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I was surprised to learn that a very old study of mine had been cited by President Trump. He used it to support his belief that he had received more votes than Hillary Clinton, and that her seeming majority of the vote count was due to the millions of illegal aliens who voted.

My study, published only in abstract form, was a retrospective examination of alien abductions in southern California as a distinguishing history between people who voted for George HW Bush and Bill Clinton in 1992 (J Irreproduc Res. 1993; 13:354-8). In the parlance of medicine we would say that being abducted by aliens was a “risk factor” for voting for Bush. That study was based on a chance observation. I had learned from patients in my clinic, then located in Los Angeles, that many more who told me that they had voted for George HW Bush than for Bill Clinton, also told me that they had suffered extra-terrestrial abductions. I thought it was worth a quick study to see if this really was true.

The intake questionnaires for neurology departments in California had already taken a very serious approach to identifying risk factors for the major neurological disorders, particularly Alzheimer’s and Parkinson’s diseases. Aside from asking about exposures to cigarettes, caffeine and pesticides, there were questions about travel abroad, to parts of the United States, where particular infectious organisms are found, and to other planets and galaxies. Alien abductions to other planets are a not uncommon problem in southern California. When that study was presented and then published, as an abstract, it was clear that the term “alien abduction” referred to extra-terrestrial abductions, not people from Mexico and other south-of-the-border alien countries. It was also clear that this applied only to people with Parkinson’s disease and not to the general population. I had no information on the wider population, and, to the best of my knowledge, none was ever published.

It was initially not clear in President Trump’s statement how he was really using the term, “alien.” In his speech on March 15, he discussed the “well known and stupidly suppressed, big-time alien landing strip near Hanger 54.” He even tweeted, “Hanger 54! All those alien landings! They’re here! They’ve been here for 30 years! Voting for bum dems. Look it up. Interspellar stupid.” [Sic. Interstellar] His next tweet, “Check out Dr. Friedman’s spectacular study on aliens. A super scientist studied the aliens! Ignored! Wear aluminum hats.” Why wear aluminum hats? It is known that certain alien groups use irradiium rays to control thought processes, to make people not see aliens and to make those who do see them, forget what they saw. Aluminum foil hats are extremely effective in stopping the rays from entering the brain.

Trump has seen the aliens himself. “I wear very thin, see-through aluminum foil brain protectors and I’ve seen them. They usually appear, I mean, haven’t you all seen, well maybe if they don’t look different, they’re always on voting lines. Especially in New Mexico, Arizona, and those terrible combat zones in African-American communities. They’re full of them. They’re all over the place. They’re a big problem. The biggest and everyone’s making believe they’re not there. It’s time for a change.”

The president reported that the real problem with extra-terrestrial aliens voting is that it is not illegal for them to vote. The legal bans on aliens all refer to human aliens. Extra-terrestrial aliens take over the brains of real humans and thus control their voting. Thus, by focusing on human aliens, no state agency has found evidence of vote tampering or illegals voting. The real issue, he notes, is the question of legality.

Nowhere in the Constitution, states former Deputy Attorney John Oo, does the word “human” appear, or “DNA.” The idea of aliens from another planet never crossed the minds of the framers of the Constitution. They were concerned with people born in a different country. Now we know better and know...
COMMENTARY

that many, at least three million voters for Hillary Clinton, according to Trump, were not “illegal aliens,” but “not-illegal-or-legal aliens” from another planet. “BIG Constitutional problem. The BIGGEST! Close loophole now or we all get kidnapped to GLX37B. Worst galaxy in the universe! Bad place! Wear your aluminum hats.” (Fashionable aluminum brain protectors available from Trump Hatters, Inc; www. Trump@ MadHatters.com)

“The only way to prevent aliens from taking over regular people’s brains and making them vote against me is extremely extreme vetting, and believe me, that’s what we’re going to have from now on.”

It is an unusual situation for a clinical researcher to be in. Having discovered that an increased incidence of alien abductions was associated with voting trends in an election in a very narrow subset of the general population, we now have a leap of intellectual boundaries. This is an excellent example of misused statistics, generalizing from a very narrow population. Clearly, there are a number of studies that need to be performed, including the very obvious one of taking a sample of people who voted against the president and doing the extremely extreme vetting, to see how many were truly extra-terrestrials. It is also possible that these voters were largely alien abductees whose brains were modified in ways that do not show up on routine MRI or CT imaging and were not actually aliens, and may be difficult to identify.

Unfortunately, you can’t tell if this is an April Fool’s satire, or real life.

Author

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A Providence resident with an urgent medical problem in the mid 1940s had limited choices. You could call your doctor, but even if your doctor had an answering service the operator might not be able to find him [no cell phones or beepers]. There were no urgent care centers and emergency rooms generally were not used, as they are today, for non-emergency care.

At a three-hour Providence Medical Association (PMA) executive committee meeting in 1945, there was discussion of establishing a medical telephone answering service but no action was taken. In 1946, the PMA formed an “exchange” to answer urgent calls directly from patients. The exchange would contact a willing PMA member to respond. The doctor then phoned the patient and determined if care, possibly a house call, was needed and, if so, how urgently.

In 1949, the PMA spent $1,400 to establish the Medical Bureau (MB), a telephone answering service exclusively for PMA members, and the tale of its unhappy demise 34 years later sheds light on a little known saga in PMA history. In addition to being an answering service, the MB continued the work of the exchange, accepting requests for urgent medical care directly from patients and became an effective stimulus for PMA membership.

In the early 1950s, there were about 3,000 “emergency” calls annually [more than 8/day]. A “sizeable majority” occurred during the night. A report in 1954 indicates that every call received a physician response. About 50% of the calls were for non-urgent issues and it was noted that 1/3 of the patients who were actually seen never paid the doctor. More than a few new doctors in Providence jump-started their practices this way. In my first year in practice [1967] I made a few such visits and several of those patients stayed in my practice till I retired 41 years later!

The “exchange” service was dropped, probably in the 1970s, and the MB became a pure answering service.

The MB was located in the basement of the old RI Medical Society (RIMS) building on Francis Street. Initially there were 3 operators but the number increased to 9 in 1950 as volume increased to 400 calls per day. There was also a supervisor, Heather Kraft (not her real name). The operators worked on a beautiful wooden switchboard, like the ones you see in the old movies. The MB functioned well for over 30 years and seemed to need and actually received little oversight from the PMA.

The trouble started in 1980 and 1981. The PMA needed to loan the MB over $10,000. It was quickly discovered that

This advertisement for the Medical Bureau ran in the 1977 edition of the Rhode Island Medical Journal.
Heather had no written records of the workings at the MB. The salaries, schedules, vacations, etc., were in Heather’s head. At that time there were 27 operators, the old switchboard was failing and replacement parts were no longer available.

An audit revealed cash assets of $1,054, expenses of $294,217, and unpaid bills of $18,019. With unjustified optimism, the PMA decided to buy a new computerized switchboard and incorporate the MB as a separate business entity with the stock wholly owned by PMA. As PMA president in 1982–’83, I was also chair of the MB. Major building renovations for safety and efficiency were required as well.

To facilitate the resurrection of the MB, a bank loan was necessary. The then current bank servicing PMA refused the loan as the PMA had no assets. In March of 1982, Old Stone Bank agreed to finance the new switchboard and the renovations to the building. The loan made to the newly incorporated MB (not to PMA) required 84 monthly payments of $2,873.81.

Additionally, the MB operators were unhappy that the new system generated data, such as how long it took to answer calls, how long the conversations lasted, how many calls they made, etc. This kind of productivity feedback was a new concept and they were wary of it. One of the operators was married to a member of the laborer’s union and the 27 operators voted quickly and unanimously to join this union.

In the next few months the PMA realized that telephone answering services [at that time] were mostly “mom and pop,” low-overhead operations with little rent and family members often acting as operators, accountants, etc. The MB’s business model was not financially sustainable.

In November 1982 Heather was replaced. The union sent a negotiator, a burly, somewhat intimidating gentleman, obviously more accustomed to negotiating for similarly burly laborers than middle-aged telephone operators. The MB then hired a labor lawyer who, to our immense relief, informed us that he would be our only avenue of communication with the union rep. Negotiations, however, were non-productive.

By April 1983 the situation was desperate. The MB was put up for sale but there were no buyers. Customers started to abandon ship. We even offered to sell the MB to the union for $1. They declined our offer. We could not even give away the MB!

So that no doctor would be at risk of losing their 24/7 answering services, $5700 was expended to install lines to divert the calls to the A-1 answering service in Pawtucket.

Life support was withdrawn on November 14, 1983 and the MB passed away peacefully.

The autopsy revealed equipment with virtually no resale value and the large outstanding loan from Old Stone Bank. The money invested in restoration of the building was not recoverable. Because the MB was a separate corporate entity there was no liability of the PMA. The PMA, however, felt a moral obligation to try to repay Old Stone Bank and requested a $200 voluntary donation from its members. More than 170 members responded. $34,250 was received and used to pay debts, mostly to Old Stone Bank.

Having lost its only essential function, PMA survives now in name only, and patients’ communications needs currently are better served by sophisticated answering services plus technology mostly inconceivable at that not-so-distant time.

(The current Medical Bureau is related to the deceased MB in name only and has no connection to PMA or RIMS.)

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Herbert Rakatansky, MD, FACP, FACG, is Clinical Professor of Medicine Emeritus, The Warren Alpert Medical School of Brown University.
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**WARWICK, RHODE ISLAND**

Sarah Brooke Stevens, RIMS Office Manager (second from left), Karen Woodbine, RIMJ Advertising Sales Representative (far right), and US Army Health Care Recruiters, (left to right) Captain Mario Martinez, Sergeant First Class Brock R. Clukey, and Staff Sergeant Kenneth M. Phipps, take a moment to view the journal on their phones while attending Rhode Island Medical Society’s Weight + Wellness Summit on March 7 at the Crowne Plaza in Warwick.

**AWENDAW, SOUTH CAROLINA**

Brothers Mark R. Migliori, MD, (left) a plastic surgeon at MMK Plastic Surgery in Minneapolis, and Stephen J. Migliori, MD, (right) a general surgeon at University Surgical Associates in Providence, view the June 2016 Ophthalmology issue of RIMJ guest edited by their brother, Michael E. Migliori, MD, Ophthalmologist-in-Chief at RI Hospital, while vacationing at their brother Donald Migliori’s home in coastal South Carolina.

A ten-foot-long American alligator suns itself at a waterway near the home, displaying no interest whatsoever in RIMJ.

Wherever your travels take you, be sure to check the latest edition of RIMJ on your mobile device and send us a photo: mkorr@rimed.org.
We are read everywhere

PALM DESERT, CALIFORNIA
A visit to The Living Desert Zoo/Gardens in nearby Palm Desert is home to a variety of wildlife exhibits, conservation and educational programs, an endangered species carousel, veterinary hospital, and hands-on exhibits, such as camel riding or feeding the giraffes. Here RIMJ managing editor Mary Korr checks the March issue of the journal in front of the savannah where giraffes roam. Nearby, is a separate cheetah habitat.

INDIAN WELLS, CALIFORNIA
On a recent trip to the SoCal desert area, Dr. Ken Korr teamed up with Dr. Ed Bough, formerly of Rhode Island, for a round of golf in Indian Wells. The Southern California desert region is a well-known to golfers, tennis players, hikers and nature lovers who visit the areas of vast wilderness and diverse ecosystems such as Joshua Tree National Park in Twentynine Palms.

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Proceedings from Bridging Health Disparities to Address the Opioid Epidemic: A Symposium at the Warren Alpert Medical School of Brown University

LUBA DUMENCO, MD; KRISTINA MONTEIRO, PhD; MICHAEL MELLO, MD, MPH; SALLY COLLINS, BA; DON OPERARIO, PhD; KAREN SCANLAN, RICHARD DOLLAse, EdD; PAUL GEORGE, MD, MHPE

ABSTRACT

OBJECTIVE/BACKGROUND: In response to the unprecedented rates of illicit drug use, including opioid addiction and overdose in Rhode Island, local healthcare institutions, led by the Warren Alpert Medical School (AMS) of Brown University, collaborated to present “Bridging Health Disparities to Address the Opioid Epidemic.” This symposium sought to educate a wide array of healthcare providers and professionals around opioid use disorder, including the state of the opioid crisis in Rhode Island, national efforts around opioid misuse and how providers can work together to stem the opioid crisis in the state.

DESIGN AND METHODS: The symposium included a keynote session which aimed to increase knowledge and decrease stigma. This was followed by two rounds of breakout sessions which focused on various components of opioid disorder treatment. We elicited feedback from participants in order to plan further interventions to educate providers in Rhode Island around the opioid epidemic.

PRIMARY RESULTS: Initial feedback was positive. More importantly, this workshop allowed us to identify gaps in knowledge amongst healthcare providers in Rhode Island in order to plan further interventions for healthcare providers, including physicians, around opioid misuse, in Rhode Island.

PRINCIPAL CONCLUSIONS: This symposium is one of the first steps that a consortium of healthcare institutions, including AMS, will take to address the opioid crisis in Rhode Island. Feedback from the event was elicited to identify gaps in healthcare provider knowledge and will be used to design and implement further interventions.

KEYWORDS: opioid, naloxone, overdose, addiction

INTRODUCTION

In recent years, Rhode Island has led the country in rates of illicit drug use, including opioid addiction and overdose, and across the country the incidence of drug overdose deaths has reached an unprecedented rate. Furthermore, from 2014 to 2015 in Rhode Island, the rate of overdose deaths from natural and semisynthetic opioids increased by 23.9%, and the rate of overdose deaths from synthetic opioids other than methadone increased by 67.1%. While the usage of illicit drugs is widespread, incidence of chronic usage and overdose is highly concentrated in certain demographic groups. In the United States, nearly half of incarcerated individuals can be classified as having a substance abuse disorder or substance dependence. The homeless population, too, exhibits a higher rate of occurrence of substance use disorders than the general public. These marginalized and underserved populations have poorer access to healthcare in general, and the issue of access is exacerbated by the stigma surrounding substance use disorders. Consequently, while the care of patients with substance use disorders can be challenging, systemic health inequities can make it even more difficult for providers to effectively diagnose and treat individuals in these susceptible populations.

In response to this public health crisis, The Warren Alpert Medical School of Brown University, Brown University School of Public Health, and the Injury Prevention Center at Rhode Island Hospital collaborated to present a symposium entitled “Bridging Health Disparities to Address the Opioid Epidemic” in October 2016. The evening featured a keynote speaker followed by several breakout sessions. Physicians, pharmacists, social workers, physician assistants, nurses, public health professionals, health professional students, and community stakeholders participated in this learning experience. This symposium sought to educate a wide array of healthcare providers and professionals around opioid use disorder, including the state of the opioid crisis in Rhode Island, national efforts around opioid misuse and how providers can work together in interprofessional teams to stem the opioid crisis in the state.

THE SYMPOSIUM

The planning committee for this event included faculty, administration, and students from the Warren Alpert Medical School, faculty and administration from Brown University School of Public Health, and faculty from the Rhode Island Hospital Injury Prevention Center. The committee members collaborated to design three main learning objectives for the evening. Namely, the event sought to ensure that at the conclusion of the activity, participants would be able to:
1. Identify opioid addiction as a public health crisis in Rhode Island
2. Identify available treatment options for at-risk populations
3. Apply the skills and strategies learned to improve care for individuals with substance abuse disorders

In addition, one of our goals of the evening, while delivering increasing knowledge and skills and changing attitudes around opioid misuse, was to elicit through our evaluation where the gaps in knowledge lie, in order to design and implement future training events.

To achieve our goals and objectives, we selected Joshua Sharfstein, MD, who serves as Associate Dean, Public Health Practice & Training at the Johns Hopkins Bloomberg School of Public Health, as our keynote speaker. Dr. Sharfstein’s work has framed prescription opioid use as a public health crisis. A focus of his work is on challenging the stigma associated with opioid use disorder, including those held by physicians, and he has advocated for the use of medication in its treatment. His presentation discussed the barriers to achieving health equity, and how these barriers stymie effective addiction treatment for certain population groups. He emphasized that the negative way in which society generally views individuals with addiction impedes progress toward improving treatment access and outcomes. He also identified populations that have a historically disproportionately low rate of success in recovery, potentially due to prejudice and inaccessibility of treatment. Dr. Sharfstein’s presentation provided the framework for the symposium: there exists inequity in not only the treatment of but the incidence of opioid use disorder, and the elimination of barriers and stigma is necessary to address this health crisis.

Following the keynote presentation, conference attendees separated into preselected breakout sessions. Each of the 10 sessions focused on a specific facet of opioid abuse and its manifestation in disparate populations. Prevention, diagnosis, and treatment across these populations, and in general, were discussed. The committee culled presenters from the group of research experts and local leaders in the combat against opioid misuse and the opioid overdose crisis to fill in what the planning committee perceived as gaps among physicians and other healthcare providers. Sessions included:

- Naloxone administration training session
- Legal implications for healthcare providers around substance misuse
- Community resources around opioid misuse
- Local [Rhode Island] efforts to address the opioid crisis
- Homelessness and street medicine
- Motivational interviewing techniques
- Development of opioid curriculum for health professional students
- Methadone treatment in prison populations
- Substance abuse rehabilitation services as specific to the LGBT population
- Alternative medicine approaches to pain management

In total, 86 providers and 110 students attended the symposium. To elicit feedback from attendees, we used a standardized evaluation from the Government Performance Results Act or GPRA, as the event was sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). We obtained responses from 65% of our attendees. Results are summarized in Table 1. Generally, our respondents reported being satisfied to very satisfied with the overall training experience, including quality of the training, quality of the instruction, and quality of the training materials. Respondents also agreed/strongly agreed that the material presented will be useful in dealing with substance abuse and that the training was relevant to substance abuse treatment.

