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JOSEPH RENZULLI, MD
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I like to use analogies to explain pathophysiology to patients. I do so because I use them myself to understand these processes. I think of them as being like the cartoons used in scientific articles showing cell receptors being pinged by chemical stimulators/inhibitors shaped like darts. One time when I used the hurdler analogy, a family member of the patient, a neuroscience teacher at a college, said he was going to use the analogy, plagiarism as the most sincere form of flattery.

The hurdler
Almost all of my patients have progressive neurologic disorders. And we all age, whether or not there’s anything wrong with us, and normal aging has a significant overlap with the progression of Parkinson’s and related disorders. I sometimes see patients in follow-up who tell me that they’ve had a tremendous decline in mobility in the past few weeks, yet, when I examine them, their exam looks pretty much like the way they appeared four months prior. When I point this out, they say, “Well, two weeks ago I could get out of a chair without using my arms and now I have to push myself up.” So, I point out the analogy with the hurdler who is on the downslope of her career. As she starts to worsen, in addition to getting slightly slower, she starts to clear the hurdles by less and less, until one day she fails to clear the hurdle and she hits it. “What a change,” she thinks, “yesterday I cleared it, and today I hit it. I must be having a bad day.” Her coach, on the other hand, saw it coming, watching her clearance worsen each day. This translates into slow declines often being perceived as step-wise losses of function. Patients appear to appreciate this analogy, which makes functional declines less frightening, as they are less random and less indicative of a major worsening of disease.

Software vs. hardware for psychogenic disorders
Studies in movement disorder clinics in the U.S. have shown that about 2–5% of new patients have psychogenic disorders, typically tremors or gait problems, but virtually any movement that a person can make. These are conversion disorders, in which, presumably psychic distress is “converted” to an organic disorder, in these cases movement disorders, rather than paralysis, muteness, blindness, GI distress or headaches. In explaining the problem to the patient it is important to stress that anxiety, depression, and stress of all types are distracting, interfering with concentration.
and impaired concentration results in worse memory. I note that when they were in school they did worse on exams if they had a headache or back pain, or had a bad night’s sleep. I point out that depression is emotional pain, just like headache or joint pain is somatic pain. All pain is distracting, interfering with attention and without attention, memory traces and memory access pathways are all subverted, leading to bona fide memory impairment, but not necessarily Alzheimer’s disease. Anxiety, similar to pain, is an interference with the memory process, acting just like pain. How can you remember something if you’re worried that your grandchild is ill, or that you may not be able to pay the next mortgage? Life distracts, especially with threatening concerns.

**Dopamine cells as gas tanks**

Patients with Parkinson’s disease wonder why their medicines work less well and for less time as the illness progresses. To explain, I use the Mickey Mouse model of dopamine brain cells working like chemical factories and storage tanks. Since L-Dopa, our main drug to treat PD, is not itself an active drug, it must enter a dopamine containing cell to be metabolized to dopamine, and then released. So, if we consider each such cell as a dopamine factory and these cells are under attack and die, the number of “chemical factories” declines in time so that no matter how much L-Dopa is provided, the cells can only produce a limited amount of the neurotransmitter. Furthermore, since the number of cells is greatly reduced with time, the ability of the brain to store the dopamine provided by the L-Dopa is greatly reduced. There are fewer “gas tanks” to store the chemical, so that mobility more closely reflects the amount of drug in the blood, unlike the early years, where storage capability was much greater.

Perhaps my most important homily/analogy is to tell all patients that exercise is an investment in the future, just like an investment in the stock market or real estate. It doesn’t help today or tomorrow, but it will in 10–15 years.

I don’t know how useful analogies are in other areas of medicine, just as I don’t know how often my colleagues use analogies. I like them because I actually think in these terms, although I know better than to think these are accurate renditions of what is really taking place, and because I do, I believe that patients do not find me condescending. ✤

**Author**

Joseph H. Friedman, MD, is Editor-in-chief of the Rhode Island Medical Journal, Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, chief of Butler Hospital’s Movement Disorders Program and first recipient of the Stanley Aronson Chair in Neurodegenerative Disorders.

**Disclosures on website**
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Drs. Feller, Binder named incoming editors of RIMJ

MARY KORR
RIMJ MANAGING EDITOR

PROVIDENCE – Drs. Edward Feller and William Binder will assume the editorial leadership of the Rhode Island Medical Journal [RIMJ] in 2019 as Co-Editors-in-Chief. They succeed JOSEPH H. FRIEDMAN, MD, who has held the position for two decades.

During its 101-year history, the Journal has had just eight editors. They shared a commitment to the Journal’s purpose as stated by inaugural editor Dr. Roland Hammond in January 1917:

“We wish all the medical interests of the state to collaborate in the production of a journal which shall truly represent the state in reality as it does in name. As our literary miss makes her bow under her new name [formerly the bi-monthly Providence Medical Journal], we bespeak for her a hearty support, believing that her sphere of usefulness is to be greatly increased.”

In advance of their tenure, RIMJ asked the incoming editors to share their perspective and vision for the Journal as it enters its 102nd year at the start of their terms.

Q. What has been your background in publications?

Dr. Feller: I have served as a longtime chairman and member of the RIMJ Editorial Board from 1983 to the present, and as a peer reviewer for multiple medical journals.

I have also co-authored more than 100 scholarly publications and more than 100 presentations at scientific meetings with Alpert Medical School (AMS) students, and have collaborated on 26 papers in the Rhode Island Medical Journal with Brown medical students as first authors.

Dr. Binder: I’ve been the director of emergency medicine and editor for the past three years at Relias Learning, an online medical education company, and have been a peer reviewer for Epidemiology and Infection. In addition, I created the case records of the Department of Emergency Medicine series in RIMJ upon coming to Brown in 2014.

Q. What unique perspective will you bring to your new position at RIMJ?

Dr. Feller: I left clinical practice in 2002 to concentrate exclusively on my career-long passion of teaching and mentoring Brown medical students. My collaborations focus on scholarly writing and editing for publication, especially on issues of the poor and underserved, health policy, cognitive diagnostic reasoning and biases, medical error, scientific misconduct and issues of media literacy.

I’m an experienced medical writer and editor passionate about excellence in diverse scholarly writing. My hope is to expand the Journal’s content to include issues related to scientific publishing for all our constituents.

Dr. Binder: I think as an emergency physician and internist [boarded in both IM and EM], I have a global view of medicine and hope to bring my perspective
regarding the interconnectedness of each discipline in medicine to the fore. I think I can help break down the silo approach that has dominated medicine for so many years as we have retreated into our specialties. I think there is much more that links us together in this field. Medicine is now more than ever a team sport – no one has an encyclopedic knowledge of medicine any longer, as much as we may pine for the “old” days. I am hoping to do my part in converting us to this new paradigm.

Q. What do you see as the primary function of the state’s medical journal?

Dr. Feller: To me, the Journal’s primary function is to be a repository of record for the depth and breadth of scholarly work by Rhode Island physicians and physicians in training. My talented Co-Editor-in-Chief and I are both committed to increased involvement of medical students and other trainees with multiple planned initiatives. We are formulating strategies to facilitate involvement of physicians in clinical practice.

Dr. Binder: My vision of RIMJ is to nudge it to lead the changing paradigm as I noted above. I think medicine is increasingly interdisciplinary in nature – successfully caring for a patient requires a holistic approach that is not limited to strictly traditional beliefs about the nature of medicine. Health care is about 18% of the GDP, and with its growth there is a lot of expertise in different fields. Perspectives from academics, social scientists, economists, and clinicians all inform how we practice. I hope we can bring this approach to the Journal.

Additionally, while we have traditionally had only Rhode Island writers, it might be interesting to add alumni of Rhode Island programs to the mix. I think this could create cross-pollination and allow us to be less insular, which, while safe, is not always the best approach for our patients and ourselves.

Q. Coincidentally, both of you have done medical volunteer work in the Himalayas, and have blended your avocations with your professional vocations. Can you briefly speak about these experiences?

Dr. Feller: I once spent eight weeks in the Himalayas at a high-altitude camp as a subject in multiple studies to assess the medical effects of altitude on ultra-endurance-trained athletes. My passion has always been running non-stop, 100-mile mountain races. I also have helped a number of AMS students participate in Himalayan Health Exchange trips as sub-interns. I’ve also collaborated with med students on published projects involving sports medicine, as well as taught an undergraduate seminar on endurance athletes – for the final exam, all 11 students finished their first marathon.

Dr. Binder: I was doing my residency in internal medicine and found an opportunity with the Himalayan Rescue Association (HRA) based out of Kathmandu. Without question, it was an incredible adventure. I met some amazing individuals, some of whom went on to continue climbing, and some who later died in climbing accidents. I treated cases ranging from cerebral malaria to peritonsilar abscesses to delivering a baby (triple nuchal cord, labor lasting 18 hours), and just about everything in between. I evacuated 6 patients due to altitude sickness – high-altitude pulmonary edema – and carried a Nepali porter from 14,000 feet down to 9,000 feet so that he could recover.

After residency I reflected upon my experiences and took another leap into the nascent emergency medicine program at Brown. After I finished my boards, I began working at the MGH and became one of the members of the section in Wilderness Medicine in the Department of Emergency Medicine. I became particularly interested in arthropod-borne diseases and continue to write and publish on these topics.
At a Glance:
RIMJ’s Editors of Yesteryear

MARY KORR
RIMJ MANAGING EDITOR

The Rhode Island Medical Journal [RIMJ] was first published in January 1917. It succeeded the bi-monthly Providence Medical Journal, which debuted in 1900.

In the inaugural edition, Editor Dr. Roland Hammond stated:

“The King is dead. Long live the King! …We wish all the medical interests of the state to collaborate in the production of a journal which shall truly represent the state in reality as it does in name. As our literary miss makes her bow under her new name, we bespeak for her a hearty support, believing that her sphere of usefulness is to be greatly increased.”

During RIMJ’s history, there have been just eight editors. The following is a brief look at the seven physicians who preceded the current editor-in-chief, JOSEPH H. FRIEDMAN, MD. They shared a passion for their profession and the Journal’s mission as stated by Dr. Hammond.

Roland Hammond, MD
(1875–1957)

YEARS AS EDITOR: 1917–1920

MEDICAL SCHOOL: Harvard,
Class of 1902

SPECIALTY: Roentgenologist,
orthopedic surgeon at Rhode Island Hospital, Memorial Hospital (chief of surgery)

TIMELINE: Dr. Hammond hailed from Bellingham, Mass. A member of the U.S. Naval Reserve Force, he served in the Harvard Units in Ireland and London in WW II. The war forced the Journal, depleted of most of its editorial staff, to cease publication for 16 months, resuming in December 1920.

EX MEDITO: A Baker Street Irregular
In 1946, Dr. Hammond co-founded “The Dancing Men of Providence,” a scion society of the Baker Street Irregulars [BSI], an organization dedicated “to perpetuate the myth that Sherlock Holmes is not a myth.” He was invested under the name Silver Blaze, a horse in one of Conan-Doyle’s mysteries.
Peter Pineo Chase, MD

(1877–1956)

YEARS AS EDITOR: 1942–1956

MEDICAL SCHOOL: Harvard, Class of 1910

SPECIALTY: Surgeon, Rhode Island Hospital; served in the Harvard Units in WWI and WWII.

TIMELINE: Dr. Chase grew up on Cape Cod. In 1942, he became RIMJ’s editor-in-chief. Wherever Rhode Island physicians served in World War II, Dr. Chase made sure the Journal was forwarded to them. He introduced two features, “Doctors at War” and “Calling all Battle Stations,” which reported news from the front. After the war, Dr. Chase traveled to Germany with the International Refugee Organization (IRO) to participate in displaced physicians’ retraining courses.

Ex Medico: For many years, Dr. Chase also wrote a health column in the daily press. On June 30, 1952, Time magazine described his column as “never stuffy, often irreverent, it reflects the Yankee horse sense of its author, Dr. Peter Pineo Chase. Dr. Chase’s horse sense comes out, literally, in his answer to a woman who wrote in recently about chlorophyll pills as deodorants. ‘You should have been with me in my school days, when I took my horse, Pilot, in from the field where he had been cropping chlorophyll-laden grass and drove him on a hot day until he reeked with sweat. He stank.’ ”
JOHN E. DONLEY, MD (b. 1880)
YEARS AS EDITOR: 1956-1960
MEDICAL SCHOOL: University of Pennsylvania, 1902
SPECIALTY: Neuropsychiatry; a pioneer in the field of hypnosis; medical director of the RI Curative Center for disabled workers, established in 1943 (now the John E. Donley Rehabilitation Center on Blackstone Blvd.), consulting physician to St. Joseph’s Hospital, Providence City Hospital, and Pawtucket Memorial Hospital; assistant editor of the Journal of Abnormal Psychology, Boston.
TIMELINE: A Providence boy, son of a jewelry manufacturer.
EX MEDICO: Cited in 1953 by President Eisenhower’s Committee on National Employ the Physically Handicapped Campaign for his “outstanding service to the disabled” in Rhode Island.

SEEBERT J. GOLDSKY, MD
(1907–1997)
MEDICAL SCHOOL: Harvard, Class of 1932
SPECIALTY: General surgery; Rhode Island Hospital, director of peripheral vascular disease clinic; The Miriam Hospital, chief of surgery
TIMELINE: Born in Providence, the son of a detective. Attended college and medical school during the Great Depression. During World War II, Capt. Goldowsky was a surgeon in the Pacific Theater.
EX MEDICO: Author of seminal biography of Rhode Islander Usher Parsons, MD, who served as naval surgeon on a ship under Commodore Oliver Hazard Perry at the battle of Lake Erie. (Yankee Surgeon: The Life and Times of Usher Parsons, 1788–1868).

STANLEY M. ARONSON, MD
(1922–2015)
MEDICAL SCHOOL: NYU College of Medicine, 1947
SPECIALTY: Neuropathologist. Key to the establishment of diagnostic laboratory test for Tay Sachs Disease and Muscular Dystrophy.
Director of Pathology, Miriam Hospital. Founding dean of Brown Medical School (1972-1981), co-founder of Hospice Care of Rhode Island and the Interfaith Health Care Ministries.
Numerous honors, awards, professorships, NIH Commissions, author of 15 textbooks and 400+ published scientific papers.
EX MEDICO: Described as a polymath. Painter, cabinet-maker, gardener, newspaper columnist, author, medical historian.

Dr. Aronson during his tenure as founding dean of Brown Medical School.
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Though a niche medical publication serving Rhode Island healthcare professionals, during the first three months of 2018, RIMJ has been accessed by approximately 5,000 readers worldwide who viewed about 11,000 pages. Sixty percent of the readers were from the United States, but the readership also spans the globe and includes the continents of Europe, Asia, Oceania and Africa.

The top 10 countries for readership were:
1. US
2. Canada
3. United Kingdom
4. Australia
5. Spain
6. Italy
7. Germany
8. India
9. China
10. Brazil

Wherever you may be, or wherever your travels take you, be sure to check the journal on your mobile device and send us a photo: mkorr@rimed.org.

MARIN, CALIFORNIA
José A. Chibrás, MD. Chief Medical Officer of Marin Community Clinics in Marin County, northern California, looks at the most recent issue of the Rhode Island Medical Journal, shown to him by his colleague, Kenneth S. Korr, MD, the Journal’s associate editor, in the Novato clinic where Dr. Chibrás specializes in adult care as well as chronic disease management. As Chief Medical Officer, Dr. Chibrás, in addition to his role as a physician, oversees all clinical staff and specialists, as well as the Quality Improvement Department of the network of federally qualified health centers which serves more than 31,000 patients a year.
KATHMANDU, NEPAL
Fawn Jade Koopman, an attorney in California, read the recent article on mentoring in the Journal’s commentary section and sent these photos taken from her trip to Kathmandu, the capital of Nepal, while visiting her aunt, an ophthalmologist in the city, and attending a family wedding. She took the photos of Mt. Everest (elevation 29,000 feet) during her flight. The other photo shows Mt. Machapuchare (elevation 23,000 feet approx.) in the Annapurna mountain range taken in the city of Pokhara in the north central Himalayas.
ABSTRACT

BACKGROUND: We conducted a cross-sectional survey of healthcare workers in two community teaching hospitals to better understand clinicians’ beliefs and practices related to cleaning of their stethoscopes. The study was conducted from September 2015 to May 2016.

