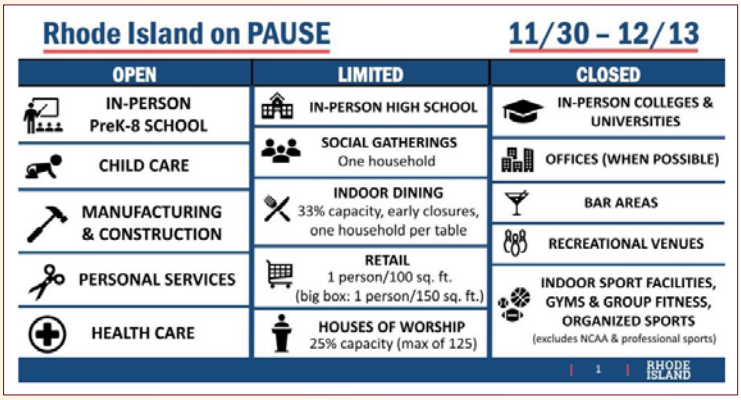
As COVID cases surge, RI 'paused' and poised to open two field hospitals



At Governor Gina M. Raimondo's press conferences on November 19th and 25th, she announced a statewide two-week "pause" which started November 30th. During that two-week period, restrictions shown in this graphic will take effect. The goal is to reduce the strain on hospitals, given that new hospitalization rates have tripled over the past five weeks and at this rate, it is unsustainable and hospitals won't have the capacity or staff.

Governor Gina M. Raimondo's said at her press conference on November 25th that COVID-19 cases are threatening to strain or overwhelm hospitals, and that plans are underway to potentially open two field hospitals at the discretion of hospital officials. The state is prepared to open the 353-bed Cranston site (shown above and below), which is operated by Care New England (CNE), at the former Citizen's Bank facility at Sockanosset Cross Road in Cranston, and the field hospital at the Rhode Island Convention Center, operated by Lifespan (bottom right).

Cranston site will open for lower acuity COVID patients

Last Wednesday, on Nov. 25th, **JAMES E. FANALE, MD**, President and CEO, Care New England, said CNE will open its site this week. "As healthcare systems across the nation are taxed, due to the COVID-19 pandemic, surge site locations nationally are being activated to handle the additional number of patients who need care. Currently, Care New England's Kent Hospital, is close to capacity, therefore in the best interest of our patients, CNE will open its field hospital early next week. This will insure that our patients receive the attention and care they need, in a safe environment," he said.

"At the Cranston field hospital location, Care New England medical experts and operations professionals have been testing and running drills to ensure that we can provide the medical care they deserve without compromising quality or safety. Initially, lower acuity patients with COVID-19 will be transferred to the Field Hospital from Kent Hospital to continue their hospitalization and recovery. We feel that this will allow us to care for all the patients who are seeking medical attention at Kent Hospital," said **PAARI GOPALAKRISHNAN, MD**, Chief Medical Officer, Kent Hospital. Dr. Gopalakrishnan will be running operations at the Cranston field hospital. ❖

(Right) Inside the field hospital at the Rhode Island Convention Center, with a capacity of approximately 600 beds to care for lower acuity patients or patients transitioning out of hospital. The convention center's main display space has been transformed into four wards comprised of 28 pods, each with 24 beds; walls and a curtain separate each individual "unit."

(Left) **Dr. Selim Suner,** on the staff at Rhode Island Hospital, and the Director of Disaster Medicine and Emergency Preparedness in the Department of Emergency Medicine, spearheaded the convention center transformation.

RI among 4 states picked by Pfizer for pilot program to study vaccine delivery, deployment

NEW YORK – On November 16, Pfizer announced the U.S. COVID-19 Immunization Pilot Program with four states, to help refine the plan for the delivery and deployment of the company's COVID-19 vaccine candidate that is being co-developed with BioNTech.

The four states – Rhode Island, Texas, New Mexico, and Tennessee – were selected for the program because of their differences in overall size, diversity of populations, and immunization infrastructure, as well as the states' need to reach individuals in varied urban and rural settings. The four states included in this pilot program will not receive vaccine doses earlier than other states by virtue of this pilot, nor will they receive any differential consideration.

To build on its coordination with the relevant U.S. agencies, Pfizer launched this pilot program to help better support the states' planning, deployment, and administration of the COVID-19 vaccine candidate. Learnings from this program will be adapted for usage across other states to help them create effective immunization programs for this vaccine.

