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Reflections from the editor-in-chief on 20-year tenure

JOSEPH H. FRIEDMAN, MD
joseph_friedman@brown.edu

I have been the editor-in-chief of the Rhode Island Medical Journal (RIMJ) since January 1999 and will leave this position in December 2018, making an exact 20 years. The journal is small, reflecting, in a very positive way, the small size of the state. We have one medical school and a significant percentage of the graduates stay here after graduation. The smallness encourages a sense of belonging, since the degrees of separation between individuals, especially doctors, is always small. It is virtually impossible for one doctor not to know a second doctor who knows a third doctor.

The journal has been, I hope, a friendly presence. Unlike the national journals which generally hope to either compete with the New England Journal of Medicine (NEJM) or take its place within the niche of whatever specialty it represents, and measures success by its impact factor, the RIMJ has always sought to encourage local health professionals to communicate with each other. We encourage junior faculty, fellows, residents and students to submit their work. We view the RIMJ as a training ground for health professionals with an interest in research or publishing for various reasons. We often offer issues with a theme, in which the guest editor, sometimes a junior faculty member, can organize an issue, write an article, and gain the experience of encouraging others to write, editing someone else’s manuscript and adding a few lines to his/her CV. Learning how to critique someone else’s work in a way that is helpful and not hurtful requires either a natural talent or a learned expertise that usually comes from having been on the receiving end of the criticism. Being told that your work is trash is an experience that makes one gentler and more understanding when critiquing someone else’s submission. It is not our approach. We try to improve submissions to make them sufficiently well written to merit publication.

I did not apply for the editorship. The late STANLEY ARONSON, MD, in addition to having been the founding dean of the medical school and a weekly contributor to the Providence Journal, had been editor-in-chief of the journal for several years. When he decided to give it up, notices went out, primarily, I think, in the journal itself. I believe that other announcements were also sent out to be posted in appropriate venues. After a period of time, and when no one applied, Stan, on bumping into me unexpectedly, asked me to take this on. On the one hand, it’s always flattering to be asked to do something, especially something that can sound prestigious, even when it’s not, but, in this case, more importantly, it was a request from Dr. Aronson himself. He thought I could do a good job. I could not turn him down [I now have the Stanley Aronson, MD, Chair in Neurodegenerative Disorders at Butler Hospital, which was not a quid pro quo for accepting the editorship]. I learned a little later that the editor’s position might not last much longer as the journal had long been going over budget. I was told that I needed to cut down on expenses. I was given a strict page limit and a year to bring the journal around. We did that, which was one measure of success. Stan told me that I should consider myself as successful when I was able to reject a submission because of poor quality, without having to worry about not having enough manuscripts to fill each issue. In days gone by, the journal often reprinted articles from other journals.

Obviously, the journal, sponsored by the Rhode Island Medical Society, has survived, although sometimes only barely, due to financial challenges. In an effort to constrain printing costs, we gave up our print edition in 2013, and now send an email blast with a link to the journal to more than 10,000 people who are registered professionally with the Rhode Island Department of Health. In 2017, readers accessed about 40,000 pages of the Journal archived online (rimed.org/rimedicaljournal-archives.asp). Annually, the Journal attracts approximately 25,000 readers, not only in the state, but worldwide.
The bulk of my job is not in deciding what to publish, but in editing submissions to improve them. We don’t aim to compete with national journals but we do aim to make the articles, which often are case reports, research involving small numbers, descriptions of new techniques or therapeutics newly available in Rhode Island, that the uninformed medical public may think are only available in Boston. We had the first minimally invasive spine surgery in New England, the first gamma knife and still the only psychiatrist-neurologist in New England who is a specialist on psychogenic seizures and movement disorders. [Since I’m a neurologist I know about these things, but not the special advances in other fields, but am sure there are many.]

I’m pleased with the journal, and hope we’ll find someone to replace me, perhaps you, who will bring the journal to a higher level, although not by sacrificing the mission of serving the medical community of our state.

[Thanks to Mary Korr and Patrick Sweeney, MD, MPH, PhD, for the data.]

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

Figure 1. Published contributions to the RIMJ from faculty, fellows, residents, and students, January 2016 through November 2017.*

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When the competent patient refuses personal care

HERBERT RAKATANSKY, MD

Arthur [not his real name] was a 45-year-old paraplegic admitted to the hospital for pneumonia. At home he required full-time care for routine personal care including body turning to prevent bedsores and cleaning and hygienic care of bowel function. After a prolonged hospital stay he refused to have the necessary personal care. Personal care refers to the activities of daily living such as but not limited to: basic hygiene, dressing, moving about, eating, etc. From another viewpoint personal care are those activities not covered by Medicare.

Consequently Arthur started to develop bedsores, and sanitary issues due to bowel function became major concerns. It might be argued, however, that the repositioning was medical care [rather than personal care] as it was due to a medical condition, paraplegia.

During this time he remained alert and lucid. His attending physician and a consulting psychiatrist agreed that he had the capacity to make decisions about his medical care. [Arthur had recently been a patient in a local hospital.]

Both medical ethics and legal standards agree unreservedly that persons with the capacity to make decisions may refuse any and all medical treatment, even if the lack of treatment will exacerbate illness and lead to death.

Capacitated, competent people may make the same decisions about non-medical, personal care. But are health-care facilities (HCFs) obligated to follow them in all circumstances?

It is clear that persons in our society may refuse personal care – even to the point of remaining homeless. Persons may continue to smoke and drink alcohol even when such activities are life threatening. An exception occurs when such behaviors threaten the well being of others. We restrict smoking in areas where second-hand smoke may affect others. We may deny alcoholics the right to drive. The state has the power to isolate persons with certain contagious diseases. People may choose to live in what most would consider unacceptable social and sanitary conditions. Some people believe that those choices result from mental illness. In our society, however, we endorse a diversity of life styles. Should we assume that a patient in a HCF who refuses personal care is de facto mentally ill and therefore does not have the capacity to refuse personal care?

It may be argued that there is an assumption that when a patient is admitted to a hospital or other health care institution they have agreed to basic personal care (not medical care) as a condition of admission. One observer has called this assumption the “web of understanding.” This agreement, however, is not spelled out. The general consent I signed upon being admitted to a local hospital in the past contained no mention of personal care and review of the current consent form reveals no change.

HCFs should have a policy that all patients will receive appropriate personal care, regardless of their decision to receive medical care and interventions. During the process of being admitted to the HCF [in non-emergency situations] this policy should be explained and acknowledged in writing by the patient or proxy.

Most cases of refusal of personal care are resolved directly by the nursing staff. Communication with patients to reassure them of the compassion felt for them and reassurance about protecting their privacy is essential.

Sometimes cultural and/or religious beliefs may be the reason for refusal and attention to these issues is appropriate (same gender care-giver, etc.). Racial bias of the patient should not be tolerated but harm to the patient must not result (see Addressing patient biases toward physicians, RIMJ December 2017).

What happens if a patient continues to deny consent for personal care? An English study reported that “there is evidence that nurses will administer the care in the absence of consent.” Presumably this is compassionate care administered for the benefit of the patient and
to decrease risk to other patients [from unsanitary conditions, etc.].

Another report documents a rise in legal actions against nursing homes. Bedsores and falling are major reasons for the lawsuits. It is not clear how many patients in this review received substandard personal care because they refused it. It is likely that almost all, if not all, patients either desired care or lacked the capacity to decide to reject care. After all, patients enter nursing homes to get good care. There is the additional possibility that poor care of our senior citizens might be interpreted as elder abuse. In this case regulatory agencies may become involved, with adverse effects on the HCF. In any case, HCFs are under significant legal pressure to provide high quality personal care even if the patient refuses it.

In today’s paradigm of shared decision-making in medical care decisions, there is little place for strong persuasion by doctors for patients to accept specific medical treatments. But that model may not apply to the decision to accept basic nursing and personal care. Provision of high-quality personal care is fundamental to the proper running of a HCF. In my opinion, it is quite acceptable for the nursing staff to be persuasive in their efforts to convince the reluctant patient of the benefits of compassionate personal care.

The staff of HCFs usually can solve such situations but a process to resolve difficult cases should be in place. As mentioned above, institutions should have a written policy about this issue.

The policy should specify that a health care proxy may not refuse the provision of personal care. First, the proxy has decision-making power over only medical care. Second, in an analogous situation it is established policy in at least one RI hospital that a proxy may not withhold pain relief (though the patient, him/herself may do so). Thus only the refusal of personal care by a capacitated patient would be problematic.

If a capacitated patient continues to refuse personal care after diligent nursing intervention and attempts at persuasion, etc., family meetings, consultation with the ethics committee, appropriate clergy, friends and others would be the next steps.

If all these steps fail to reverse the decision of the patient, a plan for essential personal care should be developed, taking into consideration both the patient’s safety and the safety and functioning of the HCF. Since touching a person against their wish is legally “battery” it is important that the HCF legal counsel be involved at this point. This individualized plan (“The Plan”), respectful as much as possible of the patient’s requests and of the cultural background, as well as the needs of the HCF should be instituted.

When such a case (admittedly very rare) arises, the HCF policy should designate a process to approve “The Plan” for the specific patient. Approval by the chief of service and/or the ethics committee, for example, could accomplish this end.

This approach balances our ethical goals both of respect for individual patient autonomy, and the principle of Justice, which considers the health and welfare of the greater community, in this case the HCF.

Arthur’s plan might include sanitary care only after defecation, turning only as much as necessary to prevent bedsores, etc.

The medical care team must remain true to its mission, the care of the patient, even when the road is a bit rocky.

**Author**

Herbert Rakatansky, MD, FACP, FACG, is Clinical Professor of Medicine Emeritus, The Warren Alpert Medical School, Brown University.
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“COLLECTING THE UNCOLLECTIBLE”
Clinical Challenges in the Growing Medical Marijuana Field

JONATHAN BARKER, MD

ABSTRACT
Unique clinical challenges arise with the growing number of patients who possess medical marijuana cards. Medical marijuana patients with mental disorders can have worsening symptoms with marijuana use. Often there is sparse continuity of care between the patient and the medical marijuana practitioner. Lack of communication between the patient’s treating practitioners and the practitioner who has authorized the medical marijuana can be problematic. This article is a discussion of the new clinical challenges practitioners are likely to encounter with the growing number of medical marijuana patients.

KEYWORDS: cannabis, cannabinoid, cannabidiol, medical marijuana

BACKGROUND
According to an article published in the Providence Journal in 2015, the number of Rhode Island medical marijuana patients increased from 4,849 in 2013 to 11,620 in 2015. The Rhode Island Department of Health issued a statement entitled, “Minimum Standards for Authorizing Medical Marijuana,” on September 30, 2011. This statement expressed that “The Rhode Island Department of Health (HEALTH)’s Board of Medical Licensure and Discipline has concerns over its ability to safely regulate the management of patients seeking authorization for medical marijuana.” Physicians who choose to authorize medical marijuana cards should be aware that the Massachusetts Board of Medicine recently suspended the license of two physicians due to their practice of authorizing medical marijuana.3

The endocannabinoid system is extremely complex, and we know relatively little about it. THC is one of more than 60 cannabinoids present in the cannabis plant.4 While there certainly may be medicinal properties of cannabinoid receptors, the current practice of dispensing a highly variable drug to the population at large and observing what happens is not only unscientific, it is dangerous. The Institute of Medicine gave the following statement upon review of the clinical uses of cannabis:

“If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug but rather to serve as a first step toward the development of nonsmoked rapid-onset cannabinoid delivery systems.”

Presently, potential clinical conditions with symptoms that may be relieved by cannabis include nausea, wasting syndromes (such as AIDS and cancer), chronic pain, inflammation, multiple sclerosis, some forms of muscle spasticity, and glaucoma.5 There is research suggesting that cannabidiol (CBD) has anti-epileptic and antipsychotic properties.6 7 8 9 10

There are special cases of severe conditions, such as treatment-resistant intractable epilepsy or end-stage diseases, for which cannabis extracts may be more beneficial than traditional FDA-approved anti-epileptic medications. However, working with patients who are using medical marijuana, even for appropriate indications, presents special challenges.

For example, I saw two patients in an outpatient, partial hospitalization day program who each reported to me during the initial intake session that they had an outpatient physician prescribing them medical marijuana. Both were daily smokers. One had become paranoid and delusional. The other was manic and had physically assaulted hospital staff. I advised both patients about the dangers of cannabis, and the potential for cannabis to worsen mania and psychosis. I was put in a difficult position when one of the patients responded by saying his outpatient psychiatrist gives him a medical marijuana card. Having two different doctors with seemingly opposing messages about cannabis confused the patient; one doctor saying it was good for the patient, and one doctor saying it was bad.

The following are issues commonly encountered in treating patients who use medical marijuana, and some suggestions for dealing with these challenges:

1. Gaining trust of the patient and forming a therapeutic alliance.

The patient may not know whom to trust. Another doctor with whom the patient has already formed a therapeutic alliance gives the patient the authority to purchase medical marijuana. This means the patient’s other doctor thinks marijuana is good for them. The patient likes using
marijuana, and may even be addicted to its use. Now a new doctor tells the patient that marijuana is not good for his/her mental health.

For the patient who is manic with no insight into the mania and enjoys being manic, it is easier to continue with the marijuana-prescribing doctor and fire the doctor opposing the use of marijuana. For the patient who has paranoid delusions that are real in the patient’s mind, and now hears that the delusions are being exacerbated or caused by the marijuana, it is easier to trust the marijuana-prescribing doctor.

