rhode Island, excluding the core cities. The ED visit rate is even higher for children under 6 years.
- Across Rhode Island, children of color are more likely to visit the ED for asthma. Black/African American children have the highest ED visit rate, with a rate that is more than three times higher than the rate for White children.
- The number of children entering kindergarten with a history of elevated blood lead levels is declining across Rhode Island, but children in the core cities are more than twice as likely to be exposed. Providence children have the second highest prevalence in the state.

Children Living in Older Housing Stock

	City of Providence	Rhode Island	United States
Housing stock built pre-1980	85.7%	73.9%	53.2%
All children living in older housing	NA	72%	50%
Low-income children	NA	84%	58%

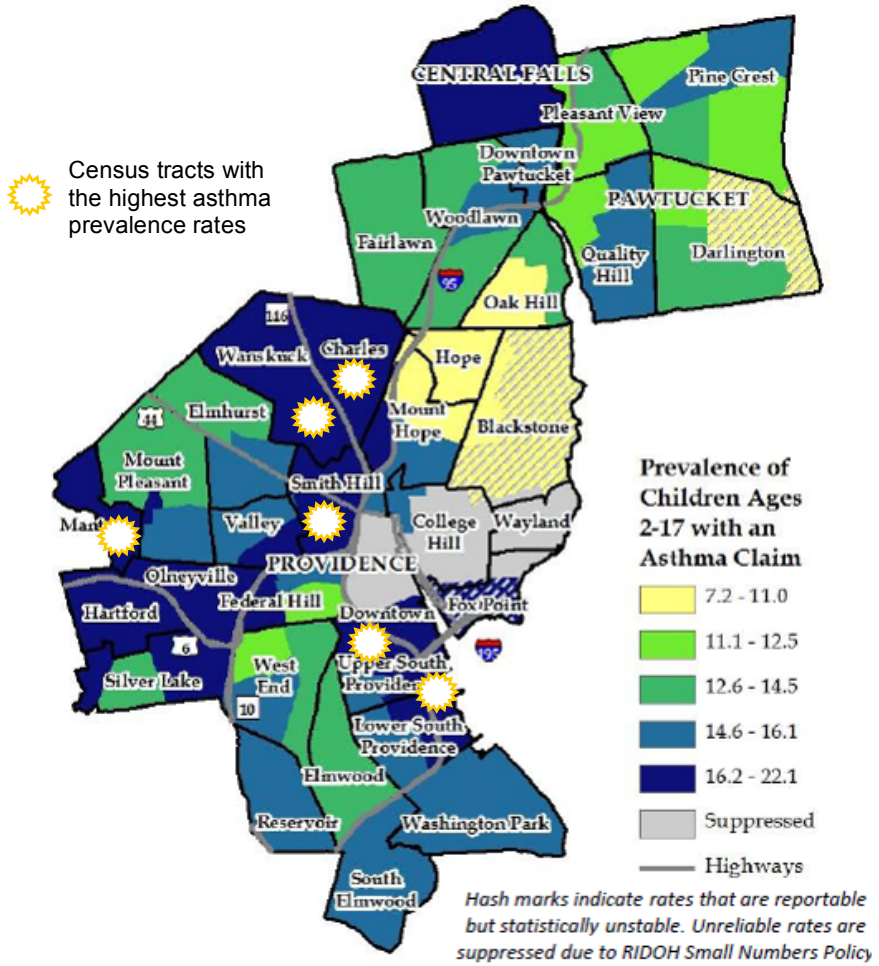
Source: US Census Bureau, 2014-2018

Providence Public School District Students with Asthma or Diabetes, as Reported in School Health Records (Count and Percent of Total Enrollment)

	Elementary School	Middle School	High School
Students with asthma	866 (8.3%)	568 (10.1%)	597 (8.0%)
Students with diabetes	14 (0.1%)	17 (0.3%)	30 (0.4%)

Source: PPSD Student Health Services, 2019-2020 School Year
Note: Prevalence includes students enrolled at public charter schools and programs (e.g. Newcomer).

Asthma Prevalence Rates Among Children in Medicaid

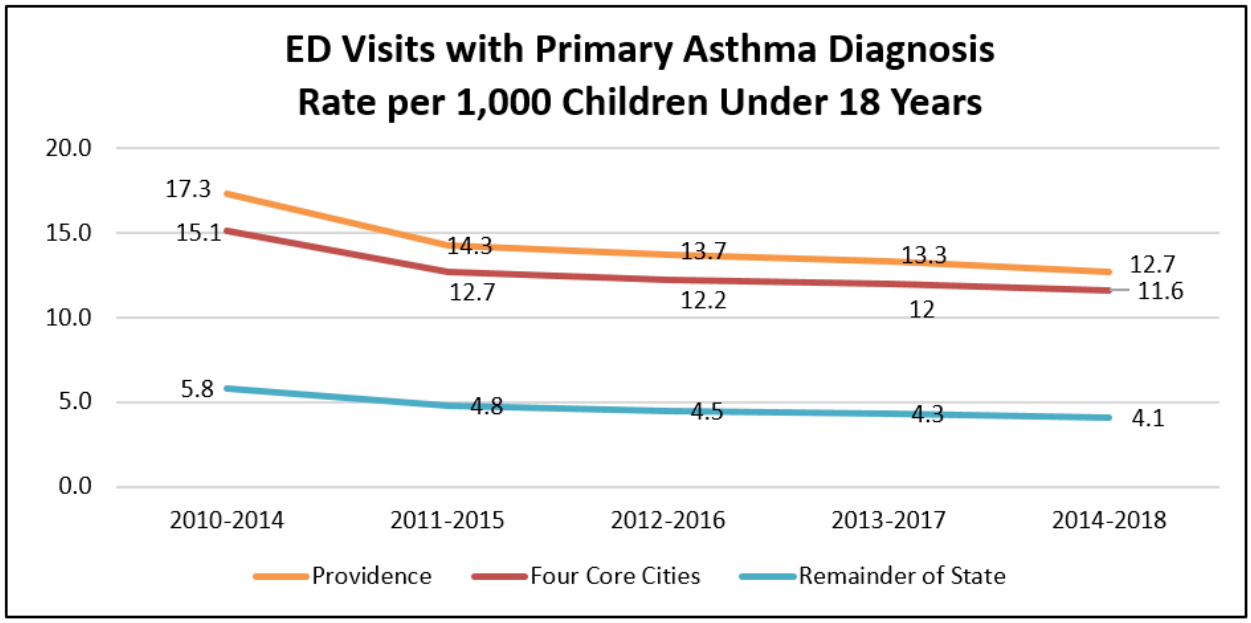


Source: Hassenfeld Child Health Innovation Institute, 2013-2017

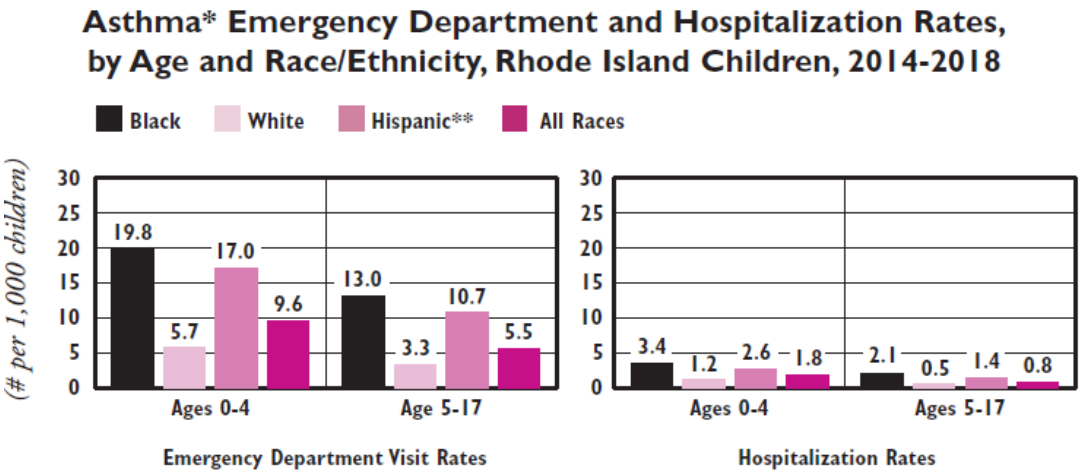
Asthma Emergency Department (ED) Visits for Children

	City of Providence	Four Core Cities	Remainder of State	Rhode Island
Under 18 years				
ED visits with primary asthma diagnosis	2,642	4,288	3,065	7,353
Rate of ED visits with primary asthma diagnosis per 1,000 children	12.7	11.6	4.1	6.6
Under 6 years				
ED visits with primary asthma diagnosis	1,484	2,382	1,559	3,941
Rate of ED visits with primary asthma diagnosis per 1,000 children	17.5	15.7	6.1	9.7

Source: Rhode Island Department of Health, 2014-2018



Source: Rhode Island Department of Health



Source: Rhode Island Department of Health, 2014-2018

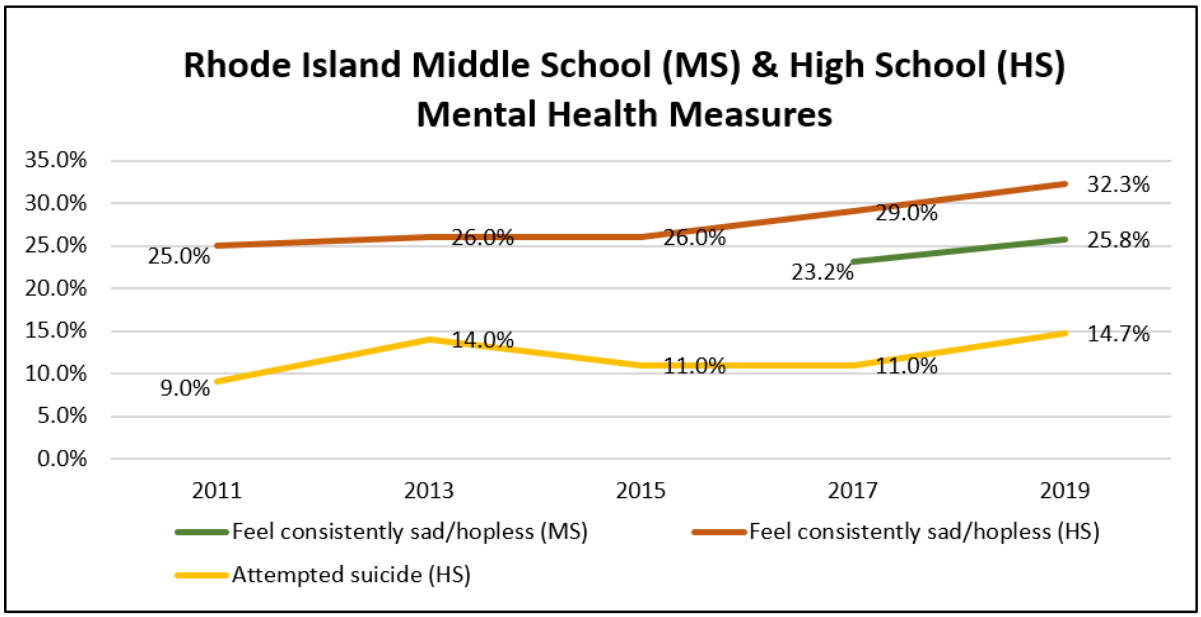
Lead Poisoning in Children Entering Kindergarten in the Fall of 2021

	City of Providence	Four Core Cities	Remainder of State	Rhode Island
Number tested for lead poisoning	2,636	4,308	6,597	10,906
Number confirmed with blood lead level ≥5 µg/dL	226	321	174	495
Percent confirmed with blood lead level ≥5 µg/dL	8.6%	7.5%	2.6%	4.5%

Source: Rhode Island Department of Health

Mental Health and Substance Use Key Findings & Supporting Data

- The percentage of Rhode Island middle and high school students who report feelings of depression is increasing. Of note, in 2019, 33% of high school students reported feelings of depression and 15% attempted suicide, an increase from 25% and 9% respectively in 2011.
- Alcohol use is declining among Rhode Island students, while substance use, including marijuana and prescription pain medication, has been generally stable. High school students are the most likely to report alcohol or substance use with nearly 1 in 4 reporting current use of alcohol or marijuana and 10% reporting misuse of a prescription pain medication.
- Across Rhode Island, LGBTQ+ students and students with a disability are the most likely to self-report depression, suicidal thoughts, and alcohol or substance use. Females are also at greater risk for these factors. Students of color generally report a higher prevalence of suicidal ideation and depression, while White students report greater use of alcohol or drugs.
- Among PPSD students in grades 3-5 and 6-12, 36% report feeling depressed. The percentage increased for both grade cohorts, and the current percentage for students in grades 3-5 exceeds the state average by 6 points. PPSD students in both cohorts also report a higher, increasing level of stress that interferes with school and extracurricular activities.
- According to PPSD school health records, less than 5% of students in elementary or high school have a diagnosed behavioral health condition compared to 9% of middle school students. This finding may indicate higher prevalence and/or higher screening rates in middle school.
- Among all Providence youth age 0-17, there were 1,124 ED visits and 422 hospitalizations to any Rhode Island hospital in 2019 for a behavioral health diagnosis (primary reason for the visit). The number of ED visits due to a behavioral health condition is generally increasing, while the number of hospitalizations is declining. Of note, nearly 60% of youth hospitalizations in 2019 were uninsured compared to 12% of ED visits. This finding indicates a lack of adequate care for uninsured youth, increasing the risk for hospitalization.
- Among Providence youth seen at a hospital for a behavioral health condition, mental health diagnoses account for nearly all hospitalizations and more than 90% of all ED visits. Mood disorders are the most common diagnosis, accounting for 25% of ED visits and 50.5% of hospitalizations in 2019. Within the ED, attention-deficit conduct/disruptive behavior disorders and adjustment disorders are also common, accounting for 22% and 17% of visits respectively. Adjustment disorders also account for 20% of hospitalizations.
- In 2019, the majority of Providence youth seen at the hospital for a behavioral health condition were age 10-17 and Hispanic or Latinx. Female youth accounted for 54% of hospitalizations and 52% of ED visits. Youth were most commonly from zip code 02903, accounting for 22% of hospitalizations and 34% of ED visits.