We also elicited demographic, quantitative, and qualitative feedback from participants using the continuing medical education evaluation from the Warren Alpert Medical School of Brown University. Of those attending the symposium, approximately 13% were MD/DOs and 17% were registered nurses. Other occupations represented included social workers (15%), nurse practitioners (7%), PhDs in various fields (4%), pharmacists (2%), and physician assistants (1%). Many of the non-physician providers who attended were front line workers around the opioid epidemic, including social workers and nurse care managers, who are screening for opioid misuse and often referring individuals for treatment. Other occupations outside of the health care fields listed on the evaluation (25%), included educators, students, and program directors. Specialties represented largely included primary care (~27%).

More importantly, we analyzed qualitative feedback, using grounded theory methodology, with three authors reviewing feedback (PG, LD, SC) and agreeing on common themes within the qualitative data. We did this for two main reasons: 1. To determine additional training gaps among physicians and healthcare providers in Rhode Island around opioid misuse and 2. To ensure the transfer of knowledge and skills around opioid misuse.

In regards to the transfer of knowledge and skills, qualitative data indicates this objective was met. Participants noted that the symposium influenced them to re-focus on patient-oriented care, and reminded them of the “importance

Table 1. Results from the Evaluation as part of GPRA (N=128)

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>How satisfied are you with the overall quality of the training?</td>
<td>1.30</td>
<td>.51</td>
</tr>
<tr>
<td>How satisfied are you with the quality of the instruction?</td>
<td>1.30</td>
<td>.50</td>
</tr>
<tr>
<td>How satisfied are you with the quality of the training materials?</td>
<td>1.48</td>
<td>.63</td>
</tr>
<tr>
<td>Overall, how satisfied are you with the training experience?</td>
<td>1.34</td>
<td>.55</td>
</tr>
<tr>
<td>The material presented in this class will be useful to me in dealing with substance abuse.*</td>
<td>1.38</td>
<td>.63</td>
</tr>
<tr>
<td>This training was relevant to substance abuse treatment.*</td>
<td>1.23</td>
<td>.44</td>
</tr>
</tbody>
</table>

Note: All items were measured on a scale from 1 (Very satisfied) to 5 (Very dissatisfied), unless denoted with an asterisk (*). Items with an asterisk were measured on a scale from 1 (Strongly agree) to 5 (Strongly disagree).
of empowering patients in their own care.” Beyond personal edification gained, qualitative data reflected an increased appreciation of degree of collaboration, among physicians and other health professionals, which is necessary to adequately address and treat substance use disorder. Finally, qualitative data indicated that providers have a profound self-awareness around the perception of substance addiction and a consciousness of the profound stigma associated with this disease. This self-awareness seemed to primarily focus on the linguistics of treatment; namely, “the proper uses of language surrounding opioid use” and “[the importance of] alternatives to stigmatizing language.” Qualitative data pointed to the language shift as a result of fitting addiction into the schema of chronic disease, noting how important it is to accept “addiction as a chronic disease and the language shifts that can go along with this.”

There was also a sense of frustration among participants, including physicians, about the subsequent implementation of best practices for addressing and treating opioid and other addictions in clinic settings. A number of participants reported that while they would work to treat opioid use disorders without bias, the “attitudes of other coworkers and stigma within the medical community” would remain unchanged. Individuals mentioned that being surrounded by an environment of providers set in their habits and unwilling to change would be detrimental to their own efforts to make changes in their practice behavior. Symposium attendees predicted encountering resistance not just from fellow providers, but from patients who may be resistant to alternative therapies and a dynamic treatment environment. Finally, participants expressed skepticism regarding their own abilities to implement that which they learned at the symposium into their own practice in the long-term. One respondent noted that “without frequent reminders of the importance of language in talking about opioid use, it could be easy to slip back into the more commonly used words ‘abuse’ ‘addict’ ‘clean’ ‘dirty’ etc.” Despite these general misgivings, nearly thirty attendees explicitly reported that they do not anticipate encountering any barriers that would prevent them from making changes in their practice behavior, which bodes well for the longevity of the lessons imparted by this event.

**LOOKING TO THE FUTURE**

As mentioned previously, this symposium is the first in a number of training sessions aimed at physicians and other providers in Rhode Island around substance misuse. Data indicated that providers information on topics such as neonatal abstinence syndrome (NAS), medication-assisted therapy for opioid misuse disorders, substance misuse in pregnant women, workplace stigma towards individuals who suffer from substance misuse and the impact of legal marijuana in Massachusetts on healthcare practices in Rhode Island. In addition, because our data revealed a persistent stigma around opioid misuse, we will focus on imparting skills to providers to empower them in conversations with colleagues and others around opioid misuse.

While this event is a small, first step in combating the opioid and substance misuse epidemic in Rhode Island, it is our hope that this symposium provides a framework [and impetus for change] for healthcare providers and community stakeholders to address this important issue. The importance of combating this epidemic cannot be understated. In 2015, nearly 300 Rhode Islanders died from drug overdose, and preliminary data from 2016 indicates that as many, if not more, Rhode Islanders died from drug overdose in this past year as well. It is key that all those who interact with patients be able to contribute to combating this epidemic.

**References**


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ABSTRACT

BACKGROUND: The challenges trainees experience in the traditional medical clinic are felt to be one deterrent to choosing a primary care career.

OBJECTIVE: We examined whether participation in a second outpatient continuity experience [Second Site] affects trainee perception of primary care practice.

METHODS: 241 current and former graduates of the Brown Alpert Medical School Internal Medicine training programs were surveyed about their experiences with Second Site.

RESULTS: Of the 232 potential responders, 160 completed the survey. Although most did not feel that the experience altered their chosen career path, a positive perception of outpatient practice was noted by 97% of the primary care respondents and 92% of the subspecialty respondents.

CONCLUSION: Second Site improved the perception of outpatient practice. A large number of our residents enter primary care, thus, few residents’ careers were influenced by Second Site. Despite this, Second Site might enhance interest in primary care careers at other institutions.

KEYWORDS: Medical education, primary care, ambulatory practice

INTRODUCTION

United States workforce researchers predict a shortage of primary care physicians. West et al. reported that far fewer trainees pursue careers in general internal medicine than subspecialty medicine. This holds true even for trainees in primary care tracks. One of the purported reasons for the inadequate numbers of trainees pursuing primary care is the experience of the traditional medical clinic. As noted by Nadkarni, “Complex patients, insufficient resources, stressed residents, stressed clinic directors, and lack of separation from inpatient duties were felt to be barriers to meaningful ambulatory education and to be one cause of negative perception of outpatient practice.”

Ambulatory training provides trainees with an essential educational experience while providing care to the underserved. However, this experience may create negative perceptions of outpatient practice and deter trainees from primary care pursuits.

Unlike many internal medicine training programs, our residents have a weekly ambulatory day, one half day spent in traditional medical clinic and the other half in their Second Site. When the resident is assigned to his/her ambulatory day, all other responsibilities are covered by a day float resident. For their three primary continuity clinics, our 128 residents are assigned to one of three clinics: the majority attend the tertiary care hospital clinic (Rhode Island Hospital), one-third attend an academic community hospital (The Miriam Hospital), and nine go to our Veteran’s Hospital clinic. In the Second Site experience, second-year residents are paired with a single precepting physician for a weekly, two-year continuity experience. Second Site is designed to provide a complementary experience to traditional medical clinic in a more “real- world” environment devoid of the challenges of traditional medical clinic. Trainees work with populations distinct form traditional medical clinic, work in efficient offices and observe mentors in the type of environment where many will ultimately practice. Residents choose their site after reviewing a biography of voluntary preceptors which includes practice demographics, preceptor expertise and ancillary services provided. Second Sites include academic and community-based practices in primary care [37% of total with representation from women’s health, men’s health, and prison medicine] as well as subspecialty medicine [endocrinology, rheumatology, infectious disease, cardiology, gastroenterology, hematology oncology, pulmonary medicine, and palliative care]. Preceptors must provide new patients, follow-up and acute visits, exposure to the “business” of medicine and provide direct observation and feedback.

METHODS

Our aim was to determine if Second Site positively influences resident perception of outpatient practice. In the spring of 2013, a questionnaire was sent to 232 current and former graduates of the Brown Alpert Medical School Lifespan-affiliated categorical and primary care residency programs. Survey participants were contacted anonymously via email and were asked to complete the online questionnaire using SurveyMonkey©.

We sought to assess resident rankings of the Second-Site experiences in comparison to rankings of traditional medical clinic for the period 2010–2012. We assessed the demographic
differences between the traditional clinics and the Second-Site practices. All resident rotations were evaluated on a nine-point Likert scale where 1 is “below expectations” and 9 is “exceeded expectations/superior to other experiences.”

Lifespan IRB approval was obtained and the study was exempted from full review.

**PARTICIPANTS**
Criteria for inclusion in the survey was successful completion or current enrollment in the residency programs during the years 2008–2013 and having an active email address.

**INSTRUMENT**
The questionnaire consisted of 14 items [see appendix]. In addition to demographic questions, respondents were queried about the Second-Site program’s rating compared to other rotations, educational value, effect on perception of outpatient practice, impact on career choice, and whether Second Site differed from their experience with traditional medical clinic. We also allowed free text comments for several of the questions. The analysis was conducted in SAS® software, where chi-square test was used for bivariate analysis.

**RESULTS**
We had a 69% response rate (160 out of 232). Two-thirds of the respondents were graduates of the program and 37% were current trainees. Fifty-three percent of the respondents were women and 47.5% were men. More respondents (62%) identified current careers in subspecialty medicine than primary care (38%) [Table 1].

Findings demonstrated that Second Site was highly valued. Three quarters of all respondents rated it as the most valuable or top third of their residency rotations. Program evaluation data for 2012–13 showed that Second Site was rated more highly than the medical clinics. On a nine point Likert scale, Second Site received a score of 7.89 compared with 6.61 for the clinic at Rhode Island Hospital and 7.13 for the clinic at the Miriam Hospital.

The program positively influenced the respondent’s perception of outpatient practice. Fifty-five of the 57 of respondents who reported a current or future career in primary care practice felt that Second Site contributed positively to their perception of outpatient practice. Additionally, 92% of those going into or currently in subspecialty medicine felt that Second Site resulted in a positive perception of outpatient practice. Of the small number of respondents who reported a negative perception, the reasons cited appear to align with reported frustrations of practicing physicians and included the burden of “paperwork, documentation, and electronic records,” “time pressures,” “long hours and hard work.”

Representative free text responses to the question, “Do you feel the Second-Site rotation impacted your perception of outpatient practice positively?” include the following: “Second Site is a wonderful glimpse into “real-life” practice, an invaluable experience and a major reason why I chose Brown IM for residency.” “Seeing how medicine is practiced in private offices is incredibly valuable since our residency clinics do not reflect that.” “Second Site provided a very different

---

**Table 1. Demographic Characteristics and Career Plans of Residents in 2009–2011**

<table>
<thead>
<tr>
<th>Residents characteristics</th>
<th>Residents</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Care Practice (n=60)</td>
<td>Subspecialty Practice (n=100)</td>
<td>Full sample (n=160)</td>
</tr>
<tr>
<td>Gender, no. (%)**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>41 (68.3)</td>
<td>43 (43.0)</td>
<td>84 (52.5)</td>
</tr>
<tr>
<td>Current trainee status no. (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate</td>
<td>36 (60.0)</td>
<td>71 (71.0)</td>
<td>107 (66.9)</td>
</tr>
<tr>
<td>PGY2</td>
<td>13 (21.7)</td>
<td>12 (12.0)</td>
<td>25 (15.6)</td>
</tr>
<tr>
<td>PGY3</td>
<td>11 (18.3)</td>
<td>17 (17.0)</td>
<td>28 (17.5)</td>
</tr>
<tr>
<td>Number of years since graduation, no. (%)a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>6 (5.6)</td>
<td>2 (1.9)</td>
<td>8 (7.5)</td>
</tr>
<tr>
<td>1-2 years</td>
<td>14 (13.1)</td>
<td>44 (41.1)</td>
<td>58 (54.2)</td>
</tr>
<tr>
<td>2-3 years</td>
<td>0 (0.0)</td>
<td>2 (1.9)</td>
<td>2 (1.9)</td>
</tr>
<tr>
<td>More than 3 years</td>
<td>8 (7.5)</td>
<td>8 (7.5)</td>
<td>16 (15)</td>
</tr>
<tr>
<td>Other</td>
<td>8 (7.5)</td>
<td>15 (14.0)</td>
<td>23 (21.5)</td>
</tr>
<tr>
<td>Career planb</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addiction Medicine</td>
<td>-</td>
<td>1 (1.0)</td>
<td>-</td>
</tr>
<tr>
<td>Allergy/Immunology</td>
<td>-</td>
<td>1 (1.0)</td>
<td>-</td>
</tr>
<tr>
<td>Cardiology</td>
<td>-</td>
<td>16 (16.0)</td>
<td>-</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>-</td>
<td>4 (4.0)</td>
<td>-</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>-</td>
<td>9 (9.0)</td>
<td>-</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>-</td>
<td>15 (15.0)</td>
<td>-</td>
</tr>
<tr>
<td>Hospitalist/ER</td>
<td>-</td>
<td>5 (5.0)</td>
<td>-</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>-</td>
<td>10 (10.0)</td>
<td>-</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>-</td>
<td>4 (4.0)</td>
<td>-</td>
</tr>
<tr>
<td>Pulmonary/other Diseases</td>
<td>-</td>
<td>10 (10.0)</td>
<td>-</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>-</td>
<td>8 (8.0)</td>
<td>-</td>
</tr>
<tr>
<td>Transplant Nephrology/</td>
<td>-</td>
<td>3 (3.0)</td>
<td>-</td>
</tr>
<tr>
<td>Nephrology</td>
<td>-</td>
<td>2 (2.0)</td>
<td>-</td>
</tr>
<tr>
<td>Undecided</td>
<td>-</td>
<td>12 (12.0)</td>
<td>-</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>12 (12.0)</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes: ** – p-value < 0.01.
a) We are only considering the residents that graduated.
b) We are only considering the residents in subspecialty practice.
Abbreviations: PGY-2 – postgraduate year 3; PGY-3 – postgraduate year 3.

---
Most respondents felt that Second Site did not change their chosen career path; however, 29% reported an effect. Of these, the six respondents who chose to describe their answer further noted that Second Site reaffirmed their interest in primary care. One respondent described how the Second-Site program influenced her/his desire to pursue primary care: “Though I didn’t know which specialty, I came in expecting to pursue fellowship and the positive experience in the primary care office definitely contributed to my decision to pursue a career in general internal medicine.” Another respondent wrote, “I had a more positive primary care experience compared to my resident clinic. I had a clear example of what a future career as a PCP would look like which can be very different than a resident clinic.” A third commented, “Second Site made me appreciate primary care and want to be in outpatient medicine.”

DISCUSSION

Four major institutions, the American College of Physicians, the Society of General Internal Medicine, the Association of Program Directors in Internal Medicine and the Alliance of Academic Internal Medicine have called for residency education reform to meet the educational needs of trainees and to improve preparation for future practice. Part of this redesign has been to increase the amount of time trainees spend in the outpatient setting. Unfortunately, increased exposure may worsen perception if the exposure is frustrating. Traditional resident clinics ask the most inexperienced practitioners to care for patients who are the most complex and challenging and often in resource-poor settings.

A 2012 study surveyed clinic directors of ACGME-accredited internal medicine training programs about their residency continuity clinic infrastructure and educational milieu. They found patient panels included patients of lower socioeconomic status and high percentages of Medicaid, Medicare and self-pay. There were high numbers of minority patients and 17% required translators. Our residency clinics care for similar patients. Clinic demographic data from 2013 shows that 50% of patients reported speaking a language other than English as their primary language. Only 3% of patients had private insurance. This is in contrast to data from two large outpatient practices where many residents rotated for Second Site. In these practices, over 90% of patients reported that English was their primary language and over 60% of patients in the outpatient practices had private insurance. Language barriers and lack of patient resources may frustrate young inexperienced doctors and may discourage some residents who might have otherwise pursued careers in outpatient medicine and primary care.

Currently, only 10–20% of internal medicine graduates nationwide practice primary care. Improving the ambulatory experience might increase this number. A recent survey of our primary care graduates from 1981 through 2012 showed that nearly 60% of our graduates practice primary care.

This contrasts with a rate of 40% in a nationwide survey of 562 graduating residents in primary care tracks surveyed by West. Residents overwhelmingly reported their Second-Site experience was distinct from traditional medical clinic and positively impacted their perception of outpatient medicine. One respondent’s comments encapsulate the frustrations trainees may feel in the challenging environment of the traditional medical clinic. “I loved clinic but the work there was tough; lots of paperwork with little support, non-English speaking patients without translators; patients with psychosocial barriers that made it difficult to care for them properly. At my Second Site, such patients do exist but were by far the exception, not the rule, allowing me to actually focus on primary care medicine.”

Our clinics share the barriers and challenges faced in most training programs. Although this study was not designed to determine if our Second-Site program ultimately resulted in more primary care providers, the number of graduates from our program choosing primary care positions suggests that it may indeed have an impact. The large number of residents from our program entering primary care may have mitigated the impact of the Second-Site experience on primary care career choice. A bigger impact of Second Site might be seen in a program where many graduates traditionally enter subspecialty medicine. In our program, Second Site may have served to reaffirm and encourage our residents’ original career goals. Given the low numbers of residents pursuing primary care nationwide, positively influencing even a single resident’s career choice toward primary care could aid in reducing the primary care physician shortage. In addition, given the positive perception of outpatient medicine noted by respondents, even if trainees do not pursue primary care, their positive perception may have downstream effects.

LIMITATIONS

Although the response rate was high, all respondents were from a single training program, limiting generalization. Respondents may have been motivated to answer the survey because of their positive experience with the program. The mixture of sites in the program, which includes primary care and subspecialty, may have confounded some of the results.