2. Treating the patient’s mental illness knowing that the patient will continue to use marijuana.

If the patient wants to continue to use marijuana but is also accepting treatment, should the doctor agree to start treatment knowing that the patient will continue to use marijuana? A similar question could be asked of a patient who has a stimulant-induced mania and is unwilling to stop the stimulants. Should the doctor treat with antipsychotic or mood-stabilizing medicine to counteract the stimulant-induced mania knowing that the patient has no intention of stopping the offending agent?

3. Contacting the outpatient provider who is providing the patient with the medical marijuana card when the patient does not want providers communicating with the medical marijuana-authorizing provider.

Patients may not give you permission to contact the marijuana-authorizing doctor because they are afraid if you talk to the marijuana-authorizing doctor, they will no longer be able to renew the medical marijuana card from that doctor.

I suggest the following for outpatient providers who are faced with the above challenges:

1. As the new provider, you should be well educated about the research accounting for the dangers and benefits of cannabis in different areas of medicine. I suggest starting the conversation with the patient by acknowledging the confusion he or she might be experiencing. By explaining the science, the patient is more likely to view you as an expert on the subject, which will make it easier for the patient to trust you.

2. I suggest continuing treatment if the patient trusts you enough to start engaging in treatment, but does not want to stop the cannabis use. With treatment, either medication or psychotherapy, the patient may gain a better understanding of the ways in which cannabis is affecting his/her mental health and agree to discontinue its use. The alternative is that the patient may continue the cannabis use without the treatment you could provide.

3. If the patient does give permission to contact the marijuana-authorizing doctor, I would suggest doing so to provide the doctor with information about the patient’s mental state while using cannabis. If the patient does not give you permission, I would suggest not breaching confidentiality unless there is an emergency, because you are likely to drive the patient out of treatment if you do so. Furthermore, marijuana is easy enough to obtain. The patient is likely to continue its use even if you breach confidentiality and the marijuana-authorizing doctor agrees not to continue providing the patient with a medical marijuana card.

Acknowledgment
I wish to thank Edward Silberman, MD, and Devra Barter, MS, for helping with the review process of this manuscript.

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Challenges of delivering medical care in resource-poor countries; thoughts on personalized medicine in US

Dr. Friedman,

I read your commentary “Personalized Medicine in the Resource-poor World” in the November 2016 issue of RIMJ and I wanted to write to express my appreciation to you for making these comments in the journal. My experiences as a Brown medical student in Ghana and later as a Fogarty Global Health Fellow in Tanzania in 2016, and your description of the hospital conditions, ring absolutely true to what I observed there and in other similar resource-limited settings in Africa.

Regarding the “thin layer” of health insurance as you describe, I traveled to Apam, Ghana for summer research at Apam Catholic Hospital and saw just exactly how thin and tenuous the health insurance layer really is. The Catholic association of hospitals [overseeing 100+ facilities nationwide] had not received insurance reimbursements from the government, for up to 6 months in some instances, so decided to boycott accepting the national insurance. What this meant at the local level in the case of Apam Catholic Hospital was an immediate overnight plummeting of patient attendance the next day. Seeing this and wondering just how impactful it was, I reviewed hospital records of the outpatient attendance counts for that first week in June when insurance acceptance stopped and the prior calendar year in June. While not an extensive review, the difference was nearly an 80% drop in attendance from the year prior, a staggering figure. Over the coming weeks it trickled up slightly and returned to normal once the insurance was accepted again, but it reminded me how precarious the situation is for so many.

So in reading your piece, I was reminded of this in Ghana and what I’ve seen in Tanzania.

I also thought that your analogy of institutionalized personal medicine in the US and the health care access in resource-limited settings was particularly insightful. When I first read of personalized medicine and later hearing former President Obama praise it so highly as the future of health care I was left confused, scratching my head that voices of criticism weren’t louder against this movement. How would it make any sense that multi-thousand dollar tests and diagnostics and specialized medicines would somehow not only be more available to people but also not cause the system more money? Such specialization would both require more R & D and create smaller markets, and thus higher costs. That we will run this test for Jane with her individualized genetic mutation, and design a medicine specific to her, and then run the test for Jill and design a different medicine specific to her – this will somehow be a boon for healthcare? So, I think it’s exact how you’ve depicted the potential of this model to create a practice as you have seen in developing countries if expanded to its logical conclusion: that only the minority who can afford it will obtain it, creating a two-tiered healthcare system, and leaving the majority to fend for themselves. But, as you also say, perhaps that is already here.

Zachary Tabb, MD ’18
Alpert Medical School of Brown University
Importance of screening for prevention, early detection of colorectal cancer

Dear Editors,

On behalf of the members of the Rhode Island Colorectal Cancer Advisory Committee, I am pleased to submit this letter and fact sheet for publication in the Rhode Island Medical Journal.

Colorectal cancer is the third most common, excluding cancers of the skin, and second leading cause of cancer death in Rhode Island when men and women are combined according to the American Cancer Society. Screening for colorectal cancer can help to prevent and detect cancer early. There are several reliable screening methods for colorectal cancer, but the best screening test is the one that gets done and reduces the burden of this largely preventable disease.

The goal of Rhode Island Colorectal Cancer Advisory Committee is to increase the rate of colon cancer screening in Rhode Island. We share a commitment to eliminating disparities in colorectal cancer screening and access to care by focusing on underserved, underinsured populations in Rhode Island. We also want to increase knowledge and awareness of CRC screening through patient education and to raise participation for those with adequate insurance to make sure they take advantage of the screening option that best fits their individual circumstances.

We are striving to meet the National Colorectal Cancer Round Table [NCCRT] of 80% by 2018 and beyond. The NCCRT 80% initiative involves over 1,500 organizations including the American College of Gastroenterology, American Cancer Society, Rhode Island Department of Health, Blue Cross Blue Shield of RI, Lifespan, RI Health Center Association, RI Medical Society and others committed to working towards a shared goal of 80% of adults, aged 50 and older, screened for colorectal cancer. As such, our organization will work to empower communities, patients, providers, community health centers, health systems, health plans, employers and others to develop partnerships to deliver coordinated, quality colorectal cancer screening and follow-up care.

In Rhode Island, close to 75% of individuals age 50–75 (CI:72.5, 76.4) reported being appropriately screened for colorectal cancer in accordance with U.S. Preventative Service Task Force’s (USPSTF) Guidelines according to the 2014 Behavioral Risk Factor Surveillance System [BRFSS] data. While our screening rates are some of the highest in the country, these rates do not consider the disparities in colorectal screening. These disparities are clearly articulated in data from the Federally Qualified Health Centers [FQHCs]. Since 2012 FQHCs have reported colorectal cancer screening rates for average-risk individuals ages 50–74 as part of their Uniform Data System [UDS] measures. Among the eight FQHC organizations in Rhode Island, which serve ethnically diverse populations and where greater than 90% of their overall patient population earns below 200% of the Federal Poverty Level [FPL], the average colorectal screening rate in 2016 was 44.7%.

Our committee seeks to address the disparities in colorectal cancer screening through the widespread adoption of multiple forms of screening, including FIT testing, and the development of a program modeled after SCUP [Screening Colonoscopies for Underserved Populations] created by Dr. Joseph DiMase in 2009. Seeing a need for increased access to colonoscopies for under- and uninsured Rhode Islanders, Dr. DiMase enlisted the support of local specialists and institutions who shared his vision of increasing screening rates among underserved populations. In less than two years, the program provided hundreds of screening colonoscopies with the support of 9 hospitals, 2 endoscopy centers, and 65 GI physicians and surgeons. For his work, he was presented the RI Department of Health’s Community Partnership Award and the 2011 National Community Service Award from the American College of Gastroenterology. Dr DiMase was a visionary humanitarian in his passion to bring the power of screening colonoscopy to eradicate colon cancer.

Colorectal cancer is a major public health problem that cannot be ignored. The good news is that we have been making progress and we have the means to tackle this problem. As Rhode Islanders, we already have the tools at our disposal to overcome colon cancer. By
working together, we will exceed 80% by 2018, and we can set an example for the rest of America and largely eliminate the burden of colon cancer in RI.

Sincerely,
Samir A. Shah, MD, FACG, FASGE, AGAF
Eric Lamy
Melissa Campbell, MPH

Members of the RI Colorectal Cancer Advisory Committee
Alyn Adrain, MD, FACG, FACP
Abdul Saied Calvino, MD
William Chen, MD
Brenda DiPaolo
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Goal: 80% in 2018

Why are organizations committing to 80% by 2018?
Colorectal cancer is a major public health problem. Colorectal cancer is the second leading cause of cancer death in the U.S. when both genders are combined and a cause of considerable suffering among nearly 135,000 adults diagnosed with colorectal cancer each year. The good news is that when adults get screened for colorectal cancer, it can be detected early at a stage when treatment is most likely to be successful, and in some cases, it can be prevented through the detection and removal of precancerous polyps. About 1 in 3 adults between 50 and 75 years old – about 23 million people – are not getting tested as recommended.

What will an 80% screening rate achieve?
In Rhode Island, our colorectal cancer-screening rate in 2014 was nearly 75%. We are close to our goal. It is estimated that 772 cancers and 529 deaths from colon cancer will be avoided in RI by 2030 if we get to 80% by 2018. Let’s all commit to increasing our screening rate to above 80% and decrease the incidence and death from colorectal cancer in RI. There are several recommended screening test options, including: colonoscopy, stool tests (guaiac fecal occult blood test [FOBT], fecal immunochemical test [FIT] or stool DNA test) and CT colonography, but the best test is the one that gets done.

We know what we need to do to get more people screened for colorectal cancer, prevent more cancers and save lives, and we share a commitment to eliminating disparities in access to care. Our organizations will work to empower communities, patients, health care providers, community health centers, health systems, health plans and other partners to close the screening gap.

What can you do to help achieve 80% by 2018?
If you are a health care provider:
• Make sure you advise your eligible patients to get screened
• Harness the power of your electronic medical record to track and improve the screening rate for the patients you follow and publicize this in your offices and send reminders as you do for office visits or vaccinations
• If you encounter barriers, reach out to the Department of Health to help overcome them

If you are a health system or insurer:
• Publicize the importance of screening for colorectal cancer as part of routine health care maintenance and the fact that screening is fully covered by insurance
• Notify by mail and email beneficiaries who are in the age range appropriate for screening

If you are a state representative or senator, Mayor of a city or town, Governor:
• Join the RI State legislature of declaring March as colorectal cancer screening awareness month and encourage your constituents to go for screening and speak to their health care provider
• Pass legislation to ensure enough funding for preventative care including colorectal cancer screening

If you are an employer big or small:
• Encourage your employees to go for screening and give them the time to do so

If you are over age 50 or African American over age 45:
• Get screened now! Talk with your health care provider about the best option for you

If you are a Rhode Islander:
• Remind your friends, neighbors, and families about screening and join us in March at the State House to raise awareness.
• Talk to your health care provider about when you should be screened for colorectal cancer

Visit: www.NCCRT.org for more information on 80% by 2018
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7. Spain
8. Italy
9. Brazil
10. China

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HUMBOLDT COUNTY, CALIFORNIA

The World’s Tallest Trees

Associate Editor of the Rhode Island Medical Journal Kenneth S. Korr, MD, checks the December issue while visiting a state park in Humboldt County, in northern California, home of the “old-growth” Coast Redwood trees, which thrive in the temperate and foggy climate.

The Coast Redwoods often exceed 300 feet in height and can live 2,000 years. They have outlived the dinosaurs and have been present on the northern coast of California for 20 million years.

In the High Sierra Nevada mountains, another species of Redwood reigns, called the Giant Sequoia.
Clinical and Translational Research in Rhode Island: Results of a Needs Assessment Survey
A study performed by the Tracking and Evaluation Key Component Activity (KCA) for Advance-CTR

CYNTHIA WILLEY, PhD; JACQUELYN FEDE, MA; JOHN STEVENSON, PhD; ANTHONY HAYWARD, MD, PhD; STEPHEN KOGUT, PhD, MBA; HEATHER FOURNIER, MA; JAMES PADBURY, MD

ABSTRACT
The Advance-Clinical and Translational Research (CTR) program was established in Rhode Island in May of 2016 with an IDeA Program Infrastructure award to collaborating institutions: Brown University, the University of Rhode Island, with the Lifespan, Care New England and Providence VA Medical Center healthcare institutions and the Rhode Island Quality Institute. To support programmatic planning, the Tracking and Evaluation Key Component Activity (KCA) of Advance-CTR developed and implemented a needs assessment survey to identify the obstacles to clinical and translational research at the participating institutions. We describe the methods used and the responses, which identified needs for study design and data analysis support. Support for project development, pilot funding and grants administration showed significant variation, depending on the affiliation of the respondent. The results of the survey are discussed in the context of Rhode Island’s significant opportunities to support and develop the capabilities of scientists who engage in translational research.