PARTICIPANTS: Among the total 358 responses received, 45%, 40%, 10% and 5% were from attending physicians, medical students, nurses, and resident physicians, respectively.

KEY RESULTS: Although the majority of the respondents (76%) frequently used a stethoscope at work, and almost all (93%) believed that stethoscopes can be involved in pathogen transmission, only 29% of participants reported cleaning their stethoscopes after every use.

CONCLUSIONS: Hospitals should include stethoscope cleaning into their overall infection prevention efforts.

KEYWORDS: stethoscope, cleaning, healthcare workers

INTRODUCTION

We live in an era of increased efforts aimed at preventing healthcare-associated infections. [1] Many US institutions, including ours, have adopted formal infection control policies regarding stethoscope cleaning, in accordance with the Centers for Disease Control and Prevention (CDC) guidelines for cleaning, disinfection, and sterilization of medical equipment, devices and supplies but the frequency and best method are not clearly specified in these guidelines.[2] Most institutions have dedicated significant resources to improving compliance with hand-hygiene [3] and have developed rigorous protocols for the prevention of catheter-associated infections,[4]or surgical-site infections. [5]In contrast, stethoscope cleaning has received relatively little attention, despite its frequent use in clinical practice. In this study, we sought to characterize healthcare workers’ beliefs and practices related to stethoscope cleaning in two community hospitals.

METHODS

We conducted an anonymous internet-based cross-sectional survey from September 2015 to May 2016, administered by email to physicians, nurses, and medical students in the outpatient and inpatient setting of two university-affiliated community hospitals. We inquired about 1) frequency of stethoscope use and frequency of stethoscope cleaning during a typical clinical practice day, 2) agent(s) used for stethoscope cleaning, and 3) belief that stethoscope may be a vector of nosocomial pathogen transmission; and 4) knowledge of and previous training related to institutional stethoscope cleaning policies. We used the chi-square test to determine differences between different respondent groups, and analyzed the data in STATA 14.1 SE for Windows.

The study was conducted as part of a larger quality improvement effort aimed at hospital infection prevention, and met the criteria for “exempt” status by our Institutional Review Board. These hospitals have stethoscope disinfection policies based on CDC guidelines.

RESULTS

A total of 358 healthcare workers participated in the survey, with attending physicians, medical students, nurses, and resident physicians responding in a proportion of 45%, 40%, 10%, and 5%, respectively. A total of 61% of our participants came from general medicine and/or its subspecialties, while 15% were from surgical specialties, and 24% were from other specialties (radiology, pediatrics, emergency medicine).

The main results of our survey are summarized in Table 1. Respondents from medical specialties were more likely to use a stethoscope most of the time at work \( P < 0.001 \). Attending physicians were more likely to report cleaning their stethoscope after every use \( P = 0.001 \) and to believe that a specific institutional policy related to stethoscope cleaning does not exist. In contrast, medical students were more likely to report cleaning their stethoscope whenever they remembered to do so \( P < 0.001 \), and to report not knowing whether an institutional policy related to stethoscope cleaning exists. Nurses were less likely to report having received any previous training on stethoscope cleaning \( P > 0.003 \), compared to other respondent groups.

DISCUSSION

We found that the majority of our clinicians use a stethoscope frequently during their practice, and almost all believe that the stethoscope could be involved in pathogen transmission...
Table 1. Response summary for our healthcare worker survey related to stethoscope cleaning during clinical practice.

<table>
<thead>
<tr>
<th>Topic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stethoscope Use During Typical Patient Care Day</td>
<td>272</td>
<td>76</td>
</tr>
<tr>
<td>Most of the time</td>
<td>53</td>
<td>15</td>
</tr>
<tr>
<td>Some of the time</td>
<td>33</td>
<td>9</td>
</tr>
<tr>
<td>Rarely or never</td>
<td>33</td>
<td>9</td>
</tr>
<tr>
<td>Stethoscope Cleaning During Typical Patient Care Day</td>
<td>102</td>
<td>29</td>
</tr>
<tr>
<td>After every use</td>
<td>84</td>
<td>24</td>
</tr>
<tr>
<td>At least once a day</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>At least once a week</td>
<td>141</td>
<td>39</td>
</tr>
<tr>
<td>Whenever participant remembers</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Does not use stethoscope in patient care</td>
<td>239</td>
<td>67</td>
</tr>
<tr>
<td>Agent(s) Used for Stethoscope Cleaning During Typical Patient Care Day</td>
<td>98</td>
<td>27</td>
</tr>
<tr>
<td>Isopropyl alcohol – based a</td>
<td>21</td>
<td>6</td>
</tr>
<tr>
<td>Ethyl alcohol – based hand sanitizers b</td>
<td>142</td>
<td>40</td>
</tr>
<tr>
<td>Other c</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of Institutional Stethoscope Cleaning Policy</td>
<td>199</td>
<td>55</td>
</tr>
<tr>
<td>Not sure policy exists</td>
<td>142</td>
<td>40</td>
</tr>
<tr>
<td>Policy does not exist</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Aware policy exists</td>
<td>321</td>
<td>90</td>
</tr>
<tr>
<td>Previous training on Stethoscope Cleaning</td>
<td>31</td>
<td>8</td>
</tr>
<tr>
<td>None remembered</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Yes, as a student</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Yes, at current workplace</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Believes stethoscope can be involved in nosocomial pathogen transmission</td>
<td>332</td>
<td>93</td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>6</td>
</tr>
<tr>
<td>Maybe</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>358</td>
<td>100</td>
</tr>
</tbody>
</table>

* a includes rubbing alcohol, or alcohol-based wipes, preps or disinfectant pads
* b available mostly as Purell throughout clinical areas
* c includes soap and water, bleach-based wipes, and CaviWipes

within the healthcare setting. However, less than one-third of our clinicians clean their stethoscope after every use, or even daily. The majority of our respondents also report minimal to no training regarding stethoscope cleaning, and are not aware of an institutional policy in this regard, suggesting that stethoscope cleaning has not received much attention as a component of institutional efforts aimed at hospital infection prevention.

Our study is limited by under-representation from several healthcare worker categories (such as allied health professionals and nurses, for example), reflects the experience of only two community teaching hospitals that may not be generalizable to other institutions, and likely suffers from the inherent bias associated with self-reporting. Our study is also limited by the over-inclusion of medical students, who rotate transiently on clinical wards, and may not be fully aware of existing institutional policies, as shown by our results. Their experience highlights the importance of including specific infection control aspects into their clinical training, which should be emphasized both theoretically in the classroom, as well as practically through role-modeling at the bedside. Nevertheless, our findings are similar to those of Ali S et al, who recently found in a similar survey that 11% of the healthcare professionals attending their Medical Grand Rounds admitted to having never cleaned their stethoscope. [6] Although prior studies implicating the stethoscope as a direct vector of nosocomial pathogen transmission and subsequent infection development are lacking, evidence of stethoscope bacterial colonization of both diaphragm and ear pieces certainly exists [7], with physicians’ stethoscopes carrying significantly more pathogens compared to nurses’ stethoscopes in one study [8]. Similarly, a study of stethoscopes used by physicians and students practicing in a pediatric ward found a bacterial colonization rate of 86%, including staphylococcal species, gram-negative rods, and drug-resistant organisms such as methicillin-resistant *Staphylococcus aureus* and *Acinetobacter baumannii*. [9] A study done at Leicester Royal Infirmary in the UK isolated *Clostridium difficile* colonies on 4.9% of physician’s stethoscopes. [10] There was general agreement among our clinicians that the potential for nosocomial pathogen transmission exists, as previously recognized [11]. However, there is less healthcare consensus regarding the optimal frequency of stethoscope cleaning, or what the most effective disinfectants might be. Previous studies have shown isopropyl alcohol to effectively reduce bacterial burden when applied to contaminated stethoscope diaphragms [8, 12], and this was the agent most commonly used by our healthcare workers, as it is easily accessible on the hospital wards.

In conclusion, we believe that healthcare institutions should include reminders, training, and policies related to stethoscope cleaning into their overall infection prevention efforts aimed at reducing nosocomial pathogen transmission and healthcare associated infections.

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To Improve Homicide Firearm Information Reporting – Rhode Island State Crime Laboratory

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ABSTRACT
Information on homicide firearms can be used to help state and local communities understand the problems of violence and decrease injuries and deaths. However, it is difficult to collect these data. To our knowledge, in the public health arena, the National Violent Death Reporting System (NVDRS) is the only system that collects detailed firearm information. The Rhode Island State Crime Laboratory (RISCL) can provide detailed information about the firearms and cartridge cases/bullets involved in firearm deaths. With help from the RISCL, the firearm information related to homicides in Rhode Island has improved dramatically. In 2015, information on caliber/gauge increased by 80%, the firearm type by 50%, the make by 50%, and the model by 20%. By documenting the process of using information from the RISCL, it is hoped that this process can be used as a model by other states when reporting on violent deaths.

KEYWORDS: homicide; firearms; Rhode Island State Crime Laboratory (RISCL); Rhode Island Violent Death Reporting System (RIVDRS)

INTRODUCTION
Information on homicides by firearms can help all states and local communities better understand the problems of violence and identify effective ways to reduce crime, injuries, violence and deaths. However, it has been difficult to collect homicide firearm data. First, during the case investigation process, law enforcement agencies usually withhold information until after the trial. Second, it is difficult to get firearm homicide information if a gun, suspect, or eyewitness is not available.

To our knowledge, in the public health arena, the National Violent Death Reporting System (NVDRS), a Centers for Disease Control and Prevention (CDC) initiative, is the only data collection system that includes detailed firearm information. NVDRS is a surveillance system that gathers violent death information and is implemented in 40 states, the District of Columbia, and Puerto Rico. The Rhode Island Violent Death Reporting System (RIVDRS) is a component of NVDRS. Our firearm data come mainly from law enforcement reports. The 2015 RIVDRS data were closed out at the end of June 2017, and the 2016 RIVDRS data will be closed out by the end of June 2018. We usually only get the initial police report. This results in extensive time lags.

The Rhode Island State Crime Laboratory (RISCL) at the University of Rhode Island is a publicly-funded, independent, non-partisan laboratory [1]. In 1978, the General Assembly passed legislation to make the RISCL the state’s official crime laboratory. In 1995, Dennis Hilliard became Director/Adjunct Assistant Professor of the RISCL and is the current Director [1]. The RISCL, staffed by scientists and former police officers, offers services related to firearms, trace evidence, and latent prints, and sponsors many continuing education classes throughout the year. The RISCL has held a certificate of accreditation in ISO/IEC 17025 since 2007 [1].

The RISCL is an excellent resource for detailed information about firearms and cartridge cases/bullets involved in firearm deaths [2]. A data sharing agreement/Memoranda of Understanding (MOUs) between the RISCL and RIVDRS was established in 2004. The RISCL examines the evidence and provides documentation for court records, which includes more detailed firearm information than is found in the police department/law enforcement report [2]. Since there is only one crime laboratory in Rhode Island, the RISCL is a very efficient data source. RIVDRS generates a list of police case numbers for homicides that included a firearm, and sends the list to the RISCL to arrange for the records to be pulled for review. The firearms data are abstracted by RIVDRS staff at the RISCL on an annual basis. The process, as described below, provides lessons learned and can be used as a model for other states in their reporting of violent deaths to the NVDRS.

METHODS
RIVDRS collects timely, accurate, and comprehensive surveillance data on all violent deaths using a web-based data entry system and guidelines provided by the CDC [3]. RIVDRS was funded in 2003 and data collection began in 2004. The primary sources, which are required, are medical examiner reports (including toxicology), death certificates, and law enforcement reports. The secondary sources, which are optional, are data from child fatality review teams, emergency department records, hospital discharge records,
Emergency Medical Services (EMS), Attorney General Office-Press Releases, state crime laboratories, National Incident-Based Reporting System (NIBRS), and Supreme Court Domestic Violence Training and Monitoring Unit [3]. RIVDRS collects information on the following: firearm type, caliber or gauge, make, model, owner, if the firearm was stolen, how the gun was stored [loaded, and locked], and gun access [3].

The RISCL examines firearms, fired cartridge cases, bullets, and tools used in a crime, and employs the National Integrated Ballistic Information Network (NIBIN) database. Firearm examinations include microscopic examinations of bullets, cartridge cases, and other tool marks; identification and test firing of firearms; restoration of defaced serial numbers; and testing for gunshot residue to determine the distance the muzzle of the firearm was from the victim [4]. The RISCL case files consist of the police department/law enforcement evidence submission report, the firearms examination report, and the firearm notes pages which may include a cartridge case worksheet, projectile worksheet, correlation results, and General Rifling Characteristics (GRC) database search results. Due to the relatively low proportion of violent deaths in Rhode Island that involve firearms and the time needed by the RISCL to process evidence, more frequent visits to the RISCL were determined to be inefficient. RISCL reports are accessed and abstracted annually on-site. Firearms used in suicide deaths are not normally sent to the RISCL, and therefore, data collected are almost exclusively restricted to homicides. Police departments do not necessarily submit evidence on all homicides, but usually do where a bullet, cartridge case, and/or the firearm, have been recovered.

RESULTS
A firearm is not recovered in every firearm homicide case. Based on previous data, less than half of firearm-related homicides have a recovered firearm. In 2015, only two firearms were recovered from ten firearm-related homicides.

The patterns of total homicides and firearm homicides were very similar from 2004 to 2015. Because of the small numbers, firearm homicides varied over the 12 years of data collection. The lowest numbers of firearm homicides were 11 in 2007 and 10 in 2015 (Figure 1). RIVDRS has collected more information on firearm type and caliber or gauge compared to firearm make and model across the years. The availability of firearm information has fluctuated from year to year (Table 1).

During its 12 years of data collection, RIVDRS has extracted firearm data from 189 homicides. Overall, among firearm information, caliber or gauge were most often available [67.2%], followed by the firearm type [58.7%], make [34.9%], and model [21.7%]. During this time, only eight of the 189 firearm homicides had firearms designated as “firearm stolen”, four cases had firearms designated as “gun

![Figure 1. Total Homicide and Firearm Homicide by Incident Year, Rhode Island 2004–2015](image_url)

Table 1. Valid Entry of Firearm Information by Incident Year, Rhode Island 2004–2015 (N=189)

<table>
<thead>
<tr>
<th>Incident Year</th>
<th>Number of Firearm Homicide</th>
<th>Caliber or Gauge</th>
<th>Firearm Type</th>
<th>Firearm Make</th>
<th>Firearm Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>2004</td>
<td>18</td>
<td>15</td>
<td>83.3</td>
<td>18</td>
<td>100.0</td>
</tr>
<tr>
<td>2005</td>
<td>21</td>
<td>17</td>
<td>81.0</td>
<td>17</td>
<td>81.0</td>
</tr>
<tr>
<td>2006</td>
<td>13</td>
<td>10</td>
<td>76.9</td>
<td>11</td>
<td>84.6</td>
</tr>
<tr>
<td>2007</td>
<td>11</td>
<td>8</td>
<td>72.7</td>
<td>6</td>
<td>54.6</td>
</tr>
<tr>
<td>2008</td>
<td>21</td>
<td>5</td>
<td>23.8</td>
<td>6</td>
<td>28.6</td>
</tr>
<tr>
<td>2009</td>
<td>17</td>
<td>8</td>
<td>47.1</td>
<td>5</td>
<td>29.4</td>
</tr>
<tr>
<td>2010</td>
<td>16</td>
<td>4</td>
<td>25.0</td>
<td>3</td>
<td>18.8</td>
</tr>
<tr>
<td>2011</td>
<td>13</td>
<td>8</td>
<td>61.5</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>2012</td>
<td>16</td>
<td>12</td>
<td>75.0</td>
<td>10</td>
<td>62.5</td>
</tr>
<tr>
<td>2013</td>
<td>19</td>
<td>19</td>
<td>100.0</td>
<td>13</td>
<td>68.4</td>
</tr>
<tr>
<td>2014</td>
<td>14</td>
<td>11</td>
<td>78.6</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>2015</td>
<td>10</td>
<td>10</td>
<td>100.0</td>
<td>9</td>
<td>90.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>189</strong></td>
<td><strong>127</strong></td>
<td><strong>67.2</strong></td>
<td><strong>111</strong></td>
<td><strong>58.7</strong></td>
</tr>
</tbody>
</table>

owner”, none were designated as stored loaded and/or locked, and three cases had valid gun access narrative (Figure 2). Before August 2013, NVDRS was limited to information on how the gun was stored (loaded, and locked) and access to firearms involving youth victims and suspects (17 years of age or younger), and data collection on adult violent deaths was optional [3]. Since August 2013, information on how the gun was stored (loaded, and locked) and access to firearms is collected on all firearm deaths regardless of age when data are available [3].