Pfizer has been working with U.S. officials in Operation Warp Speed (OWS) and the U.S. Centers for Disease Control and Prevention (CDC) to help ensure that after potential authorization or approval, the Pfizer-BioNTech COVID-19 vaccine can reach those in most need as quickly and equitably as possible. The company believes this ongoing coordination is critical to help ensure an efficient vaccine distribution as soon as possible after the vaccine receives regulatory authorization or approval, if received.

"This pilot program and our collaboration with U.S. and state officials will help us prepare for broader vaccine deployment in the near future, subject to authorization or approval, as we work to address this urgent public health need," said **ANGELA HWANG**, Group President, Pfizer Bio Group President, Pfizer Biopharmaceuticals Group. "We are hopeful that results from this vaccine delivery pilot will serve as the model for other U.S. states and international governments, as they prepare to implement effective COVID-19 vaccine programs."

In July, Pfizer and BioNTech announced the execution of an agreement with the U.S. Department of Health and Human Services and the Department of Defense to meet the U.S. government's OWS program goal to begin delivering 300 million doses of a vaccine for COVID-19 in 2021. Under the agreement, the U.S. government will first receive 100 million doses of the Pfizer-BioNTech COVID-19 vaccine after Pfizer successfully manufactures and obtains approval or emergency use authorization from the U.S. Food and Drug Administration (FDA). The U.S. government will pay $1.95 billion for those first 100 million doses, with the option to acquire up to an additional 500 million doses.

Pfizer's COVID-19 vaccine development and manufacturing costs have been entirely self-funded, with billions of dollars already invested at risk. The company will continue bearing all the costs of development and manufacturing in an effort to help find a solution to this pandemic as fast as possible. ❖

AMA strengthens policy to combat spike in national drug shortages

CHICAGO – In response to an uptick in national drug shortages that threaten patient care and safety, physicians at the American Medical Association's (AMA) Special Meeting of its House of Delegates (HOD) adopted policy underscoring drug shortages as an urgent public health crisis. The move reinforces and builds upon existing AMA policy that outlines a comprehensive framework to address ongoing drug shortages, which have been exacerbated during the COVID-19 pandemic.

The newly enhanced policy updates the AMA's approach to mitigating drug shortages, specifically related to manufacturing innovations, global supply chain transparency, and drug maker incentives.

It includes a number of recommended steps, ranging from supporting continued analysis of the root causes of drug shortages to urging drug makers to accelerate adoption of advanced manufacturing technologies. The policy also reiterates AMA's call on the federal government to continue to examine and consider drug shortages as a matter of national security.

"As the COVID-19 pandemic has illustrated, shortages of critical drugs can have a major impact on patient health. That's why it's essential for physicians to have access to the right drugs in order to provide high-quality care for our patients," said AMA Immediate-Past Board Chair **JESSE M. EHRENFELD, MD, MPH**. "While this pandemic has exposed vulnerabilities in the global medicine supply chain, the AMA remains committed to working with stakeholders to act quickly on solutions that alleviate supply shortages now and in the future."

While hospitals have experienced various drug shortages for decades, an unprecedented influx of critically ill patients due to COVID-19 has driven up the number of medications in short supply. Many of the drugs currently facing shortages are common injectable medications required for routine hospital patient care and necessary for ventilator support – such as analgesics, sedatives, and paralytics.

The AMA has partnered with multiple stakeholders to increase drug supplies and ease regulations amid the COVID-19 pandemic, including successfully urgingBx the U.S. Drug Enforcement Administration (DEA) to increase limits for some injectable controlled substances to meet increasing COVID-19 demands and joining other leading health organizations in calling for responsible ordering, prescribing,

and dispensing of potential COVID-19 medications.

The top five classes of drugs in short supply are central nervous system medications, antimicrobials, cardiovascular medications, ophthalmic and chemotherapy agents. In 2018, 55% of the medications with shortages were injectable, though this has decreased to 39% in 2019. While the reasons behind drug shortages can vary, a recent U.S. Food and Drug Administration (FDA) report estimates that more than 60% of shortages from 2014 to 2017 were due to manufacturer quality issues. The report cites a lack of incentives for manufacturers to produce lower-profit drugs and invest in quality management programs as factors.