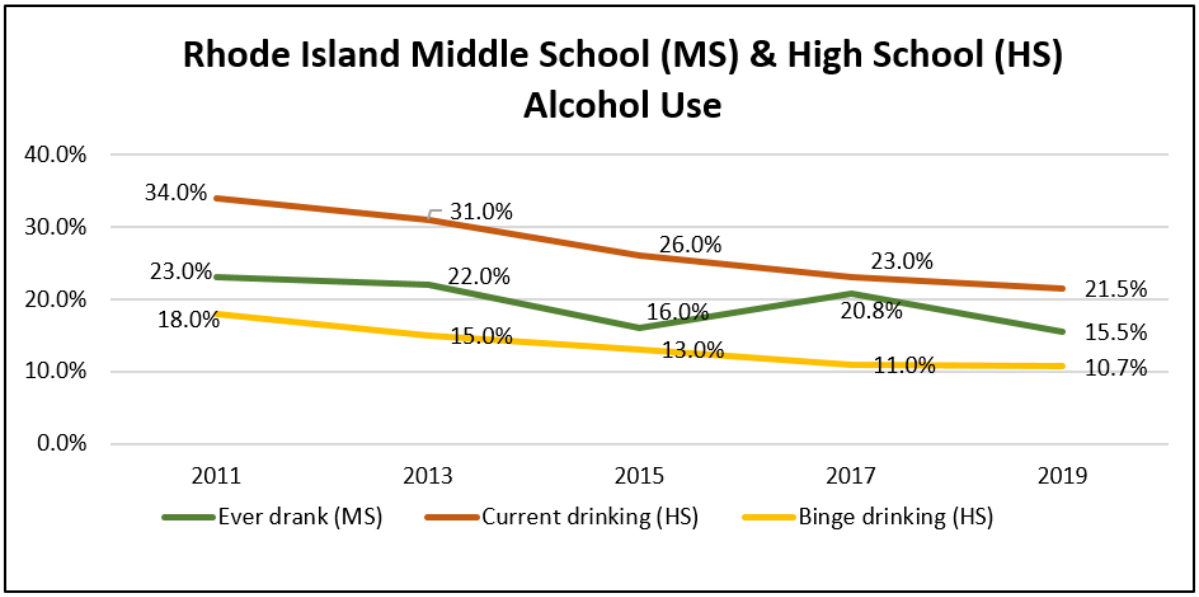


Source: Youth Risk Behavior Survey

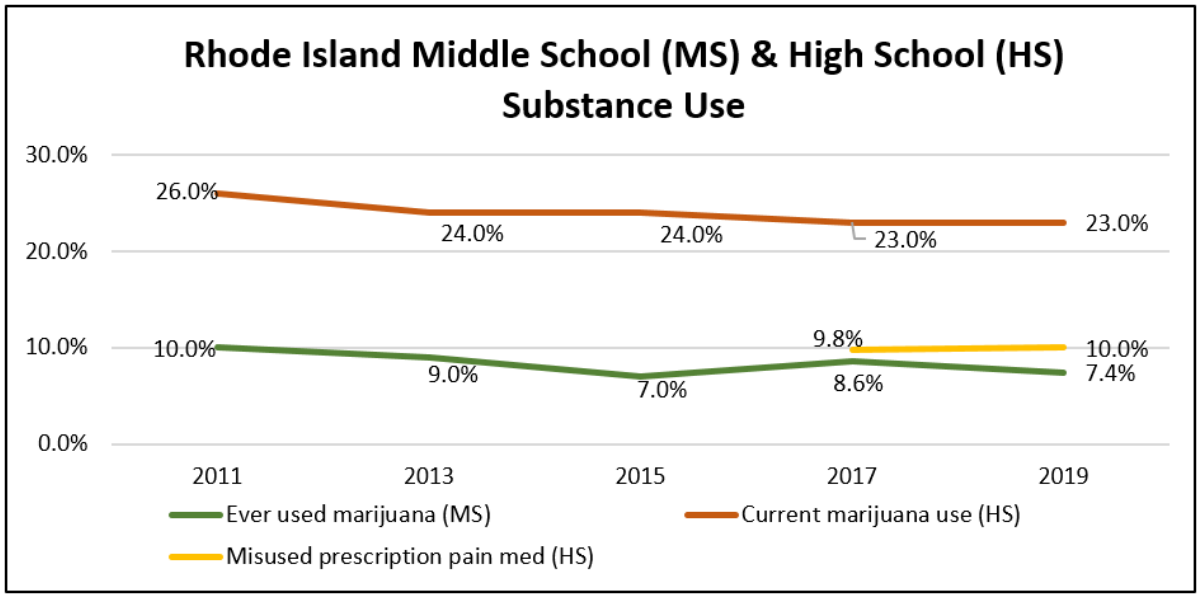
Rhode Island High School Student Mental Health Measures by Demographic Group

	Hispanic	Black	White	Male	Female	LGBT Q+	Straight	Disability
Feel consistently sad/hopeless	36.8%	27.6%	31.3%	23.9%	40.6%	63.2%	28.0%	55.8%
Made a suicide plan	13.6%	16.6%	10.6%	9.2%	14.6%	36.2%	8.6%	24.1%

Source: Youth Risk Behavior Survey, 2019



Source: Youth Risk Behavior Survey



Source: Youth Risk Behavior Survey

Rhode Island High School Student Alcohol and Substance Use by Demographic Group

	Hispanic	Black	White	Male	Female	LGBTQ +	Straight	Disability
Current drinking	17.3%	13.2%	24.0%	20.1%	22.5%	34.4%	20.1%	26.6%
Current marijuana use	19.9%	17.2%	24.6%	23.5%	21.9%	28.7%	22.7%	28.8%
Misused pain med	11.1%	13.3%	8.5%	8.6%	11.4%	22.3%	8.3%	13.9%

Source: Youth Risk Behavior Survey, 2019

Providence Public School District Grade 3-5 Mental Health Measures

	2019 Survey Results		PPSD Change from 2018 Survey
	PPSD	Rhode Island	
Feel consistently sad/hopeless	36%	30%	▲ 4% points
Stress interfered with ability to participate in school (“tremendous amount” “quite a bit” or “somewhat”)	49%	41%	▲ 1% point
Stress interfered with activities outside of school (“tremendous amount” “quite a bit” or “somewhat”)	45%	37%	▲ 2% points

Source: Rhode Island Department of Education, 2019

Providence Public School District Grade 6-12 Mental Health Measures

	2019 Survey Results		PPSD Change from 2018 Survey
	PPSD	Rhode Island	
Feel consistently sad/hopeless	36%	33%	▲ 2% points
Stress interfered with ability to participate in school ("tremendous amount" "quite a bit" or "somewhat")	61%	60%	▲ 4% points
Stress interfered with activities outside of school ("tremendous amount" "quite a bit" or "somewhat")	56%	54%	▲ 3% points

Source: Rhode Island Department of Education, 2019

Providence Public School District High School Student Alcohol and Substance Use within the Past 30 Days

	Marijuana Use	Alcohol	Prescription Drug (misuse)
Classical HS – Grade 10	8.3%	13.5%	3.9%
Classical HS – Grade 12	18.3%	23.4%	9.7%
E-Cubed HS – Grade 10	10.3%	7.9%	10.5%
E-Cubed HS – Grade 12	8.3%	12.2%	14.6%
PCTA HS – Grade 10	9.0%	14.9%	8.9%
PCTA HS – Grade 12	3.1%	8.3%	13.5%
Dr. Jorge Alvarez HS – Grade 12	7.0%	15.9%	9.1%
Mt. Pleasant HS – Grade 10	6.2%	16.1%	16.7%
360 HS – Grade 10	17.4%	21.3%	13.3%

Source: University of Rhode Island Youth Experience Survey, 2017-2018 School Year
*Note: Only high schools and grade levels with at least a 60% response rate included.

Providence Public School District Students with a Behavioral Health Condition, as Reported in School Health Records (Count and Percent of Total Enrollment)

Elementary School	Middle School	High School
359 (3.4%)	506 (9.0%)	334 (4.5%)

Source: PPSD Student Health Services, 2019-2020 School Year
Note: Prevalence includes students enrolled at public charter schools and programs (e.g. Newcomer). Behavioral health conditions include depression, suicide ideations, anxiety, assault-related behavior issues, among others.

Hospitalizations and ED Visits for a Mental Health or Substance Use Diagnosis (*Primary Reason* for the Visit) for Providence Youth Age 0-17

	2016	2017	2018	2019
ED VISITS				
Substance use only (percent of total behavioral health)	69 (6.9%)	64 (5.4%)	43 (4.0%)	82 (7.3%)
Mental health only (percent of total behavioral health)	925 (93.1%)	1,118 (94.6%)	1,043 (96.0%)	1,042 (92.7%)
Total behavioral health (percent of total ED visits)	994 (4.9%)	1,182 (5.4%)	1,086 (5.1%)	1,124 (5.3%)
HOSPITALIZATIONS				
Substance use only (percent of total behavioral health)	5 (1.0%)	9 (1.7%)	5 (1.0%)	<5 (1.0%)
Mental health only (percent of total behavioral health)	517 (99.0%)	518 (98.3%)	480 (99.0%)	418 (99.0%)
Total behavioral health (percent of total hospitalizations)	522 (13.6%)	527 (13.1%)	485 (12.3%)	422 (11.3%)

Source: Rhode Island Department of Health

Hospitalizations and ED Visits with a Documented Mental Health or Substance Use Diagnosis (*May Not* Be the Primary Reason for the Visit*) for Providence Youth Age 0-17

	2016	2017	2018	2019
ED VISITS				
Substance use only	131	121	112	131
Mental health only	1,553	2,004	1,960	2,033
Both substance use and mental health	152	151	167	180
Total behavioral health	1,816	2,276	2,239	2,344
HOSPITALIZATIONS				
Substance use only	71	73	57	27
Mental health only	561	643	546	484
Both substance use and mental health	86	66	85	80
Total behavioral health	718	728	688	591

Source: Rhode Island Department of Health

*Note: Patient records may document multiple diagnoses, including the chief complaint or primary diagnosis and secondary or coexisting diagnoses. The table includes behavioral health primary or secondary diagnoses.