In 2015, RIVDRS reported on ten firearm homicides. After visiting the RISCL, we were able to improve our information by finding data for eight firearm caliber or gauges, five firearm types and makes, and two models (Table 2).

**DISCUSSION**

Collecting firearm make and model data is difficult as compared to the firearm’s type and caliber or gauge. Homicide firearm information mainly comes from police reports. It is understandable that law enforcement data sources are reluctant to give out detailed information on homicides during ongoing investigations. Firearm information is not always included in police department reports since there is no mandate to provide firearm make and model. Also, the make and model choices in the NVDRS web-based data entry system are outdated. The CDC is planning to revise the online firearm data fields, which will include updates to make and model listings and should lead to a more comprehensive record. Collecting firearm make and model information could help to improve public health. If there is an accidental firearm discharge due to a defect in the firearm, a recall may be initiated by the manufacturer.

Police department/law enforcement reports typically do not include information regarding firearm access, storage (loaded, locked), or whether the firearm was stolen. A firearm “stored locked” includes a trigger lock, a locked closet, or a safe. Questioning relatives and family on whether the firearm was stored or loaded can be sensitive. The Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) can provide more detailed firearm information [2, 5]. The ATF firearm trace reports are designed to assist investigations by tracking the possession of specific firearms including through sales [2]. Tracing firearms helps in obtaining information on whether possession of the firearm was obtained through a secondary market, which can aid in the evaluation of the effectiveness of prevention strategies [2].

Firearms are normally traced to the first retail seller [5]. RIVDRS obtained ATF trace reports from police departments prior to 2014. Generally, the RISCL does not receive ATF trace reports from police departments. The RISCL does not receive information on the firearm owner, if it had been stolen, if it was stored loaded and/or locked, and the individual’s access to the firearm. If a firearm homicide is followed by a suicide, a firearm is usually at the scene. In this situation, firearm data are more accessible than in other firearm homicides. If the firearm and gather information on the firearm type, caliber or gauge, make, and model. However, this is not the case for a homicide-suicide where the firearm was discarded after the homicide and not used in the suicide. In 2015, we had two homicides followed by suicides. The information gathered on the firearm from one of the cases was found in the police reports. The RISCL was the source of information for the second case, which also provided firearm information pertaining to the suicide. The RISCL usually gets all firearm-related evidence for all homicides, except in the cases such as a murder-suicide, where evidence is not necessarily analyzed.

**Table 2. Change of Firearm Information in 2015 Homicide Deaths After Visiting the RISCL (n=10)**

<table>
<thead>
<tr>
<th>Firearm Characteristic</th>
<th>Before Visiting RISCL</th>
<th>After Visiting RISCL</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Caliber or Gauge</td>
<td>2</td>
<td>20.0</td>
<td>10</td>
</tr>
<tr>
<td>Firearm Type</td>
<td>4</td>
<td>40.0</td>
<td>9</td>
</tr>
<tr>
<td>Firearm Make</td>
<td>1</td>
<td>10.0</td>
<td>6</td>
</tr>
<tr>
<td>Firearm Model</td>
<td>1</td>
<td>10.0</td>
<td>3</td>
</tr>
</tbody>
</table>

Data source: 2015 Rhode Island Violent Death Reporting System.
We learned the following from our partnership with the RISCL:

1) The police case number received for our records may not be consistent with the information received by the RISCL. Additional information may need to be provided [e.g. victim names], which helps to increase the chance of matching a case.

2) If a firearm was recovered from a homicide, the agency does not have to submit the firearm to the RISCL for firearm examination or analyses. Instead, the agency may test fire the weapon and submit cartridge cases for NIBIN analyses only.

3) In terms of gun type, if a .45 auto or .40 S&W [Smith and Wesson] cartridge case is found, we cannot conclude it is from an automatic handgun. For example, some revolvers and rifles can accept .45 auto caliber and .40 S&W caliber ammunition. If we see “pellets,” we cannot state they are from a shotgun, as some handguns have the ability to fire shotshells, and there is handgun ammunition manufactured that contains pellets.

4) A full-automatic firearm shoots more than one shot at a time by a single pull of the trigger without manual reloading [6]. Semi-automatic and full-automatic firearms extract and eject the discharged cartridge cases, which are deposited at the location in a random fashion. If casings are found on the floor, we cannot assume that the gun was a semi-automatic or full-automatic due to an individual having the ability to reload a revolver while discarding the discharged cartridge cases on the ground.

5) Cartridge caliber is equal to firearm caliber. If the cartridge case is a .45 caliber cartridge, it is understood to have been fired from a .45 caliber firearm.

6) If there is a discharged .40 S&W caliber cartridge case, we cannot say the firearm make is S&W. The S&W is part of the cartridge name which does not mean it was discharged in a firearm made by S&W. Without a firearm, the RISCL cannot determine the make and model of a discharged cartridge case. Based on rifling characteristics on a bullet, the RISCL will provide a list of potential makes and models of firearms from the Laboratory’s database that have similar rifling characteristics. Make and model does not always tell you the caliper or gauge, or the type of firearm without additional research.

CONCLUSIONS

We heavily depend on the RISCL to obtain homicide firearm information. We also need to work more closely with the Providence Police Department, since most of the firearm homicides occurred in Providence. We hope that the CDC will promulgate guidelines on how states can make better use of the firearm data gathered from violent death cases.

References


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Disclaimer

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Disclosures

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Domestic Minor Sex Trafficking: Medical Follow-up for Victimized and High-Risk Youth

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ABSTRACT
Domestic minor sex trafficking (DMST) has become an increasingly recognized issue associated with both immediate and long-term physical and mental health consequences. Guidelines have focused on potential risk factors, recruitment practices, and health consequences for these youth assisting in identification and intervention efforts. However, recommendations have not been established for continuous medical intervention and follow-up for this vulnerable patient population that includes both patients involved in and at high risk for DMST. Our goal is to highlight preliminary recommendations for and the importance of medical visits for these youth. A comprehensive physical examination, STI testing and treatment, and pregnancy prevention options are important to address the patients’ concerns for their body and identify acute and chronic injuries. Further, collaborating with other medical and non-medical providers can provide essential resources for the multifaceted needs of DMST patients.

KEYWORDS: domestic minor sex trafficking (DMST), follow-up, physical examination, sexually transmitted infection (STI)

Domestic minor sex trafficking (DMST) is the commercial sexual exploitation of American children within U.S. borders. These crimes are defined as the “recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act” where the person is under the age of 18 years. DMST is emerging as a newly recognized subset of child sexual abuse and a major public health issue of pre-adolescents and adolescents in the U.S. Given the exceptional challenges of victim identification, the epidemiology of this issue is unknown.1-3

Barron and colleagues found that an overwhelming majority (86%) of Rhode Island pediatricians never received training on how to properly care for DMST patients, including initial and ongoing medical visits.4 Sex trafficking is a major public health issue in Rhode Island; this may be due to its geographic proximity to New York City, Boston and access to a major interstate highway. While local and non-local victims are trafficked in and out of Rhode Island via the Interstate, victims may also be trafficked within neighborhoods of the state. Within the setting of the state’s only outpatient child abuse pediatrics clinic, The Lawrence A. Aubin Sr. Child Protection Center at Hasbro Children’s Hospital has evaluated 75 patients for DMST involvement since August 2013.

The American Academy of Pediatrics (AAP) and the American Professional Society on the Abuse of Children (APSAC) published clinical guidelines regarding risk factors, recruitment practices, possible indicators of commercial sexual exploitation, and common medical and behavioral health problems to assist in victim identification and intervention efforts.1,2 Follow-up care for victims of DMST has not been a focus within these guidelines possibly because of the transient living conditions of these youth that may complicate medical follow-up. Consequently, there remains a dearth of specific recommendations for follow-up medical care after identification, and this component of care for this population still remains challenging.

Comprehensive medical protocols that address the plethora of medical, psychiatric and safety issues related to DMST during the initial evaluation and follow-up medical visits do not exist. Guidelines have been utilized similar to those currently used for victims of acute sexual assault.1,2 However, these guidelines do not take into account the significant differences between these two populations. Unlike victims of an acute sexual assault, youth involved in DMST have continuous high-risk exposures. Further, Varma and colleagues found that suspected sex trafficking patients were more likely to have histories of substance use, STIs, pregnancy, runaway behavior, and child protective service (CPS) involvement as compared to sexual abuse/sexual assault victims.5 Thus, extensive ongoing medical care that considers mental health and safety planning, while concurrently ensuring physical health with STI testing, treatment, and pregnancy prevention specifically for DMST patients is of paramount importance.

The cornerstone of treating this patient population is to build a foundation of trust that develops over time with multiple interactions. Establishing trust may pose significant challenges for clinicians, as many victims have an overwhelming distrust of authority figures based on histories of abuse, abandonment by caregivers, and prior involvement with CPS and/or law enforcement.6 Further, it
is possible that youth involved in DMST have developed a fear of their trafficker, being labeled a ‘prostitute’, criminalization, and returning to a poor living situation, which could include a group or an unsafe family environment. Due to these reasons, DMST patients may not be inclined to communicate openly about their involvement. Medical providers must take time to demonstrate that they can be trusted and nonjudgmental professionals with the patient’s health and safety as their priority. This may be difficult when confronted with oppositional or withdrawn adolescents; these are behaviors seen in typically developing adolescents and may be heightened in youth at risk for DMST. Probing or investigative questions related to their exploitation should be avoided. Further, information should be accepted from the patient without disputing facts or seeking to gain more specific information.

The patient should be reassured that regardless of his/her involvement in DMST, he/she can return for care without judgment. Balancing this nonjudgmental approach with the obligation to meet mandatory reporting requirements to both child protective services (CPS) and law enforcement is important. Ideally, CPS and law enforcement involvement should occur after informing the child of the report. Providers should become familiar with their state’s mandatory reporting laws as some states include reporting DMST, while other states do not. It is also important to identify which states have Safe Harbor Laws, which impacts the focus of youth involved in DMST as victims and not criminals.

Providing a full physical examination and communicating with the patient about the physical findings can begin to address the patient’s concern that their body is damaged or abnormal after the repeated physical and sexual trauma associated with their involvement. A comprehensive examination should include a thorough inspection for inflicted sexual injury, testing for STIs, physical findings (e.g., injuries inflicted by others, self-inflicted cutting, tattoos that may represent branding), substance abuse, malnutrition, and dental neglect. A genital examination, with the patient’s assent, should be part of follow-up medical visits to check for acute and chronic anogenital injuries (e.g., lacerations, bleeding, abrasions, transections).

The APSAC and AAP recommend STI testing and providing prophylaxis for pregnancy and STIs during medical visits given the transient living conditions and the decreased likelihood of follow-up for victims of DMST. However, these guidelines do not advise providers on STI testing and treatment for DMST patients who present for follow-up visits, nor do they address ongoing and high-risk exposures inherent to these youth. Follow-up visits provide a crucial opportunity to 1) detect new infections acquired during or after the initial evaluation; 2) build rapport with patients to acknowledge concerns for their physical and specifically sexual health; 3) monitor side effects and adherence to post-exposure prophylactic medication, if indicated (See Tables).

### Table 1.

**Recommendations for DMST Follow-up**

- Build a foundation of trust that develops over time with multiple interactions
- Collaborate with involved outside agencies (e.g., child welfare, law enforcement and transitional social service agencies for adolescents ageing out of state custody)
- Accept information from the patient without disputing facts or seeking to gain more specific information
- Meet state-specific mandatory reporting requirements to both child protective services (CPS) and law enforcement
- Provide a full physical examination and communicate with the patient about the physical findings
- Monitor side effects and adherence to post-exposure prophylactic medication, if indicated
- Provide follow-up testing and treatment for STIs, including N. gonorrhea, C. trachomatis, trichomonas, HIV, syphilis, hepatitis B and C based on 2015 CDC STD Guidelines and patient request
- Offer patients the option of various forms of contraception, with an emphasis on long-acting, reversible contraception (LARC) methods
- Enable the patient to have access to the provider who can see the patient emergently or refer to another member of their care team

### Table 2.

**Follow-up testing and treatment for DMST Patients**

- STI testing should include N. gonorrhea, C. trachomatis, trichomonas, HIV, syphilis, hepatitis B and C based on 2015 CDC STD Guidelines
- Provider should consider patient request for testing
- Balance testing parameters and limitations while informing patients of the uncertainty regarding the test results if the patient is having ongoing unprotected sex (e.g., C. trachomatis will remain positive up to 3 weeks and N. gonorrhea up to 2 weeks with nucleic acid amplification testing despite adequate treatment)
- The provision of STI, pregnancy, and HIV prophylaxis should be evaluated on a case-by-case basis during follow-up visits
- Review if and when the patient received prophylaxis during a prior medical visit, complete a risk assessment, and communicate openly with the patient about his/her adherence to determine medication provision.
- Consult an infectious disease specialist and child abuse pediatrician to help make this determination

Comparable to STI vulnerability, this population is susceptible to unplanned pregnancy. Offering patients the option of various forms of contraception, with an emphasis on long-acting, reversible contraception (LARC) methods is an important component of medical follow-up. Due to the transient living conditions of patients involved in DMST, there is increased risk for poor compliance with daily

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**CONTRIBUTION**

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medications, making options with extended protection an ideal choice for birth control in this population.6

Establishing collaborative relationships between providers and outside agencies [i.e. a multidisciplinary team] offers resources for the medical and non-medical needs of these youth in follow-up visits.1 Advocacy for this patient population is broad, variable and includes finding educational opportunities, appropriate housing and guardianship, specialized medical care [e.g. psychiatry, dental], mental health counseling, and legal assistance. Ongoing medical visits allow for the opportunity to connect victims to appropriate resources and referrals that can provide direct services for these youth [i.e. child protective services and other community providers].

CONCLUSION

Follow-up visits for DMST youth provide the opportunity to address the multifaceted and long-term needs of patient victims. Guidance surrounding ongoing medical care after identification and the initial evaluation has not been established. Based on clinical experience, our preliminary recommendations for follow-up visits include: STI/HIV testing and treatment, pregnancy prevention with LARCs, mental health assessment and subsequent referrals to and collaboration with other community professionals. These aforementioned interventions allow providers to demonstrate the patient’s health and well-being as a main priority, and develop an ongoing trusting relationship, regardless of continued DMST involvement. Despite the transient living conditions of DMST victims, healthcare professionals have a responsibility to encourage all victimized and high-risk adolescents to attend follow-up visits; this allows for appropriate safety planning, health care, and advocacy for this vulnerable patient population.

References


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Food Insecurity and Chronic Disease: 
Addressing Food Access as a Healthcare Issue

DOMINIC DECKER, MD, MS; MARY FLYNN, PhD, RD, LDN

ABSTRACT
Food insecurity, or lack of access to nutritionally adequate food, affects millions of US households every year. Food insecure individuals face disproportionately higher rates of chronic diseases, like diabetes mellitus and HIV/AIDS, and therefore accrue more healthcare costs. This puts into motion a cycle of disease and expense that furthers disparities between food secure and insecure patients. Our aim is to provide an overview of food insecurity, define its link to chronic disease and offer practical solutions for addressing this growing problem.

