Rhode Island Healthcare: Is There Light at the End of the Tunnel?

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It is not hyperbole to say that the past two years have been the most demanding of my career. Many physicians like myself, with decades of experience, began our careers in the midst of the HIV epidemic and helplessly watched young people waste away. We have skirmished with the epidemics of crack cocaine, H1N1, and fentanyl, and exhibited resilience despite poor-patient outcomes. Increasingly, resolve has devolved into resignation. Current conditions on the ground – that is, in the Emergency Department (ED) – are grueling. Most emergency physicians, advanced practice providers, and nurses are depleted.

Perhaps when the history of this current pandemic episode is written, the personal stressors endured during the past two years will just be a footnote to the larger story – the weakness of Rhode Island's healthcare system. A recent series of articles in *The Boston Globe* discussed the state of healthcare in Rhode Island.[1,2,3] Dr. Dina Himelfarb, the president of the Rhode Island Chapter of the American College of Emergency Physicians (ACEP), wrote in a letter to Governor McKee that we (emergency departments) "are the canary in the coal mine of healthcare…and our system is currently collapsing."[1] Dr. Himelfarb, a remarkable physician and thoughtful leader, wrote the following:

"Right now, in Rhode Island, citizens cannot consistently receive the standard of care of emergency medicine. In fact, in every hospital in the state, they are often receiving care that previously we would only equate to what one would receive in an underdeveloped country: rationing resources, unable to provide privacy, and certainly unable to provide any COVID-19 isolation precautions… Others just wait in the waiting room, waiting with their chest pain or abdominal pain which may ultimately be diagnosed as a heart attack or surgical emergency. My emergency physician colleagues across the state are attempting to see patients in chairs, in hallways, and in waiting rooms, performing the tasks of nurses and medical technicians, all in an effort to ward off our biggest collective fears, that a patient dies of treatable illness while waiting in the waiting room or leaves because of the wait time and comes back dead or dying. These nightmare scenarios have come true, in multiple departments across the state, in the past few weeks. Imagine patients dying while waiting to be seen by a doctor who is 50 feet away and, because of lack of staff and thus capacity, simply unable to treat them. This is a true tragedy that is currently unfolding for citizens of Rhode Island.[1]

Dr. Himelfarb's description of ED care in Rhode Island is depressing, but it is important to note that the breakdown in Rhode Island's healthcare system did not happen overnight; it has been in trouble for years. We are a COPD patient, on 2 liters of home oxygen, and with no reserve; unfortunately, we caught a virus. There are numerous reasons for our sickly state. These include the state's poor business climate and payor mix, a complicated and historically tumultuous relationship between the leading healthcare system and the nurses and allied professionals union, bickering among factions within RI, and, importantly, the lack of a shared vision among stakeholders. Lean business practices have led to diminished staffing over the past decade. With the advent of the pandemic, hospitals were unable to absorb the shock it caused.

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Taken together, personal stressors and systemic woes have created a sense of frustration, exhaustion, and moral injury. At my hospital, the systemic dysfunction had taken its toll even prior to the 4th wave and the advent of the Omicron variant. Left without being seen (LWBS), a marker of ED efficiency, increased to its worst level ever. Length of stay (LOS) and hospital boarding surged, while wings of inpatient beds were closed due to a lack of staffing. Over the past 24 months a

dozen mid- and late-career physicians left my department – some retired while others sought out greener pastures. My colleagues could no longer see light at the end of the tunnel.

Seeking the silver lining

Sometimes adversity offers a silver lining, and current circumstances provide an opportunity to reset the playing field in Rhode Island. At a micro level, reconsideration of professional roles in Rhode Island could allow nurses to practice at the top of their license, rather than being burdened with tasks easily accomplished by others. It is an archaic relic of a bygone era that only nurses can place intravenous lines in the ED, rather than trained techs. In our ED, nurses are sometimes burdened with cleaning rooms, reducing their time caring for patients. There are simple solutions to a deplorable situation.

State government can also play a role in improving the immediate and longstanding conditions in Rhode Island through development of a coordinated ambulance system not beholden to the individual fiefdoms that currently plague Rhode Island's EMS network. The state could also open beds and assist institutions caring for children and adults suffering from mental health issues. In addition, the Rhode Island Medical Society has quietly made numerous other suggestions to state officials that could have a profound impact on staffing. For instance, elimination of prior authorizations, the bane of medical practice, could reduce paper work, free up staff and nurses from bureaucratic purgatory, and ultimately lead to better patient care and satisfaction (It would be interesting to do a cost benefit in real dollars – not just insurance company dollars – in order to compare labor cost savings with the artificial "savings" created by delays in imaging and shifting of costs onto small business).

Merger opportunities

At the 30,000-foot view, a proposed merger between Care New England and Lifespan to create an integrated academic healthcare system with Brown University could eventually lead to reduced fragmentation and a coordinated effort to provide care south of Boston and north of New Haven. A decision is slated for mid-March, under the terms of the state's Hospital Conversions Act, when the review by the Office of the Attorney General and the Rhode Island Dept. of Health is completed. In order to create a successful entity, unions and health system leadership will need to develop a shared vision of healthcare in the state. In turn, to avoid the seduction of "Big Four" accounting and consulting firms focused on profit and lean dynamics, the new system will need to create an organization that above all values its personnel. There is no shortage of problems to solve and each group will need to give a little to benefit everyone.

While the crisis of today will eventually pass, the future of healthcare in Rhode Island is at a crossroads. It will take a collaborative effort to solve Rhode Island's healthcare woes. It won't happen suddenly, but new leadership may be just what the doctor ordered, as the current situation is untenable. It remains to be seen whether this proposed merger, if approved, will breathe new life into our moribund system and result in a green light at the end of the tunnel. ❖

References

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