The AMA's new policy underscores the need to address increasing rates of new drug shortages and ongoing supply challenges for essential medications. Recognizing that prescription drug shortages have a widespread impact on patient care and treatment, the AMA remains committed to working collaboratively with other stakeholders to further evaluate and implement recommendations that contribute to solutions for this critical public health issue. ❖

New AMA policy recognizes racism as a public health threat

CHICAGO – New policy adopted by physicians at the American Medical Association's (AMA) Special Meeting of its House of Delegates (HOD) in November recognizes racism as a public health threat and commits to actively work on dismantling racist policies and practices across all of health care.

The new policy approved by the AMA, representing physicians and medical students from every state and medical specialty, opposes all forms of racism as a threat to public health and calls on AMA to take prescribed steps to combat racism, including: (1) acknowledging the harm caused by racism and unconscious bias within medical research and health care; (2) identifying tactics to counter racism and mitigate its health effects; (3) encouraging medical education curricula to promote a greater understanding of the topic; (4) supporting external policy development and funding for researching racism's health risks and damages; and (5) working to prevent influences of racism and bias in health technology innovation.

Though previous AMA policies and principles have emphasized the need to eliminate health disparities and called on physicians to prevent violence of all kinds, the new policy explicitly acknowledges racism's role in perpetuating health inequities and inciting harm against historically marginalized communities and society as a whole.

Specifically, the new policy recognizes racism in its systemic, cultural, interpersonal, and other forms as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care. It makes clear that a proactive approach to prevent, or identify and eliminate, racism is crucial – particularly con-sidering that studies show historically marginalized populations in the U.S. have shorter lifespans, greater physical and mental illness burden, earlier onset and aggressive progression of disease, higher maternal and infant mortality, and less access to health care.

The policy describes the various forms of racism as follows:

- Systemic racism: structural and legalized system that results in differential access to goods and services, including health care services.
- Cultural racism: negative and harmful racial stereotypes portrayed in culturally shared media and experiences.
- Interpersonal racism: implicit and explicit racial prejudice, including explicitly expressed racist beliefs and implicitly held racist attitudes and actions based upon or resulting from these prejudices.

In addition, the new policy requests AMA to identify a set of best practices for health care institutions, physician practices, and academic medical centers to address and mitigate the effects of racism on patients, providers, international medical graduates, and populations. It also guides the AMA's position on developing and implementing medical education programs that generate a deeper understanding of the causes, influences and effects of all forms of racism – and how to prevent and improve the health effects of racism.

Further, the policy asks that AMA support the creation of external policy to combat racism and its effects and encourage federal agencies and other organizations to expand research funding into the epidemiology of risks and damages related to racism. Additionally, the policy asserts that the AMA will work to prevent, and protect against the influences of racism and bias in innovative health technologies.

The AMA has been leading an aggressive effort to embed equity in thoughts, actions, and processes so as not to perpetuate inequities and instead help people live healthier lives. In 2018, the AMA adopted policy to define health equity and outline a strategic framework toward achieving optimal health for all. To help navigate these challenges, in 2019 the AMA hired its first chief health equity officer to establish the AMA's Center for Health Equity to elevate and sustain efforts to address systemic level changes that can improve health.

Fully understanding that there is tremendous work still to be done to ensure that everyone has the opportunity, conditions, resources, and power to achieve optimal health, the AMA is committed to collaborating with stakeholders to confront the issue of racism within our society. The AMA continues to urge other leading health organizations to also take up the mantle of intolerance for racism as it pushes upstream to dismantle racism across all of health care – driving the future of medicine toward anti-racism. ❖

AMA announces policies adopted on final day of special meeting

CHICAGO – On November 18th, the American Medical Association (AMA) announced new policies adopted by physician and medical student leaders from all corners of medicine at the Special Meeting of the AMA House of Delegates. Policies adopted help the AMA drive the future of medicine, remove obstacles that interfere with patient care, and improve the health of the nation.

The AMA's House of Delegates is the policy-making body at the center of American medicine, bringing together an inclusive group of physicians, medical students and residents representing every state and medical field. Delegates work in a democratic process to create a national physician consensus on emerging issues in public health, science, ethics, business and government to continually provide safer, higher quality and more efficient care for patients and communities.