KEYWORDS: Clinical and Translational Research; IDeA; needs assessment; survey

INTRODUCTION
Clinical research is key to improvements in diagnosis and care. The National Institutes of Health defines translational research as: 1. “The process of applying discoveries generated during research in the laboratory, and in preclinical studies, to the development of trials and studies in humans” and 2. “…research aimed at enhancing the adoption of best practices in the community.”1 Success in a research field that is both clinical and translational requires resources that are costly and scarce, so it is important that they be distributed efficiently. Infrastructure Development Award for Clinical Translational Research (IDeA-CTR) programs are supported by the National Institute for General Medical Sciences (NIGMS) and aim to develop and integrate resources in the context of the health priorities of each of the 23 IDeA states and Puerto Rico that have historically received less NIH funding than the other 27 states.

Brown University and the University of Rhode Island, with the Lifespan, Care New England, and Providence VA Medical Center healthcare institutions and the Rhode Island Quality Institute received IDeA-CTR funding in May of 2016 to establish the Advance-CTR program in Rhode Island. Specific “Key Component Activities” (KCAs) supported by the grant include research support services (i.e., biostatistics, biomedical informatics and clinical research facilities) and award-based initiatives [pilot project awards and mentored career development awards] along with project management KCAs for administration and tracking and evaluation.

In year 1, Advance-CTR’s Tracking and Evaluation KCA completed a needs assessment survey of researchers and associated staff to identify obstacles to clinical and translational research at the participating institutions. We aimed to better understand researchers’ needs, to improve services and support offered through Advance-CTR, and ultimately to improve clinical and translational research (CTR) and health outcomes in Rhode Island. We focused on: 1. Identifying researchers interested in CTR in Rhode Island; 2. Identifying perceived barriers to conducting CTR in Rhode Island and 3. Exploring which professional development, educational offerings and support services would best assist researchers in carrying out high-quality CTR.

METHODS
Study Design
This descriptive study began in the fall of 2016 with instrument development, followed by pilot testing, and survey launch in the spring of 2017. Responses were anonymous, and the survey was exempted from review by the Institutional Review Boards of Brown University and the University of Rhode Island.

Sample
The sampling frame included faculty, post-doctoral fellows, administrators and clinical professionals from the six participating institutions. Individuals who agreed to participate received an electronic link to the survey. Non-respondents received two reminders.

To enhance our sampling outcome, we identified prominent researchers at the Advance-CTR Kick-off Retreat, and asked them to serve as “survey champions” by disseminating the
survey within their organization. We expected that this individual outreach and personal appeal would improve response rates. In addition, we e-mailed individuals in the clinical and translational research community of Rhode Island and featured the availability of the survey in email newsletters, on the Advance-CTR website, and on social media.

Instrument
A literature review was conducted in the fall of 2016 to identify translational research support needs assessment instruments for possible use or adaptation. The National Library of Medicine PubMed database was used to identify relevant publications during January 1, 2000–July 1, 2016. The search yielded 244 citations using the terms (“translational research” and “needs assessment”). Among these, three relevant studies were identified to provide guidance on key translational research needs and methods of survey dissemination.

The initial draft included an extensive range of potential questions related to research support needs. These questions were adapted from past surveys of research needs in Rhode Island, published surveys, and activities that had been planned for Advance-CTR. Next, feedback on the draft questionnaire was sought from key stakeholders to improve the relevance of the survey, and to reduce questionnaire length. At a half-day retreat, the draft instrument was distributed to 71 attendees, and discussed in groups of 10–12 individuals who encompassed the diversity of all institutions. Leaders from Advance-CTR’s KCAs were recruited to facilitate discussions and scribes took notes. Participants were asked to hand-write comments on the draft as they discussed each section. After a 45-minute discussion, each group reported on their most salient observations. All notes were collected along with all annotated copies of the draft instrument.

The instrument was subsequently revised into a Google Form version that required 5–10 minutes to complete. Structured items in the instrument addressed characteristics of respondents, specific barriers to CTR, overall satisfaction with current institutional CTR support, level of interest in various services, specific topics of interest, and preferred time frames and venues. One qualitative item asked for comments on barriers to CTR. The full questionnaire is available upon request.

Analyses
Quantitative analyses included descriptive results (frequencies and percentages) for the structured-response items, as well as significance testing with chi-square analyses for differences between respondent subgroups (created based on their affiliation). Qualitative data from the open-ended question regarding perceived barriers were content-analyzed to form inductive categories.

RESULTS
There were 171 Rhode Island-based clinical researchers who completed our survey. We are unable to determine a precise response rate, as our approach relied upon a championing model whereby requests were extended by researchers with peer influence, and also by college deans and department chairs.

The demographic data presented in Table 1 showed that approximately 50% of respondents were University-based, with 32% of respondents at the University of Rhode Island and 19% at Brown University. The rest of the respondents listed their affiliation as Lifespan, Care New England, or the Providence VA Medical Center. Overall, respondents were predominantly white [82%], female [60%], and 38% held the rank of Assistant Professor. Almost all reported university academic appointments [ranks], though approximately half [49%] listed a healthcare organization as their principal research location. Most respondents [64%] were within 5 years of their terminal degree [MD, PharmD, PhD]. When asked about the type of research that most closely aligns with their work, the leading category indicated was “clinical research” [28%), followed by biomedical/pre-clinical [27%], health services research/best practices [16%], clinical trials/efficacy [11%] and population health [10%]. Only 2 respondents viewed their research as being primarily translational.

Assessing their institution’s support for translational research, only 17.9% of researchers were either “very” or “extremely satisfied” (Figure 1). Most reported being “somewhat satisfied” [62.9%] and nearly 1 in 5 respondents overall [19.2%] indicated that they were “not at all satisfied” with support for CTR. The percentage responding either “very” or “extremely” satisfied with institutional support for CTR was highest at Brown University [28.1%] and lowest at the University of Rhode Island [13.1%].

Figure 2 highlights specific unmet needs for research support that pose barriers to translational research productivity ordered by overall ranking. Pilot project funding, protected time for research, and support for proposal development and grants administration were the most frequently expressed research support needs. Chi-square tests indicated that response frequency differed by institution for 8 of the 13 barriers presented to survey respondents.

Researchers’ interests regarding in-person consultation topics are presented in Figure 3, as the percentage responding “somewhat” or “very” interested in each particular topic. Overall, expertise in data analysis and study design drew the most interest, while clinical trial protocol review drew the least. Notably, more than 65% of all respondents were at least somewhat interested in each of the topics listed for in-person consultations. Figure 4 presents level of interest for various CTR webinar topics: data access and analysis, and research mentoring were the top selected topics.
Table 1. Characteristics of Survey Respondents (N = 171)

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>n</th>
<th>%</th>
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<tbody>
<tr>
<td>Brown University:¹</td>
<td>32</td>
<td>19%</td>
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<tr>
<td>School of Public Health²</td>
<td>17</td>
<td>53%</td>
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<tr>
<td>Warren Alpert Medical School</td>
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<td>25%</td>
</tr>
<tr>
<td>Other Brown Department</td>
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<td>21%</td>
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<tr>
<td>University of Rhode Island:</td>
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<td>32%</td>
</tr>
<tr>
<td>Health Sciences</td>
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<td>43%</td>
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<tr>
<td>Pharmacy</td>
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<tr>
<td>Nursing</td>
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<td>11%</td>
</tr>
<tr>
<td>Academic Health Collaborative</td>
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<td>4%</td>
</tr>
<tr>
<td>Other URI Department</td>
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<td>4%</td>
</tr>
<tr>
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<td>Care New England</td>
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<tr>
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<td>Female</td>
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<td>4%</td>
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<td>Hispanic or Latin</td>
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<td>1%</td>
</tr>
<tr>
<td>White</td>
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<td>82%</td>
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<tr>
<td>Left Blank or Other</td>
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<td>6%</td>
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<tr>
<td>Academic Rank</td>
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<td></td>
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<tr>
<td>Assistant Professor</td>
<td>65</td>
<td>38%</td>
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<tr>
<td>Associate Professor</td>
<td>29</td>
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<tr>
<td>Professor</td>
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<td>1%</td>
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<tr>
<td>Postdoctoral Fellow</td>
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<td>1%</td>
</tr>
<tr>
<td>N/A or Left Blank</td>
<td>15</td>
<td>9%</td>
</tr>
<tr>
<td>&quot;What type of research most closely aligns with your work?&quot;</td>
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<td></td>
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<tr>
<td>Clinical research</td>
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<td>28%</td>
</tr>
<tr>
<td>Biomedical/pre-clinical</td>
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<td>27%</td>
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<tr>
<td>Health services research/best practices</td>
<td>26</td>
<td>16%</td>
</tr>
<tr>
<td>Clinical trials/efficacy</td>
<td>18</td>
<td>11%</td>
</tr>
<tr>
<td>Population health</td>
<td>17</td>
<td>10%</td>
</tr>
<tr>
<td>Education</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Translational research</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>5%</td>
</tr>
</tbody>
</table>

¹ Percentage of total respondents affiliated with Brown University
² Percentage of those affiliated with Brown University that are within the School of Public Health

Figure 1. Institutional Efforts in Supporting Clinical and Translational Research: Percentage of researchers who responded being “very” or “extremely satisfied” with their institution’s efforts supporting translational research (versus “somewhat” or “not at all satisfied.”)

Figure 2. Perceived Barriers to Clinical and Translational Research: Percentage of researcher respondents who view a lack of each of the following to be a barrier to Clinical and Translational Research to some or great extent

Note. * Chi-Square tests indicated significantly different counts than would be expected, p<.05. Items are presented in order by the percentage of all respondents reporting each item to be a barrier “to a great extent.”
This needs assessment provides important insights regarding the environment for conducting CTR in Rhode Island. The central questions we posed in our introduction formed the basis for our survey design. First, we wanted to know, who are the researchers who might benefit from the supports offered by Advance-CTR? Our survey elicited responses from academic professionals at Brown University and the University of Rhode Island as well as less-experienced researchers and hospital-based professionals whose research interests go beyond the biomedical/pre-clinical level. The needs expressed by our respondents are thus very relevant to the mission of Advance-CTR.

Second, what are the most important barriers to CTR in our state? Across the 5 institutions represented, fewer than 1 in 5 respondents were either “very” or “extremely” satisfied with their institution’s support for CTR. This finding highlights a need for enhanced support for CTR researchers, including access to research funding and support services. The survey participants identified a lack of funding and protected time as principal barriers to conducting CTR. These two barriers are related to the extent that protected time is typically funded by research grants. Support for grant administration, support for proposal development, and data analyses support services were the next highest-reported barriers. Qualitative comments regarding barriers reinforced these quantitative findings, emphasizing the lack of the following: technical support for developing CTR, protected time (particularly for teaching and clinical personnel), mentor and collegial support, internal funding, inter-institutional coordination (e.g. IRB), and necessary laboratory facilities. All are addressable. Importantly, Advance-CTR provides resources targeted to directly address almost all of these needs and barriers.

Third, what professional development and support services would improve researchers’ careers in CTR, enhance research productivity, and ultimately improve health outcomes? The findings regarding barriers as well as those dealing with training and consultation point to the most urgent needs. In addition to internal pilot funding, which is now provided by two of the KCAs, there are several additional support mechanisms that are now available from our service KCAs: [1] help with proposal development, including research and statistical design, IRB coordination, skilled mentoring; and [2] ongoing help with project implementation and completion, including data analysis support and grant administration support. We note that some identified problems call for solutions at other levels: protected time and research space are considerations for the individual institutions represented in our collaborative.

While we were highly satisfied by the extent of participation in this needs assessment survey, there are some limitations to our study. Given our sampling procedure, we cannot be certain that our results are generalizable to the population of relevant researchers in the state. Second, a proportion of those indicating a hospital affiliation likely also hold an academic affiliation, yet we captured only the respondents’ primary affiliation of choice. Lastly, our survey reflects the...
views of researchers; it is possible that our results would differ if we had included administrators and others having knowledge of available resources and ongoing efforts to advance CTR within their institutions.

The success of a state’s health-related research enterprise has a significant impact on budgets. Research!America (2016) estimates that some $158 billion was spent on healthcare research in the US in 2015, and that about $1.3 billion of this was spent in Rhode Island. Translational research can bring major economic benefits through both groundbreaking discoveries that yield new treatments, and through the more cost-effective application of existing preventive or treatment strategies. Academic medical centers across the US have competed to participate in the NIH’s $500 million Clinical and Translational Science Award program, and institutions in smaller states, including Rhode Island, are keen to compete on an equal footing. Institutional Development Awards can provide important impetus but, in the longer run, we (Brown University and the University of Rhode Island, with Lifespan, Care New England and the Providence VA Medical Center) still need to increase our share of the national CTR budget to a level commensurate with our population.

CONCLUSION
This needs assessment survey of health researchers and research-associates identified several opportunities for improving CTR at institutions in Rhode Island. Less than 1 in 5 respondents indicated being either “very” or “extremely” satisfied with their institution’s efforts to support clinical and translational research, with lack of funding and a lack of protected time for conducting research identified as top barriers. A lack of support for grant administration and proposal development, and lack of data analysis support services were also identified as frequent barriers. These findings align with Advance-CTR, which provides resources and expertise to promote clinical and translational research in Rhode Island.

Acknowledgments
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James Padbury, MD, William and Mary Oh-William and Elsa Zopfi Professor of Pediatrics for Perinatal Research, Professor of Pediatrics, Principal Investigator, Advance-CTR, Alpert Medical School of Brown University

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CONTRIBUTION

Ghost Attack:
The East Providence Carbon Monoxide Mass Casualty Incident

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ABSTRACT
A routine call for a common medical emergency was expeditiously identified by the responding emergency medical service as a multiple victim carbon monoxide exposure. The event circumstances, exemplary fire department emergency medical services response, and ensuing hospital emergency department response are described.