Top Primary Diagnoses for Behavioral Health ED Visits for Providence Youth Age 0-17

	ED Visits	Percent of Behavioral Health ED Visits	Percent of All ED Visits
Mood disorders (e.g. depressive disorders, bipolar disorder)	280	24.9%	1.3%
Attention-deficit conduct and disruptive behavior disorders	250	22.2%	1.2%
Adjustment disorders (e.g. stress, feelings of sadness of hopelessness)	195	17.4%	0.9%
Anxiety disorders	161	14.3%	0.8%
Suicide and intentional self-inflicted injury	79	7.0%	0.4%
Substance-related disorders	68	6.1%	0.3%

Source: Rhode Island Department of Health, 2019

Top Primary Diagnoses for Behavioral Health Hospitalizations for Providence Youth Age 0-17

	Hospitalizations	Percent of Behavioral Health Hospitalizations	Percent of All Hospitalizations
Mood disorders (e.g. depressive disorders, bipolar disorder)	213	50.5%	5.7%
Adjustment disorders (e.g. stress, feelings of sadness of hopelessness)	84	19.9%	2.3%
Anxiety disorders	69	16.4%	1.9%
Suicide and intentional self-inflicted injury	18	4.3%	0.5%
Miscellaneous mental health disorders	13	3.1%	0.3%
Attention-deficit conduct and disruptive behavior disorders	9	2.1%	0.2%

Source: Rhode Island Department of Health, 2019

Demographic Characteristics of Hospitalizations and ED Visits for Providence Youth Age 0-17 with a Primary Behavioral Health Diagnosis

	Hospitalizations N=422	ED Visits N=1,124
Gender		
Male	193 (45.7%)	544 (48.4%)
Female	229 (54.3%)	580 (51.6%)
Age Group		
0-4 years	<5 (<1%)	25 (2.2%)
5-9 years	66 (15.6%)	157 (14.0%)
10-14 years	173 (41.0%)	508 (45.2%)
15-17 years	180 (46.7%)	434 (38.6%)

Source: Rhode Island Department of Health, 2019

Demographic Characteristics of Hospitalizations and ED Visits for Providence Youth Age 0-17 with a Primary Behavioral Health Diagnosis cont'd

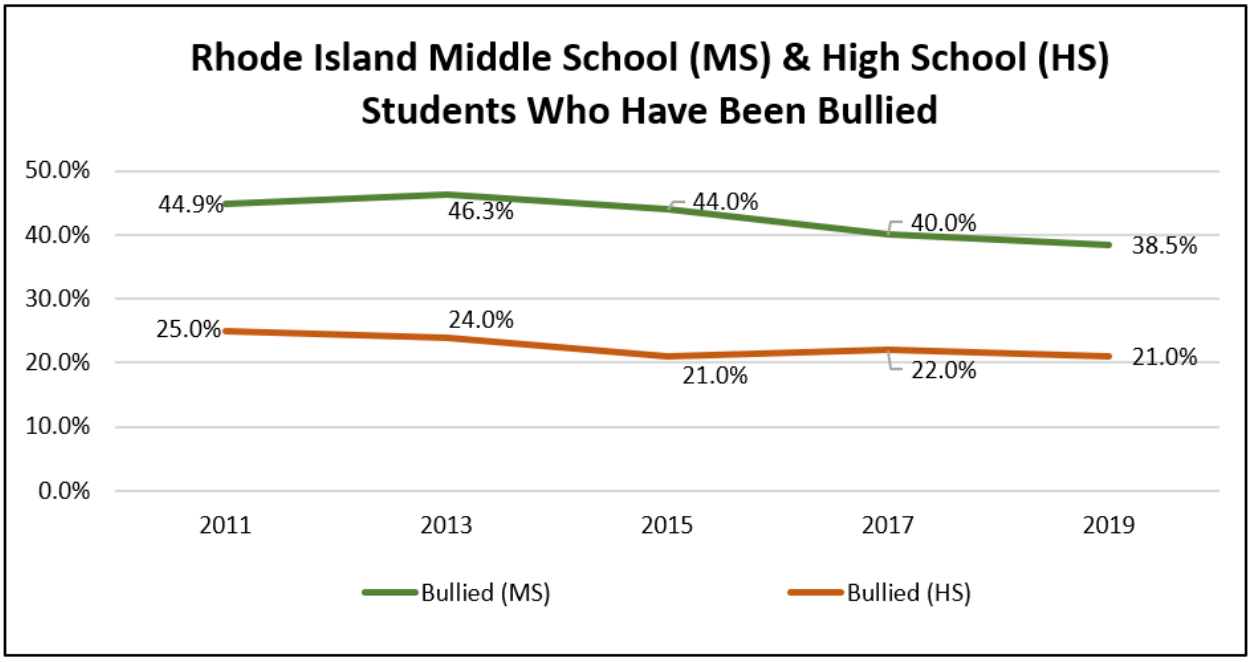
	Hospitalizations N=422	ED Visits N=1,124
Race or Ethnicity		
White	131 (31.0%)	297 (26.4%)
Black	91 (21.6%)	250 (22.2%)
Hispanic	174 (41.2%)	512 (45.6%)
Other	23 (5.5%)	63 (5.6%)
Insurance		
Private	65 (15.4%)	127 (11.3%)
Medicaid	109 (25.7%)	852 (75.8%)
Medicare	<5 (<1%)	<5 (<1%)
None	245 (58.1%)	136 (12.1%)
Zip Code		
02903	91 (21.6%)	382 (34.0%)
02908	73 (17.3%)	207 (18.4%)
02907	68 (16.1%)	157 (14.0%)
02909	56 (13.3%)	187 (16.6%)
02904	49 (11.6%)	73 (6.5%)
02905	46 (10.9%)	91 (8.1%)
02911	23 (5.5%)	<5 (<1%)
02906	12 (2.8%)	26 (2.3%)
02910	<5 (<1%)	0

Source: Rhode Island Department of Health, 2019

Trauma Key Findings & Supporting Data

- Reported bullying among Rhode Island middle and high school students is declining. Within PPSD, students in grades 6-12 report declining bullying both on school property and electronically, with lower rates than the state overall. Students in grades 3-5 also report a decline in bullying on school property, but a higher, increasing rate of electronic bullying.
- The percentage of PPSD students who report that they worry about violence at school declined, but the percentage of students who report high frequency of physical fights increased, challenging how students may define violence. Approximately half or more of PPSD students are worried about violence or have witnessed fights, a higher percentage than the state overall.
- The percentage of Rhode Island high school students who report experiencing dating violence increased more than 5 points from 2017 (9%) to 2019 (14.4%). LGBTQ+ students and students with a disability are the most likely to report experiencing dating violence, as well as bullying, followed by females.

- Children of incarcerated parents and children witnessing domestic violence is declining statewide, but Providence children continue to have higher rates than their peers in other core cities and across Rhode Island. The rate of children of incarcerated parents in Providence is more than triple the rest of the state, excluding core cities.
- The rate of child abuse and neglect in Providence is also declining, but it is double the rate for the rest of state, excluding core cities. Across Rhode Island, 81% of child abuse and neglect cases involve neglect. The most common indications of neglect are lack of supervision (41%) and exposure to domestic violence (25%).



Source: Youth Risk Behavior Survey

Rhode Island High School Students Bullying by Demographic Group

	Hispanic	Black	White	Male	Female	LGBTQ +	Straight	Disability
Bullied at school	14.1%	13.2%	18%	12.8%	19.8%	37.2%	13.0%	26.0%
Cyberbullied	11.8%	10.8%	14%	8.9%	16.9%	26.5%	10.9%	23.3%

Source: Youth Risk Behavior Survey, 2019

Providence Public School District Grade 3-5 Bullying & Violence

	2019 Survey Results		PPSD Change from 2018 Survey
	PPSD	Rhode Island	
Bullied on school property	34%	34%	▼ 1% point
Electronically bullied	17%	15%	▲ 2% points
Worry about violence in school ("sometimes" "frequently" or "almost always")	56%	41%	▼ 3% points
Physical fights at school ("sometimes" "frequently" or "almost always")	52%	28%	▲ 1% point

Source: Rhode Island Department of Education, 2019

Providence Public School District Grade 6-12 Bullying & Violence

	2019 Survey Results		PPSD Change from 2018 Survey
	PPSD	Rhode Island	
Bullied on school property	17%	20%	▼ 2% points
Electronically bullied	11%	14%	▼ 1% point
Worry about violence in school ("sometimes" "frequently" or "almost always")	47%	38%	▼ 1% point
Physical fights at school ("sometimes" "frequently" or "almost always")	58%	44%	▲ 2% points

Source: Rhode Island Department of Education, 2019

Rhode Island High School Students Experiencing Dating Violence

2013	2015	2017	2019
8.0%	9.0%	9.0%	14.4%

Source: Youth Risk Behavior Survey

Rhode Island High School Students Dating Violence by Demographic Group

Hispanic	Black	White	Male	Female	LGBTQ+	Straight	Disability
16.6%	NA	14.0%	7.4%	20.5%	37.3%	11.0%	23.6%

Source: Youth Risk Behavior Survey, 2019

Violent Crime Offenses

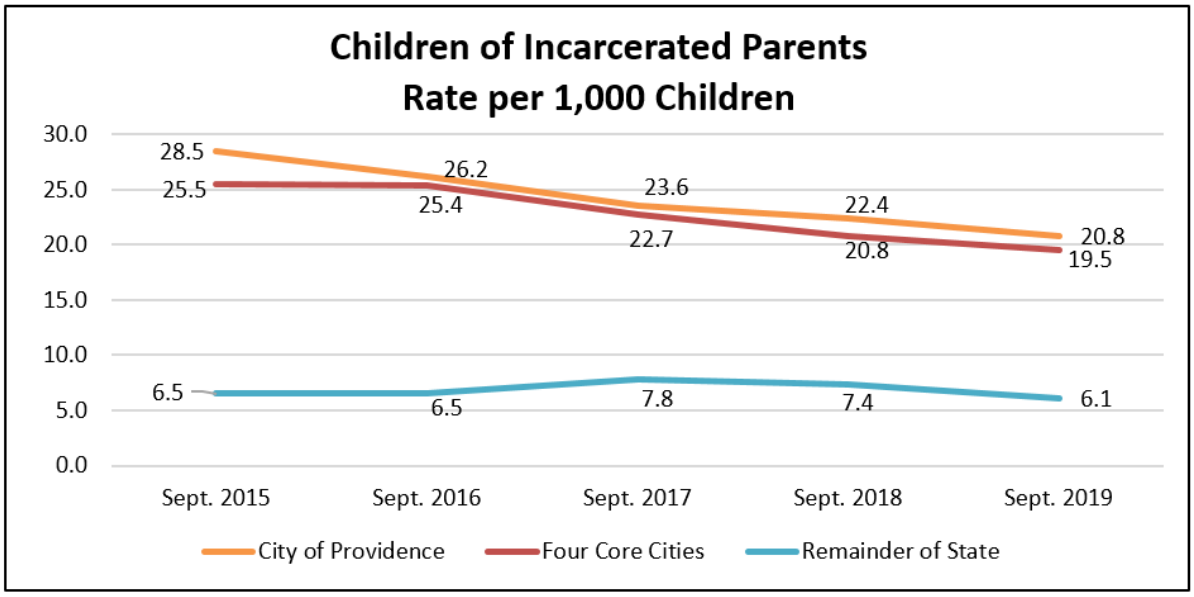
	City of Providence	Four Core Cities	Remainder of State	Rhode Island
Violent crime offenses (all ages)	819	1,469	778	2,247
Juvenile arrests for violence – Assault (count, % of RI total)	84 (16%)	215 (40%)	288 (54%)	537
Juvenile arrests for violence - Weapons (count, % of RI total)	21 (26%)	44 (54%)	35 (43%)	81

Source: US Department of Justice & Rhode Island Department of Public Safety, 2018

Children of Incarcerated Parents

	City of Providence	Four Core Cities	Remainder of State	Rhode Island
Incarcerated parents	358	601	423	1,024
Number of children reported	867	1,435	918	2,353
Rate of children of incarcerated parents per 1,000	20.8	19.5	6.1	10.5

Source: Rhode Island Department of Corrections, September 30, 2019

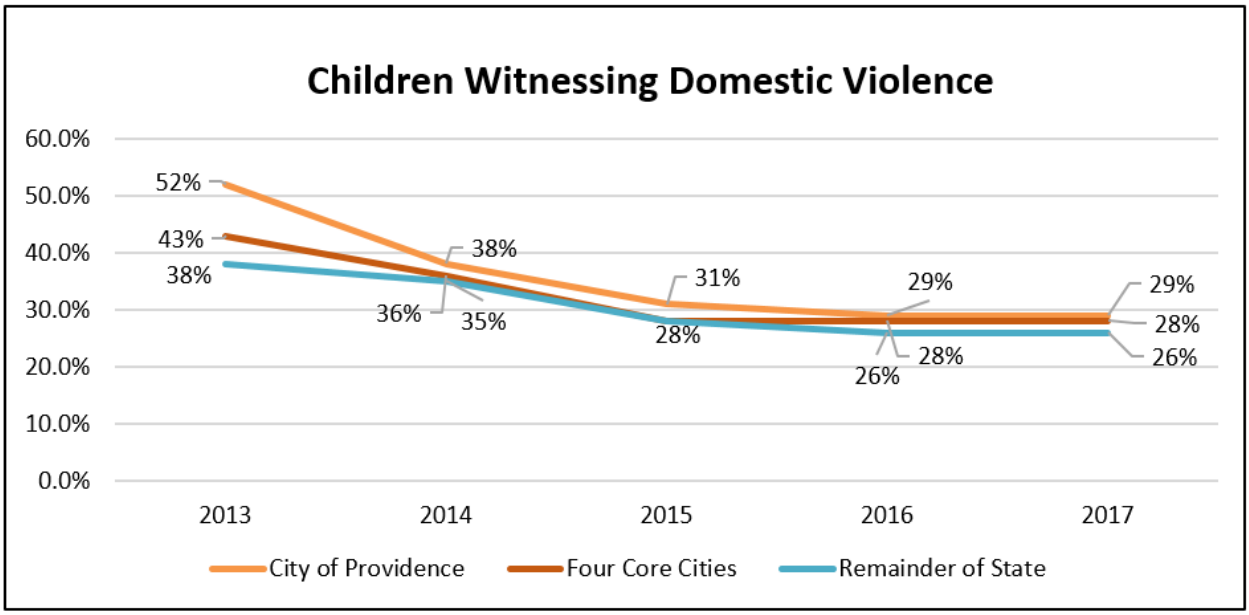


Source: Rhode Island Department of Corrections

Children Witnessing Domestic Violence

	City of Providence	Four Core Cities	Remainder of State	Rhode Island
Total domestic violence incidents	893	2,385	3,171	5,647
Incidents with children present	260 (29%)	672 (28%)	814 (26%)	1,501 (27%)