KEYWORDS: food insecurity, chronic disease, clinical nutrition, hunger-obesity paradox

INTRODUCTION
Food insecurity, defined by the United Nations Subcommittee on Nutrition, is “the limited or uncertain availability of nutritionally adequate, safe foods or the inability to acquire personally acceptable foods in socially acceptable ways.”

Food insecurity affects 15.8 million (12.7%) of US households. These numbers vary by region and state: the latest data averaged from the years 2013–15 reveal that the prevalence of food insecurity in Rhode Island is 11.8%.

The millions of individuals in the US facing food insecurity must worry about food running out, having to skip meals or go entire days without eating. Research has shown that in addition to the significant psychological distress this creates in homes, food insecure individuals face disproportionate rates of chronic medical conditions, such as obesity, diabetes, cardiovascular disease and HIV/AIDS.

DEFINING AND ASSESSING FOOD INSECURITY
“Food insecurity” is distinct from hunger. The United States Department of Agriculture (USDA) defines the latter as a physiologic condition that occurs at the individual level.

Food insecurity, on the other hand, occurs at a household level. Given the many factors that weigh on a household’s ability to procure and prepare food, assessments of food insecurity can be difficult. The USDA has prepared a questionnaire (US Household Food Security Survey Module) that stratifies food security into the following groups: food secure, low food security and very low food security.

The instrument importantly takes into account the presence of children in the home. Data from the September 2015 questionnaire [the most recent for which data is available] show that rates of food insecurity are substantially higher in households headed by single men or women with children. Furthermore, 59% of food insecure households reported use of federal nutrition assistance programs, such as Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC) and the National School Lunch Program.

CAUSES OF FOOD INSECURITY
The causes of food insecurity are numerous. In a 2016 survey of respondents from 32 cities in 24 states, the following were listed as primary factors in food insecurity:

- Un- or underemployment
- High housing costs
- Poverty
- Lack of access to SNAP/food assistance programs
- Medical or health costs

These causes also affect those living in rural areas, often to a greater degree: rates of un- and underemployment are higher in rural areas and educational attainment is lower when compared to urban and suburban areas.

Based on our own clinical experience, we add that elderly individuals, college students and those without access to reliable transportation are also at risk for food insecurity. Among all these causes, we wish to highlight the cyclical relationship between food insecurity and medical costs. Food insecurity is associated with significantly greater annualized health care expenditures: on average, food insecure individuals spend $1,800 more annually on medical costs than their food secure counterparts.

HUNGER-OBESEITY PARADOX
Food researchers have consistently demonstrated that food insecure individuals are overweight, a phenomenon known...
at the “hunger-obesity paradox.” Among studies that have been done to elucidate this is one involving over 450 patients at a community health center in Chelsea, Mass. Researchers followed these patients for three years. In those who self-reported food insecurity, body mass index (BMI) increased an average of 0.15 per year.

To broaden the scope from obesity to overall health, researchers in the Mississippi Delta surveyed over 1,400 participants and found that food insecure individuals were more likely to rate their health (measured broadly in terms of physical and mental functioning, energy, pain and mood) as poor or fair.

There are many theories that attempt to explain the obesity paradox, but one that deserves to be expanded upon is the prevalence of low-cost, energy dense “convenience” foods in impoverished areas. An influential study done in France, using food cost data from the late 1980s and early 90s, demonstrated that each additional 100 grams of fats/sweets reduced daily diet costs on the order of 6 to 46 cents, while each additional 100 grams of vegetables and fruits raised daily diet costs by 21 to 33 cents. Over weeks and months, those costs are significant.

Foods that are cheap and high in calories tend to promote overconsumption, leading to weight gain over time. And with excess weight comes the risk of developing myriad medical problems.

FOOD INSECURITY AND CHRONIC DISEASE
Food insecurity has been independently implicated in the development of a number of chronic diseases that continue to overwhelm our healthcare system. Among these conditions include type 2 diabetes mellitus (DM), cardiovascular disease, HIV/AIDS and mood disorders.

In regards to diabetes and heart disease, the role of food in both conditions is complex. As we have shown, obesity, which itself is a risk factor for diabetes and heart disease, is more prevalent in food insecure individuals.

Even after adjusting for sociodemographic factors and physical activity level, people with severe food insecurity are more likely to have type 2 DM than those without food insecurity. Blood sugar control over time, assessed by measuring hemoglobin A1C, is worse in food insecure individuals, possibly due to their inability to afford and follow a diabetic diet that limits processed foods like simple carbohydrates.

When one considers the first step in addressing diabetes after diagnosis is lifestyle intervention, it becomes clear that these fall short when patients lack access to nutritious food. Instead, many of these patients end up being prescribed medications and eventually insulin, adding to their healthcare costs and cutting into their overall income. This perpetuates the aforementioned cycle of food insecurity and chronic disease.

It is striking that some disease states, such as HIV/AIDS, which are not related to obesity in the same way as diabetes and heart disease, are also related to food insecurity. A study of over 400 people living in North Carolina revealed a higher rate of HIV infection in food insecure individuals regardless of high-risk sexual behavior. Among theories offered to account for this include the fact that patients are less likely to adhere to HIV therapy when food insecure and, even when they are adherent, absorption of protease inhibitors is limited when taken on an empty stomach.

IDENTIFYING AND RESPONDING TO FOOD INSECURITY
With an abundance of data on food insecurity as it relates to chronic disease and health care expenditures, there is urgency in identifying those at risk for food insecurity and intervening early. The American Academy of Pediatrics (AAP) suggests using two questions from the USDA food security survey to accomplish this:

Within the past 12 months, we worried whether our food would run out before we got money to buy more.

Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more.

Respondents choose often true, sometimes true, never true, or don’t know. Those who respond often true or sometimes true to either statement have a high likelihood of being food insecure. Once identified, food insecurity can be appropriately addressed by healthcare providers through referrals to food assistance programs at the local and national levels.

THE ROLE OF THE HEALTHCARE PROVIDER
We propose that healthcare providers should ask all patients, regardless of age, the two questions above. Alternatively, these questions could be targeted to those at increased risk for food insecurity, including individuals of low socioeconomic status, the elderly and those with limited access to reliable transportation. Providers with access to social workers should refer food insecure patients to social work services or direct patients to local food banks found online or by dialing 211, a nationwide number for community resources and referrals.

CONCLUSION
Individuals living without access to nutritious food are at disproportionate risk of developing chronic diseases, from diabetes to HIV/AIDS to mood disorders. Treatment of these conditions cuts away at their income and leaves them in a vicious cycle of inexpensive, nutritionally poor foods and health crises. Physician involvement in identifying and reducing food insecurity probably improves health outcomes and decreases health-related costs.
References


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Central Venous Catheters: A Closer Look at the Subclavian Vein Approach

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KEYWORDS: Central venous catheter, Subclavian vein, internal jugular vein

INTRODUCTION

Central venous catheters (CVCs) are commonly used and have a range of outpatient and inpatient indications. A subclavian vein approach has traditionally been used for placement of these catheters; however, this method exposes the patient to the high risk of subclavian stenosis as well as an increased risk for catheter fracture. In this report, we describe a patient with a chemotherapy port placed in the subclavian vein that underwent spontaneous fracture. We therefore advocate for the use of an internal jugular approach for CVCs.

CASE REPORT

A 62-year-old man with a history of Kaposi’s sarcoma was referred to interventional radiology for a percutaneous chemotherapy port study. The percutaneous port was originally placed through the left subclavian vein for adjuvant chemotherapy. Port malfunction was first noticed during a routine follow-up appointment with the patient’s hematology oncologist. Blood return was sluggish and there was a noticeable soft lump at the upper sternum after flushing. A Port study was performed under fluoroscopic guidance. The initial AP view of the chest (Figure 1) revealed luminal narrowing and “pinch off” sign at the intersection of the clavicle and first rib. Digital subtraction acquisition with contrast confirmed the location of the fracture (Figure 2). Contrast extravasation was documented at the location of the soft swelling (Figure 3). The device was removed in the interventional radiology suite. Gentle traction was used to remove the catheter, given the known damage and possible risk for embolization of the catheter tip. Upon removal, parallel 1cm long longitudinal fractures were identified at the fluoroscopically identified point of extravasation (Figure 4).
**DISCUSSION**

Various factors leading to catheter fracture have been recognized. It has been well established that catheters placed in the subclavian vein are exposed to high mechanical friction from the clavicle and first rib. Compressive forces can cause transient obstruction. Over time, repetitive stress on the catheter causes structural degradation leading to fracture. Previously reported incidences for catheter fracture have ranged from .1–1.3%.2,3

Occult fracture may first be noticed with difficulty administering or aspirating fluid through the line. More serious symptoms may present as extravascular administration of medications through the fractured line or embolization of the catheter tip.

Early diagnosis of catheter fracture is key to management. Chest x-ray can provide the earliest radiographic evidence for possible catheter fracture with a positive “pinch off” sign. Patients with a positive “pinch off” sign have an estimated 40% risk for catheter fracture and such catheters should be removed and replaced using another vessel.4 If fracture is suspected and complete transection has occurred, the patient should undergo emergent percutaneous retrieval by interventional radiology, which has been shown to be a highly successful and safe procedure.5

Catheter fractures are a rare event. Stenosis is a more common and insidious complication of subclavian venous catheter placement. Venous stenosis in the setting of subclavian catheters has a reported incidence of 32–50%, typically seen with catheters used for greater than 2 weeks of duration.5,7

The mechanism for stenosis is catheter-induced thrombosis and intimal fibrosis due to the presence of a foreign object in a narrow vessel lumen at the restricted anatomic space between the first rib and clavicle. Utilization of larger caliber vessels such as the internal jugular vein for catheter placement has been shown to minimize this complication, with reported stenosis rates as low as 3%.8

Though the subclavian vein has been the preferred site for many proceduralists, given the evidence of complications with long-term use, many have advocated for the internal jugular vein as the first-line approach.1,9,10 It is well documented that an internal jugular approach with image guidance provides a safe and reliable method for long-term central venous catheters. The course of the internal jugular vein is free of anatomic features that may cause compression or catheter damage. It has a large caliber and high flow to reduce the risk for thrombosis. Other risks such as infection are comparable to the subclavian approach, while pneumothorax risk is diminished.11 Finally, complications such as brachial plexus injuries and thoracic duct injuries are unique to a subclavian catheter and are also avoided.

**CONCLUSION**

Central venous catheter placement through the subclavian vein has a high rate of vein stenosis and increased risk for catheter fracture. Catheter fracture is less common, but may lead to dangerous complications such as extravascular extravasation of medication or embolization. Subclavian stenosis can severely limit venous access which becomes problematic for patients requiring long-term parenteral therapy. The Internal Jugular approach with imaging guidance minimizes risk and provides a proven, safe and reliable alternative.
References


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Thrower’s Fracture of the Humerus: A Case Report

MICHAEL PRUCHA, MD, MPH

ABSTRACT
Humeral fractures typically occur as the result of direct, external trauma. Here however, we describe the case of a young, amateur athlete presenting with acute right, upper arm pain after throwing a ball. Examination showed right upper arm deformity and tenderness to palpation, without any distal neurovascular deficits. X-ray demonstrated a spiral fracture of the humerus. The patient had operative repair of the injury several days later, with no complications noted on outpatient visits up to 3 months later.

CASE REPORT
A 35-year-old, right-handed man presented to the emergency department with right upper arm pain. He was a member of an amateur baseball team. Just prior to arrival he threw a ball and immediately felt a pop and sharp pain in his right upper arm. Since that time, he had been unable to move his arm due to pain. He reported no prior injury to the arm but did state that over the last several weeks he had been having an ache in that arm. He was otherwise healthy, took no medications, denied weakness, numbness and tingling in his right arm. He was a non-smoker and an occasional drinker. He used no drugs.

Physical exam was normal except for the right upper arm, which was swollen and tender to touch. He had decreased range of motion in his elbow and his shoulder secondary to the pain. He had an obvious deformity of the right bicep region. The lower arm had normal neurovascular integrity with normal range of motion in the wrist and hand. He had a 2+ radial pulse and capillary refill was less than 3 seconds.

The humeral x-ray demonstrated a displaced spiral fracture (Figure 1). The patient was placed in a coaptation splint. Reexamination revealed no evidence of radial nerve palsy or radial artery injury. The patient followed up with the orthopedic doctor on call and underwent open reduction and internal fixation of his injury within 1 week (Figure 2). Outpatient follow-up 3 months later showed routine healing without complications.
DISCUSSION

This patient’s presentation is consistent with a well-described, but rarely observed phenomenon known as a ‘Thrower’s Fracture.’ First reported in 1930,1 cases have been reportedly related to everything from a baseball,2,3 to a cricket ball,4 to a dodge ball,5 and hand grenades.6 As with our patient, many patients who present with this injury are amateur athletes who have likely not developed adequate cortical strength of their bones as compared to professional athletes.7 The injury is often preceded by several weeks to months of aching in the region of the humerus, which is thought to represent a stress fracture.2,4,8 The complexity of the throwing motion and related transfer of forces, results in significant torque being applied to the humeral shaft, leading to a fracture, most commonly in the mid to distal third of the diaphysis.

These patients can have similar complications to any mid-shaft, spiral humeral fracture including damage to the radial artery and radial nerve.9,10 In these cases, given the active nature of these athletes, and if underlying complications have occurred, surgeons may elect to repair this injury surgically,2,4,10 though this is not always necessary.

References


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Suicide in teenagers remains a major public health concern. It is the second leading cause of mortality in the U.S. for pre-teens (ages 10 to 12), adolescents (ages 13 to 18), and young adults (18 to 24 years of age). Although based on small numbers, the suicide rate for females between the ages of 10 and 14 tripled over 15 years from 0.5 in 1999 to 1.7 per 100,000 people in 2014, the largest increase (200%) of any age group in the United States during this time period. Suicides among females between the ages of 15 and 19 reached an unprecedented high in 2015 (5 suicide deaths per 100,000). But males in this age group still have suicide rates nearly three times higher (14 deaths per 100,000). Among the factors that have contributed to these trends are the pervasiveness of peer victimization (including cyberbullying) among middle school and high school students, and the upward trend in rates of major depressive episodes among teens and young adults (aged 12–20) observed between 2005 and 2014, without a corresponding increase in mental health treatment for this age group.

This report summarizes the findings from the first three years of implementing the Rhode Island Suicide Prevention Initiative (SPI). SPI is an innovative and coordinated youth suicide prevention referral system that links public elementary, middle and high schools with mental health services. The program diverts at-risk students who express suicidal ideation and/or non-suicidal self-harm from unnecessary Emergency Department (ED) visits by connecting the student to local mental health services with follow-up support.

**METHODS**

Between March 2015 and February 2018, nine public school districts in Rhode Island adopted SPI’s 4-tier model (Central Falls, East Providence, Exeter-West Greenwich, Narragansett, North Kingston, Pawtucket, Providence, South Kingston, and Woonsocket). Tier 1 trains School Support Team members in the Crisis / Response Triage Team Model and the Rhode Island Suicide Prevention Screener (RISPS). The latter is a novel evidence-based tool that integrates the Columbia-Suicide Severity Rating Scale (with elements of the Violence Injury Protection and Risk Screen) to determine if a student is in immediate danger of killing herself and needs to be transported to a local hospital, or if the child’s mental health needs can be met outside of an emergency department.

The 2nd tier links School Support Team members with clinicians at Bradley Hospital’s Kids’ Link RI™ program for children in emotional crisis. School Support staff use the RISPS results and consultation with Kids’ Link clinicians to determine the risk level of each referred student. Kids’ Link clinicians set up a mental health evaluation for the identified child within 1 to 7 days, and help parents find the most appropriate mental health services, after obtaining written parental consent.