KEYWORDS: carbon monoxide, East Providence Fire Department, detector

INTRODUCTION
On January 23, 2016, a 911 call was placed from the Holy Ghost Brotherhood Hall in East Providence, Rhode Island, requesting emergency medical service response for a patient who had collapsed in a bathroom. The facility, within a block of the East Providence Fire Department headquarters, was hosting a large social event with approximately 250 attendees. Fortuitously, the firefighter entrusted with equipment purchases had decided to augment fire engine-based carbon monoxide detectors with smaller units affixed to all of the response team basic equipment bags. This foresight and the skilled incident management by the responding agency were to prove lifesaving.

EMERGENCY MEDICAL SERVICES RESPONSE
As the initial units responded from the nearby station, the carbon monoxide detectors on the equipment bags began to alarm. While the EMTs attended the patient for whom the 911 call had been placed, arrangements for confirmation readings, general building monitoring, and additional fire engine resources were made. During this period, other event attendees developed symptoms concerning to the emergency personnel and, with confirmation of elevated CO levels, a Level One Mass Casualty Incident was declared via Fire Alarm and the decision to evacuate the building was made. The event Master of Ceremonies was tasked with assisting fire department officers in this task, complicated by a language barrier and an ongoing snowstorm. The building furnace was shut down, the building ventilated and searched for additional victims. Outside, EMS co-oximetry evaluation was performed on attendees and decisions regarding ambulance transport or issuing instruction to seek care based upon measured levels, vital signs, and any symptoms reported. Cars parked in the facility lot were searched for previously unrecognized victims. Three East Providence Fire Department ambulances, and ambulances from Barrington, Cranston, North Providence, Pawtucket, Providence, Warwick, Warren, and Seekonk transported 26 patients. Subsequently, units from Bristol, Lincoln, Attleboro, and Central Falls transported patients who had gone home and become ill. Local area hospitals were alerted. Additional persons were advised to seek evaluation at hospital emergency departments. Within approximately 30 minutes, the evacuation of the scene was complete. The building was found to have no functioning CO detectors and a furnace malfunction was confirmed as the cause of the event.

HOSPITAL RESPONSE
Rhode Island Hospital (RIH) and The Miriam Hospital (TMH) emergency departments received patients. Advance informal hospital notification occurred when the emergency medicine attending assigned to LifePACT Critical Care transport team noted texting and Twitter EMS traffic indicative of a mass casualty incident scene response increment. Arranging for notification of Hasbro Children’s Hospital’s emergency department, he went to the RIH emergency department to notify staff and monitor the situation evolution by scanner, hospital capacity and patient tracking information system units in the emergency department medical communications center. The capacity and PTS units were part of a statewide disaster information system developed after the Station Fire disaster. Formal EMS notification occurred prior to physician and nursing shift change and resulted in a decision to activate Code Triage at RIH. An anticipated decision to reduce staffing due to the snowstorm and reduced departmental census was reversed. A patient triage plan was developed for those groups of patients arriving by ambulance or by private vehicle. A Massimo co-oximeter, sometimes used to assess patients with potential exposure, was available for use at RIH and TMH. It was decided to evaluate all patients arriving by ambulance, send those with symptoms and/or carboxyhemoglobin level > 20% to critical care rooms, those with intermediate levels to urgent care areas, and to evaluate all ambulatory patients in the waiting area, assigning those with symptoms or a carboxyhemoglobin reading > 10 to immediate care. Occasional challenges were encountered tracking field levels, emergency department triage levels,
and resolving potential discrepancies. Serum carboxyhemoglobin levels were performed on 16 patients. Empiric treatment was continued for the standard required two half-lives with some variation in laboratory / monitoring measures applied along with clinical evaluation. The providers contacted the New England Regional Poison Center. Recommendations were hyperbaric oxygen therapy for pregnant patients with current carboxyhemoglobin level > 10%, those with chest pain, EKG changes or troponin elevation and carboxyhemoglobin > 15%, and for those with syncope, neurologic symptoms or carboxyhemoglobin >25%. Normobaric 100% oxygen was recommended for other symptomatic patients with close monitoring and reassessment. No patient was transferred for hyperbaric oxygen therapy.

Overall, 35 patients were treated and all released. Six patients presented at The TMH emergency department. All were treated with 100 % oxygen and observed until levels normalized.

**DISCUSSION**

Carbon monoxide poisoning continues as an insidious threat with protean symptoms, too easily ascribed to other causes, many much less serious. Carbon monoxide (CO) poisoning is responsible for up to 50,000 emergency department visits and 5000 to 6000 deaths per year, making it one of the leading causes of poisoning death in the United States [1, 2]. Accidental CO poisoning likely causes around 500 deaths annually; the number of intentional CO poisoning deaths approximately 10 times higher [1]. Overall, case-fatality rate for CO poisoning ranges from 0 to 31 percent [3].

Unlike intentional poisoning, unintended poisoning demonstrates both seasonal and regional variation, and is most common during winter months in cold climates [4]. Morbidity, predominantly due to late neurocognitive impairment, persists beyond initial stabilization in significant proportion of victims [5].

Smoke inhalation is responsible for most inadvertent cases of CO poisoning. Other potential sources of CO include poorly functioning heating systems, improperly vented fuel-burning devices, gasoline-powered electrical generators [2], and motor vehicles operating in poorly ventilated areas [3]. CO poisonings following open-air exposure to motorboat exhaust have also been reported [6]. In addition, underground electrical cable fires produce large amounts of CO, which can seep into adjacent buildings and homes [7]. An increase in carbon monoxide exposures has been reported to occur in the immediate aftermath of hurricanes [4].

This toxic exposure continues despite public safety regulations mandating detectors, at least in new construction. Detectors are relatively inexpensive and their maintenance simple although battery changes are required. Despite the potential reduction of accidental exposure deaths by 50%, and cost-effectiveness data overwhelmingly supporting their universal use, detectors are present in only about 30% of homes [8]. Carbon monoxide poses a particular danger to firefighters despite training, monitoring, and use of self-contained breathing apparatus. The astute equipment purchase and deployment decisions clearly transformed the responders’ perception of the East Providence event from an isolated common emergency medical phenomenon to one with significant morbidity and mortality risk, not only to the index patient but to those other exposed event attendees.

**References**


**Acknowledgments**

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Cocaine-Related Acute Spinal Cord Infarction
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ABSTRACT
We report a rare case of anterior spinal artery syndrome in the setting of acute cocaine use. A 31-year-old man presented to the hospital unarousable with leukocytosis and a positive toxicology screen for opioids, cocaine, benzodiazepines and cannabis. He was placed on intravenous naloxone. As the patient regained consciousness, he was found to have paraplegia, sensory loss below the level of T5, and urinary retention. MRI findings showed a signal intensity abnormality from the level of T1-4, highly suggestive of an acute ischemic spinal cord infarct.

KEYWORDS: cocaine, anterior spinal artery syndrome, spinal cord, spinal cord infarction

INTRODUCTION

Case Report
A 31-year-old man with no known medical history presented to the hospital after being found unresponsive at his home. He was somnolent and received 10mg naloxone by emergency medical services (EMS). On initial presentation, he had a temperature of 36.6 degrees C, heart rate of 108 beats per minute, respiratory rate of 25 respirations per minute, blood pressure 118/97 mmHg and oxygen saturation 100% on room air. He was arousable only to loud voice. He moved all extremities, and had erythema with evidence of track marks in his left antecubital fossa. A CT of his head was unremarkable. His laboratory workup was remarkable only for white blood cells 21.5 x10^3)/mcL. His urine toxicology screen was positive for cocaine, benzodiazepines, opiates, and cannabis. He was admitted to the intensive care unit for polysubstance overdose and was started on intravenous naloxone. The next day, the patient became increasingly alert and was found to have bilateral decreased lower extremity sensation and paraplegia. A Foley catheter was placed due to severe urinary retention. CT angiography of the chest, abdomen and pelvis revealed a normal aorta, although the Artery of Adamkiewicz was not visualized. MRI of the lumbar spine was within normal limits except for edema and contrast enhancement of the left erector spinae musculature. Thoracic spine MRI revealed a signal intensity abnormality from the T1-T4 [Figure 1]. The patient was paraplegic, with pinprick sensory loss below the level of T5, leg hypertonia and absent plantar reflexes. Deep tendon reflexes were absent in the lower extremities bilaterally. Proprioception was preserved. Sagittal MRI demonstrated anterior spine infarction, while axial MRI was not definitive [Figure 2]. The findings were attributed to acute ischemic stroke of the Artery of Adamkiewicz secondary to acute cocaine use. The patient was treated supportively and was discharged to a rehabilitation center.

Figure 1. MRI of thoracic spine illustrating area of infarction.

Figure 2. Axial MRI.
**DISCUSSION**

This case presents a rare incidence of anterior spinal artery infarction secondary to cocaine use. Our patient presented with decreased pinprick sensation and motor loss below the level of T5, with preserved proprioception, indicating preservation of the posterior columns of the spinal cord consistent with an anterior spinal cord infarction.

Although cocaine use is associated with neurological complications, they are most commonly intracranial pathologies, such as intracranial hemorrhage, subarachnoid hemorrhage, cerebral vasculitis, and seizures and only few instances of spinal cord infarction have been reported. Of the cases of spinal cord infarction reported, all appear to involve the anterior spinal artery.

The pathophysiology of cocaine-induced spinal infarction is unknown. Proposed mechanisms include vasospasm, vasculitis, vasoconstriction, embolus due to ventricular fibrillation, and thrombosis secondary to increased platelet aggregation.

Cocaine prevents the uptake of neurotransmitters at the nerve terminal, which may increase sensitization of the nerves to epinephrine and norepinephrine, resulting in vasospasm. By potentiating the effect of monoamines and delaying their reuptake, cocaine induces hypertension and thus increases the risk for cerebrovascular events. Additionally, cocaine has been shown to increase platelet production of thromboxane, and therefore increase platelet aggregation, which may also account for cocaine-induced infarction. Likewise, cocaine is also associated with ventricular fibrillation and other cardiac arrhythmias, which could cause thromboemboli.

It is impossible to distinguish cocaine-induced spinal cord infarction from other causes of ischemia. There is no specific test to determine the exact etiology, therefore clinical presentation should alert the physician. While cocaine-induced spinal cord infarction is indeed rare, it should remain in the differential diagnosis of acute spinal cord pathology in the setting of a non-traumatic etiology.

**CONCLUSION**

Our report presents a rare case of cocaine-induced spinal infarction. While cocaine has been known to cause neurologic pathology, the majority of these cases involve the brain. Clinicians should be aware of the anterior spinal artery infarction secondary to cocaine use.

**References**


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ABSTRACT
Orbital compartment syndrome typically occurs due to trauma or burns. Here we discuss a case of spontaneous lamina papyracea dehiscence associated with transient orbital compartment syndrome. A previously healthy woman presented to the Emergency Department complaining of unilateral eye pain after nose blowing. The patient did not have any pupillary or extra-ocular movement abnormalities; however, she did have mildly decreased visual acuity in the affected eye. Intraocular pressure was found to be elevated and a subsequent CT scan showed orbital emphysema with spontaneous dehiscence of the lamina papyracea. The intraocular pressure decreased within hours, and ultimately, she required no intervention.

KEYWORDS: orbital compartment syndrome, spontaneous, lamina papyracea

INTRODUCTION
Orbital emphysema is seen in the Emergency Department (ED) uncommonly, but it is usually associated with trauma or infection. Rarely, orbital emphysema has been reported after forceful sneezing or nose blowing.1,6 Most often this is associated with dehiscence of the lamina papyracea, a thin bone overlying the ethmoid sinus and comprising the majority of the medial orbital wall.7 Cases of spontaneous dehiscence are usually linked to remote trauma or active infection.8,9 Previous reports of spontaneous orbital emphysema have commonly been associated with normal intraocular pressures.3,5,6 One prior case of spontaneous orbital emphysema was associated with elevated intraocular pressure; however, in this case the patient had a recent history of an unrepaired orbital floor fracture.4

Orbital compartment syndrome, defined by an increase in intraocular pressure sufficient to cause ischemia of the optic nerve and permanent vision loss, is most often reported in cases of facial or orbital trauma, severe infection or burns. Here, we present a case of orbital compartment syndrome caused by spontaneous orbital emphysema without any history of trauma or infection which resolved within several hours of presentation.

CASE REPORT
A 30-year-old previously healthy woman presented to a community emergency department with several hours of left-sided eye pain that began after nose blowing. Pain increased with eye movement. She had no prior medical or ophthalmologic history. She denied any history of trauma, diplopia or other vision changes, sinus congestion, rhinorrhea, or foreign body sensation.

She had normal vital signs. There was no crepitus, bony tenderness, or other signs of trauma or infection although there was subtle ptosis of the left lid without exophthalmos. The otorhinolaryngologic exam was normal. Ophthalmologic exam revealed a visual acuity of 20/50 OS, 20/20 OD with normal extraocular movements (EOM) and pupillary responses bilaterally, she did note pain with movement of the left eye, particularly with lateral gaze. The conjunctiva, sclera, cornea, lens, vitreous, retina, and fundus were normal bilaterally, with no signs of corneal abrasion or foreign body on slit lamp exam. Intraocular pressures were 50 mmHg OS and 29 mmHg OD (normal pressures are between 10–21 mm Hg). Each measurement was repeated and confirmed by the attending physician.