CONCLUSIONS

Our Second-Site Program is highly valued by trainees and fosters a positive perception of outpatient medicine. Programs across the country struggling to enhance the primary care experience of their trainees may wish to consider implementing a Second Site at their own institution. Preceptors in the program find their participation rewarding and generally report that hosting a resident is cost neutral. The program requires a dedicated faculty member to oversee the program.
Other costs include token thanks to preceptors in the form of an office plaque, teaching textbook and faculty development opportunities. In starting a new program, there would be many opportunities to study the experience and find out its impact on career choices.

a The data analysis for this paper was collected using SurveyMonkey. Copyright © 2015 Palo Alto, California, USA. www.surveymonkey.com

b The code/data analysis for this paper was generated using SAS software, Version 9.3 of the SAS System for Windows. Copyright © 2016 SAS Institute Inc. SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc., Cary, NC, USA.

References

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Appendix
Survey Questions: Changing the Perception of Outpatient Practice: A Second Continuity Experience for Internal Medicine Residents
1) Current Trainee Status
PGY2
PGY3
Graduate
If graduate, state number of years since graduation
2) Gender
Male
Female
3) Career Pathway
Primary Care Practice
Subspecialty Practice
If subspecialty, please specific type
4) Did you receive your first choice for your Second Site rotation?
Yes
No
5) Did the existence of the Second Site program impact your decision to choose Brown for residency?
Mostly Positively
Mostly Negatively
Neutral
6) Did you career path change because of your Second Site experience?
Yes
No
If yes explain how
7) How would you rate your Second Site experience compared to other required rotations? Choose 1
Most valuable
Top 1/3
Middle 1/3
Bottom 1/3
Other, please specify
8) Is/was the time spent in Second Site adequate?
Yes
No
Other, please specify
9) Did you join the practice you participated in?
Yes
No
Not applicable
10) Did you join a similar practice to the one you participated in?
Yes
No
Not applicable
11) On a scale of 1 to 3, please rank the value of each of the following educational components of the Second Site program
1-Little value, 2-Moderate value, 3-Substantial value
Medical knowledge
Communication skills
Coordination of care
Record keeping
Utilization of an EMR
Office flow
Other valuable component
12) Do you feel the Second Site rotation impacted your perception of outpatient practice positively?
Yes
No
13) Do you feel the Second Site rotation impacted your perception of outpatient practice negatively?
Yes
No
14) Did you Second Site experience differ from your primary continuity experience?
Yes
No
If yes, please describe how.
CONTRIBUTION

Assault Injury and Homicide Death Profile in Rhode Island, 2004–2014

YONGWEN JIANG, PhD; MEGAN L. RANNEY, MD, MPH; JORDAN SEABERRY, BFA; LYNNE-MARIE SHEA, BA;
BRIAN SULLIVAN, MS; SAMARA VINER-BROWN, MS

ABSTRACT
Community violence, including assault and homicide, is a public health problem. We provide a profile of assault-related injury and homicide death in Rhode Island to better understand assault/homicide. The 2014 emergency department (ED) visit data, hospital discharge (HD) data, and 2004-2014 Rhode Island Violent Death Reporting System (RIVDRS) data were used for this study. Most assault injuries and homicide deaths were among persons who were 25-44 years old, male, black and Hispanic, living in urban regions, self-pay or public insurance user, and never married. Almost 63% of the homicide decedents tested positive for some illicit substance. Precipitating circumstances include a preceding argument or a conflict, another crime, intimate partner violence, and drug involvement. RIVDRS did not provide an estimate for mental illness related homicides (e.g., command hallucinations). ED, HD, and RIVDRS data can provide a profile of assault injury and homicide death for public health authorities in RI. Interventions need to focus on high-risk populations and areas to effectively prevent assault-related injury and homicide.

KEYWORDS: assault; emergency department visit data; homicide; hospital discharge data; Rhode Island Violent Death Reporting System (RIVDRS)

INTRODUCTION
Community violence, including assault and homicide, is a public health problem. Over 1.5 million people visited emergency departments for assault-related injuries in the United States in 2014, and more than 157,000 of them were admitted to the same hospitals or transferred to other hospitals for additional care. Over 16,000 homicide deaths occurred in the U.S. in 2014. Across the U.S., homicide rates vary by age, gender, and race/ethnicity. U.S. homicide rates are highest for adolescents and young adults, males, blacks and Hispanics. In 2014, the U.S. age-adjusted homicide rate was 5.1 per 100,000 population, but rates vary by race/ethnicity: non-Hispanic blacks were 18.2, Hispanics 4.5, and non-Hispanic whites 2.4. Homicide age-adjusted rates were highest among non-Hispanic black males (32.3/100,000) and Hispanic males (7.2/100,000).

Healthy People 2020, established by the U.S. Department of Health and Human Services, includes an objective of reducing homicides deaths in the U.S. by 10%. Others have shown that healthcare and public health professionals, law enforcement, community organizations, etc. can work together to decrease assault/homicide to improve the nation’s health. The first step in such collaboration is to describe the current epidemiology of violence-related morbidity and mortality. In this analysis, using the 2014 Rhode Island emergency department (ED) visit data and hospital discharge (HD) data and the 2004–2014 Rhode Island Violent Death Reporting System (RIVDRS) as proxies for assault injury and homicide death, we provide a description of the demographic and geographic characteristics of assault-related injury and homicide death in RI.

METHODS
Data source
Under licensure regulations, the 11 acute-care general hospitals and 3 specialty facilities in RI report to the RI Department of Health (RIDOH) a defined set of data items on each ED visit and every inpatient discharged. The data reported includes patient-level demographic and clinical information. RI hospitals use the standard uniform billing form (UB-04) as the basis for the ED and HD database. As most payers require a single bill for patients during a single visit/stay, ED visits in our study include only those who are discharged, transferred, or died; ED patients that are admitted to the same hospital are excluded by definition. This analysis used 2014 data just from the 11 acute-care hospitals because 3 specialty hospitals (2 psychiatric hospitals and 1 rehab) did not have any visits for acute assault. Eligible visits were defined by assault-related ED visits and hospitalizations with ICD-9-CM E-codes: E960–E969 (Injury purposely inflicted by other persons).

The National Violent Death Reporting System (NVDRS) is a state-based active surveillance system for monitoring the characteristics, trends, and magnitude of violent death and is funded by the Center for Injury Prevention and Control (CDC). RI began collecting data in 2004. RIVDRS combines information across multiple data sources including death certificates, medical examiner reports, law enforcement reports, and secondary sources (e.g., crime laboratory, uniform crime reporting, child fatality review team, and
hospital data). “Homicide is defined as a death resulting from the intentional use of force or power, threatened or actual, against another person, group, or community.” RIVDRS classifies deaths using abstractor-assigned manners of death. We combined 2004–2014 data, per NVDRS guidelines given the small sample size each year, to avoid disclosing sensitive data and to increase analytic power.

**Data analyses**

For each eligible encounter in the 2014 ED and HD data, age group, sex, race/ethnicity, city/town of residence, insurance, and patient status were obtained. RI’s 2010 census city/town populations were used for computing the assault-related ED visit rate. RIVDRS variables analyzed included age group, sex, race/ethnicity, marital status, city/town of residence, injury location, whether injury occurred at the victim’s home, weapon type, toxicology tests, and circumstances preceding deaths. All analyses were conducted with SAS version 9.4 (SAS Institute, Inc. Cary, NY). We used ArcGIS 10.2 (Environmental Systems Research Institute, Inc., Redlands, CA) to map ED visit rate by cities and towns of residence. The Jenks Natural Breaks Classification method was used to create the value ranges of ED visit rate depicted on the GIS maps.

**RESULTS**

Woonsocket (8.3/1000), Providence (8.1/1000), and Central Falls (6.1/1000) had the highest rates of residents with assault-related ED visits [Figure 1].

In 2014, there were 4,098 assault-related injury ED visits resulting in discharge, transfer, or death, and 390 assault-related injury hospitalizations in RI [Table 1]. Most ED discharges and hospital admissions were among patients who were 25–44 years old, males, blacks and Hispanics. It should be noted that blacks only account for 5.7% of the Rhode Island population and those of Hispanic ethnicity represent 12.4% of the state population based on 2010 census data. Half of the assault injury ED visits and hospitalizations occurred among those living in the four core cities, which represents 29.4% of the state’s population. The core cities are those 25% or more of children living below the federal poverty level. Almost three quarters of ED discharges/transfers were among these insured through Medicaid, Medicare, and those who were classified as “self-pay.” The majority of assault injury patients were discharged to home. Only 1.1% were seen in the ED for a firearm injury (E965 code).

During 2004–2014, 342 Rhode Islanders died of homicide [Table 2]. The majority of homicide decedents were aged 18–44 years old, male, black and Hispanic, never married, and had lived in urban regions. Most were injured in a house/apartment, but not at the victim’s residence. The top two methods of injury were firearms and sharp instruments.

In terms of substance use, 31% of decedents tested positive for alcohol, 30% for marijuana, and a total of 62.6% for any illicit substance (excluding anti-depressants and amphetamines) [Table 3]. Precipitating circumstances included a preceding argument or a conflict (31%), another crime (16%), intimate partner violence (14%), and drug involvement (including drug dealing, drug trade, or drug use) (12%).
However, circumstances were not available for 87 homicide cases (26.1%).

In 2014, the total charges associated with the 4,098 assault-related ED discharges/transfers were $15.2 million, and 390 assault injury hospitalizations were charged nearly $17.5 million by hospitals. The total length of stay for assault-related hospitalizations was 2,527 days, and the overall cost was nearly $6 million paid by insurance companies (data not shown).

**DISCUSSION**

This analysis demonstrates the high burden of injury and death due to assault in RI. In accordance with national data, young minority men living in core cities are most likely to be seen in the ED, admitted to the hospital, or die from assault-related injury.2, 4, 6 Assault injury is tremendously expensive to our state, with the majority of costs being born by Medicaid and Medicare. Our data also highlight some unique geographic characteristics of assault-related injury, where the highest ED visit rates occurred among residents of Woonsocket, Providence, and Central Falls, and the lowest rates among those in non-metro areas.

Our analysis highlights potential avenues for prevention. In RI, 62.6% of those tested for toxicology results had an illicit substance in their system at the time of death. Although the ED and HD databases did not have information on toxicology tests for non-decedents, other RI and national data confirm that alcohol and/or substance use are common precedents to assault.10-13 Others have found that interventions focused on alcohol and/or drug use among perpetrators or victims of violence, including in the ED setting, are effective at reducing future victimization and perpetration of violence.14 Identification of areas with high concentrations of alcohol outlets can reduce violence by improving policing efforts.15, 16 Alcohol and drug control policies should be added to prevention programs by law enforcement officers, public health professionals, and policy makers.17

### Table 1. Characteristics of Assault Injuries Using the 2014 Rhode Island ED and HD Data

<table>
<thead>
<tr>
<th>Characteristic of Assault Injury</th>
<th>ED Visit (N=4,098)</th>
<th>Hospital Discharge (N=390)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 18 years</td>
<td>9.4</td>
<td>12.1</td>
</tr>
<tr>
<td>18-24 years</td>
<td>28.0</td>
<td>20.0</td>
</tr>
<tr>
<td>25-44 years</td>
<td>44.3</td>
<td>37.4</td>
</tr>
<tr>
<td>45-64 years</td>
<td>17.1</td>
<td>26.7</td>
</tr>
<tr>
<td>65 years and older</td>
<td>1.2</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>59.1</td>
<td>78.0</td>
</tr>
<tr>
<td>Female</td>
<td>40.9</td>
<td>22.1</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>58.8</td>
<td>51.3</td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>16.6</td>
<td>23.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>21.3</td>
<td>21.0</td>
</tr>
<tr>
<td>Other</td>
<td>3.2</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>City/Town of Residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban (core cities)</td>
<td>53.2</td>
<td>48.7</td>
</tr>
<tr>
<td>Sub-urban regions</td>
<td>35.4</td>
<td>34.4</td>
</tr>
<tr>
<td>Non-metro/Rural areas</td>
<td>6.7</td>
<td>7.4</td>
</tr>
<tr>
<td>Out of state</td>
<td>4.7</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-pay</td>
<td>20.9</td>
<td>9.0</td>
</tr>
<tr>
<td>Medicare</td>
<td>7.8</td>
<td>17.2</td>
</tr>
<tr>
<td>Medicaid</td>
<td>40.3</td>
<td>47.7</td>
</tr>
<tr>
<td>Private</td>
<td>26.1</td>
<td>25.1</td>
</tr>
<tr>
<td>Other</td>
<td>5.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Patient Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharged to home/Self-care</td>
<td>94.1</td>
<td>65.9</td>
</tr>
<tr>
<td>Discharged/Transferred to home</td>
<td>0.0</td>
<td>13.1</td>
</tr>
<tr>
<td>Transferred to skilled</td>
<td>0.0</td>
<td>7.2</td>
</tr>
<tr>
<td>Left against medical advice</td>
<td>1.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Transferred to psychiatric</td>
<td>0.2</td>
<td>3.6</td>
</tr>
<tr>
<td>Other (including death)</td>
<td>4.3</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>E-code (external causes of injury)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E960: Fight, brawl, and rape</td>
<td>43.9</td>
<td>18.0</td>
</tr>
<tr>
<td>E961: Assault by corrosive</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>E963: Assault by hanging</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>E965: Assault by firearms</td>
<td>1.1</td>
<td>9.5</td>
</tr>
<tr>
<td>E966: Assault by cutting</td>
<td>6.4</td>
<td>24.6</td>
</tr>
<tr>
<td>E967: Child and adult</td>
<td>5.5</td>
<td>12.8</td>
</tr>
<tr>
<td>E968: Assault by other</td>
<td>41.4</td>
<td>25.6</td>
</tr>
<tr>
<td>E969: Late effects of injury</td>
<td>1.3</td>
<td>9.2</td>
</tr>
</tbody>
</table>

ED, Emergency Department; HD, hospital discharge.

a Percentages might not total 100% because of rounding.

b ED visits exclude those subsequent admissions to the same hospital.

c Core-cities: Central Falls, Pawtucket, Providence, and Woonsocket.
### Table 2. Characteristics of Homicide Deaths Using the 2004–2014 RIVDRS Data (N=342)

<table>
<thead>
<tr>
<th>Characteristic of Homicide Death</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group (mean: 33.5 years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 18 years</td>
<td>33</td>
<td>9.7</td>
</tr>
<tr>
<td>18-24 years</td>
<td>103</td>
<td>30.2</td>
</tr>
<tr>
<td>25-44 years</td>
<td>125</td>
<td>36.7</td>
</tr>
<tr>
<td>45-64 years</td>
<td>59</td>
<td>17.3</td>
</tr>
<tr>
<td>65 years and over</td>
<td>21</td>
<td>6.2</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>251</td>
<td>73.4</td>
</tr>
<tr>
<td>Female</td>
<td>91</td>
<td>26.6</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>129</td>
<td>37.8</td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>91</td>
<td>26.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>107</td>
<td>31.4</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>4.1</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>224</td>
<td>65.5</td>
</tr>
<tr>
<td>Married/civil union/domestic partnership</td>
<td>64</td>
<td>18.7</td>
</tr>
<tr>
<td>Divorced/married, but separated</td>
<td>37</td>
<td>10.8</td>
</tr>
<tr>
<td>Single, not otherwise specified/widowed</td>
<td>17</td>
<td>5.0</td>
</tr>
<tr>
<td><strong>City/Town of Residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban(core cities)b</td>
<td>210</td>
<td>62.3</td>
</tr>
<tr>
<td>Sub-urban regions</td>
<td>84</td>
<td>24.9</td>
</tr>
<tr>
<td>Non-metro/Rural areas</td>
<td>11</td>
<td>3.3</td>
</tr>
<tr>
<td>Out of state</td>
<td>32</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>Injury Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House or apartment</td>
<td>178</td>
<td>53.0</td>
</tr>
<tr>
<td>Street/highway</td>
<td>87</td>
<td>25.9</td>
</tr>
<tr>
<td>Parking lot/public garage/public transport</td>
<td>17</td>
<td>5.1</td>
</tr>
<tr>
<td>Bar/nightclub/commercial/retail area</td>
<td>15</td>
<td>4.5</td>
</tr>
<tr>
<td>Natural area/park/playground/public use area</td>
<td>14</td>
<td>4.2</td>
</tr>
<tr>
<td>Motor vehicle</td>
<td>12</td>
<td>3.6</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>Injured at Victim Home</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>125</td>
<td>37.5</td>
</tr>
<tr>
<td>No</td>
<td>208</td>
<td>62.5</td>
</tr>
<tr>
<td><strong>Weapon Type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Firearm</td>
<td>179</td>
<td>53.3</td>
</tr>
<tr>
<td>Sharp instrument</td>
<td>58</td>
<td>17.3</td>
</tr>
<tr>
<td>Blunt instrument</td>
<td>26</td>
<td>7.8</td>
</tr>
<tr>
<td>Personal weapons</td>
<td>25</td>
<td>7.4</td>
</tr>
<tr>
<td>Hanging, strangulation, suffocation</td>
<td>22</td>
<td>6.6</td>
</tr>
<tr>
<td>Motor vehicle including buses, motorcycle</td>
<td>14</td>
<td>4.2</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>3.6</td>
</tr>
</tbody>
</table>

*a Percentages might not total 100% because of rounding.