The 3rd tier provides wrap around services. Parents must provide active consent to be contacted by telephone at two weeks, three months, and 12 months after their child’s initial mental health evaluation. The Kids’ Link clinician reviews treatment recommendations, barriers to a child’s treatment, mental health/social services needed, and whether the referred student returned to school and stayed in school.

The 4th tier provides schools with universal suicide prevention gatekeeper training. Question, Persuade and Refer (QPR)® is for adults and the Signs of Suicide® Prevention Program (SOS) is for students. Schools in the cities of Central Falls, Pawtucket, Providence and Woonsocket are given priority for SOS workshops. In these cities more than 25% of the children live in poverty. Neighborhood poverty is associated with many risk factors for suicide in older adolescents.

**RESULTS**

Over three years, 328 students from elementary, middle and high schools participating in SPI were identified as needing mental health services by a School Support Team member. The referral process to Kids’ Link was completed on behalf of 258 students for a 78.7% referral rate (See Figure 1).

Reasons for incomplete referrals to Kids’ Link varied. In some cases, the parent could not be reached, despite repeated phone calls from the school or a Kids’ Link clinician. Other parents declined services. Students who did not complete the referral process were, on average, one year younger than students who completed the referral process (12 years of age versus 13 years of age, respectively), but the difference was not statistically significant.

As shown in Table 1, 62.0% of referred students were girls. Referred students ranged in age from five to 19 with a mean age of 13 years. Most parents agreed to a mental health evaluation for their child, and 89.6% of referred students agreed to mental health treatment after a referral was made.
publIC hEAl Th
health assessment for their child with telephone follow-up
at 2 weeks, 3 months and 12 months (89.5%), and to have
information shared with the child’s school (74.0%).

We explored parents’ responses to how their child was
doing two weeks after the child was first evaluated for sui-
cide (n = 164). Most parents reported that their child was now
engaged in therapy and doing better (≈ 75%), but some par-
ents were concerned that their child “continues to act out,
not doing what is told in home and school.” An estimated
15% of parents felt that therapy for their child was neither
warranted nor necessary and reported “no concerns,” or
expressed anger at the school and mental health systems for
stigmatizing their child. Attempts to reach parents who did
not respond to the 2-week call are ongoing, which speaks to
the challenge of including follow-up calls as part of a suicide
prevention screening program.

CONCluSION
A growing number of schools in the U.S. are exploring ways
to provide school-based suicide prevention screening pro-
grams. Implementing these programs is challenging. Many
school administrators are concerned about the resources
and staff time needed to implement suicide screening pro-
grams, 11 and the difficulties of separating suicidal ideation
from normal adolescent mood swings, with the potential for
stigmatizing students. Additionally, school administrators
often prefer a policy where every student who expresses any
suicidal ideation is transported to the closest hospital emer-
gency department, even if the behavior does not warrant
such transport (e.g., superficial cuts to the wrist).

Emergency departments are an indispensable compo-
nent of the U.S. health care system and play a critical role
in the care of children and adolescents with mental health
concerns. 12 But inappropriate emergency room use creates
inefficiencies in care and costs. 13 Strengths of SPI are the
direct linkage between public schools and a hospital-based
program with the capacity to provide (1) immediate consul-
tation to School Support Team members who are concerned
about a student who shows signs of suicidal ideation, and
(2) evaluation appointments within 1 to 7 days, depending on the severity
of the child’s crisis. The most common clinical disposition
for students referred for a mental health evaluation through
SPI was outpatient mental health services, either hospi-
tal-based or at a local community mental health center. This
was an important achievement. Although some emergency
department visits are likely unavoidable, most youth expe-
ririences emotional distress and in need of help do not need
to go to an emergency room.

While SPI has demonstrated success as a school-based sui-
cide prevention intervention, there are limitations to this
study that deserve mention. First, the evaluation of SPI did
not include a group of comparison schools. School districts

Table 1. Characteristics of students referred to Bradley Hospital Kids’
Link RI Program through the Suicide Prevention Initiative (n = 258)

<table>
<thead>
<tr>
<th>Suicide Prevention Initiative School Protocol</th>
<th>N</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Rhode Island Suicide Prevention Screener</td>
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<td>Completed</td>
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<td>13.2</td>
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<td>Parental Consent</td>
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<td>Refer to Kids’ Link RI with follow-up</td>
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<td>Yes</td>
<td>231</td>
<td>89.5</td>
</tr>
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<tr>
<td>Share information with school</td>
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<td>Students Referred</td>
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<tr>
<td>Girls</td>
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<td>26</td>
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<td>Boys</td>
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<tr>
<td>15 to 18 years of age</td>
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1 The protocol includes a screener, demographic referral form, and parental consent
forms to refer the child for a mental health evaluation, for telephone follow-up at
2 weeks, 3 months and 12 months, and for communication with the child’s school.
Data source: 2015-2018 Suicide Prevention Initiative Referral Database.
enrolled in SPI in the 2nd and 3rd year of implementation provide an opportunity to compare “early adopters” to “late adopters,” but SPI is not funded as a research study. Second, it would optimal to know the number of Emergency Medical Service (EMS) ambulance transports of students from their school to a local emergency room for suicidal ideation / attempts before and after SPI was implemented. Rhode Island EMS run reports include a uniform set of data elements, such as the location of the call and the EMS personnel’s impression of the patient’s primary problem or most significant condition. We are expanding the evaluation of SPI to include an analysis of EMS data. We hypothesize that results from the analysis will further support the importance of SPI as a suicide prevention model. Third, School Support Team members in four SPI school districts shared that many parents who were receptive to having their child referred for a mental health evaluation were less open to “check-in” telephone support over one year. Future evaluations will explore how parents perceive crisis intervention telephone support to improve consent rates for referral to Kids’ Link and telephone follow-up.

SPI is a response to the challenges that exist in connecting children and adolescents who have behavioral and mental health problems to mental health services beyond those available in the school. Evaluations of suicide prevention screening programs that include referral of at-risk students to mental health services with follow-up are limited, and have not been done on a national scale.11,13 Unique to SPI is the program’s reach, which includes urban, suburban and rural school districts, and wraparound follow-up services for up to one year. The Providence School District, the largest in Rhode Island, has formally adopted the SPI protocol as a stand-alone section in the district’s School Emergency Preparedness Plan for the district’s 39 schools and nearly 24,000 students. This policy change serves as model for other school districts across Rhode Island and in other states.

References

Acknowledgments
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Rhode Island Monthly Vital Statistics Report
Provisional Occurrence Data from the Division of Vital Records

### VITAL EVENTS

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<td>54</td>
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<tr>
<td>Marriages</td>
<td>808</td>
<td>7,197</td>
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<tr>
<td>Divorces</td>
<td>269</td>
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<tr>
<td>Induced Terminations</td>
<td>144</td>
<td>1,799</td>
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<tr>
<td>Spontaneous Fetal Deaths</td>
<td>72</td>
<td>836</td>
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<tr>
<td>Under 20 weeks gestation</td>
<td>69</td>
<td>774</td>
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<tr>
<td>20+ weeks gestation</td>
<td>3</td>
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* Rates per 1,000 estimated population
# Rates per 1,000 live births

### Underlying Cause of Death Category

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<tr>
<th>Underlying Cause of Death Category</th>
<th>APRIL 2017</th>
<th>12 MONTHS ENDING WITH APRIL 2017</th>
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<tr>
<td></td>
<td>Number (a)</td>
<td>Number (a)</td>
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<tr>
<td>Diseases of the Heart</td>
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<td>Malignant Neoplasms</td>
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<tr>
<td>Cerebrovascular Disease</td>
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<tr>
<td>Injuries (Accident/Suicide/Homicide)</td>
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<td>841</td>
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<tr>
<td>COPD</td>
<td>48</td>
<td>487</td>
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(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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RIMS NOTES is published electronically on alternate Fridays.

Contact Sarah if you’ve missed an issue, sstevens@rimed.org.
Working for You: RIMS advocacy activities

April 2, Monday
Council Meeting: Bradley J. Collins, MD, President

April 3, Tuesday
RIMS Physician Health Committee: Herbert Rakatansky, MD, Chair
Legislative hearings
Rep. Thomas Winfield fundraiser

Legislative hearings
Chairman Joshua Miller fundraiser
Rep. Evan Patrick Shanley fundraiser
Rep. Grace Diaz fundraiser
Meeting with RI Optometric Association: Michael E. Migliori, MD, Chair, RIMS Public Laws Committee, Richard Bryan, MD, President, RI Society of Eye Physicians and Surgeons, Giulio Diamante MD, and staff

April 4, Wednesday
Meeting with House leadership: Michael E. Migliori, MD, Chair, RIMS Public Laws Committee and staff
Legislative hearings
Chairman Robert B. Jacquard Fundraiser
Sen. James Seveney Fundraiser
Rep. Scott Slater Fundraiser

Legislative hearings
Chairwoman Erin Lynch Prata fundraiser
Brown Medical Student Health Council meeting at RIMS

April 9, Monday
Accelerating Change in Medical Education, AMA-sponsored consortium of 32 medical schools meeting at Alpert Medical School, Brown
RI Kids Count Annual Breakfast
Sen. V. Susan Sosnowski fundraiser

April 10, Tuesday
Conference call regarding RIMS’ out-of-network billing legislation
Legislative hearings

April 6, Friday
Conference call, RI Dermatology Society, regarding legislation

April 9, Monday
Chairman Joseph McNamara fundraiser

April 12, Thursday
Senate Special Commission on Physician Interstate Licensing Compact, Newell E. Warde
Legislative Hearings
SIM Grant Steering Committee, Peter Hollmann, MD, President-elect

April 13, Friday
Call with Secretary of the Executive Office of Health and Human Services regarding regulations

April 16–19, Monday–Thursday
April 16–19 Accreditation Council for Continuing Medical Education, Accreditor Summit, Chicago: Patrick Sweeney, MD, PhD, Chair of RIMS CME Committee

April 16–20, Monday–Friday
Legislative break

April 17, Tuesday
OHIC Health Insurance Advisory Committee meeting
AMA/ARC conference call on buprenorphine/Prescription Drug Monitoring Programs (PDMP)

April 18, Wednesday
Primary Care Physician Advisory Committee, Department of Health
OHIC/HealthSource Market Stability Workgroup: Peter Hollmann, MD, President-elect

April 21, Saturday
RIMS’ 11th Hour CME Event, Crowne Plaza, Warwick

April 24, Tuesday
Legislative hearings
Chairman Joseph McNamara fundraiser

April 25, Wednesday
Legislative hearings

April 26, Thursday
Legislative hearings
RIMS member seminar on managing retirement income: RIMS/Morgan Stanley

April 30, Monday
Physician Burnout Conference Planning Committee: Bradley J. Collins, MD, President and staff
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
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

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.
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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Brown receives $100M donation to advance brain science efforts

Brain Institute renamed Carney Institute for Brain Science in honor of donors

PROVIDENCE [BROWN UNIVERSITY] – A new $100 million gift to Brown University’s brain science institute from alumnus ROBERT J. CARNEY and NANCY D. CARNEY was announced in April.

The Carneys’ gift changes the name of the Brown Institute for Brain Science to the Robert J. and Nancy D. Carney Institute for Brain Science, and establishes the institute as one of the best-endowed university brain institutes in the country.

Core areas of research at the institute include work on brain-computer interfaces to aid patients with spinal injury and paralysis; innovative advances in computational neuroscience to address behavior and mood disorders; and research into mechanisms of cell death as part of efforts to identify therapies for neurodegenerative diseases that include amyotrophic lateral sclerosis (ALS) and Alzheimer’s.

Carney said he is excited that he and his wife are making their gift at a time when brain science has emerged as one of the fastest growing programs at Brown, both in terms of research and student interest.

“Nancy and I have long been impressed by the phenomenal research and education of bright young minds that we see at Brown,” Carney said. “We are excited to see the brain institute continue to grow and serve society in ways that are vitally important.”

With up to 45 labs across campus engaged in research at any given time – and 130 affiliated professors in departments ranging from neurology and neurosurgery to engineering and computer science – Brown’s brain science institute already has built a reputation for studying the brain at all scales, said address some of the largest challenges facing humanity, at the same time training the next generation of brain scientists.”

The Carney Institute had its start at Brown as the Brain Science Program in 1999, later becoming the Brown Institute for Brain Science. The scope of its work has increased dramatically in recent years, and the institute now has affiliated faculty spanning 19 academic departments, including clinical departments in the Warren Alpert Medical School.

Brown President Christina Paxson said the $100 million donation – one of the largest single gifts in Brown’s history – will help establish the University as a leader in devising treatments and technologies to address brain-related disease and injury. “This is a signal moment when scientists around the world are poised to solve some of the most important puzzles of the human brain,” Paxson said. “This extraordinarily generous gift will give Brown the resources to be at the forefront of this drive for new knowledge and therapies. We know that discoveries in brain science in the years to come will dramatically reshape human capabilities, and Brown will be a leader in this critical endeavor.”

DIANE LIPSCOMBE, the director of the institute since 2016 and a professor of neuroscience. From studying genes and circuits, to healthy behavior and psychiatric disorder, the institute’s faculty contribute expertise to routinely produce insights and tools to see, map, understand and fix problems in the nervous system.

“This is a transformative moment that is going to catapult Brown and our brain science institute,” said Lipscombe, who is president-elect of the Society for Neuroscience, the field’s international professional organization. “We will be able to crack the neural codes, push discoveries forward and

OFFICE SPACE AVAILABLE

RIMS has 442 square feet of newly renovated office space (3 contiguous offices of 200 sf, 121 sf and 121 sf), complete with convenient sheltered parking and the opportunity for tenants to share three well-equipped meeting spaces, break room, office machinery, etc. on the western edge of downtown Providence. Suitable for a small non-profit organization, boutique law firm, CPA firm or other office-based small business.

Inquiries to Newell Warde, nwarde@rimed.org

Diane Lipscombe, director of the brain science institute at Brown.
CharterCARE announces intent to purchase Memorial Hospital from Care New England

CharterCARE Health Partners CEO JOHN HOLIVER, Pawtucket MAYOR DONALD GREBIEN and other elected officials and community stakeholders held a press conference on April 12 at Pawtucket City Hall to announce CharterCARE’s intention to purchase and reopen Memorial Hospital. Reopening the emergency room would be the first step in a phased process to restore hospital services at Memorial.

“Memorial Hospital was formed in 1894 and for well over a century it provided the residents of Blackstone Valley with critical hospital care services. It survived through the decades based on the goodwill and generosity of too many people to mention. Today, we embark on a path to return Memorial Hospital to the people of Blackstone Valley and to restore this critical community asset,” said Holiver.

“Generations of Pawtucket residents came to rely upon Memorial Hospital for their healthcare needs, particularly in times of crisis. Regardless of what has transpired in the past six months, we stand here today unified around the opportunity to bring back Memorial, hundreds of employees and access to emergency room care for the residents of Blackstone Valley,” said Mayor Grebien. “I asked CharterCARE to see what they could do to address this situation, and they have responded.”

Under the terms of a proposal, CharterCARE would purchase the hospital property and infrastructure and will commit to $10 million in capital improvements. CharterCARE will host healthcare job fairs that prioritize hiring Rhode Islanders. CharterCARE will also pay property taxes to the City of Pawtucket and is working closely with the city to establish a tax stabilization framework. CharterCARE expects to submit a formal offer to CNE to purchase Memorial in the coming days.

The offer will be contingent on getting all appropriate regulatory licenses and certificates of need reinstated so that CharterCARE may provide services historically provided by Memorial Hospital. The purchase is also contingent on CharterCARE’s ability to either negotiate fair rates with insurance providers or the adoption of legislation that would mandate reimbursement rates inline with other hospitals in Rhode Island. Legislation to address the imbalance in hospital rates will be introduced in the coming days.

“Central Falls residents need a nearby community hospital for our emergency needs,” said Central Falls MAYOR JAMES DIOSSA. “Our rescues have been in waiting lines since the closure of Memorial Hospital, putting the health of our residents at serious risk. We took legal action to stop the closure of Memorial and now support this effort to reopen the hospital, its emergency department and to restore jobs and services to the Blackstone Valley.”