After discussion with the on-call ophthalmologist, the patient was transferred from the ED to the ophthalmologist’s outpatient office for an emergent evaluation for concern for acute angle-closure glaucoma. Upon evaluation at the ophthalmology outpatient office, there was concern for orbital emphysema, and the patient was again transferred to a second, tertiary care ED for an orbital CT.

By the time she was reevaluated by ophthalmology at the second ED, approximately 7 hours had passed from her initial assessment. Her intraocular pressures and visual acuity had spontaneously normalized and her slit lamp and fundoscopic exams were normal except for subcutaneous emphysema felt over her left eye. A multidetector CT face protocol revealed dehiscence of the left lamina papyracea. Representative images demonstrated extensive pre-septal air tracking along the medial rectus muscle [Figures 1, 2]. There was no retrobulbar involvement. The remainder of the orbit was intact. There was no evidence of underlying erosive process or malignancy. There was bilateral maxillary sinus thickening suggesting the possibility of acute sinusitis. Given the patient’s normalized intraocular pressures and visual acuity, no urgent interventions were performed. The patient...
was advised to avoid nose blowing, heavy lifting, or other valsalva maneuvers and to elevate the head of bed until cleared by ophthalmology. She was discharged home on seven days of prophylactic cephalexin with oculoplastics follow-up.

On outpatient oculoplastics follow-up three days after the event, the patient continued to complain of periorbital pain in the left eye with extreme gaze but denied any further visual changes. Her ocular pressures, visual acuity, and ophthalmologic exam continued to be normal. There was no evidence of entrapment, trauma, or optic nerve impingement. There were no interventions and she did not return.

**DISCUSSION**

Spontaneous orbital fractures, most commonly of the ethmoid bone, are an uncommon case of orbital emphysema. Previously reported cases, however, have presented with normal ophthalmologic exams and significant physical exam findings, including periorbital crepitus and ptosis.1-6 This case was a unique presentation with transient orbital compartment syndrome following spontaneous lamina papyracea dehiscence with minimal physical exam findings.

The medial orbital wall is comprised three bony structures: the lacrimal bone anteriorly, the sphenoid body posteriorly, and the lamina papyracea, which is a paper-thin bone.

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**Figure 1.** Face computed tomography with soft tissue windows demonstrating preseptal air. Coronal view (B) demonstrates small foci of gas medial to medial rectus muscle (arrow).

**Figure 2.** Coronal bone window (A) demonstrating dehiscence of lamina papyracea (thin arrow). Axial view (B) demonstrating protrusion of orbital fat (thick arrow).
that overlies the ethmoid sinus and comprises the majority of the medial wall. The lamina papyracea is a delicate portion of the ethmoid bone and is typically fractured following blunt orbital trauma or iatrogenically in the course of ethmoid sinus surgery. Nontraumatic lamina papyracea dehiscence has been associated with sinusitis and acute infectious processes.7

In the rare cases of orbital compartment syndrome, increased pressure can cause ischemia of the optic nerve, which may lead to permanent vision loss. Emergent interventions include lateral canthotomy and needle aspiration.9

CONCLUSION
Despite the initially abnormal ophthalmologic exam in this case, intraocular pressure quickly normalized and no acute interventions were required. We suspect that the minimal orbital emphysema was reabsorbed by surrounding tissues, leading to the spontaneous resolution of the patient’s elevated pressure.

Patients presenting to the Emergency Department with unilateral symptoms of eye pain following sneezing or nose blowing should receive a thorough ophthalmologic evaluation including intraocular pressure measurement. CT imaging of the face can be a helpful diagnostic tool in these cases as well.

References

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Drug overdose is a public health crisis in the United States.\(^5\) It is the leading cause of injury death in the U.S., causing about 52,000 deaths in 2015,\(^1,2\) and is a major public health concern in Rhode Island. Based on the age-adjusted rate of death due to drug overdose in 2015, Rhode Island ranked fifth in the U.S. The top five states included West Virginia [41.5 per 100,000], New Hampshire [34.3], Kentucky [29.9], Ohio [29.9], and Rhode Island [28.2].\(^3\) The number of drug overdoses has risen rapidly during 2009–2016. In Rhode Island, the number of drug overdose deaths exceeds the combined number of deaths due to suicide, homicide, and motor vehicle crashes in 2016.

Drug overdose deaths contribute to physical, mental, social, and public health problems, and have a major impact on individuals, families, and communities.\(^4\) One of the Healthy People 2020 goals is to “reduce substance abuse to protect the health, safety, and quality of life for all, especially children.”\(^2\) The increase in drug overdose deaths highlights the urgent need for accurate and timely surveillance. The Rhode Island Department of Health (RIDOH)’s Center for the Office of State Medical Examiners (OSME) certifies about 10% of all deaths that occur within Rhode Island, and is a critical source of information regarding drug overdose deaths. The objectives of this report were to: (1) describe Rhode Island’s longitudinal trends and geographic patterns in unintentional drug overdose death using available medical examiners’ office data; (2) compare Rhode Island’s performance to neighboring states, using the newly-available Centers for Disease Control and Prevention (CDC) data; and (3) generate a linear equation to predict future four-year deaths due to drug overdose in the absence of effective interventions.

**METHODS**

**Data sources**

Two data sources were used: (1) The OSME database was searched for all cases from January 2009 through December 2016 with drug overdose reported as cause of death. The death must have occurred within Rhode Island. The underlying cause of death must have been officially confirmed by a medical examiner. (2) The 2015 drug overdose death data on the CDC website was used to rank the 50 states and D.C.\(^3\) Death causes were classified using the International Classification of Diseases, Tenth Revision [ICD–10].\(^3\)

**Data analyses**

[1] GIS map: During 2009–2016, Rhode Island only had two teen deaths due to drug overdose, so we calculated the average annual adult death rate of drug overdose by using Rhode Island’s 2010 census city/town adult (18 years and older) populations. Mapping of drug overdose death rates by cities and towns where overdoses occurred was conducted using ArcGIS 10.2 [Environmental Systems Research Institute, Inc., Redlands, CA]. We employed the Jenks Natural Breaks Classification method to develop the value ranges of the overdose death rate.

[2] Linear equation: The drug overdose deaths were modeled as a function of the year of when they occurred. Based on Rhode Island 2009–2016 data, we generated a linear equation to predict future year deaths due to drug overdose if the current rates were to continue in the absence of effective interventions. A linear equation was used to calculate the annual number of deaths projected for 2017–2020.

**RESULTS**

During 2009 through 2016, 1,745 Rhode Island adults died of a drug overdose. The ages ranged from 16–87 years old and the average age was 42.7 [data not shown]. A trend analysis over eight years demonstrated that drug overdose deaths in Rhode Island increased significantly from 2009 to 2016. Specifically, Rhode Island OSME data revealed that the number of drug overdose deaths in Rhode Island increased nearly 2.5-fold over the past eight years. Fentanyl, as the cause of overdoses, was first reported in Rhode Island in March of 2013. Deaths due to fentanyl overdoses rose sharply during 2013–2016, while non-opioid overdose deaths remained stable [Figure 1].

In 2015, Rhode Island ranked 5th among the 50 states and Washington, D.C. for the age-adjusted rate of death due to drug overdose. Rhode Island outpaced neighboring states, except New Hampshire [Figure 2]. In New England, Vermont, Maine, and Connecticut had lower rates than Massachusetts, Rhode Island, and New Hampshire. New England states with statistically significant increases in drug overdose death rates from 2014 to 2015 included Connecticut, Maine, Massachusetts, New Hampshire, and Rhode Island [Table 1]. The crude rates display some area clustering, with the highest (worst) death rates observed in the urban [four core
Figure 1. Unintentional drug overdose deaths occurred in Rhode Island, 2009–2016

Data source: Rhode Island Office of the State Medical Examiners database.

Figure 2. 50 states and District of Columbia ranked by age-adjusted rate of drug overdose deaths, 2015a

Data source: CDC Drug Overdose Death Data Website (www.cdc.gov/drugoverdose/data/statedeaths.html)
a Ranking is based on the 50 states and District of Columbia.

Table 1. Drug overdose deaths in New England states, 2015

<table>
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<tr>
<th>State</th>
<th>Age-adjusted rate (per 100,000)a</th>
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<td>23</td>
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Data source: CDC Drug Overdose Death Data Website (https://www.cdc.gov/drugoverdose/data/statedeaths.html)
a Age-adjusted death rates were calculated as deaths per 100,000 population using the direct method and the 2000 standard population.
b Ranking is based on the 50 states and District of Columbia.

DISCUSSION

Understanding drug overdose death data can help public health professionals target high-risk populations and areas, monitor overdose deaths, and prioritize resources. The authors identify trends and geographic patterns to help strategically assign prevention, response, and treatment resources. Opioid-related drug overdose deaths have risen rapidly over the last eight years in Rhode Island. Such an unsettling trend highlights the importance of comprehensive efforts addressing this crisis in a systematic manner. Efforts focusing on prevention, improving access to substance abuse treatment, increased availability of naloxone, and strategies to promote recovery are currently under way in Rhode Island.6

The OSME data can help Rhode Island identify geographic patterns of drug overdose. Consideration of where overdoses occurred could enhance specific overdose prevention interventions, such as targeted training on naloxone administration.1 This report represents the first known estimate of drug overdose deaths in Rhode Island for the next four years in the absence of effective interventions. The projection can help plan prevention efforts, manage public health resources, and assess whether interventions are effective.5

This report has at least two limitations. [1] The adult (18 years and older) population in New Shoreham is 888 in the 2010 census data. Due to the instability of the small number, the adult drug overdose death rate in New Shoreham is not reported. [2] The study focuses on the city or town where an overdose occurred. However, when this information was
In summary, there is a clear need for continued surveillance and an interdisciplinary approach to identifying, communicating, and managing the drug overdose crisis. The OSME database will continue to be an effective source in surveillance of drug overdose deaths. If drug overdose deaths in Rhode Island decline, it implies that recent efforts may be effective.

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We thank David G. De Tora, Sr. at the Rhode Island Department of Health for his subject matter expertise on the Center for the Office of State Medical Examiners’ data. We would like to express our particular thanks to Steve Sawyer, Rhode Island Department of Health, for his GIS technical assistance.

References

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Figure 3. Average annual drug overdose rate (1/100,000) among adults aged 18 and older by overdose occurred cities and towns in Rhode Island, 2009-2016*

Figure 4. Annual number of deaths from unintentional drug overdose in Rhode Island, 2009–2016, with projections to 2020

Data source: Rhode Island Office of the State Medical Examiners database.

*The adult drug overdose death rate in New Shoreham is not reported due to the instability of the small numbers.
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Disclosure
The authors have no financial interests to disclose.

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

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<td>Cerebrovascular Disease</td>
<td>38</td>
<td>434</td>
</tr>
<tr>
<td>Injuries (Accident/Suicide/Homicide)</td>
<td>67</td>
<td>896</td>
</tr>
<tr>
<td>COPD</td>
<td>47</td>
<td>472</td>
</tr>
</tbody>
</table>

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

(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

January 2, Tuesday
RIMS Physician Health Committee: Herbert Rakatansky, MD, Chair
Meeting with RI Society of Anesthesiologists’ new leadership regarding legislation

January 3–6, Wednesday–Saturday
AMA’s Advocacy Resource Center State Legislative State Strategy Conference: Public Laws Chair Michael E. Migliori, MD, and Staff

January 8, Monday
Diabetes Prevention Program (DPP) Coverage Workgroup
House Special Legislative Commission on School Start Times: Susan Duffy, MD
RIMS Board of Directors Meeting: Bradley J. Collins, MD, President

January 9, Tuesday
Meeting with Office of the Health Insurance Commissioner’s staff regarding potential legislation and pending regulations.

January 10, Wednesday
Meeting with Board of Medical Licensure and Discipline
Governor’s Opioid Overdose and Prevention Task Force meeting: Sarah J. Fessler, MD, RIMS Immediate Past President; Gary Bubly, MD, Past President

January 11, Thursday
SIM Steering Committee: Peter Hollmann, MD

January 12, Friday
Medical Group Managers Association Telemedicine Webinar

January 16, Tuesday
Advocacy Resource Center Conference call regarding Economic Impact Study

January 17, Wednesday
Primary Care Physicians Advisory Committee (RI Department of Health)
Meeting with Senator Miller and representatives of Butler Hospital regarding potential mental health substance abuse legislation
Special Legislative Commission to Study the Effects of Legalizing Marijuana, John Femino, MD

RI Society of Anesthesiologists’ Annual Meeting advocacy update: Steve DeToy, Director of Government and Public Relations, presenting
Speaker Mattiello fundraiser: Michael Migliori, MD, Public Laws Chair

January 18, Thursday
Alliance for Healthy Rhode Island AMPAC Strategic Fundraising webinar

January 19, Friday
Medically Supervised Injection Facility (SIF) meeting, RIMS offices
RJO-ACS “80 by 2018” Colorectal Screening Campaign: Alyn Adrain, MD, Past President

January 23, Tuesday
Office of the Health Insurance Commissioner Cost Management Strategies Workgroup: Peter A. Hollmann, MD, President-elect
AMA Advocacy Resources conference call regarding scope of practice

January 24, Wednesday
Workers Compensation Advisory meeting
AMA Advocacy Resource Center conference call regarding managed care physician contract database
Legislative hearings

January 25, Thursday
Conference call with Physicians for Fair Coverage regarding legislation
Legislative hearings
Senate President Ruggerio fundraiser: Peter Hollmann, MD, President-elect

January 26, Friday
Meeting with U.S. Surgeon General Jerome Adams, MD, MPH; RI Health Director Nicole Alexander-Scott, MD, MPH, and U.S. Senator Sheldon Whitehouse at RI State House

January 29, Monday
Lobbying compliance seminar, RIMS staff

January 30, Tuesday
Legislative hearings

January 31, Wednesday
Legislative hearings

Register Now!