The policies adopted by the House of Delegates this week include:

Improving access to substance use disorder treatment amid evolving overdose epidemic

Despite some signs of progress in prescription opioid-related overdoses, the U.S. is still facing an evolving overdose epidemic that is increasingly fueled by illicit fentanyl and stimulant drugs – and becoming more deadly. In response, the nation's physicians adopted new AMA policy today advocating for expanded federal funding for states to improve access to evidence-based addiction treatment – a major barrier for the more than 2 million Americans with an untreated substance use disorder. The policy is especially aimed at bolstering long-term funding and creating a comprehensive framework to treat all substance use disorders, including treatment for patients who suffer from both substance use and mental disorders at the same time.

"The changing landscape of this epidemic poses challenges for our health system, which must prioritize access to evidence-based care for patients with substance use disorder," said AMA Trustee **THOMAS J. MADEJSKI, MD**. "We cannot lose sight of the fact that our nation's drug overdose epidemic is killing more than 70,000 Americans each year, which is why the AMA will continue to call on stakeholders to help eliminate barriers to evidence-based treatment."

Protecting residents and fellows affected by unexpected hospital closures

Building on the American Medical Association's (AMA) efforts to financially and professionally protect residents and fellows displaced by unexpected teaching hospital closures, physicians, residents and medical students at the Special Meeting of the AMA House of Delegates (HOD) today adopted policy aimed at better preparing for future events similar to the closing of Hahnemann University Hospital in 2019. The sudden shutdown left more than 570 residents and fellows without the required malpractice insurance coverage – and without a spot in a medical training program.

Under the new policy, the AMA will continue to help monitor related issues that arise at programs and hospitals owned by corporate entities. Specifically, the policy calls for revising federal regulations to specify that residency slots are not hospital assets and for developing an application process that would allow displaced residents to match with other institutions. It also asks for the creation of rules requiring teaching institutions to maintain a professional liability fund for these situations, and urging requirements so that residents are provided with an institution's financial health details, such as credit ratings or merger/acquisition information. Additionally, it directs the AMA to assist in minimizing confusion and misinformation in the event of a sudden closure by coordinating with appropriate stakeholders on communications efforts.

"The AMA remains committed to ensuring that residents and fellows are safeguarded professionally and financially in the event of an unforeseen teaching hospital closure. It is our obligation to help mitigate any related hardships that displaced residents may face in these unfortunate situations," said AMA Trustee **GRAYSON ARMSTRONG, MD, MPH**. "By creating a policy playbook to plan ahead and prepare for potential shutdown circumstances, we can better assist these physicians-in-training in moving forward as seamlessly as possible, allowing them to focus on completing their training and caring for patients."

The AMA engaged legal counsel to represent the displaced Hahnemann residents and fellows in bankruptcy proceedings, which settled in March 2020. In addition, the AMA and AMA Foundation helped fund grants to offset relocation expenses for the affected physicians. ❖

AMA adopts policy calling for continued telehealth services

At the five-day policy-making virtual meeting of the American Medical Association in November, Delegates adopted a telehealth policy directing the AMA to continue it advocacy work with legislators and regulators who have an important opportunity to codify coverage, access and payment policies that support telehealth advancements throughout the COVID-19 pandemic and beyond.

The new AMA policy states:

RESOLVED, That our AMA continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; and be it further

RESOLVED, That our AMA advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that:1. Provide equitable coverage that allows patients to access telehealth services wherever they are located;

2. Provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients (New HOD Policy); and be it further;

RESOLVED, That our AMA advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients.

RESOLVED, that our AMA support the use of telehealth to reduce health disparities and promote access to health care.

The adoption of the AMA's new telehealth policy coincides with the appearance of a new physician survey on telehealth issued by the COVID-19 Healthcare Coalition. The survey's topline findings show strong support for telehealth:

- 60% reported that telehealth has improved the health of their patients.
- 68% report they're motivated to increase telehealth use in their practices.
- 11% said they were using remote patient monitoring technologies with patients in their homes. Commonly used tools included smartphones, blood pressure cuffs, body weight scales, and pulse oximeters.
- 55% indicated that telehealth has improved the satisfaction of their work.
- More than 80% of respondents indicated that telehealth improved the timeliness of care for their patients. A similar percentage said that their patients have reacted favorably to using telehealth for care.

The survey also found barriers and challenges still exist and/or are anticipated beyond the pandemic.

- 73.3% indicated that no or low reimbursement will be a major challenge post-COVID.
- More than 64% said technology challenges for patients were a barrier to the sustainable use of telehealth.
- 58% are not able to currently access their telehealth technology directly from their electronic health records

CharterCARE Care@Home to provide physician home care visits

PROVIDENCE – CharterCARE Health Partners and its affiliate IPA physician organization have created Care@Home to provide at-risk patients who suffer from chronic medical disease issues with physician and other provider care in their home.