Source: Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit, 2017

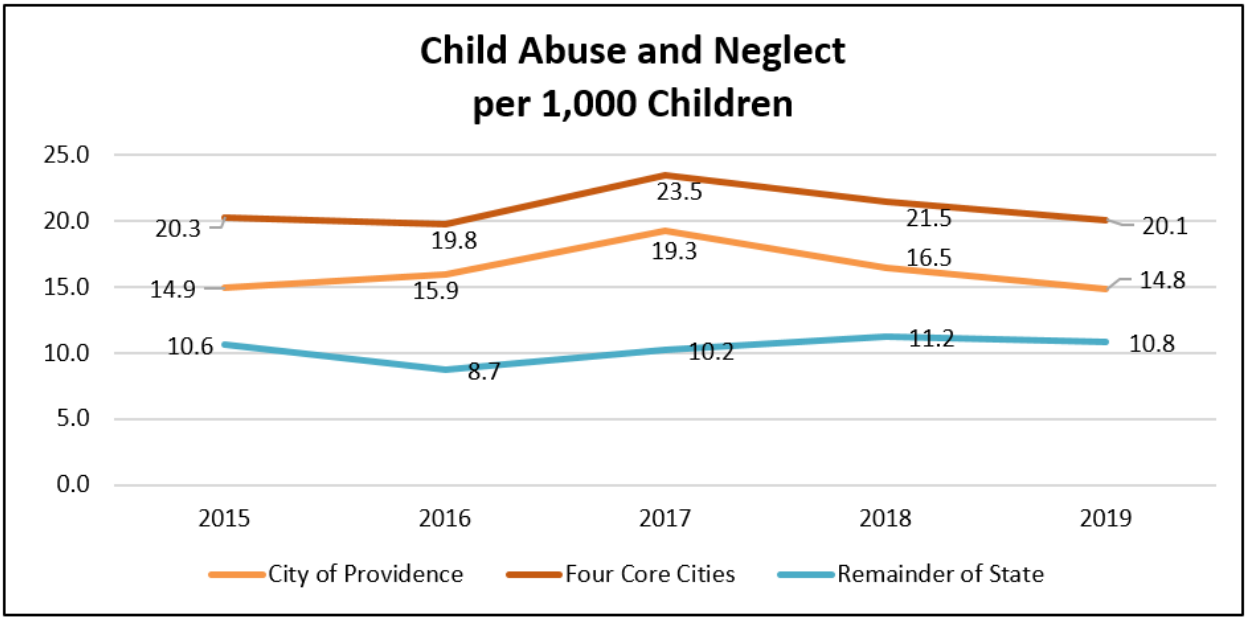


Source: Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit

Investigations of Child Abuse and Neglect

	City of Providence	Four Core Cities	Remainder of State	Rhode Island
Indicated investigations	449	1,043	1,206	2,249
Victims of child abuse/neglect	617	1,480	1,629	3,109
Child abuse/neglect per 1,000 children	14.8	20.1	10.8	13.9

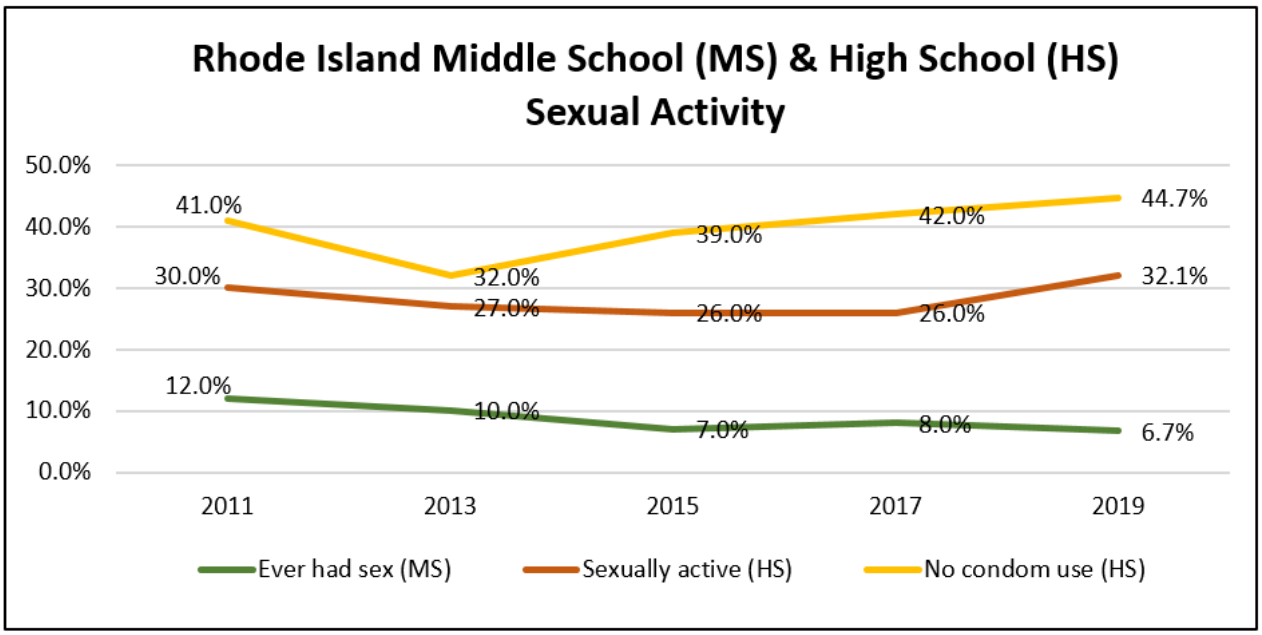
Source: Rhode Island Department of Children, Youth and Families, 2019



Source: Rhode Island Department of Children, Youth and Families

Sexual Health Key Findings & Supporting Data

- The percentage of Rhode Island middle school students who have ever had sex is declining, but the percentage of sexually active high school students increased notably from 2017 to 2019. Approximately 32% of high school students report being sexually active, and the percentage is consistent across demographic groups.
- While sexual activity among high school students is increasing, condom use is declining. Nearly half of sexually active high school students report not using a condom, with higher percentages among LGBTQ+, females, and students with a disability.
- Births to teens are declining statewide, but the Providence birth rate is more than 2.5 times higher than the state, excluding core cities. From 2014-2018, 879 teen births occurred in Providence.
- Providence has the highest rate of sexually transmitted infections (STIs) of any other Rhode Island municipality, and STIs affect young adults at a higher rate than the general population. Across Rhode Island, the rate of chlamydia and gonorrhea among young adults is more than eight times higher than the general population, and increasing.

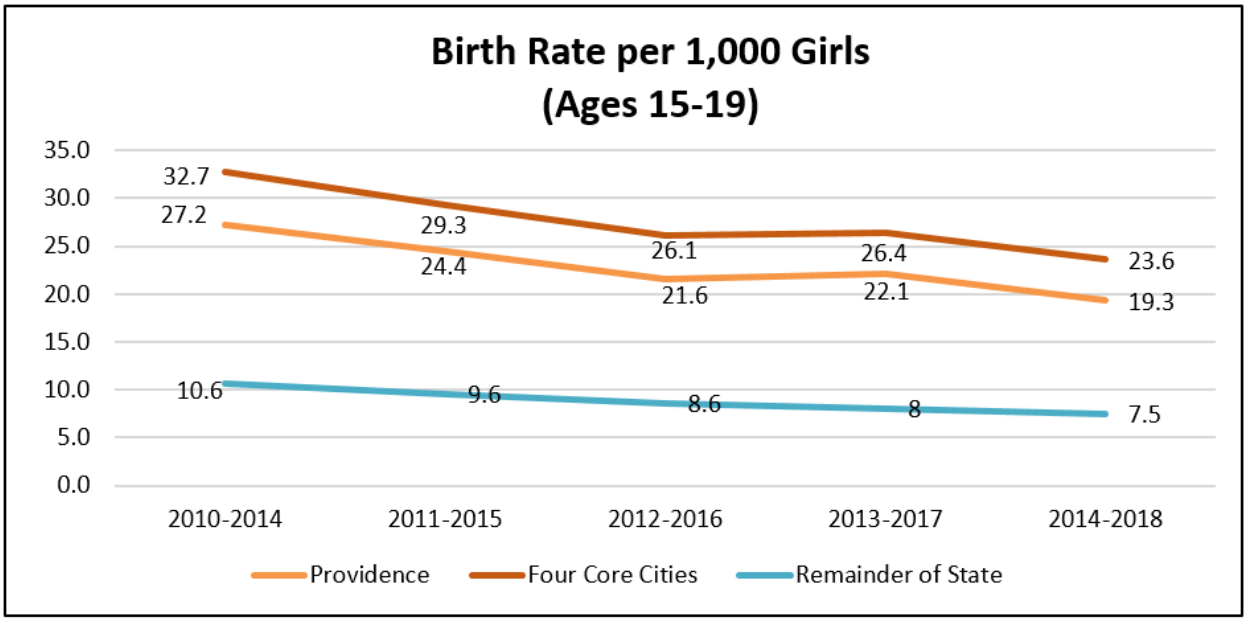


Source: Youth Risk Behavior Survey

Rhode Island High School Students Sexual Activity by Demographic Group

	Hispanic	Black	White	Male	Female	LGBTQ +	Straight	Disability
Ever had sex	43.3%	46.8%	39.5%	42.6%	39.6%	40.3%	42.3%	43.3%
Sexually active	31.2%	33.7%	32.3%	30.8%	33.4%	30.4%	33.3%	34.7%
No condom use	43.8%	NA	40.8%	38.6%	49.9%	67.9%	42.2%	49.6%

Source: Youth Risk Behavior Survey, 2019



Source: Rhode Island Department of Health

Top Three Municipalities by Sexually Transmitted Infections Rate per 100,000

	HIV	Syphilis	Chlamydia	Gonorrhea
Providence	12.2	148.2	1,075.2	296.3
Pawtucket	17.1	123.3	848.9	215.7
Cranston	9.2	65.5	482.2	126.1

Source: Rhode Island Department of Health, 2014-2018

Sexually Transmitted Infections among Rhode Island Populations per 100,000

	Chlamydia		Gonorrhea	
	Young adults age 15-24	Total population	Young adults age 15-24	Total population
2014	1,811	413	152	56
2015	1,825	434	155	55
2016	2,015	472	172	67
2017	3,643	499	476	103
2018	3,527	499	554	53

Source: Rhode Island Department of Health, 2014-2018

School Culture & Climate Key Findings & Supporting Data,

Note: Data reported by 2019 SurveyWorks, a statewide annual survey to hear from Rhode Islander's directly about their experiences in the state's public schools.

- Feelings of belonging to the school community and positive school climate are declining among PPSD students. Among students in both grades 3-5 and 6-12, perceived energy of the school is the greatest area of opportunity. A positive finding is that PPSD students are more likely to report that the behavior of other students helps their learning, indicating lower perceived impact of violence and physical fighting on the school community.
- PPSD students perceive lower teacher expectations for student learning. In comparison to students statewide, PPSD students are less likely to report that teachers have "quite high" or "extremely high" expectations, and the percentage is declining.
- Teacher-student relationships are an area of opportunity for PPSD students in grades 3-5, but an emerging strength for PPSD students in grades 6-12. While positive perceived teacher relationships are declining for students in grades 3-5, they are increasing for students in grades 6-12 and exceed state averages.
- PPSD students in grades 3-5 are among the most impacted by negative school culture and climate. They are notably less likely to report positive school energy or that people at school understand them as a person in comparison to their peers statewide. They are also less likely to report that teachers will encourage them to keep trying if they're ready to give up on a task or that teachers really want to know the answer when they ask, "How are you?," indicators of teacher expectations and relationships.
- Indicators for social emotional learning are lower for PPSD students when compared to the state overall, but generally increasing. In comparison to previous surveys, PPSD students are more likely to report that they have an adult at school and in the community that they can talk to when they have a problem.
- Statewide initiatives to encourage post-graduate aspirations among students are an area of strength for PPSD. PPSD students in both grades 3-5 and 6-12 are more likely to report that they talk about college and/or careers in class when compared to their peers statewide. However, percentages declined from previous surveys and should be monitored.