Best Practices for Pain Management and Opioid Prescribing: Fulfilling the New Opioid CME Mandate
Crowne Plaza, Warwick

Saturday, March 3
Appropriate Prescribing, Potential for Dependence, Pharmacology, and Addiction.

Saturday, March 24
Alternatives for Opioid Pain Management: Chiropractic Care, Medical Marijuana, Physical Therapy, and Acupuncture.

CME applied for. These courses fulfill the requirements set forth in Department of Health Regulations, Prescriber Training Requirement for Best Practices Regarding Opioid Prescribing. Physician prescribers holding a Controlled Substance Registration (CSR) must fulfill this specific training requirement only once and must do so before the next renewal of their CSR (June 2018).
It’s a new day.

The Rhode Island Medical Society now endorses Coverys.

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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
URI initiative helps older student chart a path to medical school

Phothisane has made med school happen. “He asked about our program on a whim, but I don’t think he thought I would say, ‘let’s explore it,’” Simmons said. “It was clear he was someone medical schools should consider, based on his native intelligence and personal attributes.”

Housed within the University’s Honors Program, Pre-Health Advising aligns with URI’s Office of National Fellowships, Brown’s Warren Alpert School of Medicine Early Identification Program, and Johnson and Wales University’s physician assistant master’s, among other resources. Students interested in pre-health advising need not be part of the Honors Program. Pre-Health advisors counsel more than 600 students and alumni on the demands of preparing for admission to graduate school in the health fields and help them overcome challenges. “There is a self-reflective element to it. You quickly become aware of your strengths and weaknesses in a way you have not confronted before,” Simmons said.

Not all who participate will pursue health professions, but the program helps students find their path. Now, well on his path to becoming the first member of his family to graduate from college, Phothisane offers advice to others contemplating their futures: “Take the first step and keep moving forward. Don’t get discouraged.”
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Dr. Robert Parker: Serving at the Providence VAMC and in Africa

Service to something greater than one’s self is something that sets veterans apart. VA employees serve those who served our country, and some serve in other ways, too, such as volunteering.

**DR. ROBERT PARKER**, a surgeon at the Providence VA Medical Center, is one of them. He splits his time between Rhode Island and Kenya.

“I went to medical school because I wanted to deliver health care to populations without it,” said Dr. Parker. “Medicine is a calling and I’ve seen how it can change the life of an individual, and entire communities, too.”

Dr. Parker spent a year in Kenya, working on esophageal cancer research with **DR. RUSS WHITE**, a thoracic surgeon associated with Brown University who spends the majority of his time at Tenwek Hospital in Kenya.

The connection enabled Dr. Parker and his wife, **DR. ANDREA PARKER**, to do their surgery residency training in Providence, where Dr. Parker did some training at the VA medical center, and where he continued to work after residency.

In 2015, he moved to Kenya with his family to work at Tenwek, where he and his wife practice medicine and teach surgery.

“The challenges we face can be immense,” said Dr. Parker, “but more incredible are the solutions we develop through partnerships with organizations from the community through global levels.”

Today he continues to serve both veterans at the Providence VAMC, and patients in Kenya.

“I’m grateful to Brown University and the VA hospital in Providence,” Dr. Parker said. “My work at VA allows us to volunteer, training local doctors and providing care for patients in Kenya who may not otherwise have access to the care they need.”

Story courtesy Providence VAMC.
Memory and Aging Program (MAP) at Butler participating in new Alzheimer’s prevention study

Investigating whether an oral medication, known as CNP520, can slow the build-up of amyloid plaques

Providence – Recently, the Memory and Aging Program (MAP) at Butler Hospital enrolled one of the initial participants in an international Alzheimer’s disease (AD) prevention study. The study is investigating whether an oral medication, known as CNP520, can slow the build-up of amyloid plaques in the brain and delay cognitive decline in individuals at risk for the disease. Amyloid build-up is one of the major causes of AD and can begin up to two decades before the onset of the clinical symptoms.

Butler Hospital is one of 185 research centers across 25 countries participating in Generation 2. The study seeks to enroll 850 people in the United States and 2,000 people worldwide. As a randomized, double-blind study, neither the research team nor the participants are aware of whether the drug or a placebo is being administered in the form of a daily pill. Participants will be followed for five to eight years, with regular follow-up evaluations to identify changes in brain amyloid through brain imaging, cognitive function through testing, and tracking of other disease biomarkers.

The new study, called Generation 2, is a clinical trial sponsored by Novartis Pharmaceuticals in collaboration with Banner Alzheimer’s Institute and Amgen. The trial is designed for cognitively healthy adults, age 60 to 75 years old, who carry at least one copy of the APOE4 gene and have a build-up of cerebral amyloid in the brain, both risk markers for Alzheimer’s.

Stephen Salloway, MD, MS, director of MAP and professor of neurology and psychiatry at the Albert Medical School, calls this a landmark event in the fight against Alzheimer’s. He remarked, “This exciting trial brings together advances in genetics, brain imaging, and pharmacology to test a medication to prevent or delay memory loss in people at risk of developing Alzheimer’s disease.”

Rhode Island Hospital joins nationwide research network

NIH-funded effort fosters emergency medicine research on a large scale

Providence – Rhode Island Hospital has joined a cadre of other medical centers nationally serving as hubs for the Strategies to Innovate EmeRgENcy Care Clinical Trials Network (SIREN). The network facilitates improved coordination and sharing of lifesaving emergency medicine research around the treatment of gravely serious conditions, such as traumatic brain injury, cardiopulmonary arrest, and sepsis.

Nationally, the network is composed of 11 hubs, each consisting of a group of hospitals. Rhode Island Hospital and its academic affiliate The Warren Alpert Medical School of Brown University lead a group that includes the emergency services of Rhode Island Hospital’s pediatric division, Hasbro Children’s Hospital, The Miriam Hospital, Newport Hospital, Women & Infants Hospital, and the R Adams Cowley Shock Trauma Center in Baltimore, Maryland.

The project is led by principal investigator Lisa H. Merck, MD, MPH, an emergency medicine attending physician at Rhode Island Hospital and director of the Division of Emergency Neurosciences at Brown University’s Alpert Medical School.

The Rhode Island Hospital SIREN hub has also entered into a five-year agreement to form a “superhub” within the SIREN network, known as the COalition for REsearch in Emergency Medicine (CORE-EM Alliance). The alliance includes five other leading emergency medicine research centers: Emory University, Tufts University, University of Arizona, University of Texas Health Science Center at Houston, and Orlando Regional Medical Center. The CORE-EM Alliance is composed of 23 Level I trauma centers and serves an encatchment area of approximately 53 million patients.

“The CORE-EM Alliance is a collaborative effort to advance research in resuscitative medicine. We are excited to partner with other leading research centers to further advance the work of the SIREN network,” said Merck. “These centers cover a substantial portion of the eastern seaboard and southeast. Individually, each center will bring a great deal of expertise to the collaboration and together, CORE-EM will serve a large, diverse patient population. Our combined numbers and collaborative expertise will enable us to contribute in a meaningful way to advancing research in resuscitative medicine.”

CORE-EM will be joining SIREN to conduct several large-scale studies of 1,000-plus patients over the next five years. Each of the six hubs within the CORE-EM Alliance is affiliated with multiple hospitals. The model is flexible and efficient, with the ability to transition seamlessly from six independent research centers, up to 30-plus enrolling hospital sites.
Care New England, Partners HealthCare announce plans to form definitive agreement

PROVIDENCE – Care New England Health System (CNE), and Partners HealthCare of Massachusetts have agreed to enter into a definitive agreement, the next step in the process for CNE to become part of Partners HealthCare.

The January 25th announcement comes after a 10-month due diligence process, which has resulted in a plan for CNE to regain solid financial footing in the coming years was approved by the Boards of Directors of Care New England and Partners HealthCare. The definitive agreement represents a more formal document that would outline the details and plans for the actual transaction. Following the development and execution of the definitive agreement, it is expected the organizations would move forward with the needed state and federal regulatory approvals. Both CNE and Partners hope to develop and execute the definitive agreement as soon as possible.

As a result of the announcement, the existing letter of intent (LOI) and exclusivity has been extended until such a time as a definitive agreement has been executed.

Care New England has maintained a close working relationship with Partners HealthCare since 2009 through a clinical affiliation with Brigham and Women’s Hospital (one of the founding members of Partners) in cardiology, and vascular, thoracic, and colorectal surgery. In addition, there has been a long-standing collaborative and collegial relationship between McLean Hospital [a Partners hospital] and Care New England’s Butler Hospital to provide high-quality behavioral health care and innovative research locally within the Rhode Island community.

The plan to move forward with a definitive agreement includes Kent Hospital in Warwick, Women & Infants Hospital of Rhode Island in Providence, the VNA of Care New England, based in Warwick, Butler Hospital in Providence; and The Providence Center in several Rhode Island locations. Under the proposal, the strong educational and research relationship that CNE has fostered with Brown University will continue to play a critical role in the health care landscape and its future development.

Said CNE President and CEO JAMES E. FANALE, MD, “We look forward to the opportunity this now affords and what it means for the delivery of high-quality health care for our patients, the community we serve, and our vital academic partnerships. We will continue to focus our efforts on the remaining work while doing so with perseverance that reflects the needs of our patients and the ever-changing health care landscape.”

Bradley Hospital, Riverside Community Care launch BRAVE Study for Anxious Youth

Study examines effective form of talk therapy to learn what makes it successful in practice

PROVIDENCE – The Pediatric Anxiety Research Center at Bradley Hospital is partnering with Massachusetts’ Riverside Community Care, a behavioral health care and human service organization, to learn what makes exposure therapy successful. Exposure therapy is a form of talk therapy that already known to be safe and highly effective for treating anxiety and obsessive-compulsive disorder [OCD].

Exposure therapy has been studied for over 50 years in more than 150 clinical trials and is very effective at all ages. National practice guidelines recommend it as a first-line treatment for anxiety or OCD. It involves working with a trained therapist to complete exposures – practice situations where people gradually learn to face fears over time.

“Exposures are a manageable way to learn through experience that most fears don’t come true – and when they sometimes do, it’s not as scary as you might have thought,” said KRISTEN BENITO, PhD, Bradley Hospital researcher and principal investigator for the study.

Despite being very effective, exposure therapy is not widely available to those affected by anxiety or OCD. It is primarily used by specialists in academic and research clinics, and most practicing therapists do not have access to exposure therapy training. The BRAVE study hopes to start addressing this problem.

“We need to get this training to more therapists, but there is no standard for teaching what successful exposure therapy should ‘look like.’ Right now, that only exists in the heads of specialists,” said Benito. “In an earlier study, we developed a brief exposure assessment tool based on hundreds of videotaped exposures with specialists. Our goal in the BRAVE study is to see whether this tool is useful for therapists and families, and whether it can tell them when exposure is ‘on-track.’”

The study takes place in Riverside Community Care outpatient locations, where participating therapists receive specialized exposure training from the BRAVE research team.
PROVIDENCE – The Pediatric Anxiety Research Center (PARC) at the Bradley/Hasbro Children’s Research Center has received a $3.4 million funding award from The Patient-Centered Outcomes Research Institute (PCORI) to compare patient-centered (primarily in the home/community) to provider-centered (primarily in the office) outpatient treatment for kids with anxiety and obsessive compulsive disorder (OCD). The aim of the study is to devise an alternative outpatient treatment model featuring a bachelor’s level clinician, or mobile exposure coach, working in conjunction with PhDs to conduct in-home therapy visits.

“We know from our research and work with pediatric patients that exposure therapy is a highly effective behavioral treatment for anxiety and OCD, but it is very challenging for kids and families to practice those skills at home,” said Jennifer Freeman, PhD, director of research and training at PARC and the study’s principal investigator. The current outpatient treatment model for youth with anxiety disorders includes shortages of appropriate providers, logistical problems with getting to treatment, and trouble getting an adequate dose of exposure treatment in the home. “We’re exploring creation of a comprehensive patient care model that delivers home-based exposure coaching at an outpatient level of care to better meet the needs of families with anxious children.”

The first evidence-based study of its kind, the five-year randomized trial will assess the effectiveness of the two treatments and provide data to determine the feasibility and acceptability of the model for families. More than 330 patients, ages five to 18 years old, seeking treatment for anxiety or OCD at PARC will be randomized to receive patient-centered treatment using home-based services or traditional provider-centered care.

Anxiety disorders and OCD are among the most common and earliest of psychiatric disorders to occur among children and persist if left untreated, often leading to depression, substance abuse, suicide attempts, and disability into adulthood. “The need for this study stems from families asking us for more help following intensive treatment in our program, and we expect the results to validate the role of home-based treatment and create better access to care and patients and families who are more engaged in treatment,” added Freeman.