Care@Home is an in-home medical care program that provides 30–60-minute in home physician visits to at-risk patients of CharterCARE Provider Group of Rhode Island, the 550-member physician IPA. Under the program, a doctor and other care team members provide integrated coordination with at risk, chronically ill patients, family members, the family physician and specialists physicians to manage the chronic condition(s), manage medication therapies and reduce the need for emergency room visits and hospitalizations.

"Knowing that I can extend my reach into my patients' home with our Care@Home team makes a big difference in their quality of life and helps me with overall care coordination", said **DR. JAMES CARDI**, a Cranston-based Internal Medicine specialist, and member of CharterCARE Provider Group.

CharterCARE CEO **JEFF LIEBMAN** stated, "Care@Home will significantly enhance our ability to manage care and provide critical services to patients who live at home with chronic disease by providing physician home visits within the framework of an integrated care plan. It will also help us to level if not decrease the costs of care provided to the chronically ill."

"The program is phenomenal, especially for my parents who have difficulty getting out," added Suzette Santos, who cares for both her parents, Analia and Cesar Pereira. ❖

Pod e-cigarettes less harmful than regular cigarettes, new study finds

In the first-ever clinical trial of fourth-generation electronic cigarettes, researchers found that adults who switched to e-cigarettes had lower levels of a major carcinogen compared to smokers who continued using combustible cigarettes.

PROVIDENCE [BROWN UNIVERSITY] – Cigarette smoking causes more than 480,000 deaths each year in the United States, according to federal government data – and some smokers find it nearly impossible to quit. Many of these smokers use regular, or combustible, cigarettes.

Physicians and scientists have for many years explored the health benefits and drawbacks of nicotine-based alternatives to cigarettes, and new research offers significant evidence that "pod" e-cigarettes are less damaging to health than traditional cigarettes.

"Nicotine is one of the most addictive substances on earth, both in animal models as well as to humans," said **DR. JASJIT S. AHLUWALIA**, a professor of behavioral and social sciences and medicine at Brown University. "So how can we help these people who can't quit smoking combustible cigarettes? They need other options, and e-cigarettes may be one such option. Our research shows that in the short-term, e-cigarettes are considerably safer than combustible cigarettes."

Ahluwalia is senior author of a new JAMA Network Open study, published on November 18th, on the world's first randomized clinical trial of fourth-generation pod e-cigarettes.

The trial included 186 African American and Latinx smokers, as racial and ethnic minority groups tend to experience higher rates of tobacco-related morbidity and mortality even when they smoke at the same rates as other groups. Two-thirds of the participants were provided e-cigarettes for six weeks, while the remaining participants were instructed to continue smoking combustible cigarettes as usual.

By the end of the study, participants who switched to e-cigarettes exhibited significantly lower levels of the potent pulmonary carcinogen NNAL compared to those who continued to smoke combustible cigarettes exclusively. The e-cigarette users also had significantly reduced carbon monoxide (CO) levels and reported fewer respiratory symptoms. These benefits – reduced NNAL, reduced CO and respiratory symptom improvements – were especially pronounced among participants who switched completely to e-cigarettes.

The researchers also measured participants' levels of cotinine, a breakdown product of nicotine, and determined that there were no significant differences between groups, an indication that e-cigarettes provided adequate replacement of nicotine.

"Anyone under 21 should not take up cigarettes, e-cigarettes or any nicotine product – hands down, the best thing to do is to never start – but if people use tobacco products, they should quit," Ahluwalia cautioned. "But if they cannot quit smoking combustible cigarettes, they should consider using novel nicotine products to either quit smoking altogether or to reduce their harm by transitioning fully to these products."

Going forward, work needs to be done to better understand the non-cancer risks associated with e-cigarettes, such as respiratory and cardiovascular disease. The researchers also plan to carry out year-long studies to further explore the harm-reduction potential of e-cigarettes.

"Most smokers who switched exclusively from combustible cigarettes to e-cigarettes during the study maintained this behavior at six months, but we need longer-term follow-up," said **KIM PULVERS**, a professor of psychology at California State University San Marcos who was the principal investigator of the study. "We also need continued study of dual users to determine whether they maintain harm reduction over time."