### Table 3. Toxicology Tests and Circumstances of Homicide Deaths Using the 2004–2014 RIVDRS Data (N=342)\(^b\)

<table>
<thead>
<tr>
<th>Toxicology Test and Circumstance</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tested</strong></td>
<td>329</td>
<td>96.2</td>
</tr>
<tr>
<td><strong>Toxicology test positive</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any toxicology</td>
<td>218</td>
<td>66.3</td>
</tr>
<tr>
<td>Any illicit substance</td>
<td>206</td>
<td>62.6</td>
</tr>
<tr>
<td>Alcohol</td>
<td>102</td>
<td>31.2</td>
</tr>
<tr>
<td>BAC&lt;0.08 g/dl</td>
<td>34</td>
<td>(33.3%)</td>
</tr>
<tr>
<td>BAC≥0.08 g/dl</td>
<td>68</td>
<td>(66.7%)</td>
</tr>
<tr>
<td>Marijuana</td>
<td>96</td>
<td>29.7</td>
</tr>
<tr>
<td>Opiates</td>
<td>45</td>
<td>13.8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>35</td>
<td>10.7</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>22</td>
<td>6.8</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>11</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Life stressor circumstance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argument or conflict</td>
<td>105</td>
<td>31.4</td>
</tr>
<tr>
<td>Physical fight (two people, not a brawl)</td>
<td>11</td>
<td>3.3</td>
</tr>
<tr>
<td>Crisis within previous or upcoming 2 weeks</td>
<td>8</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Crime and criminal activity circumstance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precipitated by another crime(^c)</td>
<td>53</td>
<td>15.9</td>
</tr>
<tr>
<td>Drug trade</td>
<td>22</td>
<td>(41.5%)</td>
</tr>
<tr>
<td>Robbery</td>
<td>18</td>
<td>(34.0%)</td>
</tr>
<tr>
<td>Assault</td>
<td>6</td>
<td>(11.3%)</td>
</tr>
<tr>
<td>Arson</td>
<td>6</td>
<td>(11.3%)</td>
</tr>
<tr>
<td>Other (specify in narrative)</td>
<td>12</td>
<td>(22.6%)</td>
</tr>
<tr>
<td>Drug involvement</td>
<td>39</td>
<td>11.7</td>
</tr>
<tr>
<td>Crime in progress</td>
<td>31</td>
<td>9.3</td>
</tr>
<tr>
<td>Gang related</td>
<td>8</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Interpersonal circumstance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimate partner violence-related</td>
<td>46</td>
<td>13.8</td>
</tr>
<tr>
<td>Jealousy (lovers’ triangle)</td>
<td>20</td>
<td>6.0</td>
</tr>
<tr>
<td>Intimate partner problem</td>
<td>15</td>
<td>4.5</td>
</tr>
<tr>
<td>Other relationship problem (non-intimate)</td>
<td>11</td>
<td>3.3</td>
</tr>
<tr>
<td>Victim of interpersonal violence within past month</td>
<td>8</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Homicide event circumstance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drive-by shooting</td>
<td>15</td>
<td>4.5</td>
</tr>
<tr>
<td>Victim was a bystander</td>
<td>11</td>
<td>3.3</td>
</tr>
<tr>
<td>Caretaker abuse/neglect led to death</td>
<td>6</td>
<td>1.8</td>
</tr>
<tr>
<td>Victim was an intervener assisting a crime victim</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>Random violence</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>Walk-by assault</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Circumstance Not Reported</strong></td>
<td>87</td>
<td>26.1</td>
</tr>
</tbody>
</table>

\(^a\) Subcategories do not sum to 100% because test results of victims can be positive for alcohol or multi-drugs.

\(^b\) Percentages might exceed 100% because multiple circumstances might have been coded.

\(^c\) Number will not equal the sum of the column because a death could have been precipitated by more than one other crime.
injury in core cities, focused neighborhood-based interventions on these areas may be effective. In other municipalities, area-based interventions, such as greening of vacant lots, have effectively decreased incidence of violent crime. Future research needs to focus on the characteristics of suspects including mental health status, history of violence, alcohol/drug abuse, and relationships with victims to improve homicide intervention.

Most homicide victims died by firearms. Current RI law restricts adults with a mental illness history and a felony conviction to purchase firearms. However, we also need strict enforcement of laws against carrying concealed guns. Studies in other states have shown that stricter firearm permitting laws are associated with reductions in homicide rates. Others have shown that changes in gun sales practices can reduce gun use in violent crime.

The Nonviolence Streetworkers Program at the Institute for the Study and Practice of Nonviolence has been in operation for 12 years, with the impact greatly felt within the neighborhoods served throughout RI. Victims from economically challenged and under-served communities easily relate to the Nonviolence Streetworkers, who come from their neighborhoods. As a result, there is a trust factor between them which does not exist with the typical service provider, and a credibility factor that allows relationships to be easily and readily built with trust. The Streetworkers have been heavily utilized by victimized youth and their families.

The Streetworkers are available 24 hours a day and have responded to every shooting in the City of Providence since the program’s inception. They offer immediate support to victims of violence and their families, providing referrals and information when appropriate. Often, they accompany the victim and family to the Emergency Room and act as liaison between staff and family. They are simultaneously working with the family and friends of the victim in a process of coming to terms with the event, to reject retaliation, and convincing the survivors of the need to live for the sake of the family.

It is the Victim Services team at the Institute for the Study and Practice of Nonviolence that interfaces with primary and secondary victims of violence after receiving the referral information from the Streetworkers after their immediate response to the incident. On a regular basis, the Victim Services interface with both primary and secondary victims of crime, offering crisis counseling, contacting clients for follow-up, assisting with filing compensation claims, accompanying and advocating within the justice system, and providing information and referral about services, jobs, and job training. Because of the Streetworkers’ omnipresence throughout the Providence neighborhoods, they are able to respond to smaller fights between groups of young people, advocate for the victims, and keep it from escalating into a larger criminal act that would create more victims. The intervention this Streetworker Outreach Team provides is paramount to ending our state’s generational cycles of violence.

Limitations include the following: [1] ED and HD data did not have unique identifiers, so we lacked the ability to link patient-level data. Also, there was no unique identifier for the RIVDRS/hospital data linkage; [2] toxicology and circumstance information are not included in the ED and HD datasets; and [3] circumstances surrounding a homicide death were underreported in RIVDRS for the following reasons: [a] investigators are not able to identify circumstances on unsolved homicides that occurred with no witnesses; and [b] law enforcement agencies are reluctant to give out detailed information on homicides during ongoing investigations. We usually only get the initial police report with no additional information even when the case investigation is over. However, we have made strides by requesting arrest records for suspects, which provide more information. In addition, to complement our homicide circumstances, we also receive the National Incident Based Reporting System (NIBRS) data.

In conclusion, ED, HD, and RIVDRS data can provide a profile of assault injury and homicide for public health authorities in RI. Interventions need to focus on high-risk populations and areas to effectively prevent assault-related injury and homicide.

References


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Disclaimer
The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Rhode Island Department of Health, Rhode Island Hospital, Brown University, the Institute for the Study and Practice of Nonviolence, and Lincoln Police Department.

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CASE REPORT

IgG4 Aortitis: A Case Report
SHIVALI MARKETKAR, MD; MARK LEGOLVAN, DO

ABSTRACT

IgG4 aortitis is one of the entities seen in the spectrum of IgG4-related disease (IgG4-RD). It is characterized by serologic (elevated serum IgG4) and histologic features including a lymphoplasmacytic infiltrate with increased numbers of IgG4-positive plasma cells, storiform fibrosis and obliterative phlebitis. Some studies have described a correlation between infections and IgG4 aortitis. We describe a patient with an aneurysm of the infrarenal descending abdominal aorta with features of IgG4-RD, as well as culture evidence of *Streptococcus sanguis*.

KEYWORDS: IgG4, aortitis, plasma cells

CASE REPORT

History

Our patient is a 50-year-old veterinarian from the Dominican Republic who presented as an outpatient with the complaint of intermittent periumbilical pain for two years. The pain radiated to his back and to his groin bilaterally and lasted for 2-3 hours. It occurred a few times a week and was self-subsiding. The patient denied any fever or symptoms suggestive of an underlying infection. The physical examination apart from abdominal tenderness was unremarkable. The labs were significant for positive c-ANCA. The WBC count, ESR and CRP were within normal limits. A CT of the abdomen was then performed, which demonstrated a saccular aneurysm of the abdominal aorta measuring 1.2x1.8 cm beginning infrarenally and encasing the inferior mesenteric artery. Radiology favored a mycotic aneurysm due to the site, appearance and surrounding retroperitoneal fat stranding. [Figure 1]

The patient subsequently underwent surgical resection of the aneurysm, was prescribed ceftriaxone for six weeks and tapering doses of prednisolone for three months post-surgery. He followed up with urology for testicular pain in 2014 and was subsequently lost to follow-up.

Pathology Findings

The aneurysm was received as multiple tan-yellow tissue fragments measuring 4.5 x 3.5 x 2.0 cm. Retroperitoneal tissue was sent separately as multiple tan-red soft tissue fragments measuring 1.5 x 1.0 x 0.5 cm. Microscopically on H &E stain the retroperitoneal soft tissue and aortic wall demonstrated bands of storiform fibrosis, a lymphoplasmacytic infiltrate and obliterative phlebitis. [Figure A]

The lymphoplasmacytic infiltrate was composed predominantly of sheets of polyclonal plasma cells [Kappa/lambda staining.] The plasma cells stained for CD138 and equivocally for Kappa/lambda. [Figure B]

They were IgG positive with predominant IgG4 positivity (>60/hpf). [Figures C and D] Steiner’s stain and gram stain were negative for spirochetes and bacteria respectively. A flow cytometry performed on the tissue identified 51% CD5+ T cells and 48% polytypic CD19+ B cells, with a surface Ig kappa to surface Ig lambda cell ratio of 1.5.

Serology

The patient had persistently raised serum IgG4 at 199mg/dl prior to aneurysm resection and this value dropped to 114mg/dl once he was started on steroids (N: 4.0-86.0), subsequently lost to follow-up.

Microbiology

*Streptococcus sanguis* was isolated from the broth of retroperitoneal tissue and in spite of antibiotic therapy the patient’s serum still showed elevated IgG4 levels.

Figure 1. CT scan showing aortic aneurysm.
**DISCUSSION**

**Clinical features**

IgG4-RD usually presents subacutely and the majority of patients are not constitutionally ill. Fevers and elevated C-reactive proteins are unusual. It is incidentally detected through histology or radiology. The presentation can range, depending on the site of involvement, and usually presents with pain or swelling of the particular site. Multiorgan disease may be evident at diagnosis but can evolve metachronously over months to years. Spontaneous improvement, sometimes leading to clinical resolution of certain organ system manifestations, is reported in a minority of patients. Common findings in IgG4-RD are tumefactive lesions and allergic disease. Many patients with IgG4 disease have allergic features like atopy, asthma, eczema and modest peripheral blood eosinophilia. Up to 40% of patients with IgG4-related diseases have allergic diseases like bronchial asthma or chronic sinusitis.

**DIFFERENTIAL DIAGNOSIS**

Diseases such as giant cell arteritis, Takayasu arteritis, rheumatoid arthritis, and syphilis should be considered in the differential diagnosis when an aortic lesion is found. Differentiating between a chronic infectious aneurysm and IgG4-related aortitis may have some overlap; however, when a diffuse lymphoplasmacytic infiltrate with obliterative phlebitis and keloidal fibrosis is found, IgG4-related disease is high on the index of suspicion. It is confirmed by immunohistochemistry. Some studies have noted the plasma cell...
response in infectious aortitis is focal as opposed to the diffuse response in IgG4 disease. Occasional granulomas found in IgG4 related disease may sometimes confound the diagnosis, hence staining of the plasma cells for IgG4 is necessary for definitive diagnosis.4,5

IgG4-RD as is it now known is a multisystemic disease with more than one organ being involved. IgG4-RD should be considered in any patient found to have aortitis or periaortitis. There can be different epicenters of the disease, based on which it can be classified, including retroperitoneal fibrosis, inflammatory abdominal aortic aneurysm, a combination of retroperitoneal and aortic involvement [as seen in our case] and thoracic aorta.6 Recently reported data indicate that IgG4-related aortic disease may be more common than previously realized.7 It has been shown that a significant percentage of thoracic lymphoplasmytic aortitis cases, 40% of inflammatory abdominal aortic aneurysms/abdominal periaortitis cases, and a portion of retroperitoneal fibrosis cases are all caused by IgG4-RD.7 A national study of autoimmune pancreatitis in Japan suggested a male-to-female ratio of 2.8:1.8

Characteristic pathologic features of this condition are the involvement of blood vessels by the lymphoplasmytic infiltrate and disruption of the elastic lamina causing obliteration of the blood vessels known as obliterator phlebitis. Fibroblastic proliferation due to release of TGF-B by the plasma cells is seen leading to florid fibrosis. Sometimes eosinophils are seen admixed with the lymphoplasmytic infiltrate as IL-5 is also released in the process.9 Granulocytic epithelial lesions and rare granulomas have been associated mostly with autoimmune pancreatitis.

The majority of patients are men and older than 50 years of age.1,9,10,11,12 The disease is difficult to diagnose in the later phases of organ involvement, when fewer plasma cells are present and fibrosis may predominate in some tissues.1 Serum IgG4 may not always be elevated; in such cases the histology plays an important role in diagnosis. Sometimes misdiagnosis may occur due to moderate elevation of serum IgG4 concentration and the finding of occasional IgG4 positive cells in the tissues. This dilemma can be resolved by the ratio between IgG positive cells and IgG4 positive cells in the tissue and the overall morphology.1 Serum IgG4 values may not always correlate; according to a multicenter study from Japan, IgG4 levels failed to normalize in 115 of 182 patients treated with glucocorticoids.13 The same study showed that the majority of patients with high levels of IgG4 were in remission and about 30% of them relapsed eventually.13 Table 1 from the 2011 study4 defines the criteria for diagnosis of IgG4-RD.

Various pathophysiological mechanisms have been proposed for the disease including genetic risk factors, bacterial infection and molecular mimicry and autoimmunity.1 Although various inciting factors have been hypothesized, the definitive cause is still elusive. No specific autoantibody has been consistently described in patients with IgG4-RD, but nonspecific antibodies to other immune mediated conditions is common.14 It has been proposed that infection may be a causal factor.15 According to recent reports, it has been found that increased IgG4 is due to Th-2 dominated cytokine production due to increased T cells which can be upregulated due to bacterial infection.16 However, these are just a few studies and there is no convincing evidence for the role of infection in the IgG4-RD, as the majority of cases are not associated with infection.

**CONCLUSION**

Our patient demonstrates a rare case of IgG4 aortitis which was correlated with increased serum IgG4 and IgG4/IgG ratio. In spite of the finding of *streptococcus sanguis* in the retroperitoneum and the possibility of an infectious etiology, the classical histological findings of storiform fibrosis obliterator phlebitis and increased plasma cells along with immunohistochemistry showing increased IgG4 plasma cells should prompt us towards the diagnosis of IgG4 aortitis.

**Table 1.**

<table>
<thead>
<tr>
<th>Comprehensive diagnostic criteria for IgG4-RD, 20114</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinical examination showing characteristic diffuse/localized swelling or masses in single or multiple organs.</td>
</tr>
<tr>
<td>2. Hematological examination shows increased serum IgG4 concentrations (≥135 mg dl-1).</td>
</tr>
<tr>
<td>3. Histopathologic examination shows</td>
</tr>
<tr>
<td>(i) Marked lymphocyte and plasma cell infiltration and fibrosis.</td>
</tr>
<tr>
<td>(ii) Infiltration of IgG4+ plasma cells: ratio of IgG4+/IgG+ cells &gt;40% and &gt;10 IgG4+ plasma cells per HPF.</td>
</tr>
</tbody>
</table>

Definite: 1 + 2 + 3

Probable: 1 + 3

Possible: 1 + 2

However, it is important to differentiate IgG4-RD from malignant tumors of each organ (e.g. cancer, lymphoma) and similar diseases (e.g. SS, primary sclerosing cholangitis, Castleman’s disease, secondary RPF, Wegener’s granulomatosis, sarcoidosis, Churg-Strauss syndrome) by additional histopathological examination. Even when patients cannot be diagnosed using the CCD criteria, they may be diagnosed using organ-specific diagnostic criteria for IgG4-RD.

**References**


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Unexpected Serious Cardiac Arrhythmias in the Setting of Loperamide Abuse

SOMWAIL RASLA, MD; PARAG PARIKH, MD; PETER HOFFMEISTER, MD; AMY ST. AMAND, PharmD; MARINA K. GARAS, DO; AMR EL MELIGY, MD; TARO MINAMI, MD, FACP, FCCP; NISHANT R. SHAH, MD, MPH, MSc

ABSTRACT

Loperamide (Imodium) is a non-prescription opioid receptor agonist available over-the-counter for the treatment of diarrhea. When ingested in excessive doses, loperamide can penetrate the blood-brain barrier and is reported to produce euphoria, central nervous system and respiratory depression, and cardiotoxicity. There is an emerging trend in its use among drug abusers for its euphoric effects or for self-treatment of opioid withdrawal. We report a case of ventricular dysrhythmias associated with loperamide abuse in a 28-year-old man who substituted loperamide for the opioids that he used to abuse.

KEYWORDS: Ventricular tachycardia, Lopermide, opioid abuse, QTc prolongation, Arrhythmias

INTRODUCTION

Opioid abuse is one of the main causes of morbidity and mortality in the United States. Loperamide is an over-the-counter opioid receptor agonist used for the treatment of diarrhea. Loperamide abuse is a growing concern that requires careful medical attention. There is an increasing use of loperamide for its euphoric effects or for self-treatment of opioid withdrawal. We report a case of ventricular tachycardia in the setting of loperamide abuse.

CASE REPORT

A 28-year-old man with post-traumatic stress disorder and remote history of opioid abuse was admitted to the inpatient psychiatric unit for loperamide abuse. The patient is a veteran and bodybuilder who had been abusing loperamide for five months. He was taking about 400 mg daily (recommended dose: 4 mg plus 2 mg after each loose stool, with maximum dose of 16 mg/d) after he ran out of Oxycodone (100-150 tabs daily). Prior to the admission, he experienced three episodes of rapid heartbeats followed by near syncope. The patient denied any family history of sudden death or dysrhythmias. On the second hospital day, while moving from a recumbent position, he felt a skipped heartbeat, followed by palpitations and faintness. On examination, he was noted to have regular rhythm and a 3/6 systolic ejection murmur at the left parasternal border, non-radiating with otherwise normal exam including orthostatic vital signs. An electrocardiogram revealed sinus rhythm at the rate of 50 beats per minute with a prolonged QTc at 601 milliseconds and T-wave inversions precordially (Figure 1). The patient’s electrolytes were within normal limits and troponin was negative.

Figure 1. Sinus bradycardia at 50 BPM, premature atrial complexes, T-wave inversion in V2, V3, V4 and aVL leads, and prolonged QTc at 601 ms, PR 200 ms.