Providence Public School District Grade 3-5 Culture and Climate

	2019 Survey Results		PPSD Change from 2018 Survey
	PPSD	Rhode Island	
Belonging	57%	60%	▼ 3% points
People at school understand you as a person (“quite a bit” or “completely”)	62%	65%	▼ 3% points
Feel connected to the adults at school (“quite a bit” or “extremely”)	52%	52%	▼ 3% points
Climate	61%	64%	▼ 1% point
Positive energy of the school (“slightly” “somewhat” or “very”)	66%	73%	▼ 2% points
How much the behavior of other students helps learning (“a little bit” “some” or “tremendous amount”)	43%	39%	No change
Expectations	73%	78%	▼ 1% point
Likeliness that teachers will make you keep trying if ready to give up (“quite likely” or “extremely likely”)	77%	83%	▼ 2% points
Teachers’ expectations for you (“quite high” or “extremely high”)	74%	77%	▼ 1% point
Relationships	70%	75%	▼ 1% point
Level of concern by teachers if visibly upset (“quite concerned” or “extremely concerned”)	71%	73%	No change
Extent that teachers really want to know the answer when ask, “How are you?” (“frequently” or “almost always”)	61%	66%	No change
Social Emotional Learning	65%	69%	No change
Have an adult at school to talk to if have a problem (“Yes”)	89%	93%	No change
Have an adult outside of school to talk to if have a problem (“Yes”)	85%	91%	▲ 1% point
Aspirations	35%	28%	No change
How often you talk about college in class (“frequently” or “almost always”)	21%	13%	▼ 1% point
How often you talk about jobs and careers in class (“frequently” or “almost always”)	31%	22%	No change

Source: Rhode Island Department of Education, 2019

Providence Public School District Grade 6-12 Culture and Climate

	2019 Survey Results		PPSD Change from 2018 Survey
	PPSD	Rhode Island	
Belonging	32%	33%	▼ 2% points
People at school understand you as a person (“quite a bit” or “completely”)	33%	33%	▼ 2% points
Feel connected to the adults at school (“quite a bit” or “extremely”)	22%	23%	▼ 1% point
Climate	40%	42%	▼ 2% points
Positive energy of the school (“slightly” “somewhat” or “very”)	44%	46%	▼ 3% points
How much the behavior of other students helps learning (“a little bit” “some” or “tremendous amount”)	26%	23%	▼ 1% point
Expectations	54%	60%	No change
Likeliness that teachers will make you keep trying if ready to give up (“quite likely” or “extremely likely”)	51%	56%	▲ 1% point
Teachers’ expectations for you (“quite high” or “extremely high”)	55%	59%	▼ 2% points
Relationships	43%	45%	▲ 1% point
Level of concern by teachers if visibly upset (“quite concerned” or “extremely concerned”)	38%	37%	▲ 1% point
Extent that teachers really want to know the answer when ask, “How are you?” (“frequently” or “almost always”)	36%	34%	▲ 1% point
Social Emotional Learning	54%	57%	No change
Have an adult at school to talk to if have a problem (“Yes”)	79%	83%	▲ 2% points
Have an adult outside of school to talk to if have a problem (“Yes”)	82%	88%	▲ 2% points
Aspirations	49%	48%	No change
How often you talk about college in class (“frequently” or “almost always”)	25%	18%	▼ 1% point
How often you talk about jobs and careers in class (“frequently” or “almost always”)	29%	22%	▼ 3% points

Source: Rhode Island Department of Education, 2019

Key Informant Interviews Summary

Background

Key Informant Interviews were conducted to garner deeper qualitative insight on the priority health and support service needs among students and to develop a more coordinated, efficient, and effective system for addressing student health. Interviews were conducted with 23 community stakeholders representing the broad interests of the community.

The objectives for the interviews were to:

- Understand health and socioeconomic factors that impact students' wellbeing;
- Identify gaps in school-health related support, resources, services, or functions;
- Determine common and unique factors across demographic groups and/or neighborhoods within PPSD;
- Identify school and community assets available to help students improve their health;
- Collect input on priorities and recommendations from health and human service partners, parents, and students to meet perceived health priorities.

Whole School, Whole Community, Whole Child as a Model

Key Informant Interview participants were asked a series of questions about the health and social service needs of students, using the Centers for Disease Control (CDC) Whole School, Whole Community, Whole Child (WSCC) model as a guide. The WSCC model is the CDC's framework for addressing health in schools, emphasizing the role of the community in supporting the school, the connections between health and academic achievement, and the importance of evidence-based school policies and practices. More information about WSCC can be found at the website https://www.cdc.gov/healthyschools/wscc/index.htm.

Participants

A list of initial Key Informant Interview participants was identified through recommendations from the City of Providence Healthy Communities Office (HCO). These participants included representatives from PPSD, the Rhode Island Department of Health, the Rhode Island Department of Education, and health and human service agencies. Participants were asked to suggest others to include in the interviews, which expanded the participant list to include parent and student advocacy groups and additional representatives from PPSD and health and human service agencies. A full list of participants is included in Appendix A.

Summary of Findings

Key themes derived from the interviews are outlined below. Further analysis of these findings follows this section.

Student Health and Wellbeing

- **Existing services to address student health are viewed as effective and meaningful, but capacity needs to be expanded to meet the needs of all students across the district.**
    - Specific services mentioned during interviews included the Healthy Communities Office, The Providence Center, Project Aware, Project Success, Familias Unidas, PPSD school nurses, and Young Voices, among others.
    - Challenges include the need for additional staff, including social workers, counselors, and administrative support at each school to assist with paperwork and follow-up with families and community partners; office space to meet with students; and access to technical equipment including internet and printers.
- **Ensuring students receive the required immunizations for school attendance has been successful and PPSD boasts 74-96% of students, dependent on grade level, in compliance with requirements.**
    - School nurses spend significant administrative time checking records and sending multiple communications to student homes.
    - Coordination between primary care and school nurses advances these initiatives.
    - Required and recommended health and wellness visits including immunizations, well-child visits, and dental visits are typically on-track for elementary age students and begin to taper off as students age.
    - Language, lack of a primary care provider (PCP), family moves/school transfers, and undocumented status increase challenges and reduce compliance for required health documentation, which can keep children from being allowed to attend school.
- **Behavioral health conditions—particularly anxiety—are prevalent among students. Childhood trauma is a significant health issue for PPSD students.**
    - Based on the results of a recent Cognitive Behavioral Interventions for Trauma in Schools (CBITS) assessment, it is estimated that 80-90% of PPSD students have experienced trauma. Structural and systemic racism contributes to trauma.
    - Student behavioral health conditions are often complex and a result of multiple factors that may cause trauma including bullying, poverty, food insecurity, housing quality or homelessness, fear for undocumented family members, language barriers, violence, drugs and alcohol use, and other individual influences.
    - “School policy is often aimed at punishing or correcting the action, not treating the underlying behavioral health need.”

- **Other top health concerns for students are asthma, obesity, and vaping.**
    - Older schools and housing stock and/or poor housing conditions likely contribute to asthma rates among students.
    - Education about and access to healthy foods and physical activity impact obesity.
    - With healthy choice vending machines and distaste for school meals, students stop at bodegas or corner stores on the way to school for less healthy foods.
    - School actions to suspend students caught vaping do not treat the underlying health issue or treatment needs. E-cigarette and vaping education needs to be included in health education curriculum.
    - School nurses can help coordinate care if they have permission from parent/guardian to work with a PCP, but often paperwork is not completed to gain this permission.
    - Student health records are captured at every school nurse visit and may be a useful tool to determine top health needs among students, augment PCP care, or guide health education topics.
- **Current and comprehensive health education that includes physical and mental wellbeing, sexual health, personal hygiene, gender identity, and other health influences for youth is needed.**
    - Health curriculum is outdated both in content and mode of delivery. Some content is delivered via VHS tape.
    - Students describe health class as disengaging and not relatable to their experiences. They report that instructors seem uncomfortable or unfamiliar with the subject matter, which diminishes the content, even when it is current.
    - Key informants asserted that PPSD is “surrounded by health expertise” (Care New England, Lifespan, Brown University, University of Rhode Island, etc.) that could provide competent, relevant, and current health information.
    - Partnerships with health and human service providers like Sojourner House have been successful in providing health education to students on specific topics.
    - Students may not receive accurate or comprehensive sexual health information at home, increasing the need for comprehensive health education at school.
- **Recognition of the connection between student nutrition and school achievement is under-emphasized.**
    - Actions to improve school nutrition including healthier vending options, school/community gardens, improved meal preparation, etc. have been recognized as steps in the right direction. Key informants noted additional areas to be addressed.
    - All PPSD students are eligible for free and reduced meal program, but many students forgo school meals because they are unappealing to them.

- Budget and space constraints impact the quality of food. Title one funding does not provide for “best foods.” School meals are prepared offsite and delivered to schools. Temperature and presentation of food can reduce appeal to students.
- A partnership with food vendor Sodexo is aimed at improving nutrition and reflecting the cultural cuisine of students. Sodexo has contributed funds toward community efforts to improve food security.
- The COVID-19 health crisis has highlighted the need for year-round food security programs. There is opportunity for more outreach to improve food security, coupled with nutrition education. Current initiatives include food distribution, school/ community gardens, Farm Fresh RI, URI SNAP-ED, and food justice education.

> **A district-wide process for determining health policies, soliciting and approving school-community partnerships, and oversight of health programming is needed.**

- Leadership in school health is often diffuse or uncoordinated; and is unable to address policy, systems, and environmental health issues. School health and wellbeing policies and programs vary greatly among schools.
- Schools that have available resources—including funding and partners—in combination with motivation and cooperation from individual school leaders have more health and wellbeing programs for their students.
- A committee that oversees district-wide health initiatives with local school health committees was recommended.
- A district-wide, public health approach to student health promotion is needed to increase awareness and support for priority needs and streamline initiatives.
- Community-based health and social service organizations find it difficult to partner with the school district due to delays in paperwork processing and lack of communication from the central office.

Key Factors that Influence Student Health

> **Language barriers reduce ability for effective communication between school and home. Approximately 50% of students come from homes where English is not the primary language spoken. Combined, students and families speak 55 different languages and hail from 91 countries of origin.**

- PPSD has a high rate of new and transitioning students and multilingual learners, making it harder to inform families of school policies, direct families to resources, and general communication.
- Students are often expected to translate for parents, at times for sensitive information, which may not be properly conveyed.
- ESL class size and teachers vary throughout the school year and among schools, which negatively impacts learning for students.

- Health promotion services and programs – including communication about school meals – need to be culturally specific and relevant and offered in multiple languages. Few programs are offered in languages other than English or Spanish.

> **Students of color make up more than 90% of the student body. There is a long-standing (40+ years) history of bias and disenfranchisement of families of color, which impacts engagement and relationships among families and school leaders.**

- Families of color feel "unheard and underrepresented" in school decisions. There is both perceived and experienced bias toward families of color.
- Teacher and staff training doesn't always include capacity for engaging with parents or context for why it is important.
- The perception that East Side schools "get more" is reinforced through those school communities' ability to raise funds and influence how funds are spent.
- "We need to change the narrative about what PPSD schools are. We need to change what people expect, and what they have come to think they deserve."
- "As a parent, it's hard to believe the district is sincere about engaging the community when there is no formal process or structure in place."

> **School culture and climate is seen as a top issue among students, families, and teachers and impacts the learning environment. There is a prevailing message that "school is failing" in every aspect.**

- There are dedicated adults and students within every school and they are succeeding at making small differences, but it is an uphill battle. When they get tired, there are not enough others to carry the torch.
- High turnover in teachers, staff, and administrators impacts consistency in policies and ability to carry through with initiatives, and changes priorities.
- Violence, bullying, fights, and disrespectful behavior is common and creates a hostile environment where wellbeing is not prioritized.
- Initiatives like Young Voices provide student-led opportunities for empowerment and advocacy to improve school community and policy.
- There is an opportunity to change the narrative to celebrate successes and what is going well to rebuild pride and momentum.
- "The physical state of schools does not reflect a place that you want to go to learn."
- Teachers and staff do not reflect the student population.
- There is a lack of understanding and acceptance of cultural differences and challenges that students face at home and in community. Recommendations for anti-bias training for teachers have not been acted upon in community's eyes.
- PPSD administration is limited by collective bargaining agreement in discipline for teachers, mandatory days for professional development.

Community Engagement Summary

Background

Community engagement was an integral part of the School Health Needs Assessment research. In assessing student health needs, the Healthy Communities Office solicited feedback from parent and student advocacy groups, conducted interviews with family members, and administered a health survey among Providence youth. Research findings from other engagement activities by community partners, including community forums conducted by the Rhode Island Department of Education, were also reviewed to promote collaboration across existing initiatives and reduce duplication of efforts.

The following is a summary of key themes from community engagement initiatives.

Rhode Island Department of Education Community Forums

The Rhode Island Department of Education (RIDE) conducted nine public community forums in June and July 2019 in response to the PPSD review by the Johns Hopkins Institute for Education Policy. Nearly 1,110 people attended the forums, including students, parents, teachers, and community leaders. The following is a summary of key themes based on participant feedback with select comments. The full report is available for viewing here.