“We are committed to Rhode Island, and to the Blackstone Valley community. We are prepared to invest $10 million into Memorial, and reopen this facility creating a first wave of over 100 jobs with more to come. Currently, we are the lowest reimbursed hospital system in the state. We want to work with state and legislative leaders to correct this imbalance,” said Holiver.

As a first step, CharterCARE is committed to reopening the emergency room and will then look to phase in outpatient services.

Last October, Care New England announced it would be shutting down emergency services and in-patient units at the hospital, after the failure of a proposed sale to Prime Healthcare. The announcement affected approximately 700 employees, limited access to hospital care in the Blackstone Valley and caused an emergency room crisis when other area hospital emergency rooms were inundated with an overflow of patients during the winter.

“Memorial will not be what it was overnight, but by reopening the emergency room as a first step we can bring back over one hundred jobs. Our goal would be to bring this hospital back in phases by offering services that best meet the demands of the community,” added Holiver. ✤

Statement from CNE regarding Memorial Hospital

In response to the CharterCARE announcement made on April 12 regarding the purchase and reopening of Memorial Hospital, Jim Beardsworth, CNE spokesman, said, “We made the difficult decision more than six months ago to close Memorial Hospital and begin transitioning the facility into an outpatient center. In the process, we preserved 200 local jobs and positioned community-based health care for a solid future. Today’s announcement by Prospect Health/CharterCare certainly comes as a surprise as there has been no previous discussion or formal proposal submitted to Care New England.

“Any plan to reopen the closed facility, as suggested today, is simply unfeasible especially since we previously had conversations with CharterCare about buying Memorial and those proved fruitless. Today’s announcement represents nothing more than an opportunity to muddy the health care landscape with an ill-conceived plan with no true thought for serving the community need.”
CharterCARE debuts new first-responder ‘Twiage’ technology

PROVIDENCE – Fatima Hospital and Roger Williams Medical Center are the first hospitals in Rhode Island to utilize Twiage, a new technology that enables first responders to send crucial information about a patient’s status, symptoms, and needed care to a hospital before arrival. On April 11, EMS teams from Providence rescue used Twiage to communicate with both the Roger Williams and Fatima Hospital Emergency Departments while en route with patients.

Nine cities and towns in Rhode Island have already trained their EMS professionals to utilize Twiage and those rescue teams are using the technology to better communicate with the Emergency Departments at both CharterCARE hospitals.

“My members love Twiage,” said Providence EMS rescue chief ZACH KENYON. “Having an app on the phone makes it so easy and fast, which frees up valuable time for patient care.”

With the Twiage app, EMS teams can send videos or photos of patients and information like symptoms, medications, or tests like an EKG performed on the rescue. All of this information can help the Emergency Department team better assess needs while preparing for the patient’s arrival. Twiage also allows EMS professionals to provide accurate GPS tracking of their vehicle so hospitals have a more accurate idea of arrival time.

“Timely care is essential – and in some cases, lifesaving – when it comes to emergency medicine,” said REBECCA BROCCOLI, Associate Director, Emergency Services, CharterCARE. “Real-time information and GPS tracking for incoming rescues allows us to better prepare for an ambulance’s arrival so we can accelerate potentially lifesaving emergency care.”

Armed with this information in advance, staff in the Emergency Department can map out a course of action for patients before their arrival. The information is then transmitted back to the paramedic through the app, which reduces time in the Emergency Room waiting area and introduces the patient more quickly to direct care. This can be especially important when a patient is exhibiting symptoms of a stroke or similar condition where immediate care is critical.

Twiage is a secure, HIPAA-compliant web app. Once the EMS team arrives at the Emergency Department, the patient’s medical information is deleted from the rescue teams’ app and becomes irretrievable.

“We are proud to be the first hospitals in Rhode Island to utilize Twiage,” said DR. JOHN JARDINE, EMS Director for CharterCARE. “By embracing this innovation, we are ensuring patients get diagnosed and treated more quickly, which can make a tremendous difference in both outcomes and a patient’s experience.”

“CharterCARE has a history of leadership in emergency medicine,” said JOHN J. HOLIVER, CharterCARE CEO. “We are home to the state’s only elder-friendly hospital emergency departments, were the first to post our ED wait times on our websites, and now, are the first to utilize Twiage.”

On April 12, the Providence EMS crew became the first to use Twiage at Roger Williams Medical Center. EMS team members from the first two crews that utilized Twiage are pictured here with Demetra Ouellette, President, Roger Williams Medical Center; Rebecca Broccoli, Associate Director, Emergency Services, CharterCARE, and Darlene Cuhna, Chief Operating Officer, CharterCARE.
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A new study shows that Lifespan and Care New England teaching hospitals and The Warren Alpert Medical School supported 26,449 jobs across the state last year. Those jobs, on average, provided $69,189 in wages, salaries, and benefits for a total of $1.83 billion in labor income to Rhode Island.

The study by the Association of American Medical Colleges (AAMC) also found that its member organizations in Rhode Island infused $2.46 billion into the state in direct and secondary economic impact. Secondary benefits include purchases of equipment, services, or supplies, and employee purchases at local businesses.

Conducted by RTI International on behalf of the AAMC, the study examined the economic impact of medical schools and teaching hospitals represented by the AAMC in 46 states, the District of Columbia, and Puerto Rico.

Lifespan, Rhode Island Hospital and The Miriam Hospital as well as Care New England (CNE) and its Women & Infants Hospital are AAMC members, as is Brown’s medical school.

“The AAMC findings further validate the vital role Lifespan plays as an economic engine for Rhode Island as we fulfill our mission of providing world-class health care to our patients as well as advancing medical discovery. Our investment in our physicians, clinical staff, researchers and other health care professionals has been unflinching in recent years despite the challenging environment,” said TIMOTHY J. BABINEAU, MD, president and CEO of Life-span, the state’s largest health system and largest private employer.

Babineau pointed to Lifespan’s nearly 25 percent increase in its workforce from 2009 to 2017. Lifespan has 14,882 employees across the health system, which also includes Newport Hospital, Gateway Healthcare and Bradley Hospital, another academic affiliate of Brown but not a member of the AAMC.

“Academic medical centers contribute to their local environment in a number of ways. It is easy to see how the research and clinical care that take place improve human health. The academic activities also garner grant support from the National Institutes of Health and philanthropic foundations. In so doing, they provide good paying jobs and generate intellectual property and knowledge about diseases that can lead to new companies and eventually new therapies,” said JACK A. ELIAS, MD, senior vice president for health affairs and dean of medicine and biological sciences at Brown.

“Academic medical centers contribute to the research and clinical care that take place improve human health. The academic activities also garner grant support from the National Institutes of Health and philanthropic foundations. In so doing, they provide good paying jobs and generate intellectual property and knowledge about diseases that can lead to new companies and eventually new therapies,” said JACK A. ELIAS, MD, senior vice president for health affairs and dean of medicine and biological sciences at Brown.

“The contributions of medical students, residents, fellows, and other trainees across our Care New England hospitals are crucial to our ability to provide high quality care, conduct groundbreaking research, and train the next generation of caregivers,” said JAMES E. FANALE, MD, CNE’s president and chief executive officer. “We attract some of the best and brightest from across the country and around the globe. These trainees contribute to our local economy and, through this foundation of education, offer long-term financial contributions locally and nationally.”

CNE’s Butler Hospital is an academic affiliate of Brown as well but not a member of the AAMC. CNE’s Kent Hospital has an academic affiliation with the University of New England College of Osteopathic Medicine, which is not a member of AAMC.

In addition to national data, the full report also provides state-level data on jobs and labor income created, total economic value added by medical schools and teaching hospitals, and impacts of the medical research conducted by AAMC member institutions.

View the full report at www.aamc.org/economicimpact.

**Rhode Island Data Overview**

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<th>Indirect Jobs</th>
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**Rhode Island Economic Impact**

Source: RTI analysis of 2015 and 2016 AAMC data, reported in 2017 dollars. The jobs and economic impact for the University of Washington WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) program are included in the results for Washington state; however, each regional WWAMI campus does have a local impact on jobs and the economy.
AMA marks milestone in efforts to create the medical school of the future

Leading medical schools convene in Providence to expand work reshaping how future physicians are trained – building on innovations developed by Brown University and 31 other leading medical schools as first cohort of medical students to receive training under national curricula redesign efforts begin to graduate in May.

PROVIDENCE – The American Medical Association [AMA] is marking five years of progress in its ongoing work to develop bold, innovative ways to improve physician training that can be implemented across medical education. The AMA, along with the Warren Alpert Medical School of Brown University, convened its 32 school Accelerating Change in Medical Education Consortium in Providence recently to build on efforts underway to ensure future physicians across the country are prepared to care for patients in the changing health care landscape.

Brown’s Medical School is among this select group of schools that developed a new curriculum as part of the AMA’s Accelerating Change in Medical Education Consortium to reshape medical education nationwide. Through the $1 million grant it received in 2013 to work with the Consortium, Brown created a first-in-the-nation program designed to train physicians who, with a focus on population and public health, can be future leaders in community-based primary care at the local, state or national level. This is an important innovation given that the modern health system will require physicians to think beyond caring for just an individual’s health and take into account the health of a population to improve patient safety and health care quality.

“Since launching this bold effort nearly five years ago, the AMA and our 32-medical school Consortium have made significant progress toward ensuring future physicians are prepared to meet the needs of patients in the modern health system,” said AMA CEO & Executive Vice President JAMES L. MADARA, MD “This May, the first medical students to receive full training under the new curricula developed at some Consortium schools will begin to graduate—directly impacting the way that health care is delivered to patients nationwide. During a period of rapid progress, new technology, and changing expectations from government and society, we believe these students will be better equipped to provide care in today’s modern, technology-driven health care environment.”

Launched in 2015, Brown’s new Primary Care-Population Medicine program is helping its students learn how to deliver care that meets the needs of patients in modern health systems – the main objective of “Health Systems Science,” the third pillar of medical education which was identified by the AMA Consortium that should be integrated with the two existing pillars: basic and clinical sciences. Brown was among the 11 founding Consortium schools to formalize the strategy and write a textbook to help physicians navigate the changing landscape of modern health systems, especially as the nation’s health care system moves toward value-based care. The “Health Systems Science” textbook was released in 2016 and is being used by medical schools across the country – including Brown – to ensure future physicians learn about value in health care, patient safety, quality improvement, teamwork and team science, leadership, clinical informatics, population health, socio-ecological determinants of health, health care policy and health care economics.

“The support of the AMA Consortium has been critical to the development and success of our innovative Primary Care-Population Medicine program. In addition, all of our medical students now have instruction in health systems science, helping them to understand the broader context of health care in which they will be practicing. We are excited to welcome the AMA, representatives of the other Consortium schools, and leaders in medical education to Brown and Providence,” said ALLAN R. TUNKEL, MD, PhD, associate dean for medical education at the Warren Alpert Medical School.

The AMA launched its Accelerating Change in Medical Education initiative in 2013 – providing $11 million in grants to fund major innovations at 11 of the nation’s medical schools, including Brown’s Warren Alpert Medical School. Together, these schools formed a Consortium to share best practices with a goal of widely disseminating the new and innovative curricula being developed to other medical schools. The AMA expanded its Consortium in 2015 with grants to an additional 21 schools to develop new curricula that better align undergraduate medical education with the modern health care system. These innovative models are already supporting training for an estimated 19,000 medical students who will one day care for 33 million patients each year – including an estimated 500 medical students in Rhode Island who will one day care for more than 900,000 patients annually.

The AMA will continue to work with more leaders and innovators from medical and health professions education to advance its efforts aimed at accelerating change in medical education to ensure future physicians are prepared to quickly adapt to the changing health care landscape and provide value-based care as soon as they enter practice.
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Hospital leaders testify in opposition to significant reductions in the governor’s proposed FY 2019 state budget

PROVIDENCE – On April 11 hospital leaders from throughout the state testified at the House Committee on Finance Subcommittee on Human Services hearing regarding the Executive Office of Health and Human Services proposed FY 2019 State Budget. Their testimony focused on the restoration of state funds, which were included in the 2018 State Budget, to provide the state’s match to the federal funds available through the Disproportionate Share Hospital [DSH] program.

The Medicaid Disproportionate Share Hospital [DSH] program provides financial assistance to hospitals that care for our state’s most vulnerable populations – children, the poor, the disabled and elderly.

Last year, the budget introduced by the Governor established the Licensing Fee or provider tax paid by the hospitals at 5.652%. The final budget passed by the General Assembly and signed by the Governor increased the Licensing Fee to 5.856%. This generated $182 million in state revenue. The hospitals have worked in partnership with the State on this issue every year.

Hospital Association of Rhode Island President TERESA PAIVA WEED testified that “the current budget does not include the funding needed to draw down on all of the federal DSH funds agreed to in the FY 2018 enacted budget. Absent this restoration, the impact on the hospitals in Rhode Island is a total loss of over $32 million.”

LOU GIANCOLA, chief executive officer of South County Health, testified that “the $800,000 reduction in state funding to South County Health resulting from the Governor’s proposed budget would undermine the financial health of an important resource for the residents of South County.”

CharterCARE Health Partners Chief Executive Officer JOHN HOLIVER stated that this reduction “threatens to destabilize our hospitals and jeopardize the efforts we have made to transform the Rhode Island healthcare delivery system.”

“Full restoration of the DSH funds is critical to our hospitals, our employees and to our ability to fulfill our vision of creating a community of healthier people,” said JAMES FANALE, MD, president and chief executive officer of Care New England Health System. “The disproportionate share funding provides partial compensation to our hospitals for the treatment and services provided to Medicaid patients, uninsured and underinsured individuals, and our hospitals will be in serious and immediate jeopardy if these funds are not restored.”

MICHAEL SOUZA, chief executive officer of Landmark Medical Center, located in Woonsocket, remarked in his testimony on the importance of the DSH funds to hospitals that primarily serve Medicaid populations. According to Souza “the proposed budget will leave hospitals with one option…to further reduce expenses that ultimately impact patient care.”

Study examines low-current stimulation with VR for treating PTSD

PROVIDENCE – Can virtual reality exposure augmented with a small amount of electrical stimulation help treat posttraumatic stress disorder?

A team of physicians and scientists, led by DR. NOAH S. PHILIP and DR. MASCHA VAN ‘T WOUT-FRANK of the Center for Neurorestoration and Neurotechnology at the Providence VA Medical Center and Brown University, are now recruiting participants at the Providence VAMC for a study examining whether a small amount of electricity – called transcranial direct current stimulation, or tDCS – can improve PTSD symptoms and quality of life when used to augment virtual reality therapy, which provides simulated warzone exposure in a safe environment.

“Virtual reality plus tDCS seems to help Veterans suffering from PTSD, even in individuals who have tried many medications and treatment approaches with little to no benefit,” said Philip. “PTSD affects as many as 25 percent of Veterans and is a signature injury of the recent wars in Iraq and Afghanistan.”

Prior research by this group demonstrated that tDCS can be used to stimulate the ventromedial prefrontal cortex, a brain region not sufficiently active in people suffering from PTSD. This tDCS-Augmented Virtual Reality Exposure, or TAVRE, study is the first of its kind to combine tDCS with VR therapy and will evaluate whether improvements in PTSD symptoms extend to quality of life.

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For more information, visit the TAVRE study website at https://clinicaltrials.gov/ct2/show/NCT03372460.
URI/stat partner in 11 projects to serve Medicaid recipients

Rhode Island’s Executive Office of Health & Human Services has partnered with the University of Rhode Island to develop innovative education and training programs that will prepare the health care workforce with the knowledge and skills needed to help achieve the goals of the R.I. Medicaid Health System Transformation Project.

The funding comes from about $130 million in matching funds awarded to the state in 2016 by the federal Centers for Medicare and Medicaid Services. Most of the award was earmarked for redesigning the health care delivery system that serves the more 300,000 Medicaid beneficiaries. About five percent was set aside for workforce development to train future health care workers.