![Figure 1. Sinus bradycardia at 50 BPM, premature atrial complexes, T-wave inversion in V2, V3, V4 and aVL leads, and prolonged QTc at 601 ms, PR 200 ms.](image-url)
his other medications including Fluoxetine, Prazosin, and Quetiapine were discontinued. Pacer pads were applied and the patient was transferred to the ICU for close monitoring. While in the ICU, he developed sinus bradycardia with a persistent prolonged QTC despite an infusion of six grams of magnesium sulfate. A continuous isoproterenol infusion was begun. A transthoracic echocardiogram revealed a normal ejection fraction of 60% with mild apical hypertrophy. Overnight he had a brief episode of nonsustained ventricular tachycardia (VT) [Figure 2]. The patient’s QTc remained prolonged at 600 milliseconds on the third hospital day. Due to dynamic EKG changes including intermittent T-wave inversions, he was evaluated with coronary angiography, which did not reveal any evidence of obstructive coronary artery disease or congenital coronary anomalies. Due to the apical hypertrophy, cardiac magnetic resonance imaging (cMRI) was performed to rule out infiltrative cardiomyopathy and the results were negative with no evidence of underlying anatomical cardiac pathology. The QTc interval improved to 459 milliseconds on the fifth hospital day [Figure 3]. An exercise stress test prior to discharge showed no significant change in the QTc interval, which ruled out congenital long

![Figure 2. Telemetry rhythm strip showing a run of non-sustained Ventricular tachycardia.](image)

![Figure 3. Normal Sinus Rhythm at 66 BPM, QTc interval 459ms, PR interval 170 ms, QRS 88 ms.](image)
toxicities, as seen in our case. 

Serum loperamide levels are 9-13 hours, but the half-life may increase following ingestion of larger doses due to slowed gastrointestinal transit through inhibition of calcium channels. 

Loperamide-induced cardiotoxicity is theorized to be due to dose-dependent effects on the voltage-gated L-type calcium channel, hERG/I\textsubscript{kr}, potassium channel and cardiac sodium channels, similar to the action of Vaughan-Williams class IA, III, and IV anti-arrhythmics. Class IA agents such as quinidine, procainamide, and disopyramide lengthen refractory period, widen the monophasic action potential, and slow conduction via cardiac sodium channel blockade. The most serious side effect of cardiac sodium channel blockade include QRS prolongation, polymorphic ventricular tachycardia and torsades de pointes. Class III agents such as sotalol, ibutilide, and dofetilide block the cardiac potassium channel, delaying repolarization, which can cause QT prolongation. Class IV agents such as diltiazem and verapamil block cardiac calcium channels in the sinoatrial and atrio-ventricular nodes, reducing heart rate and conduction, which can result in bradyarrhythmia. Loperamide is known to exhibit its anti-secretory effects in the gastrointestinal tract through inhibition of calcium channels. 

Loperamide abuse for euphoric, opioid-like effects or self-treatment of opioid withdrawal symptoms is an emerging trend. In June 2016, the Food and Drug Administration (FDA) issued a warning statement to health care providers about potential serious adverse outcomes, including cardiac dysrhythmias and mortality. Data from the National Poison Data System indicate a national increase in intentional loperamide misuse. The risk factors for loperamide abuse include young age, male gender, previous opioid dependence or abuse, and previous treatment with methadone or buprenorphine. According to epidemiologic analysis, co-ingestions include antidepressants, analgesics, and benzodiazepines.

We report the importance of educating both the public and health care providers of the potential life-threatening effects of loperamide abuse in the context of the opioid addiction epidemic in the United States. Loperamide is inexpensive and readily accessible in pharmacies without a prescription or governmental regulation. Loperamide-induced cardiac dysrhythmias should be on the differential diagnosis in patients with a history of opioid abuse or dependence who present with cardiac arrest or syncope with abnormal electrocardiographic findings. Clinicians should report such cases to FDA Medwatch.
References


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Development and Use of a New Opioid Overdose Surveillance System, 2016
MEGHAN MccORMICK, MPH; JENNIFER KOZIOl, MPH; KELLY SANCHEZ

Rhode Island is experiencing an epidemic of overdose deaths. 1,2,4 Overdose deaths have occurred from illicit drugs, prescription medications, and combinations of both. 2,3 Since 2011, overdose deaths have increased by almost one third. 3 At least 329 people died of drug overdoses in 2016, up 13 percent from 2015. 4 This public health crisis has affected the lives of men, women, and children, from all walks of life, and from communities all over the state.

The Rhode Island Department of Health (RIDOH) in conjunction with lawmakers and stakeholders in the overdose epidemic have taken measures to improve surveillance of this problem. In April 2014, RIDOH passed emergency regulations that require all hospitals and emergency departments to report cases of opioid overdose within forty-eight (48) hours to RIDOH. 4 In October 2014, the legislation became final. Hospitals and emergency departments were first asked to fax reports to RIDOH. 4 In October 2015, RIDOH transitioned to an electronic reporting system. 5 The development of the Opioid Overdose Reporting System was a recommendation made by the Centers for Disease Control and Prevention (CDC) staff during a site visit to RIDOH. The intent of the Opioid Overdose Reporting System is to identify clusters of overdoses in near real time to target interventions in high-risk areas and to vulnerable populations. 4 The development of this reporting system provided information about overdose patients so that specific risk factors could be identified and referral to counseling or other substance abuse services could be made. The information collected can be modified at any time to meet the surveillance needs of the epidemic. The availability of near real time data allows for prompt interventions and responses.

METHODS
We used 2016 data from the Opioid Overdose Reporting System. Reports were made by hospital staff through an online form. 2016 was the first full year in which the electronic reporting system was used. RIDOH staff met with all Emergency Departments individually in early 2016 to ensure consistent reporting criteria among all hospitals and to improve compliance with the regulation.

Reporting methods varied by hospital. Two methods were most common. The first method was centralized reporting. The electronic health record was used to generate a report daily and a designated staff member then entered the overdose cases into the reporting system. The next most common method had Emergency Department clinical staff report in real time when an overdose case presented to the Emergency Department.

The overdose report requires information about patient demographics, risk factors, co-morbidities, and patient outcome. If a patient was discharged at time of reporting, the reporting system also requires information about connection to follow-up services and naloxone distribution.

There were 1,567 overdose case reports in 2016. Reports were removed from this analysis if the report date was before the listed admission date (n=5), the patient was younger than 18 years old (n=24), and if the overdose was attributed to a non-opioid substance (n=15). 1,523 overdose events remained for analysis.

Although this analysis focused on adults aged 18 and older, we do receive overdose case reports for those aged less than 18. During 2016, there were 24 overdose case reports among children aged less than 18.

Demographic variables of age, ethnicity and sex were reported as collected. Asian, Native American and Other race responses were grouped into one category labeled “Other” due to low numbers of reports in these categories. Risk factors were excluded from reporting if less than twenty cases had been reported.

The patient outcome variable initially only collected whether the patient had died or had been discharged. Due to programmatic needs, the patient outcome question was modified in March of 2016 to include additional outcomes, including transfer to another facility.

Primary substance is defined as the substance suspected to have caused the overdose. Due to low numbers, “Opium,” “Other synthetic narcotics” and “Other” responses were combined into one “Other” category.

RESULTS
Demographics of reported overdose cases are displayed in Table 1. The 70.5% of overdoses occurred in men. More than one-third (34.1%) of overdose reports occurred in ages 25 to 34. White (83.5%) and Non-Hispanic (78.5%) were the most prevalent race and ethnicity, respectively.

Patient characteristics and outcomes are found in Table 2. 78.1% of cases were discharged, and only 4% of resulted in death. 58.2% of reported overdoses were attributed to heroin.
A small percent (2.0%) of overdoses were attributed to methadone. Of the patients who were discharged (n=1190), about a third (34.8%) were discharged with a naloxone kit.

Reported risk factors in overdose cases are displayed in Table 3. Substance abuse was the most frequently reported risk factor, being reported in 71.6% of overdose cases. Depression was reported in a quarter of cases (25.1%), and 17.1% of reported cases had experienced a prior overdose that required medical care.

**DISCUSSION**

The Opioid Overdose Reporting System allows for near real time surveillance of an ongoing epidemic. The flexibility of the system allows for modification and addition of required information as the surveillance needs change. However, the system has significant limitations. Compliance with the reporting regulation has varied by hospital. As a result, these data are not well suited for geographic analysis of where overdoses occur. The amount of under-reporting in 2016 is not yet known. A future analysis comparing Opioid Overdose Reporting System data to the Emergency Discharge Dataset to determine the extent of under-reporting will occur when the discharge data for 2016 become available. Since identifying information is not collected, program interventions may be directed at the community level, but we are unable to target the individuals who have had a reported overdose. Despite these limitations, the reporting system is an important asset in surveillance of the opioid epidemic.

The regulation and reporting system do not distinguish between intentional and unintentional overdoses. As a result, these data likely include suicide attempts. The response and follow-up services needed for an intentional overdose differ from that of an unintentional overdose.

The high frequency of reporting prior overdoses requiring medical care as a risk factor suggests the importance of naloxone distribution at discharge. Nearly two-thirds of discharges
did not leave the emergency department with naloxone. The emergency department has an important opportunity to try to connect overdose patients with recovery services.

The overdose epidemic had mostly been defined by deaths as death data had been available sooner than emergency department discharge data. Overdose deaths represent only a small portion of overdoses. The development of a near real time surveillance system of emergency department usage due to overdose provides a greater picture of the epidemic.

References
1. Montanaro M, Alexander-Scott N. Rhode Island’s strategic plan on addiction and overdose: four strategies to alter the course of an epidemic. In: Rhode Island Department of Health (RIDOH) and Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH). Providence, RI: The Governor’s Task Force on Overdose Prevention & Intervention; 2015.

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Jennifer Koziol, MPH, is the Drug Overdose Prevention Program Manager in the Division of Community Health and Equity at the Rhode Island Department of Health.

Kelly Sanchez is a Master’s of Public Health student at Brown University.
Rhode Island Monthly Vital Statistics Report
Provisional Occurrence Data from the Division of Vital Records

<table>
<thead>
<tr>
<th>VITAL EVENTS</th>
<th>OCTOBER 2016</th>
<th>12 MONTHS ENDING WITH OCTOBER 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>Live Births</td>
<td>935</td>
<td>11,644</td>
</tr>
<tr>
<td>Deaths</td>
<td>868</td>
<td>9,942</td>
</tr>
<tr>
<td>Infant Deaths</td>
<td>5</td>
<td>61</td>
</tr>
<tr>
<td>Neonatal Deaths</td>
<td>5</td>
<td>47</td>
</tr>
<tr>
<td>Marriages</td>
<td>894</td>
<td>6,989</td>
</tr>
<tr>
<td>Divorces</td>
<td>240</td>
<td>3,039</td>
</tr>
<tr>
<td>Induced Terminations</td>
<td>240</td>
<td>2,237</td>
</tr>
<tr>
<td>Spontaneous Fetal Deaths</td>
<td>33</td>
<td>531</td>
</tr>
<tr>
<td>Under 20 weeks gestation</td>
<td>28</td>
<td>459</td>
</tr>
<tr>
<td>20+ weeks gestation</td>
<td>5</td>
<td>72</td>
</tr>
</tbody>
</table>

* Rates per 1,000 estimated population
# Rates per 1,000 live births

<table>
<thead>
<tr>
<th>Underlying Cause of Death Category</th>
<th>APRIL 2016</th>
<th>12 MONTHS ENDING WITH APRIL 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (a)</td>
<td>Number (a)</td>
</tr>
<tr>
<td>Diseases of the Heart</td>
<td>201</td>
<td>2,383</td>
</tr>
<tr>
<td>Malignant Neoplasms</td>
<td>176</td>
<td>2,275</td>
</tr>
<tr>
<td>Cerebrovascular Disease</td>
<td>36</td>
<td>431</td>
</tr>
<tr>
<td>Injuries (Accident/Suicide/Homicide)</td>
<td>68</td>
<td>871</td>
</tr>
<tr>
<td>COPD</td>
<td>51</td>
<td>466</td>
</tr>
</tbody>
</table>

(a) Cause of death statistics were derived from the underlying cause of death reported by physicians on death certificates.
(b) Rates per 100,000 estimated population of 1,056,298 (www.census.gov)
(c) Years of Potential Life Lost (YPLL).

NOTE: Totals represent vital events, which occurred in Rhode Island for the reporting periods listed above. Monthly provisional totals should be analyzed with caution because the numbers may be small and subject to seasonal variation.
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Contact Sarah if you’ve missed an issue, sstevens@rimed.org.
Working for You: RIMS advocacy activities

March 1, Wednesday
Legislative Hearings

March 2, Thursday
Legislative Hearings
Senate Majority Leader Ruggerio Fundraiser

March 3, Friday
Meeting with RI Director of Health, Nicole Alexander-Scott, MD, and RI Chapter, America College of Emergency Physicians
Meeting with RI Podiatric Medical Society: Sarah J. Fessler, MD, President

March 6, Monday
Meeting RI Tobacco Policy Coalition regarding Governor’s budget
RIMS Board of Directors meeting: Sarah J. Fessler, MD, President

March 7, Tuesday
RIMS Physician Health Committee: Herbert Rakatansky, MD, Chair
RIMS Weight-Wellness Summit [unique day-long gathering of 280 registrants, 30 speakers, made possible by the Coverys Community Healthcare Foundation]

March 8, Wednesday
Board of Medical Licensure and Discipline, Department of Health
Governor’s Overdose and Intervention Task Force
Legislative Hearings

March 9, Thursday
Senate Leadership PAC fundraiser
Diabetes Prevention Program Stakeholders Meeting
Legislative Hearings
SIM Steering Committee: Peter Hollmann, MD

March 13, Monday
Meeting with Blue Cross Blue Shield of RI: Sarah J. Fessler, MD, President; RIMS staff
Meeting with Department of Health Staff regarding Diabetes Prevention Programs (DPP)

March 15, Wednesday
Primary Care Physician Advisory Committee, Department of Health
RI Tobacco Policy Commission meeting

Legislative hearings
Inaugural meeting of the Collins Committee: President-elect Bradley Collins, MD, Chair [topic: patient safety]

March 16, Thursday
Legislative hearings
Chairwoman Fogarty fundraiser

March 21, Tuesday
Legislative hearings

March 22, Wednesday
Legislative hearings

March 23, Thursday
Legislative hearings

March 28, Tuesday
RI Academy of Family Physicians Legislative Day: RIMS Staff Chairman Craven fundraiser Chairman Miller fundraiser

March 29, Wednesday
Legislative hearings
Meeting with Senate leadership regarding legislation: Michael E. Migliori, MD, Chair, RIMS Public Laws Committee

March 31, Friday
Meeting with Todd Handel, MD, regarding Medical Marijuana Oversight Committee

RIMS is pleased to introduce Marc Bialek, the new Director of Membership. Marc has over 13 years of experience working for national and international non-profit trade associations and societies. He has worked for The National Restaurant Association, the U.S. Green Building Council, The Society of American Military Engineers and InfoComm International. He has recently moved to Rhode Island with his wife and three children. Marc looks forward to working with RIMS leadership on recruitment, retention and most importantly engagement. Marc will be working with the 11 specialty societies that RIMS manages.
It’s a new day.

The Rhode Island Medical Society now endorses Coverys.

Coverys, the leading medical liability insurer in Rhode Island, has joined forces with RIMS to target new levels of patient safety and physician security while maintaining competitive rates. Call to learn how our alliance means a bright new day for your practice.

401-331-3207
First Weight + Wellness Summit Held in RI
Almost 300 attend to network and share ideas, solutions

The Rhode Island Medical Society and the Rhode Island Health Center Association convened the state’s first Weight + Wellness summit on March 7, with approximately 300 people in attendance. SARAH FESSLER, MD, president of the Rhode Island Medical Society, welcomed the diverse group of attendees from the medical and healthcare community, the state, and community organizations and businesses, to the event; along with JANE HAYWARD, president of the Rhode Island Health Center Association; ANYA RADER WALLACK, acting secretary of the Executive Office of Health and Human Services; and ANDY MOFFIT, first gentleman of Rhode Island.

According to the summit planners, “The inspiration for this Summit was provided by the many individuals and organizations that are working to make

RIMS president Sarah Fessler, MD, welcomed attendees to the Summit.

Jane Hayward, president and CEO of the Rhode Island Health Center Association, served as master of ceremonies for the event.

Anya Rader Wallack, acting secretary of the Executive Office of Health and Human Services.

Andy Moffit, first gentleman of Rhode Island, helped introduce the event.

More than 20 exhibitors displayed their programs and organizations at the event.
Among the speakers was Dean of URI’s College of Health Sciences Gary Liguori, PhD.

Dr. Dieter Pohl, bariatric surgeon at Roger Williams Medical Center, served on the physician advisory committee for the event.

daily habits of smart nutrition and healthy living convenient and affordable for all Rhode Islanders. We wanted to showcase the diversity of local initiatives and provide an opportunity for like-minded people to learn and interact on the multifaceted topic of weight and wellness.”

After the event, Catherine Norton, assistant director of professional and community services at RIMS and a member of the planning committee, said there was a “tremendous response from attendees to organize another similar event. The W+W Planning Committee will meet in April to discuss the next steps.”

The event, held at the Crowne Plaza in Warwick, was funded through an educational grant from the Coverys Community Healthcare Foundation, and partially sponsored by Blue Cross Blue Shield of RI.

Dr. Dieter Pohl, bariatric surgeon at Roger Williams Medical Center, served on the physician advisory committee for the event.