Key Themes

- **PPSD has a low level of academic instruction and expectations**
  - "Teachers at my school have to modify their lessons and set the bar low for students…students aren't pushed to do their homework or do well, which in turn leaves students unprepared for the SAT and for college." -Providence Student
  - "I had a 9th grader who didn't know how to read. How do I support the student and the family members? I'm here anticipating and hopeful that we come together as a community to support our students." -Providence Teacher
- **Parents feel powerless**
  - "My child, who's in middle school and is brilliant…is reading at a second-grade level. I had to pay out of pocket to get him an evaluation, and not many families have that resource...how many kids are in our schools who have not gotten what they need?" -Providence Parent
  - "My child has an IEP. The only reason I know about a 504 plan is because I googled it." -Providence Parent

- **Teachers and staff are demoralized and disenfranchised**
  - “I care so much about my students. I work long days with limited resources. We want the best for them, but there are so many obstacles in the way - discipline, curriculum, and social-emotional. We're afraid to speak out. It's hard to feel seen and valued." -Providence Teacher
  - "I have seen leaders at every level come and go. Teachers want real change. They want to be challenged and to be able to teach students in a calm, clean environment." -Providence Teacher
- **Principals and school leaders have no authority**
  - Principals reported that they had “no say” in determining the grade level in which teachers work.
  - “No subs to be found, no money for PD (professional development), and we’re not a community school anymore.” -Providence Principal
- **Schools are crumbling across the city**
  - “The ceiling in my classroom is falling. What does that say to our children?” -Providence Teacher
  - “My child’s school does not have any drinking water.” -Providence Parent
- **Poor school culture and safety concerns**
  - “I send my daughter to school to learn and saw that she was bullied. I saw that she was becoming a bully, too, because she said that’s how you survive. She’s in the 4th grade.” -Providence Parent
  - “What I’ve witnessed is segregation. Racial segregation. There is no integration in our schools…we are showing them that they are not good enough.” -Providence Parent
- **System governance gets in the way of student outcomes**
  - “The system is broken and needs to be fixed - we all need to work together and hold each other accountable. The changes need to be made without personal agendas.” -Providence Parent

Providence Public School District Parent Interviews

Parents Leading for Educational Equity (PLEE) was engaged as a key informant as part of the School Health Needs Assessment. PLEE is committed to creating a better education system for Rhode Island children of color in partnership with their parents and allies. Interviews were conducted with PLEE members who are parents of PPSD students. Many of the parents also served on the PTO and/or were alumni of PPSD schools. The following is a summary of key themes based on feedback from interview participants.

Key Themes

- **Existing health promotion programs are not consistent across the school district. The process for fostering and maintaining school-community partnerships to support health programming needs to be streamlined.**
    - Successful school-based health programs are not "scaled up" to serve all district students. Lack of consistent funding and turnover in school leadership contribute to discontinued programs.
    - "Not only is there a difference from school to school, but also classroom to classroom. Our PTO funds one field trip each year and there are consistently two to three teachers who opt out. There is no way to force them."
    - Schools are surrounded by accomplished parents with connections to local health expertise and community organizations. "Use me to make connections to programs and take the load off of administrators." "An uninformed or overwhelmed principal is the difference between community partnerships or not."
    - Community partners offering student health programs often need to report outcomes to secure funding and support. The district was seen as not supporting these initiatives with needed paperwork stalled in the central office.
- **Social emotional learning (SEL) is a key need for students and should be implemented at a young age.**
    - Social and emotion learning programs vary greatly both across and within schools, with inconsistent support and training among staff and teachers.
    - "There are a ton of kids attending schools with profound trauma, and teachers don't know how to address it." Many educators do not live in Providence and are White, contributing to a lack of understanding and trust to address trauma issues.
    - Armed police officers in schools can have an escalating effect on students, particularly students of color who may experience trust issues with law enforcement. "Are the cops in schools trained to understand child and youth development? It's very different than dealing with an adult population."

- **Parents do not feel informed about the health education being offered to students. Sexual health education is seen as lacking.**
    - "It's unfortunate, because at any age, parents should be aware of the health education being offered to our children to support it or be an ally."
    - "I have a son in sixth grade who hasn't had sexual education. I have a daughter in fourth grade who has friends with their period, but it's not being talked about in schools."
- **Parents lack consistent communication from the district. Communication tools like Skyward are helpful, but not universally known or accessible to all parents.**
    - "I just got access to Skyward, and my son has been enrolled for two years." "Years ago, there were meetings to instruct parents on signing up for Skyward, but there haven't been lately with the administration changes."
    - Parents generally receive adequate classroom-related information from teachers, but lack information from the larger school and district, including leadership or policy changes and available programs.
    - "We need mandatory new student orientation. It's a big district and parents need to be informed and know the expectations of the school."
    - Distance learning due to the COVID-19 health crisis has highlighted disparities in communication among parents who do not have computer or internet experience. "Parents need to know how to use the tools. They need training on how to use Zoom. Just giving a helpline without saying what kind of help it offers, isn't helpful."
    - Text and phone call communications were seen as most helpful to parents.
- **PPSD students hail from 91 countries of origin. The diverse cultures and communities that comprise the student body and the city overall need to be engaged to promote an inclusive and empowering environment.**
    - "There's a lot of emphasis put on one specific language, Spanish, but how do we find the champions from all backgrounds to engage the community?"
    - "If families don't see themselves in the staff or think that no one will speak their language, they aren't going to engage. Research shows that as a result, students are less likely to academically achieve."
    - Faith-based and cultural organizations were identified as potential partners for engaging with diverse residents. Parents also recommended tailored student instruction based on cultural background and professional development for teachers to learn about their students' cultures.

- **Physical activity and sports programs are positive outlets for students, but capacity needs to be expanded to serve all students throughout the year.**
    - Parents perceived that sporting programs do not have designated or adequate staffing. “There is one person who is coaching multiple sports or a parent who is volunteering his/her time.”
    - After school programs offer the opportunity for students to engage in physical activity, but many of these programs are first come, first serve and are only available to students for one semester. The district rotates enrollment each semester to increase the number of students who can participate. Parents saw opportunity to engage community organizations to provide more after school programs, but recognized that funding and staffing are barriers.
    - Large economic differences among students and families heighten the need for physical activity to be offered as part of the school curriculum. “Well-off families regularly access the outdoors and exercise. Low-income families may not have this opportunity. Kids need to be able to get it at school.”
- **Mental health is a top health concern for students. Stigma and lack of counselors are barriers to receiving mental health care at school.**
    - “Kids don’t want the school to know their business. They’re afraid of the stigma.”
    - “Students are afraid to talk about what is happening in their homes. Kids are changing their behaviors at the turn of a dime and teachers don’t know why. Every school should have a mental health worker or counselor all the time. You never know what day is going to be a bad day.”
    - Some students and parents prefer to receive mental health services at home, but these services are seen as “much harder to get,” and not as timely.
    - “Schools need to offer physically health space, but also space in the day to be healthy (e.g. mindfulness).”
- **Nutrition education and healthy, appealing food options are needed in schools.**
    - “Schools are doing a fair job with mental health, but we’re not seeing as much around food deserts or healthy food preparation or nutrition education.”
    - The meals offered by schools are seen as lacking nutritional value and promoting inappropriate portion sizes. “Why is a kindergarten student getting the same size lunch as a fifth grade student?”
    - School meals are not appealing to students and do not reflect the cultural diversity of the school community. “The food in our school system isn’t working. It’s not relevant to them, they don’t eat it, and then they’re starving. We need diverse choices. One hot, one cold, and one salad is not enough choice.”
    - “All students are eligible for free meals, but it fosters inequity when the parents who can afford to send a lunch to school can send a healthy lunch.”

- Partnership programs between Sodexo and URI SNAP-Ed, offering the opportunity for students to collaboratively design school meals and taste test, were seen as positive initiatives. Parents also recommended farmer's markets at schools and snack time as an opportunity to introduce new, healthy foods.

> **School facilities do not support health due to physical structural issues and unsafe outdoor environments.**

- Many of the schools have one common area for meals, physical education, and assemblies. This setup creates scheduling issues when providing school lunch. "The lunch time for elementary students is 10:30am."
- Physical structure issues, including leaks, electrical problems, and lack of central air, create unsafe and uncomfortable learning environments.
- Elementary schools often lack designated recreation areas for students of different ages, creating potentially unsafe environments for younger students who are playing in the same space as older students.
- School outdoor recreation space is not always separated from nearby roads, creating traffic issues like speeding cars. Some schools rely on city parks for recreation space, which fosters a sense of community, but can also leave students vulnerable. One parent described an incident when individuals under the influence were at the basketball court while kids were out for recess.

> **Providence schools that are seen as supporting student health offer integrated wellness opportunities and mentoring programs and foster strong partnerships with local community-based organizations.**

- "The Met (Metropolitan Regional Career and Technical Center) has their own on-campus health center. They are able to do a lot of the things that a traditional PCP can do, including STI testing. They also have a gym on campus that is accessible before and after school. Brown University students bring in programs like SHAPE (sexual health education)."
- Students need the opportunity to engage in mentoring with community members. One parent recommended The Met's Young Man of Color (YMC) program that connects young men of color with men of color in the community as mentors.

Student Health and Wellness Survey

A Student Health and Wellness Survey was conducted with middle and high school students in May 2020 to solicit youth perspectives on priority health needs and recommendations for health and social support services. The survey was open to all Providence middle and high school students, regardless of school or school district. The survey was made available online in both English and Spanish and distributed by the HCO and community partners via social media.

Despite wide distribution efforts, a small number of students (n=31) completed the survey. Results should be interpreted with caution. The low response to the survey highlights communication and engagement barriers during the COVID-19 health crisis.

Nearly all respondents (87%) were PPSD students from 12 different middle or high schools. More than three-quarters of respondents were in high school, with the largest proportion in 10th grade, followed by 11th grade. Respondents were nearly evenly split between male and female. Approximately half identified as White and nearly 20% identified as Black/African American. Approximately 44% or respondents identified as Hispanic/Latinx.

Survey Respondents – School Attendance

	Percent	Count
Are you a Providence Public School District (PPSD) middle or high school student?		
Yes	87.1%	27
No	12.9%	4
Which PPSD middle or high school do you attend?		
Classical High School	18.5%	5
Mount Pleasant High School	14.8%	4
West Broadway Middle School	11.1%	3
E3 (E-Cubed Academy)	11.1%	3
Hope High School	11.1%	3
Nathanael Greene Middle School	7.4%	2
Roger Williams Middle School	7.4%	2
Esek Hopkins Middle School	3.7%	1
Gilbert Stuart Middle School	3.7%	1
Central High School	3.7%	1
Evolutions High School	3.7%	1
TIMES2 STEM Academy	3.7%	1
Other Schools		
The Grace School at Meeting Street	25.0%	1
School One	25.0%	1
Trinity Academy for the Performing Arts	25.0%	1
Not in school	25.0%	1

Survey Respondents – Characteristics

	Percent	Count
Grade Level		
6th grade	0.0%	0
7th grade	6.5%	2
8th grade	12.9%	4
9th grade	12.9%	4
10th grade	32.3%	10
11th grade	25.8%	8
12th grade	6.5%	2
Not applicable/Prefer not to answer	3.2%	1
Gender Identity		
Male	48.2%	13
Female	44.4%	12
Transgender, gender fluid, or gender non-conforming	3.7%	1
Prefer not to answer	3.7%	1
Race and Ethnicity		
White	51.9%	14
Black/African American	18.5%	5
Two or more races	14.8%	4
Other	7.4%	2
American Indian/Alaska Native	3.7%	1
Prefer not to answer	3.7%	1
Hispanic or Latinx (any race)	44.4%	12

Key Themes

- Mental health was a primary concern for survey respondents. When asked to consider the biggest health issues among their friends and other students, respondents identified mental health as the top issue. When asked to rate their own mental health, 47% of respondents rated it as “fair” or “poor.” Mental health services were the most commonly reported needed resource to improve youth health.
- Bullying was also identified as a top health issue by respondents. SurveyWorks results for PPSD students generally showed a lower, declining incidence of bullying, but physical fighting and violence on school property exceeded state averages.
- Other top identified resources needed to improve student health were sexual health education or resources and career training or internships. Comprehensive sexual health education was also identified as a need by key informants and PPSD parents.

- When asked to consider the biggest health concerns within the community they reside in, the top three issues identified by respondents were poverty, alcohol or drug use, and racial or cultural discrimination. These issues were also identified as top concerns by secondary data findings and key informant feedback, as well as other health needs assessment conducted for the overall Providence population.
- Less than half of respondents reported being "happy" or "extremely happy." Mental health was one of the top concerns for respondents, as well as socioeconomics. Approximately 40% of respondents indicated they "always" or "usually" worry about safety, food, or housing.

Top 5 Biggest Health Concerns for Youth

	Percent	Count
Mental health (anxiety, depression, suicide)	58.1%	18
Bullying	41.9%	13
Stress	29.0%	9
Alcohol or drug use	25.8%	8
Tobacco use (cigarettes, vaping)	25.8%	8

Top 5 Biggest Health Concerns in the Community

	Percent	Count
Poverty	35.5%	11
Alcohol or drug use	32.3%	10
Racial or cultural discrimination	29.0%	9
Tobacco or vaping	25.8%	8
Crime or gang activity	22.6%	7
Neighborhood safety/violence	22.6%	7

Top 5 Programs Needed to Improve Health for Youth

	Percent	Count
Mental health services	48.4%	15
Sexual health education or resources	35.5%	11
Career training or internships	29.0%	9
After school activities	22.6%	7
Healthcare services at school	22.6%	7

Health and Wellbeing Indicators

	Percent	Count
In general, how happy or unhappy do you usually feel?		
Extremely happy	10.0%	3
Happy	36.7%	11
Neither happy nor unhappy	43.3%	13
Unhappy	3.3%	1
Extremely unhappy	6.7%	2
Average	**3.4**	

In general, how would you rate your physical health?		
Excellent	13.3%	4
Very good	30.0%	9
Good	30.0%	9
Fair	16.7%	5
Poor	10.0%	3
Average	**3.2**	

In general, how would you rate your mental health?		
Excellent	13.3%	4
Very good	16.7%	5
Good	23.3%	7
Fair	40.0%	12
Poor	6.7%	2
Average	**2.9**	

How often do you worry about safety, food, or housing?		
All the time	10.0%	3
Usually	30.0%	9
Sometimes	30.0%	9
Rarely	20.0%	6
Do not ever worry	10.0%	3
Average	**3.1**	

Best Practice Student Health Programming

Evidence-based and promising practices are interventions that include measurable results to guide decision making and planning. They may include programs, system changes, or policies, among others. When applied to health, they are typically designed to prevent health risk factors or promote healthy behaviors, improve health outcomes, and/or effect environmental or social conditions. Evidence-based practices have been proven to effect positive change through rigorous scientific study. Promising practices demonstrate positive, measurable outcomes, but may lack sufficient evidence to be proven successful across a wide range of settings.