In addition to patient and family engagement, the study will measure participants’ anxiety and OCD symptoms and severity and functional impairment. Study results are expected to include identifying methods for increasing outpatient treatment access, continuation, effectiveness, and efficiency for kids with anxiety and OCD. In the longer term, project stakeholders – ranging from patients and their families to insurers – will contribute to establishing a new patient-centered service delivery model. “We are working to create a better, more accessible model of care for patients and families in need,” said Freeman.

“This project was selected for PCORI funding not only for its scientific merit and commitment to engaging patients and other stakeholders, but also for its potential to fill an important gap in our health knowledge and give people information to help them weigh the effectiveness of their care options,” said PCORI Executive Director Joe Selby, MD, MPH. “We look forward to following the study’s progress and working with PARC to share the results.”

PARC’s study was selected for PCORI funding through a highly competitive review process in which patients, clinicians and other stakeholders joined clinical scientists to evaluate the proposals. Applications were assessed for scientific merit, how well they will engage patients and other stakeholders and their methodological rigor among other criteria.

Freeman’s award has been approved pending completion of a business and programmatic review by PCORI staff and issuance of a formal award contract.

About The Pediatric Anxiety Research Center (PARC)

Located on Bradley Hospital’s main campus in East Providence, Rhode Island, The Pediatric Anxiety Research Center (PARC) is a nationally recognized, integrated research and clinical program encompassing outpatient services and an intensive treatment program for anxiety and obsessive compulsive disorder (OCD). PARC’s mission is to provide state-of-the-art assessment and behavioral and pharmacological treatment to children ages five to 18 who experience significant impairment in their daily lives due to anxiety and obsessive-compulsive (OC) spectrum disorders. Research on the etiology, phenomenology, maintenance, and course of child OCD, anxiety, and tic disorders is also conducted at PARC.

About The Patient-Centered Outcomes Research Institute (PCORI)

PCORI is an independent, nonprofit organization authorized by Congress in 2010. Its mission is to fund research that will provide patients, their caregivers and clinicians with the evidence-based information needed to make better-informed healthcare decisions. For more information about PCORI’s funding, visit www.pcori.org.
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Recognition

Dr. Peter DeBlasio, Jr. receives 2017 Distinguished Service Award at Fatima

Dr. Peter DeBlasio, Jr., an ophthalmologist who has been on staff at Our Lady of Fatima Hospital for more than 35 years, was presented with the 2017 Distinguished Service Award for his many contributions at the annual CharterCARE Health Partners’ Medical Staff physician reception on December 11.

Each year, the medical staff at Fatima Hospital recognizes physicians who have served with distinction for more than 20 years.

Dr. DeBlasio has served as Chief of Ophthalmology at Fatima and Director of the Ophthalmic Diabetes Clinic since 1990. He has served on numerous boards and committees at Fatima including service as president of the medical staff.

Dr. DeBlasio completed a Glaucoma Fellowship from Harvard Medical School/Massachusetts Eye and Ear Infirmary. He completed his residency in Ophthalmology at Rhode Island Hospital. Dr. DeBlasio received his medical degree from the University of Bologna Faculty of Medicine and Surgery and completed his clinical training at the Brown University Program in Medicine.

Dr. DeBlasio is a member of several professional societies and is past president of the Rhode Island Society of Eye Physicians and Surgeons.

Dr. Ira Singer and Dr. Jody Meharg receive 2017 Distinguished Service Award at physician reception

Each year, the medical staff at Roger Williams Medical Center recognizes physicians who have served with distinction for more than 20 years. Dr. Ira Singer and Dr. Joseph “Jody” Meharg were presented with the 2017 Distinguished Service Award for their many contributions at the annual CharterCARE Health Partners’ Medical Staff physician reception on December 11, 2017.

Dr. Singer is a board-certified orthopedic surgeon with Orthopaedic Associates, Inc. Dr. Meharg is the Director of the Intensive Care Unit at Roger Williams Medical Center.

Dr. Singer earned his medical degree from George Washington University and went on to serve as Chief Resident in Orthopaedics at Massachusetts General Hospital. He completed a Reconstructive Knee and Arthroscopic Surgery Fellowship at Brigham & Women’s Hospital. He has been on staff at Roger Williams since 1996.

Dr. Meharg received his medical degree from Albany Medical College, where he also completed his residency. He completed his fellowship in Pulmonary/Critical Care Medicine through Brown University. He has been on staff at Roger Williams since 1991 and has been named “Teacher of the Year” 13 times in the Internal Medicine Residency Teaching Program at Roger Williams.

Pictured here at the event (from left to right) are: John Holiver, CEO, CharterCARE Health Care; Dr. Joseph Mazza, medical staff president; Dr. Peter DeBlasio; and David Kobis, President of Fatima Hospital.
Visiting Nurse of HopeHealth named as a Top Agency of the 2017 ABILITY/HomeCare Elite

Visiting Nurse of HopeHealth today announced that it has been named a Top Agency of the 2017 HomeCare Elite®, a recognition of the top-performing home health agencies in the United States. For 12 years, HomeCare Elite has annually identified the top 25 percent of Medicare-certified agencies and highlighted the top 100 and top 500 agencies overall.

The ranking is developed by ABILITY® Network, a leading information technology company helping providers and payers simplify the administrative and clinical complexities of health-care, and sponsored by DecisionHealth, publisher of Home Health Line and the Complete Home Health ICD-10-CM Diagnosis Coding Manual.

“We are proud of the exceptional tradition of quality care at Visiting Nurse of HopeHealth,” said DIANA FRANCHITTO, CEO & president of HopeHealth. “The heart of what we do every day is providing care that focuses on what is best for the patients and providing support for their families. We provide quality care to patients where they most want to be, at home.”

HomeCare Elite agencies are determined by an analysis of performance measures in quality outcomes, best practices implementation, patient experience (HHCAHPS), quality improvement and consistency, and financial health. In order to be considered, an agency must be Medicare-certified and have data for at least three outcomes in Home Health Compare.

Rhode Island Hospital operating room nurses earn Clinical Excellence Award

National AORN CORE award recognizes continuous improvement, evidence-based practice; OR nurse onboarding and education critical to success

PROVIDENCE – Rhode Island Hospital’s operating room nursing staff was recently recognized by the Association of periOperative Registered Nurses [AORN] with a “Committed to OR Excellence Award” [CORE], receiving the honor’s gold-level designation. According to AORN, “The AORN CORE Award™ recognizes the individual perioperative unit(s) that distinguishes themselves by improving every aspect of perioperative patient care.”

Gold-level designation indicates evidence of excellent and sustained unit performance and patient outcomes. One award is granted nationally each year, and the designation is valid for three years.

The national award is the result of careful review by AORN of Rhode Island Hospital’s application, a process that requires self-evaluation and extensive description of the perioperative unit’s practices in six areas, including:

- Leadership structures and systems
- Appropriate staffing and staff engagement
- Effective communication
- Knowledge management, learning and development
- Evidence-based practice and processes
- Outcome measurement

One notable element to Rhode Island Hospital, which boosted performance in several of these areas, is the hospital’s onboarding program developed to suit the individual needs of new staff, from novice nurses to experienced RNs changing their area of practice.

The program also pairs long-time OR nurses with all medical students, physician assistant students and nurse practitioner students to ensure consistent, aseptic practice and the highest quality of care. The Rhode Island Hospital OR is also hoping to partner with local colleges to give nursing students OR experience in addition to the usual practicum on medical and surgical floors.

“Our whole education plan is based on national safety goals,” says JOYCE SMITH, RN, BSN, MBA, education coordinator for perioperative services at Rhode Island Hospital. “We try to be unique and novel with educational delivery, which in turn ensures that every patient gets the highest quality and safest clinical care possible.”

Rhode Island Hospital scored a perfect 450 score in the outcome measurement section of the AORN review, which is exceedingly rare.

“Rhode Island Hospital undoubtedly boasts some of the best nursing care in the state,” said BARBARA RILEY, DNP, senior vice president and chief nursing officer for Rhode Island Hospital. “Designations like this further demonstrate that our nurses, and the strength of the nurse leadership and education on our units, are among the best in the country.”

“Across the country, hospital facilities continuously strive to provide consistent, high quality patient care and it is important they be recognized for their achievement,” said LINDA GROAH, MSN, RN, CNOR, NEA-BC, FAAN, Executive Director/CEO of AORN. “The CORE Award is a testament to Rhode Island Hospital’s clinical experience and their commitment to their patients and staff.”

Recognition
South County Hospital receives three 2018 Women’s Choice Awards

South County Hospital was recently notified that it earned three Women’s Choice Awards for 2018: America’s Best Hospitals for Obstetrics, America’s Best Hospitals for Patient Safety and America’s Best Stroke Centers. Understanding that women in the United States make approximately 80 percent of the healthcare decisions for their families, the Women’s Choice Award was designed to empower every woman to make smarter healthcare choices by providing publicly available reporting on the best hospitals. Award recipients are based, in part, on survey results that identify women’s healthcare preferences.

Earning the Women’s Choice Award for America’s Best Hospitals for Obstetrics ranks South County Hospital in the top 17 percent of the 2,720 hospitals in the country that offer obstetrical services. South County Hospital has received the Women’s Choice Award for Obstetrics each year since 2015.

The America’s Best Hospitals for Patient Safety recognizes South County Hospital’s safe surgery practices and low rates of complications and infections, based on data reported on 11 factors. The Hospital is ranked in the top 16 percent of 3,179 hospitals in the country for patient safety.

The award for America’s Best Stroke Centers recognizes South County Hospital for meeting high standards for stroke care as determined by the Joint Commission, as well as meeting or exceeding numerous performance measures set by the Centers for Medicare and Medicaid Services. The Joint Commission is an independent, not-for-profit organization whose accreditation and certification is recognized nationwide as a symbol of quality.

In addition to the standards that hospitals must meet or exceed to qualify for Women’s Choice Awards, the organization identifies hospitals that use an Inpatient Safe Surgery Checklist, reports low rates of early elective deliveries (one percent or less) and those that have a Baby Friendly USA designation as determined by World Health Organization (WHO) and United Nations Children Fund (UNICEF).

In 2017, South County Hospital was the only hospital in the northeast to receive two five star ratings from the Centers for Medicare and Medicaid – for Hospital Quality and Patient Experience – and one of only 19 hospitals in the country to receive the two top ratings.

“It is a testament to our ongoing commitment to the families within our community. We could not have achieved this exceptional recognition without the hard work and support from each of our employees,” said Louis R. Giancola, president and CEO of South County Health. “Every day they demonstrate an ongoing commitment to our patients and to our community.”

Recognition

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A health care ministry of the Roman Catholic Diocese of Providence.
Grants

W&I awards grants from Constance A. Howes Women’s Health Innovation Research Fund

Women & Infants Hospital has awarded three approximately $25,000 grants from the Constance A. Howes Women’s Health Innovation Research Fund. The research fund, which has raised more than $400,000, was established in 2014 with contributions from more than 150 donors to honor former hospital president Constance A. Howes and to support research studies that advance women’s health and gender-based research.

Awardees are Women & Infants researchers Valery Danilack, MPH, PhD, research associate in the Division of Research, Department of Obstetrics and Gynecology; Paul DiSilvestro, MD, director of the Division of Gynecologic Oncology in the Department of Obstetrics and Gynecology; and Niharika Mehta, MD, obstetric internist in the Center for Obstetric and Consultative Medicine.

The team from Dr. Danilack’s proposal, “A Qualitative Study of Experiences and Preferences with Labor Induction,” will conduct qualitative interviews of patients and providers to elucidate their experiences and preferences in regard to the labor induction process.

Dr. DiSilvestro’s grant will enable him to continue his work, “miRNA Biomarkers for Early Detection of Ovarian Cancer.” MicroRNAs (miRNAs) represent a promising breakthrough in both early detection and targeted treatment in epithelial ovarian cancer, the leading cause of mortality among all gynecologic malignancies.

Dr. Mehta will work with co-primary investigator Isabelle Malhame, MD, obstetric medicine fellow. Their project, “A Risk Assessment Tool for Cardiovascular Severe Maternal Morbidity,” aims to develop a risk assessment tool that will allow clinicians to identify those women at highest risk of developing cardiovascular severe maternal morbidity during pregnancy and after delivery.
Women & Infants Hospital's Emergency Department achieves Level 3 certification

In response to Governor Gina Raimondo’s Executive Order to establish a statewide task force to address the opioid epidemic, Women & Infants’ Emergency Department partnered with other Care New England facilities and the Rhode Island Department of Health (RIDOH) to ensure the needs of this specialized patient population are met.

At the Governor’s Task Force Meeting held recently, RIDOH and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) presented Women & Infants with its Level 3 Certification as part of the Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder.

“Many have patients, friends, family, and even colleagues who have been personally affected by addiction and opioid use disorder. While accidental drug overdose has been a growing problem across the nation, Rhode Island has been one of the most severely impacted states in recent years,” said Roxanne Vrees, MD, medical director of emergency obstetrics and gynecology at Women & Infants, and Nicole Alexander-Scott, MD, MPH, director, Rhode Island Department of Health.

Women & Infants’ plan has four fundamental areas focusing on treatment, overdose rescue, prevention, and recovery. The team developed organizational policies, clinical protocols, and institutional infrastructure to ensure that patients are managed appropriately.