The exhibitors included:

American Heart Association & American Stroke Association
Ascensus College Savings
CharterCARE Health Partners
Chiropractic Society of Rhode Island
City of Providence Healthy Communities Office
Community Health Network, RIDOH
Farm Fresh RI
F.I.T. Club
Fuel Up to Play 60
Greater Providence YMCA
Grow Smart RI
Healthcentric Advisors
Neighborhood Health Plan of Rhode Island
Newport Wellness Hub
Nutrition Outreach Programs
SNAP & EFNEP
Rhode Island Academy of Nutrition and Dietetics
Rhode Island Bike Coalition
Rhode Island Healthy Schools Coalition
Rhode Island Public Health Institute
Rhode Island Quality Institute
United States Army Health Care
Urban Greens Food Co-Op
We Quit

Vincent Pera, MD, The Miriam Hospital’s co-director of The Center for Weight and Wellness and the director of the hospital’s Weight Management Program.
The Rhode Island Medical Society continues to drive forward into the future with the implementation of various new programs. As such, RIMS is expanded its Affinity Program to allow for more of our colleagues in healthcare and related business to work with our membership. RIMS thanks these participants for their support of our membership.

Contact Marc Bialek for more information: 401-331-3207 or mbialek@rimed.org

Doctor’s Choice provides no cost Medicare consultations. Doctor’s Choice was founded by Dr. John Luo, a graduate of the Alpert Medical School at Brown University to provide patient education and guidance when it comes to choosing a Medicare Supplemental, Advantage, or Part D prescription plan. Doctor’s Choice works with individuals in RI, MA, as well as CT and helps compare across a wide variety of Medicare plans including Blue Cross, United Health, Humana, and Harvard Pilgrim.

Neighborhood Health Plan of Rhode Island is a non-profit HMO founded in 1993 in partnership with Rhode Island’s Community Health Centers. Serving over 185,000 members, Neighborhood has doubled in membership, revenue and staff since November 2013. In January 2014, Neighborhood extended its service, benefits and value through the HealthSource RI health insurance exchange, serving 49% the RI exchange market. Neighborhood has been rated by National Committee for Quality Assurance (NCQA) as one of the Top 10 Medicaid health plans in America, every year since ratings began twelve years ago.

RIPCPC is an independent practice association (IPA) of primary care physicians located throughout the state of Rhode Island. The IPA, originally formed in 1994, represent 150 physicians from Family Practice, Internal Medicine and Pediatrics. RIPCPC also has an affiliation with over 200 specialty-care member physicians. Our PCP’s act as primary care providers for over 340,000 patients throughout the state of Rhode Island. The IPA was formed to provide a venue for the smaller independent practices to work together with the ultimate goal of improving quality of care for our patients.
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Membership in The Rhode Island Medical Society (RIMS) makes you a part of a dynamic network of physicians, residents, students, physician assistants, and healthcare professionals who represent, like you, the best of the profession.

The ABCs of membership

Advocacy: RIMS membership offers a cohesive platform for its members to speak with a unified voice on local, state and national issues through committee participation, policy development, legislative representation, educational conferences, and stakeholder seminars.

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Collegiality: Social events, networking opportunities, professional development.

Strength: In numbers. If you are already a member, thank you for your support. If you’re not, join us today. Group, military and new practitioner discounts; medical students join for free.

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Contact Mark Bialek, Director of Membership

RIMS Leadership: Treasurer José Polanco, MD; Secretary Christine Brousseau, MD; President-Elect Bradley J. Collins, MD; President Sarah J. Fessler, MD; Vice President Peter A. Hollman, MD; and (seated) Immediate Past President Russell A. Settipane, MD.

RIMS Executive Director Newell E. Warde, PhD, hosting a free CME seminar for members of the Medical Society.

RIMS maintains close contact with federal and state lawmakers to represent physician and patient interests in emerging legislation. RIMS Public Laws Chair Michael E. Migliori, MD, at left, and RIMS Director of Government and Public Affairs Steven R. DeToy shown here following their meeting with RI Representative David R. Cicilline.

RIMS hosts social events throughout the year for members and guests.
RIMS gratefully acknowledges the practices who participate in our discounted Group Membership Program

For more information about group rates, please contact Marc Bialek, RIMS Director of Member Services
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Brain Week RI speaker shares lifelong struggles with schizophrenia

MARY KORR
RIMJ MANAGING EDITOR

PROVIDENCE – ELYN R. SAKS, JD, PhD, shared her harrowing and lifelong struggles navigating the shifting, delusional scaffolds of schizophrenia at Brown University on March 12.

The author of the best-selling memoir, The Center Cannot Hold: My Journey Through Madness, was the keynote speaker for Brain Week RI, presented by the Cure Alliance for Mental Illness during international Brain Awareness Week.

A law professor and MacArthur “genius” Fellowship recipient, Saks described the first serious manifestation of the illness when she was a Marshall Scholar at Oxford University. “I was in terrible shape…I heard voices in my head. I wandered the campus thinking about ways to commit suicide. At the same time I had no awareness of the severity of my condition.”

Taken to the hospital by a professor, a glance in a mirror showed a wild, disheveled person she did not recognize, and which shocked her. “Until that moment I did not understand I had a mental illness.” But it would take decades before she acknowledged the depths of her illness. “My thought was I was different…my challenge was to take that woman in the mirror and tame her. I thought of it as a transient mood or thought disorder.”

When she returned to this country to study at Yale Law School, her condition deteriorated. “I was overwhelmed,” she said. One night, after failing to convince two fellow students that the memos they were preparing for a professor had been infiltrated and changed by unknown entities, she climbed to the roof of the law library and began singing the Beatles’ Golden Slumbers: ‘Once there was a way to get back homeward…once there was a way…’

Shortly thereafter, she was admitted to a hospital.

“During the next year, I would spend five months in the psychiatric ward. At times, I spent up to 20 hours in mechanical restraints, arms and legs tied down with a net tied tightly across my chest. I never struck anyone. I never harmed anyone. I never made any direct threats. If you’ve never been restrained yourself, you may have a benign image of the experience. There’s nothing benign about it,“ she said.

After being released from the hospital, she resisted advice to take a menial job and drop out of law school, and returned to classes the next semester. She started “talk therapy,” which she said helped her cope with her stresses and fears and gave her a safe place to, at times, unravel.

After graduation, she worked as an attorney in Connecticut before joining the USC Gould law school faculty in Los Angeles.

Saks said for years she resisted taking medications, thinking that if she could cope without medications she could prove to herself that she was not really mentally ill, that it was some grave mistake. “My motto was, the less medicine, the less defective. My L.A. analyst, Dr. Kaplan, was urging me just to stay on

BRIEF BIO

Elyn R. Saks, JD, PhD
Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at University of Southern California Gould School of Law
Adjunct Professor of Psychiatry at the University of California, San Diego, School of Medicine; and Faculty at the New Center for Psychoanalysis
Recipient of MacArthur Fellowship in 2009.
JD, Yale Law School
PhD, Psychoanalytic Science from the New Center for Psychoanalysis. Los Angeles, CA
Her 2012 TED talk has been viewed more than 3 million times (https://www.ted.com/talks/elyn_saks_seeing_mental_illness)

Books
Informed Consent to Psychoanalysis: The Law, The Theory, and The Data (with Shahrokh Golshan) (Fordham University Press, 2013)
The Center Cannot Hold: My Journey Through Madness (Hyperion, 2007)
Refusing Care: Forced Treatment and the Rights of the Mentally Ill (University of Chicago Press, 2002)
medication and get on with my life, but I decided I wanted to make one last college try to get off.”

She describes this in the following passage from her memoir:

I started the reduction of my meds, and within a short time I began feeling the effects. After returning from a trip to Oxford, I marched into Kaplan’s office, headed straight for the corner, crouched down, covered my face, and began muttering. ‘Head explosions and people trying to kill. Is it okay if I totally trash your office?’

‘You need to leave if you think you’re going to do that,’ said Marder.

‘Okay. Small. Fire on ice. Tell them not to kill me. Tell them not to kill me. What have I done wrong? Hundreds of thousands with thoughts, interdiction.’

‘Elyn, do you feel like you’re dangerous to yourself or others? I think you need to be in the hospital. I could get you admitted right away, and the whole thing could be very discrete.’

‘Ha, ha, ha. You’re offering to put me in hospitals! Hospitals are bad, they’re mad, they’re sad. One must stay away. I’m God, or I used to be.’

She then said, “Eventually, I broke down in front of friends, and everybody convinced me to take more medication. I could no longer deny the truth, and I could not change it. The wall that kept me, Elyn, Professor Saks, separate from that insane woman hospitalized years past, lay smashed and in ruins.”

She said the acceptance of mental illness and the therapeutic value of psychoanalysis and effective drugs, mentioning clozapine, was “like daylight dawning. After 20 years I understood I had a real illness...by making peace with the lady in the chart, the less it defined me.”

Saks added, “I did not make my illness public until relatively late in life, and that’s because the stigma against mental illness is so powerful that I didn’t feel safe with people knowing. If you hear nothing else today, please hear this: There are not “schizophrenics.” There are people with schizophrenia, and these people may be your spouse, they may be your child, they may be your neighbor, they may be your friend, they may be your coworker.”

She said her lifeline has been her friends, family, and the support of her colleagues.

Her goal is to translate ideas into action “so that those of us with a mental illness can find a life worth living. Hope for a cure lies in research.”

To that end, she donated the $500,000 proceeds of her MacArthur Fellowship to establish the Saks Institute for Mental Health, Law, Policy, and Ethics, a think tank founded to foster interdisciplinary and collaborative research among scholars and policymakers around issues of mental illness and mental health.
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IN THE NEWS

Match Day 2017:
Primary care programs top choice among Alpert students

PROVIDENCE – St. Patrick’s Day 2017 coincided with the biggest Match Day yet at Brown, with 115 Alpert Medical School students learning where they’ll begin practicing medicine after they graduate this spring.

This year saw big numbers of Alpert students – 42 in all – matching to primary care programs, which include family medicine, internal medicine and pediatrics. Emergency medicine drew another dozen students. Obstetrics and gynecology, with 11 matches, and radiology, with nine, rounded out the most popular specialties this year.

Most of the medical school’s Class of 2017 graduates will stay in the Northeast, with 15 training at Brown-affiliated programs in Rhode Island. One student participated in the military match and will complete his residency at the Eisenhower Army Medical Center in Georgia.

Link to the complete 2017 match: https://www.brown.edu/academics/medical/about-usfacts-and-figures/md-2017-match-list

Paper shows promise, risks of trans-cranial stimulation treatment for psychiatric disorders

PROVIDENCE – A recent paper published online in the American Journal of Psychiatry finds that a new type of stimulation in psychiatry has promise, but also potential pitfalls, and shows a need for more high-quality studies.

Low-intensity transcranial electrical current stimulation, or tCS, is a form of neurostimulation that uses a low power current delivered to the brain.

“This is the first comprehensive review of low-current stimulation in psychiatry,” said DR. NOAH PHILIP, a psychiatrist and researcher at the Providence VA Medical Center, lead author of the paper. “Low current stimulation has the potential to revolutionize how we deliver non-invasive brain stimulation through small, portable devices, but there are risks, and we want to help clinicians and researchers understand this rapidly growing field.”

The review supports application of one type of tCS for major depression: transcranial direct current stimulation, known as tDCS. However, tDCS devices are not approved for treating medical disorders, evidence was inconclusive for other therapeutic uses, and use is associated with both physical and psychiatric risks. The complete paper can be found on the American Journal of Psychiatry’s Psychiatry Online website at: http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2017.16090996.

“If eventually proven safe and effective, the ease of use and accessibility of the devices could render tCS a broad-reaching and important advance in mental health care, both for veterans and the general population,” concluded Dr. Philip.

Dr. Noah Philip, psychiatrist and researcher at the Providence VA Medical Center, is the lead author of a recent paper published online in the American Journal of Psychiatry which finds that low-intensity transcranial electrical current stimulation, known as tCS, has promise in psychiatry, but also potential pitfalls, and shows a need for more high-quality studies.
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Remember-It's your money & that's a lot to lose.
RI releases nation’s first statewide standards for treating overdose and opioid use in hospitals and emergency settings

Naloxone distribution, discharge planning, and opioid-use screenings now required

PROVIDENCE – Leadership from hospitals and emergency departments throughout Rhode Island joined Governor Raimondo’s Overdose Prevention and Intervention Task Force today to release a first-in-the-nation set of statewide guidelines to save lives by ensuring consistent, comprehensive care for opioid-use disorder in emergency and hospital settings in March.

In addition to establishing a common foundation for treating opioid-use disorder and overdose in Rhode Island hospitals and emergency departments, the standards establish a three-level system of categorization that defines each hospital and emergency department’s current capacity to treat opioid-use disorder. All emergency departments and hospitals in Rhode Island will be required to meet the criteria for Level 3 facilities. As a facility’s capacity to treat opioid-use disorder develops, that facility can apply for a higher designation.

Hospitals and emergency departments will be categorized based on initial self-assessments and follow-up evaluations by the Rhode Island Department of Health (RIDOH) and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

Sample requirements for a Level 3 facility

[all Rhode Island emergency departments and hospitals]:
- Dispense naloxone to all patients at risk
- Educate all patients who are prescribed opioids on safe storage and disposal
- Provide comprehensive discharge planning to people who overdose
- Screen all patients for substance-use disorder
- Report all overdoses within 48 hours to RIDOH
- Offer peer recovery support services

Sample requirement for a Level 2 facility:
- Maintain capacity for the evaluation and treatment of opioid-use disorder

Sample requirement for a Level 1 facility:
- Maintain a “Center of Excellence” where patients can receive buprenorphine treatment for opioid-use disorder

The standards were developed by members of Governor Raimondo’s Overdose Prevention and Intervention Task Force, which is co-chaired by REBECCA BOSS, Acting Director of BHDDH, and NICOLE ALEXANDER-SCOTT, MD, MPH, Director of Health. The standards were also developed with input from hospitals and emergency departments throughout the state. Leadership from several hospitals, including Butler Hospital, the Miriam Hospital, and Kent Hospital, attended the March Task Force meeting to show their support for the standards.

“The hallmarks of quality patient care in any individual healthcare facility are consistency, continuity, and coordination,” said GARY BUBL Y, MD, FACEP, Medical Director of the Miriam Hospital’s Department of Emergency Medicine.

“Rhode Island is applying these principles at a statewide level in a way that will profoundly shift how opioid-use disorder is treated. These standards are a model that can be replicated in states across the country that we hope will prevent overdoses and save lives.”

“The development of these standards by Governor Raimondo’s Overdose Prevention and Intervention Task Force will ensure that best practices in the treatment of opioid use disorder are replicated at Butler and at each hospital throughout Rhode Island,” said LAWRENCE PRICE, MD, President and Chief Operating Officer of Butler Hospital. “A public health issue as significant as the overdose crisis demands this kind of careful coordination throughout the state.”

The requirement that all Level 3 hospitals and emergency departments provide comprehensive discharge planning stems from the 2016 Alexander C. Perry and Brandon Golder Law. The structure and support included in a discharge plan are intended to help an individual who has overdosed not do so again.

At least 329 Rhode Islanders died of drug overdoses in 2016. Although Rhode Island has seen a steady decline in the number of overdose deaths caused by prescription medication, the state has seen sharp increases in overdoses caused by the synthetic opioid fentanyl. In 2016, approximately 57% of Rhode Island’s overdoses involved fentanyl, compared to 47% in 2015 and 35% in 2014.

The complete standards, titled Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder, are available online.
New IDSA guideline on ventriculitis and meningitis

New IDSA guidelines recommend a team approach for the successful diagnosis and treatment of complex neurological infections related to placement of devices in the brain, or as a result of neurosurgery or head trauma. The first comprehensive guidelines on healthcare-associated ventriculitis and meningitis are now available in the journal Clinical Infectious Diseases.

The guidelines provide parameters regarding when clinicians should consider the possibility of ventriculitis or meningitis in patients who have cerebrospinal fluid shunts and drains, intrathecal drug pumps, deep brain stimulation hardware, or who have undergone neurosurgery or suffered from head trauma. Due to the complexity of these infections, they need to be managed by a multidisciplinary team most often featuring infectious diseases specialists, neurologists, neurosurgeons and neurocritical care specialists.

The guidelines help clinicians determine when to suspect ventriculitis or meningitis and start patients on appropriate antimicrobial therapy while awaiting culture results to confirm the infection and organism causing it. Additionally, the guidelines recommend when a device should be removed and replaced.

The guidelines also delve into various ways these infections may be prevented, such as using prophylactic antibiotics during placement of the devices, as well as employing “practice bundles,” specific steps neurosurgeons should take when placing shunts and drains.

In addition to lead author, ALLAN R. TUNKEL, MD, PhD, the guidelines panel includes: Adarsh Bhimraj, MD, FIDSA; Thomas P. Bleck, MD, FIDSA; Karin Byers, MD; Hugh J.L. Garton, MD; Rodrigo Hasbun, MD, FIDSA; Sheldon L. Kaplan, MD, FIDSA; W. Michael Scheld, MD, FIDSA; Diederik van de Beek, MD, PhD; and Joseph R. Zunt, MD, MPH. The panel represents pediatric and adult ID specialists, those who specialize in neurosurgery, neurology, neurocritical care and infection prevention and, in addition to IDSA, organizations whose members care for these patients, including the American Academy of Neurology [AAN], American Association of Neurological Surgeons [AANS] and Congress of Neurological Surgeons [CNS], Neurocritical Care Society (NCS) and the Society for Healthcare Epidemiology of America (SHEA). The guidelines were endorsed by the NCS and SHEA, and their value and educational content affirmed by AAN, AANS, and CNS.
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Dana-Farber Cancer Institute, Lifespan sign long-term agreement to advance cancer treatment and research

Providence – Dana-Farber Cancer Institute and Lifespan leadership are creating a strategic alliance to advance cancer treatment and research. The new agreement, signed March 21, 2017, will support the expansion of clinical trials, offer access for Lifespan physicians to cancer-specific disease expertise for complex cases, and create a program to coordinate the treatment of bone marrow transplant patients, with transplants provided in Boston at Dana-Farber/Brigham and Women’s Cancer Center and care surrounding the transplant in Rhode Island at Lifespan. The two organizations already share patient information through their respective cancer-specific electronic health record systems and will use the same clinical trials management platform, resulting in better care coordination.