“Reforming the state’s health care system requires partnership, initiative and commitment from all health care stakeholders including private sector payers, providers, publicly-funded health care systems and advocates to ensure we keep our focus on improved outcomes, better care and lower cost,” said Health and Human Services Secretary Eric J. Beane. “This strategic investment in education will support future job growth in Rhode Island.”

“For 2018, more than $1.5 million will flow back to URI, funding 11 new projects being used to promote improved access and quality of care for Medicaid beneficiaries in Rhode Island,” according to Bryan Blissmer, director of URI’s Institute for Integrated Health and Innovation, which is spearheading the University’s involvement.

The Institute is part of URI’s Academic Health Collaborative, which comprises the Colleges of Health Sciences, Nursing and Pharmacy. The Institute provides research, evaluation and programmatic expertise to the University and to external partners and manages delivery of related services. These include care management for Medicaid recipients, clinical and professional consultative services, quality improvement plans, program evaluation, analytic and subject matter expertise and support of grant funding to deliver health care transformation.

The projects are:

- Enhancement of a Home-based Primary Care Program — College of Nursing, Denise Coppa, $152,909.
- Interpersonal Team Education and Evaluation — College of Health Sciences, Phil Clark, $268,625.
- Five-Year Master’s Degree in Mental and Behavioral Health Counseling — College of Health Sciences, Mark Robbins, $61,538.
- The R.I. Generating Health Care Transformation Project — College of Health Sciences, Kathleen Melanson, $150,470.
- Establishing a URI Interprofessional Collaboration Center of Excellence — College of Pharmacy, Mary-Jane Kanaczet, $156,146.
- Nurses for Obesity Prevention: A Need for Education — College of Health Sciences, Alison Tovar, $66,683.
- Developing and Training Health Professionals in Rhode Island Communities — College of Health Sciences, Brian Quilliam, $85,193.
- URI Academic Collaborations Officers embedded at Rhode Island Department of Health — College of Pharmacy, Jeffrey Bratberg, $60,481.
- Interprofessional Workforce Development — College of Health Sciences, Lyn Stein, $138,015.

URI receives $1M gift for nursing scholarships

The University of Rhode Island has received a $1 million gift to provide scholarships for students in the College of Nursing. The gift comes from the estate of Eleanor Ferrante Barlow and her late husband, Edward, of Rumford and Westerly, RI.

The Barlows’ bequest will establish the Eleanor F. Barlow Nursing Scholarship Endowment. The scholarships will support students from Rhode Island public high schools who enroll in URI’s nursing program.

“The future of nursing and its critical role in the delivery of health care depends heavily on our ability to provide opportunities to explore innovation and discovery, through research and experiential learning,” says College of Nursing Dean Barbara Wolfe. “This generous gift from Eleanor and Edward Barlow will make these opportunities available to a greater number of Rhode Island students interested in pursuing Mrs. Barlow’s own profession. I am deeply grateful and excited about the future of the program.”

The College is also part of the University’s Academic Health Collaborative, which includes the colleges of pharmacy and health sciences and allows for enhanced multi-disciplinary opportunities.

“Our ability to offer exceptional students scholarship support strengthens our competitiveness and enhances the impact URI nursing students have on health care in our community and around the globe,” says University Provost Donald H. DeHayes.

A 1947 graduate of the Memorial Hospital School of Nursing, Barlow dedicated her life to the profession, starting as a registered nurse and later serving as nursing supervisor of the operating rooms at Memorial. Barlow was also a founding member of the hospital corporation and an active member of the hospital’s nursing alumni association. Eleanor Barlow died in 2016, five years after the death of her husband, a Brown University graduate and former president of the Seekonk Lace Co.
Brookdale Overview

Independent Living *An ideal retirement living experience*
- Spacious apartments with minimal maintenance
- Restaurant-style dining
- Plenty of planned activities every day

Assisted Living *The right choice for people who need extra help with daily activities*
- Qualified staff assists with taking medication, dressing, bathing, etc.
- Floor plans, from studio to two-bedroom apartments
- Activities and events for various levels of acuity

Alzheimer’s & Dementia Care *Person-centered care for people at various stages*
- Programs that leverage the latest dementia care research
- A care philosophy defined by more than the symptoms of Alzheimer’s & dementia
- An experienced staff who help residents thrive

Rehabilitation & Skilled Nursing *For short-term surgerical recovery or long-term rehabilitation*
- Around-the-clock, licensed nursing care
- Providing clinical resources in a comfortable setting that feels like home
- A mission and focus to helping residents get well and then get home as quickly as possible

Personalized Living *For people who just need a little help with things*
- One-on-one non-medical services for home care needs
- Additional personal needs for those in assisted living or home such as escorts to doctor appointments and more

Home Health *For qualified people in need of therapy or rehabilitation — all in the comfort of home*
- Get Medicare-certified assistance from experienced professionals
- Many healthcare services such as wound care and stroke therapy

Therapy *Specialized programming personalized to encourage recovery*
- An emphasis on education, fitness and rehabilitation that helps seniors retain or enhance their independence
- Most insurances accepted

Hospice *Promoting comfort by addressing the full range of needs of patients and families*
- Primary focus of quality of life
- Specially trained staff help families and patients cope with overwhelming feelings accompanying end-of-life care

Not all services are available at all communities. Contact community for details

The Rhode Island Network

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Brookdale Cumberland  Brookdale East Bay
Brookdale Smithfield  Brookdale West Bay
Brookdale Greenwich Bay  Brookdale South Bay
Brookdale Pocasset Bay

For more information about how we can help you serve your patients’ needs

Click Here
Southcoast Health implements innovative care model to treat patients with complex medical histories

Program results show 26 percent reduction in 30-day readmission rates of high-utilization patients

NEW BEDFORD – Southcoast Health announced in April that it has reduced 30-day readmissions by 26 percent for patients with a personal history of recurrent inpatient utilization and reduced 30-day Emergency Department (ED) revisits by 14 percent for patients with a personal history of recurrent ED utilization in preliminary data analysis. These results were achieved through a new care model called MyCare Teams, which Southcoast Health created and implemented with the assistance of the Massachusetts Health Policy Commission’s CHART-2 grant.

During the program’s duration from 2016 to 2018, more than 2,000 individual patients received services with 50,000 patient encounters provided by the MyCare Teams. The data and lessons learned through those encounters helped Southcoast Health better understand the eligible patient populations and their needs.

“Over two years, we achieved phenomenal results for our patients,” said PATRICK GANNON, Chief Quality Officer and CHART Operational Investment Director at Southcoast Health. “The participating patients and the entire health system, not just our hospitals, are beneficiaries of the CHART initiative. We’ve learned how to accelerate, revitalize and transform healthcare for patients who are the highest and oftentimes most chronic utilizers of inpatient and emergency department services. Traditional care models do not work for the CHART-eligible patients; we had to create something new and innovative.”

“Our partnership with community hospitals is a critical part of the Health Policy Commission’s efforts to achieve the Commonwealth’s cost containment and quality improvement goals,” says DAVID SELTZ, Executive Director of the Health Policy Commission. “CHART hospitals were issued a challenge: Propose initiatives that will put you on a path of transformation, while meeting critical health care needs of your community. As the preliminary data released today shows, Southcoast Health has met that challenge. Southcoast’s results show that their program is working to achieve its goals and positively impacting its patients. We look forward to continuing to partner with Southcoast Health and the communities it serves to build a more coordinated and affordable health care system.”

According to the U.S. Department of Health & Human Services’ Agency for Healthcare Research and Quality, 20 percent of the population accounts for 80 percent of total healthcare expenditures.

Southcoast Health created multidisciplinary care teams (including physician, mid-level prescriber, registered nurse, social worker, nurse care manager, community health worker, clinical pharmacist, and a community resource specialist) to care for patients. Teams provided intensive medical and behavioral health services, linkages to outpatient treatment providers, palliative care, diabetes education, and assistance accessing social services support.

“We have since converted the lessons learned during CHART into an Accountable Care model for care navigation,” said LORI DAKIN, Executive Director of Behavioral Health at St. Luke’s Hospital for Southcoast Health. “We are better able to treat patients across the continuum of care, which makes for a more efficient and effective healthcare experience for high-risk patients. These are patients that often fall between the cracks. We learned that revitalization is hard, but necessary. We see firsthand what transforming a patient’s care can mean for every life we touch.”

Southcoast Health’s electronic health record system, Epic, provided the digital infrastructure and technological advancements to help collect and analyze patient data. The CHART leadership team also utilized community health workers as part of the MyCare Teams.

BCBSRI launches MAT program with Roger Williams

Blue Cross & Blue Shield of Rhode Island (BCBSRI) has partnered with the Addiction Services Center at Roger Williams Medical Center to deliver medication-assisted treatment (MAT) to Rhode Islanders struggling with opioid use disorder.

“BCBSRI remains committed to the Governor’s Overdose Prevention and Intervention Task Force goal, shared by legislative leaders, to increase the number of people accessing MAT each year,” said MATT COLLINS, MD, vice president of clinical integration at BCBSRI. “As part of this program, BCBSRI will collect critical metrics that can help drive positive health outcomes, including measuring access to treatment, services utilized, length of stay, engagement with primary care providers and successful completion of the MAT program, along with others.”

“Roger Williams Medical Center is excited to have partnered with BCBSRI to support patients in all stages of their recovery. We understand that patients engaged in MAT need flexibility in their treatment,” said DEMETRA OUELLETTE, president of Roger Williams. “Our partnership with BCBSRI has allowed us to advance our programming to meet the unique needs of patients in need of MAT. We look forward to reviewing our metrics to further build on the strengths of the program and team.”

In addition to medication support, the MAT program will offer comprehensive clinical treatment to BCBSRI members. These comprehensive services include an initial clinical assessment and physician evaluation with ongoing care provided, individual and group counseling, and case management. All services are bundled into one monthly rate and would be charged in one monthly copayment for the member.
Newport Hospital program addresses dual addiction, mental health issues

Newport Hospital has opened a new track within its existing Partial Hospitalization Program, entirely dedicated to patients with co-occurring substance use and mental health disorders.

“Substance use and mental health disorders often go hand in hand,” says JON BRETT, PHD, director of the program. “By treating the whole person, rather than one disorder, we’re breaking down those silos and working toward creating a full continuum of care in our community for patients struggling with mental health/substance use disorders.”

The Partial Hospitalization Program delivers short-term, comprehensive, outpatient treatment to adults struggling with mental and behavioral health issues, such as depression, anxiety, bipolar disorder and now, co-occurring substance use disorders. The program offers a structured, intensive treatment environment during the day, while enabling patients to return home at night and on weekends.

“We’re so pleased to get this program launched and make this crucial treatment option accessible to residents of Newport County and beyond,” says CRISTA F. DURAND, president of Newport Hospital. “This program responds to a pressing community need, and was made possible by the generous support of many engaged and caring donors. We all know the toll that addiction and mental illness can take on our families and our community, and we are committed to providing comprehensive care.”

The new track is housed in freshly renovated and expanded space – created with the generous support of donors – in the Borden-Carey Building on the Newport Hospital campus, and officially welcomed its first patients on April 2.

RI Foundation awards $280,000 in healthcare grants

The Rhode Island Foundation awards more than $280,000 in grants to seven local organizations for everything from providing medical care to uninsured Rhode Islanders to reducing non-emergency EMS runs.

“Developing an inclusive primary care system that promotes healthy lives is one of our core strategic initiatives. These grants will advance our continuing efforts to make quality health care more accessible and affordable,” said NEIL D. STEINBERG, the Foundation’s president and CEO.

The Foundation awarded the grants through its RIGHA Foundation Fund, which was created after Harvard Pilgrim Health Care acquired the former Rhode Island Group Health Association. In 2010, Harvard Pilgrim Health Care and the RIGHA Foundation transferred its $1.6 million endowment to the Rhode Island Foundation. Harvard Pilgrim Health Care continues to make annual contributions to the fund, which promotes the development of an effective primary health care system in the state.

“Philanthropic support can provide the seed funding necessary to take innovative programs like these to the next level. Our goal is to reduce the cost of delivering high quality primary health care to Rhode Islanders,” said Karen Voci, president of the Harvard Pilgrim Health Care Foundation.

Blackstone Valley Community Health Care (BVCHC) received $70,000 to add health coaches to its primary care teams. The goal is to promote health behavior change and bridge the linguistic and cultural barriers between its medical staff and its patients. BVCHC operates Notre Dame Express Health, the only acute care walk-in clinic in Central Falls.

“We provide care to 60 to 70 percent of the population of Central Falls. Deploying health coaches within a single clinical enterprise that can instantly produce clinical data on patients has potential to have a profound impact on the public health of an entire community that has high levels of poverty, unemployment and poor health outcomes,” said RAY LAVOIE, executive director.

BVCHC will recruit participants in the Community Health Worker Training program at Rhode Island College. The grant will be used to pay stipends to the participants.

“Their role is to facilitate patient behavior change using common motivational techniques to improve health. Working as health coaches will enable trainees to amass the 1,000 hours of work experience required for certification,” said DR. MICHAEL FINE, medical director.

The City of Central Falls received $35,000 to help develop partnerships between the city’s EMS service and nearby urgent care centers, starting with the urgent care center at the Central Falls Neighborhood Health Station.

“These partnerships will help us make sure that use EMS is available whenever it is needed, and that Central Falls residents have access to the urgent care and primary care they need. We are creating a more efficient healthcare system for Central Falls residents by working with both hospital emergency departments and the resources we have here in Central Falls,” said MAYOR JAMES DIOSSA. “This has become particular important since Memorial Hospital closed, which made this grant particularly important to the people of Central Falls.”

The goals include improving the delivery of primary health care, reducing instances of non-emergency 911 calls, reducing the number of non-emergent emergency room transports and reducing the number of Central Falls residents
being re-admitted to hospitals due to poor management of chronic disease.

**Clinica Esperanza** received $20,000 to screen people who are likely to be insured within the next five years for chronic diseases, including diabetes and cardiovascular disease, and to develop treatment programs to manage their health.

“We bear witness to the impact that lack of access and knowledge about healthcare in the low-income population that we serve. Our patients eat cheap, poor quality, fat- sugar- and salt-laden food. They have limited time to exercise. Many are illiterate, and most have very poor understanding of the impact of diet on health. As a result, more than 50 percent of our patients are overweight or obese,” said **ANNIE DEGROOT**, medical director.

“Their obesity leads to the development of insulin resistance, diabetes, hypertension, and heart disease, all of which are more prevalent in low income groups, especially the predominantly Hispanic population that we serve. Lack of access to primary and preventative healthcare, and perhaps more important – lack of health literacy – accelerate disparities in health right here in our community and contribute to the economic instability of communities that are already impoverished,” she explained.

**The Rhode Island Free Clinic** received $20,000 to provide low-income, uninsured patients with expanded behavioral health services, including psychiatry and medication management, psychotherapy and group counseling.

“The goals are to improve patients’ overall health and encourage them – through increased support and health literacy – to self-manage their conditions,” said **MARIE GHAZAL, CEO**.

“We look forward to expanding behavioral health services for uninsured, low-income adults, mobilizing outstanding volunteers, integrating behavioral health services into our medical home model, and improving patient health outcomes by serving more patients, with more visits, in more areas of care than ever before,” she said.

**Rhode Island Hospital** received $50,000 to expand its Connect for Health program from Hasbro Children’s Hospital to an additional location – its adult primary care clinic in South Providence. Under the program, when patients identify a need, such as adequate food or housing, they will be referred to Connect for Health. Trained health advocates will then help patients access community services to address those needs.

“When your basic needs are not met, you are at increased risk for poor health. As indicated by research, the majority of health outcomes are attributable to factors outside of traditional health care delivery – the social and environmental determinants of health,” said **CARINEL LEGRAND**, Connect for Health Program Coordinator.

Under the program, when people who visit the clinics identify a need, such as inadequate food or housing, they will be referred to Connect for Health. Trained health advocates will then help patients access community services to address those needs.

“The advocates, mostly Brown University student volunteers, use a web-based, community directory to identify services that match the patient’s needs and map them out based on proximity to the patient’s address. Advocates then develop an action plan for their ‘client’ and follow up with him or her until all needs have been addressed or until the client is equipped to navigate the resource landscape on his or her own,” she said.