Ahluwalia said that because many individuals who use both e-cigarettes and combustible cigarettes will switch back to exclusively combustible cigarettes over time, there is a critical need for interventions that support those who try to switch to e-cigarettes but fail. He also emphasized the importance of alternatives to quitting outright, given the challenge that quitting poses for so many cigarette smokers.

"It's possible that nicotine e-cigarettes and other harm-reduction products will be game-changers for our field," Ahluwalia added. "I hope this study stimulates more people to do this research and to have an open mind about this. I also hope it inspires them to let science inform policy rather than emotion."

In addition to Ahluwalia and Pulvers, additional contributors include **CHRISTOPHER H. SCHMID** and **KEXIN QU** from Brown; **NICOLE L. NOLLEN** from the University of Kansas School of Medicine; **DR. NEAL BENOWITZ** from the University of California, San Francisco; and **MYRA RICE** from California State University San Marcos.

Schmid served as a consultant for legal firms representing Eli Lilly, Boehringer-Ingelheim and Gilead outside the study. Benowitz received personal fees from Pfizer and Achieve Life Sciences and served as a consultant to pharmaceutical companies that market smoking cessation medications and as an expert witness in litigation against tobacco companies outside the study. Dr. Ahluwalia received personal fees from Lucy Goods outside the study. These points were fully disclosed in the study. ❖

The study was funded by the National Institutes of Health (5SC3GM122628) and was also supported by the NIH-funded Center of Biomedical Research Excellence (P20GM130414) and the National Institute of General Medical Sciences of the NIH (U54GM115677).

Lung cancer report finds RI ranks as a Top 10 State for early diagnosis, 5-year survival, surgery, screenings and access to treatment

PROVIDENCE – Lung cancer is the nation's leading cause of cancer deaths, and it's estimated that 920 Rhode Island residents will be diagnosed with this disease in 2020 alone. The recently released 2020 "State of Lung Cancer" report from the American Lung Association examines the toll of lung cancer throughout the nation and outlines steps every state can take to better protect its residents from lung cancer. The report finds that while Rhode Island was ranked as a top 10 state in 5 out of 6 categories, the rate of new lung cancer cases in the state was higher than average (69.8 per every 100,000), highlighting the work that must still be done.

For the first time, this year's report explores the lung cancer burden among racial and ethnic groups at the national and state levels. The report finds that while more Americans are surviving the disease, nationally people of color are facing poorer health outcomes than white residents. Although this report did not indicate that Rhode Island had substantial lung cancer health disparities, every state can do more to ensure no one faces lung cancer alone.

The 3rd annual "State of Lung Cancer" report highlights the positive trend of increased lung cancer survival, as the nationwide five-year lung cancer survival rate of 22.6% reflects a 13% improvement over the past five years. In Rhode Island the survival rate is 25.9%, showing a 5 year improvement of 16% and earing it a third place ranking out of 47 states reporting survival data. The report also found that the state earned top 10 rankings for early diagnosis (25.7%), surgery as part of the first course of treatment (28.2), high risk people receiving screenings (10.5%), and for the number of people receiving no treatment (11%).

"While we celebrate that more Americans are surviving lung cancer, too many people are being left behind, and the disease still remains the leading cause of cancer deaths," said **DANIEL FITZGERALD**, Senior Manager of Advocacy for the American Lung Association in Rhode Island. "One local takeaway from the report is that much more can and must be done in Rhode Island to prevent the disease, as we are seeing a greater number of new cases here in Rhode Island than elsewhere."

"It's great to see the progress that Rhode Island has made for lung cancer patients, but we still have work to do," said **DR. SAURABH AGARWAL**, a cardiothoracic radiologist at Rhode Island Medical Imaging. "Our incidence rate is far too high, and we must continue to get our high risk population into early diagnosis screenings if we want to save lives."

Part of the reason that lung cancer is so deadly is because most cases are diagnosed at a later stage, after the disease has spread. Lung cancer screening is the key to catching lung cancer early when the disease is most curable, but only 22.9% of lung cancer cases nationally are diagnosed at an early stage. This simple screening test has been available since 2015, and while Rhode Island ranked 6th out of 49 states in this category, only 10.5% of those eligible in Rhode Island have been screened.

"Lung cancer screening is a powerful tool to save lives," said Dr. Agarwal. "Unfortunately, we're only seeing a fraction of those who qualify actually getting screened. We're pushing for greater awareness of this test to save more lives here in Rhode Island."