A top priority of Dana-Farber and Lifespan Cancer Institute’s work together is to offer the latest and most advanced clinical trials to patients in Rhode Island. While many of these trials will be developed at and provided by Dana-Farber, there will also be opportunities for clinical trials developed at the Lifespan Cancer Institute to be offered to Dana-Farber patients. Increasing access to diverse patient populations is a common research goal to help accelerate the development of new therapies.

“Clinical trials are essential to improving care, and they can offer great benefits to patients,” said Eric Winer, MD, chief strategy officer and chief of the Division of Women’s Cancers at Dana-Farber Cancer Institute. “This alliance will mean more clinical trials will be available through the Lifespan Cancer Institute in Rhode Island. In addition, access to Dana-Farber in Boston for complex care will be seamless. Our breast cancer physicians from the two organizations have been meeting and we are very excited about ways we can collaborate to assure patients access to the latest treatments.”

The most promising cancer treatments and research are in the areas of immunotherapy and targeted treatments, fields where Dana-Farber has been a pioneer. “By combining the skills of our doctors with the power of cutting-edge science, we are well-positioned to not only bring cancer care in Rhode Island to the next level but help push treatment breakthroughs that have global implications,” said David Wazer, MD, director of the Lifespan Cancer Institute.

Howard Safran, MD, chief of the Division of Hematology/Oncology, at the Lifespan Cancer Institute said, “Our physicians look forward to collaborating with disease site experts at Dana-Farber and we have already started to hold meetings.”

An immediate benefit to the agreement is offering Lifespan patients a bone marrow transplant program with local coordination and care seamlessly tied into Dana-Farber. “Dana-Farber has one of the largest and most respected bone marrow transplant programs in the world. With this new alliance, Lifespan patients will be offered the opportunity to have their transplants at Dana-Farber with coordinated post-care provided close to their homes by Lifespan physicians,” said Dr. Safran.

Other areas to be explored include genomics and precision medicine, cancer disparities, innovation in the delivery of cancer care, and potential synergies in basic research. The two organizations have collaborated on a multi-site grant application for genomics with a health disparities component.

“Lifespan Cancer Institute’s patients will continue to receive excellent cancer care in Rhode Island, but patients with rare and more complex cancers will benefit from seamless referrals and coordination of care with Dana-Farber. The new agreement gives us the ability to offer the latest and most cutting-edge clinical trials to patients from Rhode Island and surrounding areas. Successful cancer programs and new discovery depend on access to large populations of patients,” said Timothy Babineau, MD, president and CEO of Lifespan. “We are proud to be working with one of the leading cancer centers in the United States.”

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URI researchers receive pilot project funding from Advance-CTR
Collaborations with Brown University, Bradley Hospital target environmental and behavioral health issues

KINGSTON – Pilot Projects involving two researchers at the University of Rhode Island have been awarded federal funding through Advance Clinical and Translational Research (Advance-CTR), a statewide effort to support clinical research that can be translated into approaches and policies that improve the health of Rhode Islanders.

Marcella Thompson, assistant professor in the College of Nursing/Academic Health Collaborative, and Kunal Mankodiya, assistant professor in the College of Engineering, along with colleagues at Brown University and Bradley Hospital, will each receive one-year grants of $75,000 through Advance-CTR’s initial round of funding.

“We were delighted that URI faculty submitted many outstanding applications for the Pilot Projects awards,” said Dr. Sharon Rounds director of the Pilot Program at Advance-CTR, based at Brown University and comprising an equal partnership of Brown, URI, Lifespan, Care New England, the Providence VA Medical Center, and the Rhode Island Quality Institute. “The two URI investigators who submitted the funded applications do very interesting and impactful research in collaboration with other Advance-CTR partners.”

Thompson and co-principal investigator Dinah Spears of the Narragansett Indian Tribe are collaborating with Elizabeth Hoover, Gregory Wellenius and Alison Field of Brown University to examine exposure to PCBs and mercury among members of the tribe, whose traditional diet includes locally caught fish. The project, “Community-Engaged Tribal Research to Assess Dietary Exposures to Mercury and PCBs,” will send trained tribal members into their community to collect data on eating habits and the rate of local fish consumption. The analyses and survey findings will provide the community with information needed to weigh the benefits and risks of eating local fish.

“This is just one phase of our community engaged research with the tribe on a complex environmental health issue,” Thompson said of the project.

Mankodiya is working with Dr. Kerri Kim and Dr. Daniel Dickstein of Bradley Hospital/Brown University on the project “Brain/Behavior Mechanisms in Emotional Dysregulation in Adolescents with Mood and Anxiety Disorders.” It examines the effects of dialectical behavior therapy in teenage girls with significant mood disorders, including chronic suicidal thoughts and behavior. Specifically, the researchers are using fMRIs (which measure changes in blood flow in the brain) to examine the potential brain-based changes associated with completing treatment and in comparison to a control group. Participants will also wear smart watches to monitor their bodily responses – heart rate, skin response, temperature and activity level – to emotional stimuli throughout their typical day. Mankodiya will head this portion of the study, applying a data analysis platform that he and his team at URI have built that uses smart watches as real-world assessment tools. These findings will be compared to those revealed in the fMRIs.

“We can see when there are episodes that indicate they are experiencing anxiety or mood swings, determine the day of the week, the time of day, what they are doing and the number of incidents,” he said. “This is very exciting for me. I like to solve problems, but not in the lab, in real life.”

Eleanor Slater Hospital joins HARI
PROVIDENCE – The Hospital Association of Rhode Island announced Eleanor Slater Hospital has joined its membership, effective April 1, 2017. HARI will provide the hospital with a variety of resources and services to support its unique mission in caring for Rhode Island patients.

The hospital will benefit from peer-to-peer learning, quality and patient safety initiatives, data analysis and reports, professional development opportunities and industry news and insights. In addition, Cynthia Huether, chief executive officer of Eleanor Slater Hospital, will join the HARI Board of Trustees as an ex-officio, non-voting member.

Life’s a challenge — take it
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Research evaluates association between maternal mental health and discharge readiness in mothers of preterm infants

Each year, more than 450,000 babies are born preterm in the U.S., many of whom spend days, weeks or even months in a neonatal intensive care unit (NICU). The mothers of these infants are at increased risk for maternal mental health disorders including depression, anxiety and posttraumatic stress, which could impact their transition home to care for their infant.

New research indicates that mothers with a history of mental health disorders feel less ready for discharge from the NICU than with mothers without a mental health history.

The research, entitled “Maternal Mental Health and Neonatal Intensive Care Unit Discharge Readiness in Mothers of Preterm Infants,” has been published in The Journal of Pediatrics. The research team was led by ELISABETH C. MCgowAN, MD, a neonatologist at Women & Infants Hospital of Rhode Island, and also includes KATHELEEN HAWES, PhD, RN; RICHARD TUCKER, BA; MELISSA O’DONNELL, MSW; and BETTY VOHR, MD; as well as NAN DU, BS, MD, from Yale New Haven Children’s Hospital.

“Our primary objective was to evaluate the association between maternal mental health disorders and discharge readiness,” said Dr. McGowan. “We defined discharge readiness as parental emotional comfort and confidence with infant care, in addition to attainment of skills and knowledge, with parent mental well-being critical to parenting readiness.”

For this study, 934 mothers of infants born preterm [earlier than 37 weeks gestation] between 2012 and 2015 and who were participating in a transition home program completed a discharge readiness questionnaire. The questionnaire measured perceptions of staff support, infant well-being [medical stability], maternal well-being [emotional readiness/competency], and maternal comfort [worry about her infant]. Social workers obtained a history of mental health disorder.

“We hypothesized that mothers with a history of mental health disorders would report decreased perceptions of NICU discharge readiness compared with mothers without a history,” explained Dr. McGowan. “We concluded that the one-third who reported a history of mental health disorder indeed had decreased perception of their infant well-being in addition to their own well-being during the critical time of NICU discharge. This indicates that there is an unmet need for provision of enhanced transition home services for the mother-infant dyad.”

Congratulations to the Rhode Island Medical Journal on 100 years of publication
Research evaluates treatment of thyroid disease in pregnancy
Refutes need for universal screening

Observational studies over the past 30 years suggest that subclinical thyroid disease during pregnancy may be associated with adverse outcomes, including a lower-than-normal IQ in offspring. The results of these studies led several professional organizations to recommend routine prenatal screening for and treatment of subclinical hypothyroidism in pregnant women.

New research, however, indicates that universal screening for and subsequent treatment of subclinical hypothyroidism does not result in improved health outcomes for mothers or babies. The research was conducted through the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units (MFMU) Network and has been published March in the New England Journal of Medicine.

The research team concluded that, compared to no treatment, treatment for subclinical hypothyroidism or hypothyroxinemia during pregnancy did not result in significantly better cognitive outcomes in children through age five.

“The results of our study, the largest and most rigorous on this issue, do not support screening for subclinical hypothyroidism or hypothyroxinemia during pregnancy,” said Dwight Rouse, MD, one of the authors on the paper and the principal investigator for the MFMU at Brown University/Women & Infants Hospital of Rhode Island. “Our results do not apply to women with actual hypothyroidism during pregnancy – such women should be treated during pregnancy, as treatment benefits them and their babies.”

The MFMU conducted two multi-center, randomized, placebo-controlled studies at its 15 centers, including at Women & Infants, a Care New England hospital. They screened women with singleton pregnancies before 20 weeks gestation for subclinical hypothyroidism, characterized by a mildly high thyroid-stimulating hormone (TSH) level and a normal thyroxine (T4) level, and for hypothyroxinemia, characterized by low maternal free thyroid hormone (fT4) concentrations with TSH in the normal range.

In separate trials, women were randomly assigned to receive levothyroxine, a commonly used medication to treat hypothyroidism, or placebo. Thyroid function was assessed monthly throughout the pregnancy, and children underwent developmental and behavioral testing for five years.

The research team found that treatment for subclinical hypothyroidism or hypothyroxinemia did not improve cognitive outcomes in children through five years and, moreover, did not improve obstetric or immediate neonatal outcomes.

The findings of the MFMU study support current American College of Obstetricians and Gynecologists (ACOG) recommendations against universal thyroid screening during pregnancy.

URI, South County Health sign memorandum of understanding
Institutions to work together to improve community health, educate health care professionals

Kingston – The University of Rhode Island and South County Health, a nonprofit health care provider in South Kingstown, have signed a memorandum of understanding to enhance education for health professionals and advance the well-being of local communities.

In 2016, URI created the Academic Health Collaborative – comprising the Colleges of Health Sciences, Nursing and Pharmacy – to further innovation across disciplines in the rapidly changing landscape of population health and health care. The Institute for Integrated Health and Innovation acts as the community engagement and research arm of the Collaborative and will implement joint efforts with South County Health, which operates South County Hospital and three other community health entities.

URI and South County Health already collaborate on the Healthy Bodies, Healthy Minds initiative. South County Health launched this effort to diminish disparities and improve the overall health of local residents through education, health care and social service. The new agreement formalizes this relationship and offers additional opportunities for collaboration.

The purposes of the new partnership are:
• Design and implement student experiences that advance the education of health professionals while providing service to the community;
• Seek funding for innovative community health programs that build on collaboration among URI, South County Health and community partners;
• Enhance educational opportunities for South County Health employees seeking to gain skills and knowledge in their health professions;
• Identify and pursue funding for clinical research that engages South County Health patients and marshals the expertise of URI faculty.

Specific initiatives, projects and collaborations are being developed as a result of this agreement, and details will be announced as they emerge.

“The University’s academically robust programs related to health and health care make it a uniquely qualified partner for South County Health, as we work to advance our common goals of educating highly skilled health care professionals and improving the health of the communities where we live and work,” said Bryan Blissmer, acting director of URI’s Institute for Integrated Health and Innovation.
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Appointments

Dr. Fingleton to lead clinical cardiac surgery operations, quality at Lifespan

James G. Fingleton, MD, has been named chief of clinical cardiac surgery operations and quality at Lifespan’s Cardiovascular Institute beginning April 1.

The appointment is a homecoming for Dr. Fingleton, who was a member of The Miriam Hospital’s open-heart surgery program for 17 years and later was a key member of the combined Rhode Island Hospital and The Miriam open-heart program.

Dr. Fingleton returns to Lifespan from Southcoast Health System, where he served as chief of cardiovascular surgery for five years.

His clinical interests include multiple arterial grafting, aortic aneurysm surgery, and minimally invasive valve repair and replacement.

Michael Souza takes the helm at Landmark, succeeding Charest

Michael Souza, former president of the Hospital Association of Rhode Island (HARI), has been appointed CEO of Landmark Medical Center in Woonsocket, and began his new position on March 27.

He replaces Richard Charest, who retired as both president and CEO of Landmark on Feb. 17.

Souza has served as HARI president since 2014. He previously worked at Signature Healthcare in Brockton, Mass., and was once the director of financial planning at Landmark.

Paiva Weed appointed president of HARI

M. Teresa Paiva Weed has been appointed president of the Hospital Association of Rhode Island (HARI), where she will oversee day-to-day operations of the association and direct member services. Paiva Weed joins HARI following the departure of Michael Souza who has served as president since 2014.

Paiva Weed was first elected to the Rhode Island Senate in 1992. In January 2009, she was elected by her colleagues to serve as president of the Senate. During her time as a legislator, she was a major developer of the RiCare program, lead sponsor of legislation creating CurrentCare, and played a key role in several important public health bills including mental health, substance abuse, and lead poisoning. She is also an independent legal practitioner.

Dr. Iraklis Gerogiannis named chair of Southcoast cardiothoracic surgery

Dr. Iraklis Gerogiannis has been named Southcoast Health Chair of Cardiothoracic Surgery. Dr. Gerogiannis has served as the Medical Director of Cardiac Surgery for the last three years.

“Dr. Gerogiannis is a highly skilled cardiac surgeon with extensive experience in minimally invasive surgical procedures, TAVR, CABG and valve and arrhythmia surgery,” stated Dr. Margaret Ferrell, Physician-in-Chief of Cardiovascular Care Center at Southcoast Health.

Prior to joining Southcoast Health, he practiced in the Boston region and was an assistant professor of surgery at Tufts University School of Medicine.

John K. Findley, MD, named chief of Integrated Behavioral Health Services for CharterCARE

John K. Findley, MD, has been named Chief of Integrated Behavioral Health Services for CharterCARE Health Partners. In this position, Dr. Findley will provide direct oversight of the inpatient and outpatient behavioral health management programs while providing strategic leadership for all clinical and operational efforts in Behavioral Health throughout the CharterCARE system.

Dr. Findley has served as Medical Director of the Dual Diagnosis Unit and Geri-Psychiatry Unit at Roger Williams Medical Center since June 2012. He previously held clinical positions at Geisinger Medical Center, Massachusetts General Hospital, Whidden Hospital, Baldpate Hospital, North Shore Medical Center, and Tufts Medical Center, where he was Chief of Psychiatric Consultation from 2006–2009.

Dr. B. Star Hampton named vice chair of education for Dept. of OB/GYN

B. Star Hampton, MD, FACOG, of Providence, has recently accepted the position of vice chair of education for the Department of Obstetrics and Gynecology at The Warren Alpert Medical School of Brown University starting June 1, 2017.

Dr. Hampton is a board certified urogynecologist in the Division of Urogynecology and Reconstructive Pelvic Surgery at Women & Infants Hospital of Rhode Island, and an associate professor of obstetrics and gynecology at the Warren Alpert Medical School.
Drs. Smith, Pasquarello, Bica join University Orthopedics
University Orthopedics announced the addition of Drs. Matthew Smith, George Pasquarello and David Bica to its organization.

Matthew Smith, MD, EMHL, serves as Director of System Integration. Dr. Smith treats patients with cervical, thoracic and lumbar epidural spinal steroid injections, facet injections, medial branch blocks and radiofrequency ablation, sacroiliac joint injections and radiofrequency ablation. In addition, Dr. Smith treats patients with peripheral joint and soft tissue injections, peripheral nerve blocks, medicolegal consultations and electromyography and nerve conduction studies.

George Pasquarello, DO, brings over 20 years of practice as a clinical specialist in neuromusculoskeletal medicine/osteopathic manipulative medicine and pain medicine.

David Bica, DO, performs osteopathic manipulative medicine for the treatment of neck and lower back pain, fluoroscopic spinal injections and both diagnostic and interventional musculoskeletal ultrasound.

Recognition

AMA honors former RI HHS Secretary, Elizabeth Roberts
The American Medical Association (AMA) recently presented Elizabeth H. Roberts, former Rhode Island Secretary of Health and Human Services, with the Dr. Nathan Davis Award for Outstanding Government Service. She was selected for the AMA’s top government service award for her commitment to working with the medical community to improve public health across her 20 years in public service.

Sharon Rounds, MD, to receive American Thoracic Society’s Trudeau Medal
Sharon Rounds, MD, will receive the American Thoracic Society’s Trudeau Medal at their 2017 international conference in May. The Trudeau Medal recognizes lifelong major contributions to the prevention, diagnosis, and treatment of lung disease through leadership in research, education, or clinical care.

Sharon Rounds, MD is Professor of Medicine and of Pathology and Laboratory Medicine at Brown Medical School and staff pulmonary/critical care physician at the Providence VA Medical Center.

Hasbro Children’s Hospital recognizes Brite Lites’ winners
Hasbro Children’s Hospital named this year’s winners of the annual Brite Lites awards. The honorees were among many employees nominated by patients and families who best exemplify the hospital’s ‘four Cs’ – caring, communication, cooperation and competence. The winners are:

- Jodi Russell, BSN, RN, a pediatric transport nurse
- Erica Chung, MD, a pediatric hospitalist
- Christine Pham, MD, a pediatric resident
- Anthony Fusco, CRT, a respiratory therapist
- Julia Jacavone, BSN, RN, pediatric float novice nurse

Dr. Mermel receives Milton Hamolsky Outstanding Physician Award
The medical staff of Rhode Island Hospital recently honored Leonard Mermel, DO, ScM, with the 2016 Annual Milton Hamolsky Outstanding Physician Award. Dr. Mermel, an internationally noted expert in infectious diseases and infection control, is the medical director of Rhode Island Hospital’s Department of Epidemiology & Infection Control.