The following section highlights select evidence-based and promising practices for student health. The Providence Healthy Communities Office will consider these practices when developing action plans for addressing priority health needs among students.

Student Health Best Practices

Whole School, Whole Community, Whole Child (WSCC) Model
The WSCC model uses a comprehensive school reform approach to overhaul all parts and systems of a school's operation, integrating curriculum, instruction, professional development, parental involvement, classroom management, and school management efforts. The following are examples of evidence-based strategies and promising practices for using the WSCC model to promote student health before, during, and after school.

- Integrating School Health Services Across the WSCC Framework
- Integrating Nutrition Across the WSCC Framework
- Integrating Out of School Time Across the WSCC Framework
- Integrating Physical Education and Activity Across the WSCC Framework

In implementing the WSCC model, schools may utilize the CDC's Health Education Curriculum Analysis Tool (HECAT) to help conduct a clear, complete, and consistent analysis of health education curricula.

The HECAT features:

- Guidance on using the HECAT to review curricula and using the HECAT results to make health education curriculum decisions
- Customizable templates for recording important descriptive curriculum information for state or local use in the curriculum review process
- Tools to analyze preliminary curriculum considerations, such as accuracy, acceptability, feasibility, and affordability
- Tools to analyze curriculum fundamentals, such as teacher materials, instructional design, and instructional strategies and materials
- Specific health-topic concept and skills analyses
- Guidance on using the HECAT for developing a health education scope and sequence

Community Schools - Promising Practices

Community schools partner with a variety of community service organizations to provide academics, youth development, family support, mental and physical health resources, and social services for students and families, as well as community development opportunities through partnerships. Services can include tutoring, mentoring, case management, counseling, early childhood and adult education, extracurricular activities, after-school care, medical care and dental services, and welfare and employment assistance. Community schools are frequently located in low-income areas and are financed through a mix of public and private funds. Community schools are open to students, their families, and the broader community every day, even when school is not in session. (Provided by County Health Rankings)

Implementation Examples

- Family League of Baltimore, Baltimore, MD: The Family League of Baltimore in partnership with Baltimore City Public Schools and the Mayor and City Council, currently has 45 community schools across the city, each with a full-time community school coordinator, that provide students with health and mental health supports, after-school programs, and access to food, among other services. These efforts have contributed to reducing chronic absenteeism and increasing student participation in after-school programs.
- Community Achieves, Nashville, TN: An initiative of 23 schools serving more than 17,000 students that identifies, recruits, and coordinates organizations to support the needs of students and their families. Community Achieves partners with organizations like the Nashville Area Chamber of Commerce adding to the district's nearly 600 external programs, supports, and partnerships working in Community Achieves schools. Sixteen thousand students are being served in programs focusing on health and wellness; more than 2,100 students took advantage of college and career readiness opportunities last school year; and scholarship funds offered have doubled to almost $16 million.

Other Resources

- https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/community-schools
- http://www.communityschools.org/

Healthy Schools Campaign – Promising Practices

Healthy Schools Campaign (HSC), a national nonprofit organization, works to ensure that schools can provide students with healthy environments, nutritious food, health services, and opportunities for physical activity. While rooted in Chicago and their work in Chicago Public Schools, HSC provides resources, policy, and program recommendations that support and advocate for healthy schools at the local, state, and national level.

Programs

- Healthy Students, Promising Futures (HSPF) Learning Collaborative: HSPF brings together state teams committed to increasing access to Medicaid services in schools and promoting safe and supportive school environments. State teams currently include representatives from the state education agency, state Medicaid agency, and two local school districts. Fifteen state teams currently participate in HSPF.
- School Health Access Collaborative (SHAC): SHAC was launched to support increased access to school health services for Chicago's most vulnerable students. SHAC brings together key stakeholders to address issues such as the barriers and opportunities related to data sharing between health and education and strategies to address these. SHAC is also exploring ways that Medicaid Managed Care Organizations can better support school health services, among other opportunities.
    - Other Resources: Guide to Expanding Medicaid Funded School Health Services
- Cooking Up Change: Cooking up Change challenges high school culinary students across the country to create a healthy and delicious school lunch that meets national nutrition standards on a tight budget. Using only ingredients and equipment commonly available for school food service, students create recipes that appeal to their peers and can easily be replicated on a large scale in real school kitchens. Cooking up Change elevates student voices in the national conversation about school food.
    - Other Resources: Chicago Public Schools' School Meal Program
- Fit to Learn: An innovative professional development program for educators. It provides practical methods for making health and wellness a regular part of the school experience while meeting academic standards. Fit to Learn resources provide teachers with the knowledge and skills to implement a number of provisions of school wellness policies.
- Parents United for Healthy Schools: The Parents United approach involves empowering parents to make wellness a central part of the home, school, and community experience. Parents gain the knowledge and skills to develop strategies and organize school wellness teams to support health-promoting changes. Parents United released the Parents' Practical Guide for Healthy Schools / Guía Práctica de Padres para Escuelas Saludables, which brings together strategies and resources for parent leaders.
- Space to Grow: Space to Grow transforms schoolyards into beautiful and functional spaces to play, learn, garden, and enjoy being outside. Schoolyards include spaces for physical activity and areas for outdoor learning and exploration, such as outdoor classrooms, native trees and plants, vegetable gardens, and art installations.

Multi-Component School-Based Obesity Prevention Interventions – Evidence-Based Practices

Multi-component school-based obesity prevention interventions involve educational, environmental, and behavioral activities and typically address both physical activity and nutrition before, during, or after school. Multi-component school-based interventions typically include healthy living and nutrition education classes, enhanced physical education and increased physical activity opportunities, school-wide promotion of healthy food options and food environment improvements, capacity building and professional support for teachers and staff, and family education and support. (Provided by County Health Rankings)

Implementation Examples

- Coordinated Approach to Child Health (CATCH): CATCH is an evidence-based coordinated school health program designed to improve nutrition and physical activity in students attending kindergarten through 8th grade. Additional CATCH programs include CATCH Kids Club for after school settings and CATCH Early Childhood for use in preschools. This program is conducted in schools and after-school programs, and incorporates familial and community involvement in a comprehensive effort to reduce cardiovascular disease. The program is funded by The National Heart, Lung, and Blood Institute (NHLBI).
- Bienestar Health Program, Texas: The program is a culturally relevant intervention that was developed to reduce or prevent type 2 diabetes mellitus in low-income children and especially low-income Mexican-American children. The program consists of a health class and physical education curriculum, a family program, a school cafeteria program, and an after-school health club. The health curriculum covers nutrition, physical activity, self-esteem, self-control, and diabetes. The physical education curriculum promotes an active lifestyle and the after-school program promotes leisure time physical activity. Bienestar involves the child's entire community in the program by offering cooking classes for the parents and educating cafeteria staff and after-school caretakers.
- Every Little Step Counts, Phoenix, Arizona: Every Little Step Counts was an effort to create a culturally appropriate healthy lifestyle education program for Latino adolescents at highest risk for type 2 diabetes. Participants were referred to the clinic by local school nurses. The initial appointment included a discussion of medical history and a physical exam. Following the exam, children and their parents attended culturally appropriate healthy lifestyle education classes. Approximately three months after the end of the classes, participants returned for a one-on-one appointment with a dietician where challenges in maintaining behavior change were discussed. Adolescents continued with follow-up sessions on problem solving, dietary adjustments, and other counseling. Participants showed reduced BMI and total cholesterol, and a decrease in fasting insulin.

Other Resources

- https://mainehealth.org/lets-go (5-2-1-0 program)
- https://us.humankinetics.com/blogs/ewkm (Eat Well & Keep Moving)
- https://sparkpe.org/ (Sports, Play and Active Recreation for Kids program)

Trauma-Informed Schools – Promising Practices

Trauma-informed schools include trauma-informed strategies and education for all students (tier 1), supplemental supports for some students (tier 2), and intensive interventions for students who suffer from trauma exposure (tier 3). These multi-component interventions typically include revisions to disciplinary policies, social-emotional instruction, school-wide culturally appropriate education about trauma, parent/caregiver education and engagement, data monitoring and routine screening, and individualized intensive support (e.g., cognitive behavior therapy or wrap around services) for students who exhibit symptoms of trauma. Trauma-informed schools often develop community partnerships to support these efforts. (Provided by County Health Rankings)

Implementation Examples

- Alive and Well Communities (AWC), St. Louis, MO: The AWC is one of six Every School Healthy funded sites by the America's Promise Alliance. AWC partners with school districts in the St. Louis area to support the adoption and implementation of trauma-informed practices. AWC has facilitated trainings for dozens of schools focused on increasing an awareness of trauma and building personal and organizational capacity to support trauma-informed practices. In 2016, AWC launched an 18-month trauma-informed learning pilot program with 26 schools, creating Trauma Teams, gathering baseline data, providing training, and facilitating support. In 2018, AWC joined the Building Community Resilience Collaborative at George Washington University's Milken Institute School of Public Health, working with four other communities across the country to address Adverse Childhood Experiences and Adverse Community Environments.
- Washington State Compassionate Schools Initiative: The Compassionate Schools Initiative provides resources to schools aspiring to consider a trauma responsive infrastructure. Compassionate Schools support all students and are focused ultimately on helping Washington teachers understand fundamental brain development and function, learning pedagogy, recognize a mandate for self-care, correctly interpret behaviors, manage negative behaviors successfully with compassionate and effective strategies, and engage students, families, and the community.
- OnTrack Greenville, Greenville, SC (2019 RWJF Culture of Health Prize Winner): The OnTrack initiative was started in four schools in Greenville County. Since its introduction, the initiative has influenced how schools deal with children experiencing a high level of trauma, taking a multi-tiered approach to improving educational outcomes. Schools employ a data-based early warning and response system that attempts to identify students who are beginning to disengage. Faculty and staff are trained to deal with students facing trauma such as homelessness, divorce, abuse, neglect or hunger, and counselors work to bring support to families. As part of OnTrack, the district has added school-based health clinics at four middle schools and one high school.

Other Resources

- https://www.americaspromise.org/campaign/every-school-healthy
- http://www.traumainformedcareproject.org/resources/bibliography%20of%20resources%20for%20schools%20to%20be%20trauma%20informed.PDF

School-Based Social and Emotional Instruction – Evidence-Based Practices
School-based social and emotional instruction focuses on five core competency areas: self-awareness, self-management, social awareness, relationship skills, and responsible decision making. Such instruction typically includes efforts to develop skills such as recognizing and managing emotions, setting and reaching goals, appreciating others' perspectives, establishing and maintaining relationships, and handling interpersonal situations constructively. Skills may be modeled, practiced, and then applied throughout the school day. Social and emotional learning (SEL) can also be called emotional literacy, emotional intelligence, mental health, resilience, life skills, or character education. (Provided by County Health Rankings)

Implementation Examples

- Caring School Community Program (CSC): CSC is an elementary school program that builds classroom and school community. It focuses on strengthening students' connectedness to school--a pivotal element for promoting academic motivation and achievement, for fostering character formation, and for reducing drug abuse, violence, and mental health problems. CSC has been extensively and rigorously evaluated in several studies over the last couple decades.
- RULER: RULER, a project of the Yale Center for Emotional Intelligence, operates in schools nationally and internationally. RULER works to develop emotional intelligence in students from preschool to high school and in all adults involved in their education. Parents also participate in training so that they can reinforce the emotional skills that students learn at school. The approach empowers school leaders and teachers to create a genuinely safe space for students to learn and grow.
- Lifting the Interests of Families and Teachers (LIFT): LIFT is designed to decrease the likelihood of two major factors that put children at risk for subsequent antisocial behavior and delinquency: 1) aggressive and other socially incompetent behaviors with teachers and peers at school and 2) ineffective parenting, including inconsistent and inappropriate discipline and lax supervision. LIFT efforts are fortified by systematic communication between teachers and parents. A "LIFT line" is implemented in each classroom, including a phone and an answering machine that families are encouraged to use if they have any questions for the teachers or have concerns that they wish to share.
- Steps to Respect: A research-based, comprehensive bullying prevention program developed for grades 3 through 6 by Committee for Children, a nonprofit organization. The goal of the program is to decrease school bullying problems by 1) increasing staff awareness and responsiveness, 2) fostering socially responsible beliefs, and 3) teaching social-emotional skills to counter bullying and promote healthy relationships. Thus the program also aims to promote skills (e.g., group joining, conflict resolution) associated with general social competence.