More treatment options are available for lung cancer than ever before, yet not everyone is receiving treatment following diagnosis. Rhode Island ranked as the 7th best state in this category, but still 11% of those diagnosed did not receive any form of treatment.

"We want to ensure that everyone has access to treatment options and quality and affordable healthcare. No one who wants care should have to forgo treatment due to lack of access or cost," Fitzgerald said. ❖

JAMA Network Open article focuses on women's access to healthcare

PROVIDENCE – On November 9, 2020, JAMA Network Open published an article which focuses on women's access to healthcare. **BENJAMIN P. BROWN, MD, MS**; **LUCIANA E. HEBERT, PhD**; **MELISSA GILLIAM, MD, MPH**; **ROBERT KAESTNER, PhD**, conducted a study assessing data from 18 states around the country from the years 2000 to 2014. In those states and years, their study found that a highly-restrictive climate around abortion regulations was associated with a significantly lower abortion rate, compared to a less-restrictive climate.

The study found that a highly-restrictive legislative climate was associated with a lower abortion rate (0.48 fewer abortions per 1,000 women [95% CI –0.92 to –0.04], or approximately a 17% decline from the median abortion rate). A highly-restrictive legislative climate was still associated with a lower abortion rate after adjustment for distance to a provider (0.44 fewer abortions per 1,000 women [95% CI –0.85 to –0.03]).

Legislative climate was not significantly associated with distance to a provider, suggesting that a restrictive climate itself may act as a barrier to abortion care

"We have robust data from around the globe that suggests individuals continue to need abortions, regardless of the legal status of that care. When we see a drop in the abortion rate associated with a highly-restrictive legislative climate, it raises the concern that people who need abortions are being prevented from accessing this basic health care," said Dr. Brown, an Assistant Professor of Obstetrics and Gynecology, Clinician Educator, Division of General Obstetrics and Gynecology, Women & Infants Hospital. ❖

Fatal overdoses in Rhode Island continue to rise

Community-level factors, COVID-19, and counterfeit pills all considered contributors

New data from the Rhode Island De-partment of Health (RIDOH)'s Office of the State Medical Examiners (OSME) indicate a sharp increase in accidental drug overdose deaths during the first seven months of 2020. (It can take up to 90 days for the OSME to confirm a decedent's cause and manner of death.)

There have been 233 accidental drug overdose deaths between January and July 2020, compared to 185 during the same period last year. Between these two periods, all drug fatal overdoses increased by 26% and opioid-involved fatal overdoses increased by 33%. During July, more Rhode Islanders died of drug overdoses than any month since the State started tracking fatal overdose data. Similar trends are being seen nationally.

The stressors and isolation of the COVID-19 pandemic are believed to be factors in this increase, resulting in what researchers call a *syndemic*, which is the amplified result of two or more diseases that exist simultaneously in a community. However, Rhode Island's increase in overdose deaths started before the state's first COVID-19 case. Other factors that are likely contributing to the increase are polysubstance use (the use of more than one drug at the same time), counterfeit pills, and the presence of illegally made fentanyl in drugs like cocaine, counterfeit pills, methamphetamine, and other substances.

Counterfeit pills, which often look like prescription medications, are in greater supply throughout the United States, particularly oxycodone (an opioid) and benzodiazepines (a sedating drug). These pills vary in purity and potency and can contain unknown amounts of fentanyl. It is impossible for an end user to know what drugs might be present in counterfeit pills. These counterfeit pills are even more lethal when crushed and snorted. One pill can cause a fatal overdose.

"What underlies the diseases of substance use disorder and COVID-19 are factors in our communities that affect people's abilities to be healthy and safe, such as housing, employment, education, and discrimination," said Director of Health **NICOLE ALEXANDER-SCOTT, MD, MPH**. "While getting prevention and treatment resources into the community to prevent overdoses immediately, we need to continue working to address these larger structural issues. Every single overdose is preventable. There is help and there is hope for everyone who is living with the disease of substance use disorder."

"The increased potency of drugs combined with the challenges of COVID-19 have stressed an already fragile system," said **KATHRYN POWER, MEd**, Director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)."These challenges might have led people who were in recovery to relapse. In other cases, people who use drugs occasionally, like cocaine, might have succumbed to an overdose by not knowing fentanyl was present."