Fatima, RWMC employees of the year
Yvonne Britto and Kathryn “Bea” McCullough have been named 2016 Employees of the Year for Fatima Hospital and Roger Williams Medical Center, respectively.

Yvonne is Lead Milieu Therapist for Behavioral Health and has been with Fatima since 2015. Bea is a social worker for Outpatient Addiction Medicine and has been with the organization since 2005. Both were recognized on March 15, 2017 along with other hospital Employees of the Year at the Hospital Association of Rhode Island’s “Celebration of Excellence” event.
HARI honors ‘Hospital Heroes’

Individuals from throughout the state were recently honored at “Celebration of Excellence in Hospital Care,” an annual awards ceremony held by the Hospital Association of Rhode Island (HARI). Employees from HARI’s member hospitals were recognized by the HARI Board of Trustees for exemplary performance and dedication to health care. In addition, the recipient of the Edward J. Quinlan Award for Patient Safety Excellence was honored.

Recipients of the Award for Excellence in Hospital Care include:
- Micaela Condon, Therapist, Butler Hospital
- Yvonne Britto, Lead Milieu Therapist, Fatima Hospital
- Lisa Ferry, Registered Nurse, Kent Hospital
- Theresa Pinard, Registered Nurse, Landmark Medical Center
- Donald MacDonald, Clinical Coordinator, Memorial Hospital of Rhode Island
- Jill Lizotte, Registered Nurse, Providence VA Medical Center
- Kathryn McCullough, MSW Social Worker, Roger Williams Medical Center
- Barbara Renner, Patient Financial Advocate, South County Hospital
- Joanne Miller, Patient Coordinator Team Leader, Westerly Hospital
- Dana Ciolfi, Medical Technologist, Women & Infants Hospital

Fatima Hospital was the recipient of the Edward J. Quinlan Award for Patient Safety Excellence. The award is a tribute to Edward Quinlan who championed quality improvement and patient safety initiatives while he served as president of HARI for two decades.

Total Joint Center at Miriam awarded second Joint Commission Gold Seal of Approval

The Total Joint Center at The Miriam Hospital has earned The Joint Commission’s Gold Seal of Approval® for Advanced Certification for Total Hip and Total Knee Replacement.

Earlier this month, The Miriam Hospital underwent a rigorous onsite review by the Joint Commission to become one of only 32 advanced total hip and knee centers in the country. Joint Commission experts evaluated compliance with advanced disease-specific care standards and total hip and total knee replacement requirements, including orthopedic consultation, and pre-operative, intraoperative and post-surgical orthopedic surgeon follow-up care.

CNE staff honored by HARI

Four Care New England employees were recently honored at a “Celebration of Excellence in Hospital Care,” an annual awards ceremony held by the Hospital Association of Rhode Island (HARI). The HARI Board of Trustees selected 10 employees from HARI’s member hospitals who exhibited exemplary performance and dedication to health care.

Care New England recipients included: Micaela Condon, therapist, Butler Hospital, from Riverside; Lisa Ferry, registered nurse, Kent Hospital, from Warwick; Donald MacDonald, clinical coordinator, Memorial Hospital of Rhode Island, from Attleboro; and Dana Ciolfi, medical technologist, Women & Infants, from Narragansett.
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PAUL E. BARBER, SR., MD, 95, passed away on Thursday, March 16, 2017. He was the beloved husband of Barbara A. (Mendes) Barber, with whom he would have celebrated his 32nd wedding anniversary on March 30, 2017, and the late Josephine A. (Gregoire) Barber.

Paul was a graduate of West Warwick High School class of 1939 where he was an accomplished basketball and baseball letterman, he then received his Bachelor’s Degree from the Rhode Island State College in April of 1943, served in the U.S. Navy during WWII from July 1943 to November 1945, and then graduated from Tufts University School of Medicine in 1946 and followed on to a rotating internship at the U.S. Naval Hospital until 1947 when he was then enlisted into active duty in the U.S. Navy Medical Corp and served in French Morocco.

He finished his residency in Obstetrics at the Providence Lying-In Hospital in 1950. He was a member of the active staff of Kent Hospital from 1951 to 1995. However, his daily involvement at Kent Hospital continued until present day. He was also a member of The American Medical Association, R.I. Medical Society, Kent County Medical Society, and the American Academy of Family Physicians.

He was also a member on the Board of Trustees for Kent Hospital and Blue Cross. For more than half a century, Dr. Barber devoted his entire career to the health and wellbeing of the families of Kent County. Following graduation from Medical School, Military service, and completion of his residency, Dr. Barber opened a private practice in West Warwick where he had continued to care for his patients for more than sixty years. Dr. Barber made everyone feel special and always took the time to stop and talk.

He was the father of the late Deborah A. Grandchamp, Gregory P. (Geraldine) Barber, John A. (Barbara) Barber, Paul E. Barber Jr., Claudia A. Greene, Heidi A. (Brad) Austin, Kim A. Barber and Jill A. Legault. Paul was the stepfather of Anita M. (Steven) Forest, Patricia A. Houle and the late Richard N. “Rick” Houle. He was educated in Italy, graduating from the University of Naples School of Medicine in 1954. After two years in the Italian Army, he immigrated to the United States to serve an internship at the St. Francis Hospital, Miami Beach, FL, where he met his future wife. They traveled to and settled in Rhode Island where he completed an internal medicine residency and cardiology fellowship at local hospitals. After 44 years of private practice in the Pawtucket and Central Falls area, he retired to Fort Myers, FL.

In lieu of flowers, memorial contributions to the Dr. Paul E. Barber Sr. West Warwick High School Scholarship Fund, C/O Centreville Bank, 1218 Main St., West Warwick, RI 02893 will be appreciated.

JAMES R. GUTHRIE, MD, of Saunderstown, passed away on March 17, 2017. He was the beloved husband of Sybil (Waters) Guthrie for sixty-five years. He was retired from the University of Rhode Island, where he served as a physician. In 1971, Dr. Guthrie moved to Rhode Island to become medical director of the University of Rhode Island Student Health Services, where he worked for 26 years before retiring in 1997. Dr. Guthrie was also on the staff of the Emergency Department at South County Hospital. He was a member of the American Academy of Pediatrics, the Rhode Island Medical Society, the Newport Preservation Society and the Naval War College Foundation.

In addition to his wife, he leaves his four children: Keith R. Guthrie and his wife Kathleen of Marietta, GA, Donald C. Guthrie of Lawrenceville, GA, Ellen G. Smiley and her husband Philip of South Kingstown, and Ann G. Hourahan and her husband Donald of Saunderstown; eight grandchildren and a great-grandson.

Memorial contributions may be made to Doctors Without Borders [www.doctorswithoutborders.org].

ARTURO LONGOBARDI, MD, passed away on Feb. 16, 2017 in Ft. Myers, FL. He was born in Campagna Italy on June 14, 1928. He leaves behind his wife Mary (Dudas) of 58 years; his sons, Steven Longobardi, MD; Vito Longobardi, MD, and daughter Eva Longobardi; his grandchildren, Stefan, Nicolas, Anton, Christian, Marcus, Andreas, Danika and Angeline Longobardi, and daughters-in-law Yen and Melissa.

He was educated in Italy, graduating from the University of Naples School of Medicine in 1954. After two years in the Italian Army, he immigrated to the United States to serve an internship at the St. Francis Hospital, Miami Beach, FL, where he met his future wife. They traveled to and settled in Rhode Island where he completed an internal medicine residency and cardiology fellowship at local hospitals. After 44 years of private practice in the Pawtucket and Central Falls area, he retired to Fort Myers, FL.
Editorial

The Future of Medical Psychology

There are some men so constituted by temperament or by training or both, that the worst thing which can happen to a good cause is that they should get hold of it. Such men are moody, irritable, and intolerant of the views of others; they do not distinguish between knowledge and mere opinions; they are forever mistaking metaphors for proofs, and in the advocacy of their beliefs they repel rather than gain adherents. Not that they intend to do these things; it is rather that their enthusiasm gets the better of their judgment. Should you tell them that their propaganda is marked by party spirit they are surprised, perhaps even hurt; yet all the while their cause is really good. Medical psychology is a good cause which has suffered in this way.

...There is still in medical psychology a great mass of information which can be turned to practical uses. To seek out the more or less hidden mental causes of various bodily symptoms; to investigate the mutations and permutations of instinctive tendencies which hinder or frustrate personal development; to resolve certain moral conflicts which make for unhappiness; to give point and direction to the will; to rob some fears of their significance and to dull the edge of others, all this and more is the business of medical psychology.

Failures there will be, and those too in plenty, but whoever justly condemned a thing because it is not always successful? As well cease to operate because some patients do not recover. Moreover, medical psychology is nothing esoteric; it ought to be and can be part of every physician’s therapeutic outfit. And yet we are perhaps not far wrong when we say that the helps of medical psychology are not utilized as freely as they might be. There is no more difficulty about acquiring a fair working knowledge of medical psychology than there is in acquiring knowledge of the principles of immunity, perhaps not as much. If our professors of therapeutics spent less time discoursing about the supposed virtues of musk and more on the elucidation of some simple psychological procedures the difficult task of physicians would be rendered a little easier.

We do not wish to entouse over much, for assuredly a becoming restraint ought to be with us always. Yet we cannot help thinking that here is a field of fertile endeavors where the workers are all too few. And lastly may we indulge the hope that when the history of twentieth century medicine comes to be written, the chapter on psychology will be as impressive as the ones on physics and chemistry?
Over 1,000 bacteriological tests are made daily in this Hood laboratory, one of six operated by H. P. Hood & Sons at the company’s milk plants in New England.

H. P. HOOD & SONS
Miscellaneous

Growth of medical science gives rise to new journals
The rapid development of the special branches of medical science is in no way better illustrated than in the establishment of journals dealing with the specialties. The New Year has seen the inauguration of several such journals, at least three of which have come to our desk. We extend our best wishes for a long and successful career to:


District Societies
Dr. George A. Matteson and Dr. Lucius C. Kingman gave interesting descriptions of their experiences with the Harvard Unit in France to the Providence Medical Association. Dr. Matteson described the organization of the British Base Hospital at which the work of the Harvard Unit has been carried on since the early part of the war. Dr. Kingman described the variety of cases treated and some of the methods used.

Ambulance Corps
William H. Reese, ’17; Frederick L. Lathrop, ’19; and Hugh W. MacNair, ’17, Brown University, will sail on May 17 to join the American Ambulance Corps in France.

State Board of Health
An examination for the license to practice medicine in this state will be held by the State Board of Health April 5–7, 1917.
Appointments
Dr. Dana E Robinson has recently been assigned to Providence as United States Health Officer and Port Physician. He succeeds Dr. Edward R Marshall, who has been assigned to New York.
Dr. J. Edward Tanguay of Woonsocket has been appointed to the Board of Parole.
Dr. John W. Keefe has been appointed to the new Penal and Charitable Commission.

Hospitals
Rhode Island Hospital expands infant’s ward; to hold flag-raising children’s event
An addition to the infants’ ward to accommodate 14 patients and to be used for the treatment of feeding cases is completed.
A flag-raising ceremony will be held on April 19, to be attended by all children who can be moved outdoors. Mr. Amos will act as master of ceremonies, which will consist of the singing of patriotic songs.

Rhode Island Hospital expands infant’s ward; to hold flag-raising children’s event
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The south ward has recently been equipped with a system of cubicles or isolation booths which are stalls with glass partitions so arranged that the children can be effectively separated for several days after admission to the hospital.

Providence City Hospital opens outpatient department
The outpatient department of the city hospital at the Delaine Street Nursery will be opened early in April. The Department of Medicine physician in charge is Dr. SH Matthews.
The building in which the outpatient work is to be done is the property of Hope Day Nursery and connected with the Grace Memorial Home on 2 Delaine St. Since May 1915 the City Hospital has conducted a clinic for tuberculosis in a room at the home. This clinic has attracted interest in that section of the city, and the late Lyra Nickerson within the year gave money for the erection of a two-story building. There are seven rooms and the waiting room on the second floor, and all are to be devoted to this outpatient work. City Hospital was asked to conduct these clinics and the Board of Hospital Commissioners voted to do so.

70 YEARS AGO – APRIL 1947

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Safeguarded constantly by scientific tests, Coca-Cola is famous for its purity and wholesomeness. It’s famous, too, for the thrill of its taste and for the happy after-sense of complete refreshment it always brings. Get a Coca-Cola, and get the feel of refreshment.

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Quarts are Back!
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April 1917: U.S. enters World War I
Rhode Island Hospital forms Naval Base Hospital No. 4

MARY KORR
RIMJ MANAGING EDITOR

On April 6, 1917, the United States joined Britain, France, and Russia to fight in World War I. In the April 1917 issue of the *Rhode Island Medical Journal* the editors reported that Rhode Island Hospital had nearly completed the organization of a naval base hospital approved by the War Department. The unit would consist of 250 beds, 10 medical and surgical physicians, one dentist, 40 nurses, 14 nursing assistants, several pharmacists and a cadre of civilians to work as clerks, cooks and orderlies.

Dr. George A. Matteson was named director and chief of the surgical section and Dr. Halsey DeWolf, chief of the medical service. Grace McIntyre was appointed chief of nursing.

The American Red Cross raised $17,000 to outfit the hospital. When the United States entered the war, the RIH unit No. 4 was taken into government service. Initially, medical staff members trained a corps of hospital apprentices from the U.S. Navy. The training included instructions in dressings, bandaging, care and handling of patients, and demonstrations of laboratory and X-ray protocols.

By September 1917, according to a report in the *Rhode Island Medical Journal*, the unit increased the number of beds to 500, and added 8 physicians and 20 nurses to the staff. The Journal reported that the equipment for the hospital was practically complete and stored in the basement of Rhode Island Hospital. According to the report, “generous friends have donated three motor ambulances. One of these ambulances is now in exhibition in a motor agency in Providence.”

Dr. Matteson, a U.S. Naval Reserves Lieut. Commander, was called to active duty. Two members of the unit, Dr. Roland Hammond, and Dr. Alex M. Burgess, took courses prior to being sent overseas. Dr. Hammond attended the School for Instruction in Military Roentgenology at Cornell Medical College. Dr. Burgess attended a school for laboratory methods at the Rockefeller Institute under Dr. Simon Flexner.

The RIH unit was then sent to Queenstown, Ireland, working alongside U.S. Naval Hospital Base No. 6 in the spring and fall of 1918. The hospital consisted entirely of prefabricated barrack-like buildings shipped from the United States.

Medical personnel from Rhode Island Hospital served in the Navy Base Hospital No. 4 in Ireland.
In May 1918. The hospital opened Oct. 11, 1918. Within a few days after opening its wards were filled with victims of the influenza epidemic, according to Navy archives.

In the History of American Red Cross Nursing, Head nurse Grace McIntyre recalled the unit’s first patients.

“Our hospital was opened thirty hours after our arrival, to meet an emergency caused by the *Aquitania*, which cut the *Shaiv*, a destroyer, in half. Several men had been killed and about twenty, I think, injured. Dr. Carpenter, our commanding officer, was much pleased with the manner in which the nurses threw themselves into the work after their strenuous voyages, both across the Atlantic and the Irish Sea.”

Rhode Island Hospital’s Naval Base Hospital No. 4 worked in Queenstown, Ireland, with U.S. Naval Base Hospital No. 6. The hospital consisted of two operating pavilions, seven wards, barracks, and supply rooms.

Medical personnel sent this Christmas card from the RIH unit in 1918.

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In the early spring of 1917, The American Red Cross formed a local branch in Providence to raise funds for the war effort. What is less known is that at the same time the American Red Star Animal Relief national organization also started a local branch in Providence – the first in the nation – to assist the U.S. Veterinary Corps and raise funds for the care of sick and disabled Army animals serving in the war effort. Horses and mules were instrumental, especially in the early days of the war, in pulling ambulances of wounded soldiers to field hospitals. The local press reported that more than $200,000 worth of horses and mules were an integral part of the Allied European forces.

The American Red Star Animal Relief organization began in April 1916, when the American Humane Association offered its services to the War Department for “the purpose of rendering assistance in the event of war to wounded animals employed by the Army.”

Secretary of War Newton D. Baker approved of the initiative and invited the Society to launch efforts similar to those of the American Red Cross. “Without horses it would be practically impossible to support an Army on the fighting field,” he said in giving his endorsement. “The work is a most commendable, patriotic and humanitarian one and I hope that it will be strongly supported all over the United States…the saving of a horse often means the saving of a soldier. Without horses and mules the Army would be paralyzed on foreign fields where conditions are such that any form of motor traffic is not to be relied upon with the certainty that the faithful animals give,” announced the Secretary.

The Society identified the areas of greatest need, which included establishing veterinary field hospitals, and purchasing medical supplies and equipment to treat injured animals.

In total, more than 240,000 draft and combat horses, mules, and dogs were used by the U.S. Army during the war. The Humane Society noted that their “bravery and endurance were equaled only by the courage and the skill of their riders.”

Perhaps the most famous war horse of the era was Kidron, a sorrel horse with white hind socks ridden by the commander of the American Expeditionary Forces, Gen. John J. ‘Black Jack’ Pershing, and upon whom Pershing rode on in victory parades in Paris after the war. Gen. Pershing transported Kidron home on a ship, but the U.S. Dept. of Agriculture placed the horse in quarantine for several months, much to Pershing’s dismay, who had wanted his horse to appear with him in numerous victory parades around the country. The New York Times reported: “While his master is being idolized by a grateful people in the principal cities of the nation, Kidron will be forced to play the ignoble role of a patient in the quarantine quarters of Newport News, where veterinarians will watch to determine if he has a contagious disease. The misfortune of Kidron is keenly felt by General Pershing and the public, who had looked forward to seeing the General ride his charger at the head of parades in his honor...a war mount has been considered as second only to the General himself in importance.”

Gas masks for man and horse demonstrated by American soldier, 1917.
Help him to help U.S.!

Help the Horse to Save the Soldier

THE AMERICAN RED STAR ANIMAL RELIEF

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