Other Resources

- https://www.collaborativeclassroom.org/programs/caring-school-community/
- https://www.air.org/topic/education/social-and-emotional-learning

Diversity and Equity

The following programs and resources are designed to promote diversity and equity in schools, empowering both students and school staff. The evidence-base for these programs is undocumented.

Teaching Tolerance

The mission of Teaching Tolerance is to help teachers and schools educate children and youth to be active participants in a diverse democracy. Teaching Tolerance provides free resources to educators—teachers, administrators, counselors and other practitioners—who work with children from kindergarten through high school. Our program emphasizes social justice and anti-bias. Educators use our materials to supplement the curriculum, to inform their practices, and to create civil and inclusive school communities where children are respected, valued, and welcome participants. From film kits and lesson plans to the building blocks of a customized Learning Plan—texts, student tasks and teaching strategies—our resources help bring relevance, rigor, and social emotional learning into classrooms.

Anti-Defamation League (ADL)

ADL is a leading anti-hate organization and a global leader in exposing extremism, delivering anti-bias education, and training law enforcement. ADL provides a wide range of anti-bias tools and strategies for K-12 educators, administrators, students and family members to promote safe, respectful, and inclusive learning environments. Resources include Classroom Tips and Strategies; Definitions and Language; Discussion and Activity Guides; Film Discussion and Activity Guides; Historical Information; and Holidays, Events, and Special Months.

Alameda Unified School District (AUSD), California Anti-Bias Framework

AUSD developed an anti-bias and anti-bullying resource webpage to provide teachers, staff, parents, and guardians with resources on talking to students about hate, bias, bigotry, and intolerance. AUSD's stated vision of preparing students to be responsible citizens includes instruction in how to embrace diversity, stand up to bias, and critically evaluate the events taking place in the local, national, and international communities. AUSD is using Teaching Tolerance and Anti-Defamation League resources for its anti-bias curricula.

Respect for All Training Program, New York City, NY

In order to support the city-wide Respect for All initiative, New York City Department of Education's provided a two-day training program for all secondary school educators. The training was implemented so that every secondary school in the district would have staff members who could support lesbian, gay, bisexual, transgender, and questioning (LGBTQ) students. Pre and post questionnaires revealed that educators demonstrated statistically significant increases in: knowledge of appropriate terms, access of appropriate resources, awareness of own practices, empathy for LGBTQ students, belief in the importance of intervening in anti-LGBTQ remarks, communication about LGBTQ issues, engagement in activities to make schools safer for LGBTQ students, and frequency of intervention in anti-LGBTQ name-calling, bullying, and harassment.

Comprehensive Risk Reduction Sexual Education – Evidence-Based Practice
Comprehensive risk reduction programs provide information regarding contraception and protection against sexually transmitted infections (STIs). Sometimes called abstinence-plus programs, many efforts emphasize abstinence and delayed initiation of sex in addition to broader risk reduction components. Such programs can take place in schools (e.g., as part of the health curriculum) or in community settings; program components vary by implementer and specific model. (Provided by County Health Rankings)

Implementation Examples

- Sisters Informing, Healing, Living, and Empowering (SiHLE), Birmingham, AL: SiHLE is an intervention to reduce sexual risk behaviors among sexually experienced African American adolescent girls. Small groups of African American adolescents are led by an African American female health educator and peer educators in interactive discussions about the risks of sexual behavior including sexually transmitted diseases, HIV transmission, and pregnancy. Through role playing and skills-building the intervention provides girls with strategies to reduce risk such as abstaining from sex, using condoms, and having fewer sexual partners. The program also emphasizes ethnic and gender pride, and the importance of healthy relationships.
- Reach for Health Community Youth Service: The goal of the Reach for Health Community Youth Service program is to reduce risky sexual behavior and prevent STDs and unintended pregnancy among seventh and eighth grade urban African American and Latino youth. Reach for Health combines a classroom teaching component with community service work. This health curriculum has 40 core lessons that teach students about human sexuality while also focusing on three health risks that urban youth often face: drug and alcohol use, violence, and risky sexual behavior that may lead to pregnancy or STD infection. In addition to the core curriculum, each student is assigned to a community-based organization where he/she is required to provide service for about three hours each week. Long-term impact has been recorded among participants after two years: this includes delayed initiation of intercourse and reduced frequency of intercourse among sexually active adolescents.
- Poder Latino: Community AIDS Prevention Program for Inner-City Latino Youth: The program is a sexual health and HIV prevention program aimed at Latino adolescents. The program is designed to increase awareness about HIV/AIDS by targeting communities with public service announcements about risk reduction and encouraging sexually active teens to use condoms. Peer educators reinforce project messages at school workshops, community organizations, and health centers. Condoms are available along with explanations of proper use at events.

Other Resources

- https://advocatesforyouth.org/about/
- https://powertodecide.org/

Appendix A: Community Partners

Providence By All Means (BAM) Cabinet Members

Cabinet Member	Organization
Jorge Elorza, Mayor	City of Providence
Diana Perdomo, Chief of Policy	City of Providence
Nin Pande, VP, School Board	Providence Public School District
Carrie Bridges Feliz, Director	Lifespan Community Health Institute
Dr. Kenneth Wong, Professor	Brown University
Karla Vigil, Co-Founder	EduLeaders of Color R.I.
Sabina Matos, City Council President	City of Providence
Nirva LaFortune, City Council	City of Providence
Rebecca Boxx, Executive Director	Children & Youth Cabinet of Rhode Island
Maryellen Butke, City Consultant	City of Providence
Edda Carmadello, Executive Director of Specialized Instruction and Services	Providence Public School District
Ellen Cynar, Director	City of Providence Healthy Communities Office

Key Informant Interview Participants

Key Informant Interviews were conducted with community stakeholders representing health and social services; community health experts; youth and family advocates; and civic and social leaders, among others. A total of 23 individuals, identified below, participated in an interview.

Key Informant	Organization
Marco Andrade, Ph.D., Executive Director of Systemwide Performance	Providence Public School District
Christopher Asura, Chief of Special Projects, Health Equity Institute	Rhode Island Department of Health
Linda Barovier, Assistant Administrator	Rhode Island Behavioral Healthcare, Developmental Disabilities and Hospitals
Dana L. Benton-Johnson, LICSW, Ed.M, Manager of Social Emotional Services	Providence Public School District
Rebecca Boxx, Executive Director	Children & Youth Cabinet of Rhode Island
Carrie Bridges Feliz, MPH, Director	Lifespan Community Health Institute
Edda Camadello, Executive Director of Specialized Instruction and Services	Providence Public School District
Peter Chung, Deputy Director	Young Voices
Jillian Fain, Deputy Director of Youth and Education	City of Providence
Elizabeth Farrar, Associate Administrator	Rhode Island Behavioral Healthcare, Developmental Disabilities and Hospitals
Kirtley Fisher, Associate Chief of Staff	Rhode Island Department of Elementary and Secondary Education
Donna O'Connor, Health Services Administrator	Providence Public School District
Katie Orona, MPH , Policy Analyst	Rhode Island KIDS COUNT
Sounivone Phanthavong, MPH, Program Administrator – Adolescent, School, and Reproductive Health	Rhode Island Department of Health
Janet Pichardo, Director Family & Community Engagement	Providence Public School District
James Pinel, Vice President of Adult and Child and Family Services	The Providence Center
Pat Raymond, RN, MPH, Chief, Center for Preventive Services & Deputy, Division of Community Health & Equity	Rhode Island Department of Health
Rosemary Reilly-Chammat, Ed.D., School Health Policy and Program Specialist	Rhode Island Department of Elementary and Secondary Education
Ramona Santos, Co-Founder	Parents Leading Educational Equity
Mike Simoli, Project Manager, Healthy Homes and Environment	Rhode Island Department of Health
Solight Sou, Wellness Coordinator	Providence Public School District
Linda Tavares, LMHC, QMHP, Associate Director	The Providence Center
Karin Wetherill, Co-Director	Rhode Island Healthy Schools Coalition

Appendix B: Secondary Data Sources

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Appendix C: Academic Achievement by PPSD School

Providence Public School District Elementary Schools by Academic Achievement

Elementary School	2019 Star Rating [1]	ELA [2] Proficiency (%)	Math Proficiency (%)	ELP [3] (%)	Student Chronic Absence (%)	Teacher Chronic Absence (%)
Alfred Lima, Sr.	1	12.9	9.6	47	29.0	4.9
Charles N. Fortes	1	19.3	17.0	98	40.5	7.8
Harry Kizirian	1	15.2	9.6	59	43.3	6.8
Robert L Bailey IV	1	17.4	14.0	56	22.2	3.2
Alan Shawn Feinstein Elementary at Broad Street	2	12.6	10.5	52	31.3	0.0
Anthony Carnevale	2	12.3	12.2	52	30.2	2.5
Asa Messer	2	21.5	18.5	67	27.4	3.3
Carl G. Lauro	2	6.6	8.3	58	37.9	3.6
Dr. Martin Luther King, Jr.	2	17.5	8.1	58	33.7	2.6
George J. West	2	17.9	8.5	53	30.7	5.6
Lillian Feinstein Elementary Sackett Street	2	19.8	18.8	56	25.9	4.1
Mary E. Fogarty	2	12.3	3.6	55	36.3	3.9
The Sgt. Cornel Young Jr & Charlotte Woods Element	2	12.6	7.5	60	27.3	0
Vartan Gregorian	2	46.8	33	43	21.5	4.8
Veazie Street School	2	22.2	13.8	49	37.5	10.9
Frank D. Spaziano	3	19.3	16.4	63	27.7	0
Leviton Dual Language School	3	29.1	26.8	62	17.4	20.7
Pleasant View School	3	23.2	14.5	41	33.6	0
Reservoir Avenue School	3	43.8	35.4	58	18.7	17.1
Robert F. Kennedy	3	36.6	31.6	41	22.6	3.8
Webster Avenue School	3	29.5	21.7	60	27.5	3
William D'Abate	3	30.7	25.9	64	22.9	0

Source: Rhode Island Department of Education, 2018-2019

[1] Reflects overall school performance based on a scale of 1 to 5 stars, with 5 stars indicating higher performance.

[2] English Language Arts (ELA).

[3] English Language Proficiency (ELP), percent of students who met target for progress.

Providence Public School District Middle Schools by Academic Achievement

Middle School	2019 Star Rating [1]	ELA [2] Proficiency (%)	Math Proficiency (%)	ELP [3] (%)	Student Chronic Absence (%)	Teacher Chronic Absence (%)
Gilbert Stuart	1	6.1	3.6	19%	33.1	3.4
Governor Christopher DelSesto	1	5.1	4.3	19%	39.3	10.1
Nathan Bishop	1	17.1	13.2	13%	43.7	12.0
West Broadway	1	8.1	7.4	22%	42.0	2.6
Esek Hopkins	2	11.6	6.1	22%	46.5	7.2
Nathanael Greene	2	22.8	18.7	17%	29.2	9.7
Roger Williams	2	6.6	3.6	22%	40.6	8.1

Source: Rhode Island Department of Education, 2018-2019

Providence Public School District High Schools by Academic Achievement

High School	2019 Star Rating [1]	ELA [2] Proficiency (%)	Math Proficiency (%)	ELP [3] (%)	Grad Rate [4] (%)	Student Chronic Absence (%)	Teacher Chronic Absence (%)
360	1	10.5	5.3	29%	NA	53.0	0.0
Academy for Career Exploration (ACE)	1	20.0	4.2	9%	77.8	37.9	5.9
Central High School	1	13.2	4.6	33%	69.9	62.8	8.0
Dr. Jorge Alvarez	1	6.9	0.9	27%	62.4	53.5	12.3
Evolutions	1	12.4	3.4	19%	NA	53.9	0.0
Hope	1	9.3	2.0	35%	66.1	62.9	3.0
Mount Pleasant	1	9.8	2.4	28%	68.7	49.5	3.1
Providence Career and Technical Academy	1	18.1	2.2	41%	96.9	49.6	4.4
Juanita Sanchez Educational Complex	1	10.9	0.9	28%	62.5	59.0	9.9
E-Cubed Academy	2	13.3	4.7	52%	83.2	40.5	3.9
Classical	5	88.9	69.2	NA	97.3	26.9	5.7

Source: Rhode Island Department of Education, 2018-2019

Providence Public School District TIMES2 STEM Academy[5] Academic Achievement

2019 Star Rating [1]	ELA [2] Proficiency (%)	Math Proficiency (%)	ELP [3] (%)	Grad Rate [4] (%)	Student Chronic Absence (%)	Teacher Chronic Absence (%)
3	23.7	14.9	52%	92.9	23.0	15.9

Source: Rhode Island Department of Education, 2018-2019

[1] Reflects overall school performance based on a scale of 1 to 5 stars, with 5 stars indicating higher performance.
[2] English Language Arts (ELA).
[3] English Language Proficiency (ELP), percent of students who met target for progress.
[4] Graduation rate within 4 years.
[5] TIMES2 STEM Academy has a nonstandard grade configuration and is reported separately.