**The Scituate Health Alliance** received $35,000 to support the cost of providing a town nurse. Working in collaboration with primary care providers at Well One, social service agencies, religious and volunteer groups, the local libraries and other partners, the town nurse helps ensure that the community’s primary health care needs are being met.

“The goals are to increase the number of residents who use primary medical and dental care, to increase the number of residents who use the Health Access voucher and to provide the community with access to information about health care services,” said John Marchant, president of the Alliance.

According to the Alliance, Scituate is the only town in the United States to guarantee residents access to primary medical and dental care.

“Despite the fact that there is a great deal of evidence of the value of primary medical and dental care for prevention, early detection and treatment for health concerns, far too many members of our community need assistance in order to take advantage these services,” said **LYNN BLANCHETTE, PHD, RN**, vice president of the Alliance. “Retaining the town nurse will enable this program to grow and ensure that unmet primary care needs at the individual and population level are being met, through community assessment, program planning and evaluation.”

**The Providence Center** received $54,000 to support its School Counseling and Support Program in seven Providence elementary and middle schools. The services for students and families include individual counseling, family counseling, parent training, support groups and assessments.

“Trauma during childhood, poverty, and incarcerated parents are factors that are proven to have a negative effect on a child’s success in school, and later in life,” said **DEBORAH O’BRIEN**, President of The Providence Center. “Connecting our school-based behavioral health clinicians with students’ primary care providers will help deliver coordinated care that will meaningfully address the social determinants of children’s health.”
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Brian Ott, MD, honored with Hamolsky Lifetime Achievement Award

PROVIDENCE — The Rhode Island chapter of the American College of Physicians has awarded BRIAN OTT, MD, FACP, director of the Alzheimer’s Disease and Memory Disorders Center at Rhode Island Hospital, the Milton Hamolsky Lifetime Achievement Award. Dr. Ott has served as director of the center, the largest memory diagnostic and treatment center in Rhode Island, since 2005, dividing his time between clinical care and research. He has been affiliated with Rhode Island Hospital since 1995.

Dr. Ott is a professor of neurology at the Warren Alpert Medical School of Brown University, and adjunct professor of neuroscience and pharmacy practice at the University of Rhode Island. He is also a fellow of the American Academy of Neurology, the American Neurological Association and the American College of Physicians. He has received excellence in teaching awards for his work with both medical students and geriatric psychiatry fellows. He is the director of the Brown University and Rhode Island Hospital Aging and Dementia Fellowship.

“I am honored to be recognized by the American College of Physicians which has been a leader and major force in support of medical research and excellence in health care for all,” Dr. Ott said. “This acknowledgment is particularly meaningful coming from my fellow physicians in Rhode Island.”

Dr. Ott has been principal investigator or co-investigator on more than 80 research grants, from policy and advocacy groups, foundations, and pharmaceutical companies, totaling over $19 million in funding. Ott contributed to the pivotal clinical trials that led to the approval of tacrine, the first drug for the treatment of Alzheimer’s disease, as well as other cholinesterase inhibitor drug trials. Later, he was an investigator and author on reports for clinical trials of memantine, the most recent drug approved for Alzheimer’s. Currently, he leads six clinical trials for the treatment of early Alzheimer’s and two clinical trials for the prevention of Alzheimer’s.

He is widely published in a range of topics including driving, quality of life, experimental pharmacotherapy, and pharmaco-epidemiology in people with preclinical Alzheimer’s disease, mild cognitive impairment and dementia. His current research includes understanding the changes in the blood-brain barrier that may contribute to Alzheimer’s disease, the effects of cholesterol lowering drugs on cognition, and the development of effective primary and secondary drug therapies aimed at the ultimate prevention of Alzheimer’s disease. He has contributed to over 140 research presentations at national and international scientific meetings.

He serves on the national steering committees for the Alzheimer’s Disease Cooperative Study and the Alzheimer’s Disease Neuroimaging Initiative. He has served on boards and committees of the local chapters of the Alzheimer’s Association and the American College of Physicians. He currently serves on the Governor’s Commission on Aging and the Rhode Island Executive Committee for the Alzheimer’s State Plan.

An advocate of the anti-nuclear war movement, Dr. Ott has been a member of the Physicians for Social Responsibility and the International Physicians for Prevention of Nuclear War. He served as chair of the Sierra Club New England Chapter Nuclear Issues Committee, and during his tenure was co-recipient of the Code Blue Award from the Greater Boston Physicians for Social Responsibility. He is also an active supporter of the Rhode Island Coalition Against Gun Violence.

The Milton Hamolsky Lifetime Achievement Award is given each year “in recognition of academic, clinical, research and administrative excellence to a physician who epitomizes the attributes of the award’s namesake, Dr. Milton Hamolsky.” The late MILTON HAMOLSKY, MD, was an endocrinologist who came to Rhode Island Hospital in 1963 and served as the first full-time physician-in-chief.

South County Health Wound Care Center receives national excellence award

The South County Health Wound Care Center has been recognized with a national award for continued excellence in wound healing and for clinical excellence by Healogics Inc., the nation’s leading and largest wound care management company.

For nine consecutive years, the South County Health Wound Care Center has received the Robert Warriner III MD Center of Excellence Award.

To meet the criteria for the Center of Excellence Award, the South County Health Wound Care Center achieved patient satisfaction rates higher than 92 percent, a healing rate of at least 91 percent in less than 30 median days, along with several other quality standards for two years in a row. Across the country, there were 630 Centers eligible for the Center of Distinction award, of which 334 achieved this honor in 2018.
Appointments

Dr. B. Star Hampton to lead Undergraduate Medical Education Committee

B. STAR HAMPTON, MD, FACOG, of Providence, has been appointed to a two-year term as chair of the Undergraduate Medical Education Committee of the Association of Professionals of Gynecology and Obstetrics (APGO). This 12-member committee addresses issues of medical student education and faculty development in a changing health care environment, producing teaching tools, organizing faculty development seminars, and promoting innovative teaching methods for continued excellence in undergraduate medical education.

Dr. Hampton is a urogynecologist in the Division of Urogynecology and Reconstructive Pelvic Surgery and vice chair of education for the Department of Obstetrics and Gynecology at Women & Infants Hospital; and an associate professor of obstetrics and gynecology at The Warren Alpert Medical School of Brown University.

Dr. Hampton is a graduate of the Mount Sinai School of Medicine in New York City and completed a residency in obstetrics and gynecology at New York University Medical Center in New York City. Following residency, Dr. Hampton completed a three-year fellowship specializing in urogynecology and reconstructive pelvic surgery at New York University Medical Center. She has achieved board certification in Female Pelvic Medicine and Reconstructive Pelvic Surgery (FPMRS) by the American Board of Obstetrics and Gynecology (ABOG).

Dr. Hampton specializes in non-surgical and surgical approaches to pelvic organ prolapse and urinary incontinence, including minimally invasive options for pelvic floor disorders. She is a national leader in medical education as well as the field of urogynecology and reconstructive surgery. Dr. Hampton is committed to teaching physicians in training, takes an active part in the academic growth of her field, and travels yearly for international women’s health outreach.

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A health care ministry of the Roman Catholic Diocese of Providence.
Kathleen Peirce named to board of Visiting Nurse Association of America

KATHLEEN PEIRCE, RN, BSN, MS, vice president of operations, executive director, and chief nursing officer of the VNA of Care New England, has been named to the board of directors of the Visiting Nurse Association of America (VNAA). Peirce is among six new board members voted on at the VNAA annual National Leadership Conference in Washington, DC, recently. The VNAA supports, promotes, and advocates for the role of mission-driven, home-based care providers including home care, hospice, and palliative care.

Peirce has been a registered nurse for more than 30 years. Her experience includes acute care and 20 years of home health and hospice care. She joined the VNA of Care New England in 2014 after working for Hartford HealthCare and Masonicare Home Health and Hospice in Connecticut, serving as chief operating officer.

Dr. Joseph Renzulli named Chief of Urology at South County Health

JOSEPH RENZULLI, II, MD, FACS, has joined the South County Health medical staff as Chief of Urology. He will provide patient care and perform robotic surgery through the South County Health Urology practice.

Dr. Renzulli, a graduate of Boston University School of Medicine, completed his urologic surgery residency at Yale New Haven Medical Center and is board-certified by the American Board of Urology. Before joining South County Medical Group, he was part of the medical staff at Brown University and Lifespan for 12 years, and currently holds a position as an Associate Professor at the Yale School of Medicine.

With years of experience treating urologic disorders and performing urologic surgeries, Dr. Renzulli has published over 50 peer-reviewed publications and 70 abstracts. His research is largely focused on prostate cancer and robotic assisted laparoscopic prostatectomy outcomes, two areas that will play a key role in treating patients at South County Health.
Appointments

Bharat Ramratnam, MD, named Chief Science Officer at Lifespan, a new position

BHARAT RAMRATNAM, MD, has been named as Lifespan’s Chief Science Officer, it was announced last week.

The new, part-time, role of Chief Science Officer (CSO) was established to provide scientific guidance to the Vice President, Research Administration and to senior Lifespan management on matters of biomedical and translational science.

The CSO will serve as a leading scientist of the research community and help foster a climate of scientific inquiry at the highest ethical standards. The CSO will advise and assist Lifespan officials in representing the research enterprise with external parties, including local, state and federal government.

Among other responsibilities, the CSO will co-chair the Research Advisory Committee, help determine the goals and status of institutional core labs, and advise on the ongoing laboratory space management and new construction.

Dr. Ramratnam, who assumes the new role immediately, will continue to serve as Medical Director of the NIH supported Lifespan Clinical Research Center and Principal Investigator of Rhode Island Hospital’s NIH-funded COBRE (Center for Cancer Research Development).

He received his bachelor’s and medical degrees from Brown University, completed his internal medicine residency and chief residency at The Miriam Hospital. He was a clinical scholar at Rockefeller University in New York and completed a postdoctoral fellowship in virology at the Aaron Diamond AIDS Research Center, The Rockefeller University in New York.

He has received numerous awards including the NIH Career Development Award, the Doris Duke Clinical Scientist Award, the Daland Fellowship in Clinical Investigation from the American Philosophical Society, and the Culpepper Award from the Rockefeller Brothers Fund. Locally, he received the Lifespan Bruce Selya award for Research Excellence, and the Dean’s Teaching Excellence Award from the Warren Alpert Medical School of Brown University. Dr. Ramratnam serves as a permanent member of the NIH AIDS Immunology and Pathogenesis Study Section.

His current research focuses on host factors that impact HIV-1 replication and latency. His laboratory has made important contributions in multiple fields including virology, basic RNA biology, extra-cellular communication and translational medicine.

In addition to his Lifespan roles, Dr. Ramratnam serves as Vice Chair of Research for the Department of Medicine.

Recognition

Lifespan hospitals earn A rating from Leapfrog

PROVIDENCE – All eligible Lifespan hospitals – Rhode Island Hospital, The Miriam Hospital and Newport Hospital – earned an “A” grade in the most recent Leapfrog Hospital Safety Grades announced recently.

The Leapfrog Group is a Washington D.C.-based organization that assigns grades of A, B, C, D and F to hospitals across the country, based on performance in preventing medical errors, infections and other harms. Nationally, approximately 2,500 hospitals are graded twice per year, and just 750 earned an “A,” putting Lifespan’s three hospitals in the top third of graded hospitals. This is the third time in recent years that Lifespan’s facilities have achieved top grades across the board.

“Whether it’s in patient experience, infection prevention, clinical outcomes or any other measure, there is always a dedicated community of professionals working together in pursuit of excellence,” said CATHY E. DUQUETTE, PhD, RN, Lifespan executive vice president for nursing affairs. “We are proud that our three hospitals have again achieved this top distinction as measured by The Leapfrog Group.”

Developed under the guidance of an expert panel, the Leapfrog Hospital Safety Grade uses 27 measures of publicly available hospital safety data. It is peer reviewed, fully transparent and free to the public.
Obituaries

PETER ANTHONY PIZZARELLO, MD, 77, of Providence and Longboat Key, FL, passed away peacefully on April 21, 2018. He is survived by his beloved wife of 51 years, Karen Hancock Pizzarello; his children Lisa Pizzarello Pryor and her husband Lawrence Pryor of Providence; Laura Pizzarello Scott of San Francisco, CA, and Peter Pizzarello, Jr., MD and his wife Martha Pizzarello, MD of Providence; his four grandchildren, Arden and Avery Pryor and Franklin and Anna Pizzarello; and his brother Donald J. Pizzarello, PhD of Brooklyn, NY.

A graduate of Saint Louis University Medical School (1967), he completed his Brown University orthopedic surgery residency at Rhode Island Hospital (1972), and served as Major and Chief of Orthopedic Surgery at Cutler Army Hospital, Fort Devens, MA (1972-1974).

At the start of his long career, he performed surgery at Rhode Island Hospital and was an Assistant Clinical Professor at Brown University Medical School. He held staff privileges at Saint Joseph’s Hospital and Our Lady of Fatima Hospital and maintained his private practice, Orthopedic Services, on Admiral Street in Providence. He proudly served as a member of the Medical Advisory Board of R.I. Workers’ Compensation Court for 24 years and as president of the medical staff of Our Lady of Fatima Hospital (1995-1997). For more than 40 years, he skillfully and compassionately diagnosed and cared for people of all ages.

As a long-standing member of Metacomet Country Club and Longboat Key Club, he found great joy, friendships and appreciation of nature’s beauty in the game of golf. His family was his greatest treasure and legacy, and his memory will always be with them.

Contributions in his memory may be made to St. Edward Food and Wellness Center, 997 Branch Avenue, Providence, RI 02904 and The Pizzarello Pryor Family Endowed Fund for financial aid at The Wheeler School, 216 Hope Street, Providence, RI 02906.

JACQUES G. SUSSET, MD, passed away peacefully April 12, 2018 at Roger Williams Medical Center, Providence. He was the beloved husband of Anastasia [Triantopoulos] Susset. Born in Paris, France, he was a son of the late Jean-Charles and Marie-Jeanne (Faure) Susset.

Dr. Susset was one of the founders of urodynamics and established many surgical procedures. He was also a medical researcher of the American Board of Surgery and Clinical Professor of Urology Emeritus at Brown University. He was an active member of the American Urological Association, the American College of Surgeons and the Association Francaise d’Urologie in Paris as well as other organizations. He contributed to revolutionize medicine by supporting the creation of urodynamic testing and uroflowmetry.

After graduating from the University of Paris in 1944, he served on the faculty of Medicine for Paris and Public Assistance Hospitals. He fulfilled his compulsory military obligations in surgery at Cherbourg Maritime Hospital with the French Navy.

He moved to Montreal, Canada in 1955 and completed his residency in urology at Royal Victoria Hospital. In 1977 while serving as Professor and Chairman of the Department of Urology in Sherbrooke, Canada, he moved to the United States and accepted a position as senior urologist at St. Paul Ramsey Hospital in Minnesota. In 1979, he served as Director of Urodynamics at Roger Williams Medical Center and Chief of Urology at the Providence VA Hospital. Afterwards, he went into private practice in Providence and joined the University Urological Associates.

He received his Master of Science Degree from McGill University and a Master of Art Degree from Brown University. He received an Honorary Doctorate from the University of Claude-Bernard, Lyon, France. In 1998, he was the recipient of the Lifetime Achievement Award by the Urodynamics Society in recognition of significant accomplishments and leadership in the field of neurology.

Besides his wife, he is survived by one daughter, Francoise Susset and her partner, Lucas Lemonnier; one son, Pierre Susset and his wife, Julie Grenier; two stepsons, and six grandchildren. He was the father of the late George Susset.

Contributions in Dr. Susset’s memory to Assumption Greek Orthodox Church, 97 Walcott Street, Pawtucket, RI 02860 or St. Jude’s Children’s Research Hospital, 501 St. Jude Place, Memphis, TN 38148-0142 would be appreciated.