Director Power and Dr. Alexander-Scott are the co-chairs of Governor Gina M. Raimondo's Overdose Prevention and Intervention Task Force.

"The collision between the COVID-19 and opioid epidemic has really highlighted how crucial social determinants of health- safe housing, good employment, access to mental health support- are to sustaining long-term recovery," said **DR. JON SOSKE** of Rhode Island Communities for Addiction Recovery (RICARES). "So many people have relapsed after evictions, layoffs, and traumatic losses- and these have hit racialized communities hardest. Addressing these issues at a systemic level is crucial going forward."

Additional data points

- Accidental drug overdose deaths decreased by 8.3% between 2016 and 2019, dropping from 336 to 308.

- Rhode Island is on track to exceed 2016's total by at least 25%.
- During the first seven months of 2020, non-fatal overdoses fluctuated by month. During April and May, the numbers of non-fatal overdoses that EMS responded to in Rhode Island were lower.
- All Rhode Island cities and towns are being affected. Particular overdose hotspots include Providence, Pawtucket, Warwick, and Woonsocket. Fatal overdoses doubled among Warwick and Providence residents during the first six months of 2020. In North Kingstown and Scituate, the total number of fatal overdoses during the first six months of 2020 exceeded the towns' total numbers for all of 2019.
- While the rate of fatal overdoses among White Rhode Islanders declined between 2016 and 2019, that rate increased in the first seven months of 2020. Overdose rates generally increased among African American and Hispanic Rhode Islanders from 2016 to 2019 and continued to increase during the first seven months of 2020.
- Overdose death data by month and year are available online.

Current action steps

In response to these trends, RIDOH and BHDDH hosted an emergency, online Community Overdose Engagement (CODE) meeting in July with more than 150 state and community stakeholders. Actions steps coming out of that meeting that are either in the implementation or planning phase are:

- Increased street outreach activities in overdose hotspots across the state. Certified peer recovery support specialists from community-based organizations like AIDS Care Ocean State, Community Care Alliance, East Bay Recovery Center, Parent Support Network, and Project Weber/RENEW distribute naloxone, sterile syringes, and fentanyl test strips and provide wrap-around services and basic needs to individuals who use drugs.
- Increased housing support for vulnerable populations in Woonsocket and Providence. Through the West Elmwood 02907 CODE project, Amos House maintains additional beds within its temporary housing assistance program. Project Weber/RENEW in Providence offers recovery housing grants for clients, and Sojourner House in Woonsocket will provide a drop-in housing clinic for emergency services.
- Strategic placement of Substance Abuse and Misuse Teams (SMART) at Rhode Island Hospital's and Landmark Hospital's emergency departments. Trained staff are ready to connect patients who have recently experienced an overdose to local treatment and recovery support services.
- Collaboration with a community-led work group and expert advisors across state agencies to explore the development of an overdose prevention center. Health services such as STI testing, addiction treatment, housing supports, and basic services (i.e., showers, food, and clothing) would be available at such a center. This would also be a place where people could use pre-obtained substances while being peer or medically supervised. Sterile equipment and immediate overdose response resources would be available to reduce overdose and infectious disease risk. ❖

Lifespan Cancer Institute expands radiation therapy program to East Greenwich

EAST GREENWICH – Lifespan Cancer Institute is now offering radiation treatment at its location in East Greenwich, adding to the range of sophisticated oncology options available on-site and marking the second radiotherapy setting in the Lifespan system. Lifespan Cancer Institute also offers radiation treatment at Rhode Island Hospital.

"Lifespan Cancer Institute has undergone extraordinary growth in recent years and continues to extend its world-class cancer care across Rhode Island. In addition to sites at Rhode Island Hospital, The Miriam Hospital and Newport Hospital, the Cancer Institute is located at satellite locations in Lincoln – which opened during the past year – and East Greenwich," said **DAVID WAZER, MD**, director of the institute and a leading radiation oncologist. "Since the East Greenwich location already offers infusion serves for chemotherapy as well as physician visits, the addition of radiation treatment further reduces the need for patients in the West Bay to have to travel to multiple sites for appointments.

"We have been actively recruiting some of the nation's foremost clinicians and researchers and greatly expanding the number and diversity of clinical trials we can offer our

patients, including promising and newly emerging immunotherapies," said Dr. Wazer. "The continuing expansion of our suburban clinics means patients in the region no longer need to go to the hassle or expense of driving great distances or going to big cities to get the most advanced cancer care." ❖