This designation formalizes the hospital’s commitment to this health care problem and requires that the hospital maintain standard protocols, capacity, and commitment to the following:

• Follow the discharge planning standards as stated in current law.
• Administer standardized substance use disorder screening for all patients.
• Educate all patients who are prescribed opioids on safe storage and disposal.
• Dispense naloxone for patients who are at risk, according to a clear protocol.
• Offer peer recovery support services in the Emergency Department.
• Provide active referral to appropriate community provider(s).
• Comply with requirement to report overdoses within 48 hours to RIDOH.
• Perform laboratory drug screening that includes fentanyl on patients who overdose.
Kristen Matteson, MD, named Ob/Gyn Director of Division of Research

KRISTEN A. MATTESON, MD, MPH, of Barrington, has been named director of the Division of Research for the Department of Obstetrics and Gynecology at The Warren Alpert Medical School of Brown University and Women & Infants Hospital. Dr. Matteson, who is also an associate professor of obstetrics and gynecology, is recognized nationally for her expertise in the field of abnormal uterine bleeding and clinical research methods.

Dr. Matteson was part of the team to design and lead the department's Resident Research Curriculum and she revitalized the Women's Health Fellows Workshop in Clinical Research Design. Dr. Matteson serves as the research director for the NIH-funded Brown/Women & Infants Hospital Women's Reproductive Health Research [WRHR] scholars program, and she directs a Brown-wide research career development seminar series. She continues to be instrumental in optimizing resources for conducting research and submitting grant proposals in the department.

Dr. Matteson's research, national presentations, and publications focus on abnormal uterine bleeding, evidence-based medicine in gynecology, and research methods. Dr. Matteson is conducting a randomized clinical trial funded by the NICHD comparing two non-surgical treatments for heavy menstrual bleeding. Dr. Matteson works with the International Federation of Gynecology and Obstetrics Menstrual Disorders Committee and the American College of Obstetricians and Gynecologists (ACOG). She has served on the Society of Gynecologic Surgeons Systematic Review Group, the editorial board of The Obstetrician and Gynecologist, and the ACOG PROLOG task force for Patient Management in the Office. In addition to several other leadership roles, Dr. Matteson is currently the chair of the ACOG Committee on Gynecologic Practice.

In addition to her research leadership, Dr. Matteson practices both obstetrics and gynecology and supervises residents and medical students in Women & Infants' Obstetrics and Gynecology Care Center [OGCC], on the labor floor, in the inpatient gynecology service, and in the operating room. She has been consistently recognized for her teaching and has been awarded outstanding teacher of the year awards since 2006. Dr. Matteson has been recognized with the national CREOG [Counsel on Residency Education in Obstetrics and Gynecology] Excellence in Teaching Award and continues to be sought after as an advisor and mentor for residents, medical students, and faculty.

Erica Hardy, MD, named director of Women’s Infectious Disease Consult Service at W&I

ERICA HARDY, MD, MMSc, of Pawtucket, has been named director of the Women’s Infectious Disease Consult Service at Women & Infants Hospital.

A collaborative service of the hospital’s Department of Obstetrics and Gynecology and the Department of Medicine, as well as the Integrated Program for High-Risk Pregnancy, this service provides inpatient infectious disease consultation to all providers at Women & Infants Hospital in both obstetrics and gynecology and their respective subspecialties. Outpatient consultations are available to referring providers from throughout southern New England.

Dr. Hardy completed a residency in medicine and pediatrics at Brown University in the Rhode Island Hospital/Hasbro Children’s Hospital program. She went on to complete an infectious disease fellowship at Beth Israel Deaconess Medical Center in Boston. During fellowship, she completed a master’s of medical science at Harvard Medical School. In addition, she holds a master’s degree in philosophy with a concentration in medical ethics from the University of Maryland.

Dr. Hardy’s clinical and research interests include infectious disease issues in women, including congenital infection, complex sexually transmitted infections, as well as the medical care and follow-up of survivors of sexual assault. She has grant funding from the Center for AIDS Research to explore the female genital tract immunology after sexual assault, as well as vaginal microbiome in women initiating long-acting contraception.

Dr. Hardy is the co-director of the Women & Infants Hospital Antimicrobial Stewardship Committee. She sees inpatient and outpatient infectious disease consults and is involved in medical education. She has been presented with several teaching awards from medical students while on their ob/gyn and obstetric medicine rotation, and from ob/gyn residents.

Dr. Wendy Stern named President-elect of the Board of Directors for the New England Otolaryngological Society

NEW BEDFORD – Southcoast Health announced recently that DR. WENDY STERN has been selected to serve as President-elect of the Board of Directors for the New England Otolaryngological Society [NEOS].

Dr. Stern has served as a councilor on the Board of Trustees for two years. This new appointment will be for three years, with Dr. Stern moving from President-elect in 2018 to President in 2019, and finally to Immediate Past President in 2020.

“"I am excited to become the President of this illustrative organization that is dedicated to the advancement of the science and practice of otolaryngology," said Dr. Stern. “It is pleasure to serve fellow otolaryngologists and otolaryngology residents that practice and train in New England.”
Appointments

Joseph Brady, MD, joins South County Health medical staff

South County Health welcomed JOSEPH BRADY, MD, to its medical staff. During his 23 years as a general surgeon, Dr. Brady worked in private practice and was a member of the surgical staff at Kent Hospital in Warwick. The board-certified physician brings extensive experience to South County Health including expertise in procedures such as routine and complex hernia repair, cholecystectomies, colon procedures, biopsies, and other surgical expertise.

Dr. Brady developed a program to use robotic technology in general surgery and was the first surgeon in Rhode Island to perform a single-site cholecystectomy using robotics. His experience includes open, laparoscopic and robotic colectomy.

He earned his medical degree and completed his residency in general surgery at Hahnemann University in his hometown of Philadelphia, Pennsylvania.

Dr. Brady is part of the surgical team at South County Surgery, Wakefield, RI.

Jason Boulware, DO, named site director of Emergency Medicine at RWMC

JASON BOULWARE, DO, has been named site director of Emergency Medicine at Roger Williams Medical Center. Dr. Boulware, who received his degree as a Doctor of Osteopathic Medicine from the New York College of Osteopathic Medicine, has practiced in the Emergency Departments of both CharterCARE-affiliated hospitals – Roger Williams and Fatima Hospital – since 2012. He has also more recently practiced in the Emergency Department of the VA Medical Center in Providence.

Dr. Boulware completed his residency in Emergency Medicine at St. Barnabas Hospital and Regional Trauma Center, where he served as chief resident.

Dr. Boulware holds memberships or is certified by a number of professional organizations including the American Osteopathic Board of Emergency Medicine, American College of Osteopathic Emergency Physicians, American Osteopathic Association, and the American College of Emergency Physicians.

URI names Mary Leveillee, PhD, Associate Dean of the College of Nursing

The University of Rhode Island has appointed MARY LEVEILLEE, PhD to the position of associate dean of the College of Nursing.

Leveillee joined the College’s faculty full time in 2000, teaching undergraduate psychiatric and mental health nursing in lecture and clinical settings. Leveillee’s research focuses mainly on women’s issues, eating disorders and client-nurse relationships, all areas where she worked extensively in both inpatient and outpatient psychiatric settings.

Leveillee was a staff nurse at Butler Hospital in 1987. After finishing her master’s degree in nursing, she became an outpatient therapist at the hospital and eventually assumed the role of coordinator of the Eating Disorder Program. In 2014 she returned to Butler Hospital full time and became senior vice president and chief nursing officer, serving in that position until 2017.

Leveillee holds Adult Psychiatric and Mental Health Clinical Nurse Specialist Board Certification from the American Nurses Credentialing Center.

She earned her PhD and master’s degrees in nursing from URI in 2012 and 1991.

Office Space Available Now

Professional/Medical Office Suite

63 Eddie Dowling Highway, North Smithfield

Contact Jim for pricing or info:
Jim Conway
(401) 447-6062
jim@conwaycommercial.com

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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

Brookdale Center of New England
Brookdale Cumberland
Brookdale Smithfield
Brookdale Greenwich Bay
Brookdale Pocasset Bay

Brookdale Sakonnet Bay
Brookdale East Bay
Brookdale West Bay
Brookdale South Bay

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

Click Here
Obituaries

KWANG WON AHN, MD, 84, of Providence passed away on January 7, 2017 at home. He was the husband of Ihn Bang [Hong] Ahn. He was a retired 3rd generation physician, having specialized in internal medicine and oncology. Dr. Ahn graduated at the top of his medical school class at Seoul National University and then spent several years in Uganda with his family as a local physician delivering hundreds of babies, performing surgery and caring for all walks of life. He returned to Seoul and then emigrated to Providence where he completed another residency and fellowship at Brown University. After his chief resident year, he joined a well-established practice in Providence and over the course of the next 40 years cared for citizens of RI from all walks of life. He was a Clinical Assistant Professor of Internal Medicine in the Department of Medicine at Brown University and served as a team doctor for the Brown football team for several years. Dr. Ahn was a “living legend” at Roger Williams Hospital upon retirement. He was an avid golfer and fan of the Patriots, Celtics, Red Sox and Bruins.

Dr. Ahn was the loving father of Sung Eun Ahn of Coto de Caza, CA, and Min Shick Ahn, MD, of Hopkinton, MA. He was the beloved grandfather of Nicholas Ahn, Harrison Ahn, Coleman Ahn and Nathalie Ahn.

In lieu of flowers, donations in his memory to the Alzheimer’s Association, www.alz.org, would be appreciated.

JOSEPH CIABATTONI, PhD, MD, 77, of Saunderstown, passed away at home on January 25, 2018 after a courageous battle with pancreatic cancer. He was the beloved husband of Susan [Difilippantonio] Ciabattoni.

In addition to his wife, Susan, he is survived by his loving son, Joseph C. Ciabattoni, and his wife, Christine, of Tiverton.

Dr. Ciabattoni received his PhD from MIT, in 1965. Dr. Ciabattoni was a Professor of Organic Chemistry at Brown University, from 1965–1973. During this period, he was awarded a Senior Fulbright-Hays Scholarship and attended the University of Padova in Italy. Dr. Ciabattoni, next attended Yale University, 1973–76, where he received his MD degree. He completed his residency at Rhode Island Hospital and was a practicing physician for over 30 years.

Dr. Ciabattoni was an avid fisherman, and enjoyed gardening and cooking. He was known for his famous eggplant meatballs and pasta sauce. Dr. Ciabattoni was a communicant, greeter and member of the Knights of Columbus of St Mark Church, Jamestown and a communicant of St. Thomas More Parish, Narragansett. He was an active volunteer of the Jamestown Community Farm. This kind, generous man will be deeply missed by his family and friends.

Memorial contributions may be made to: Tomorrow Fund, RI Hospital Campus, 593 Eddy St, Providence, RI 02903.

MARTIN E. FELDER, MD, passed away on December 31, 2017, in Carlsbad, California. He was born and raised in Fall River, Massachusetts. He graduated from Brown University in 1952, and from Tufts University medical school in 1956. Dr. Felder entered an internship and residency program at Ohio State University, and during that time also joined the U.S. Public Health Service, completing his service as a lieutenant-commander.

Dr. Felder started his private practice in Providence in 1963 and became instrumental in the development of Brown University’s medical school. When he retired from the medical school in 2003, the university honored him as an Emeritus Professor for his dedication to teaching. He served as chief of general surgery at the Miriam Hospital, and was a member of numerous medical societies, including the New England Surgical Society.

He was an avid golfer, a Silver Life Master in duplicate bridge, and collected and was a connoisseur of fine wines.

He is survived by his wife, Velma Felder of Carlsbad, his sons Mark Felder of Laveen, Arizona, Lawrence Felder of Scottsdale, and four grandchildren.

As was his wish, any donations in Dr. Felder’s memory may be made to the public library of one’s choice.

PERRY GARBER, MD, passed away on January 23, 2018.

Dr. Garber was born on June 3, 1935 in Providence to the late Louis and Carrie Garber of Providence and was an extraordinary individual. He put himself through Providence College and the University of Cincinnati College of Medicine, and established his own medical practice in Cranston. He improved the lives of his many patients for over 50 years and was affiliated with the Roger Williams Medical Center in Providence.

Husband of the late Sharon A. Garber for 51 years, he is survived by his daughter and son-in-law, Stacy and Adam Bozek of Rye, NY. He was the father of the late Jolie Savdie and the brother of the late Dr. Martin Garber. Also surviving him are cherished granddaughters Katherine and Abby Bozek of Rye, NY, sister-in-law Molly Garber of Cranston, brother-in-law Joel Licker of Cranston, son-in-law Marc Savdie of Miami, Florida, and dear nieces and nephews.

He loved traveling throughout the world with Sharon, especially to exotic, off-the-beaten-path locations, and was conversant in over ten languages. He loved meeting people from diverse cultures and was extraordinarily knowledgeable about world history.

Donations in his memory can be made to the RI Community Food Bank, www.rifoodbank.org, 200 Niantic Avenue, Providence, RI 02907.
DR. KENNETH LAMBERT died suddenly on December 23 of cardiac arrest. He was 79 years old.

Kenneth Lawrence Lambert was born in Kansas City in 1938. His mother, as a 10-year-old, had come to America from Belgium. His adored grandfather was a Flemish coal miner who, at the beginning of WWII, was imprisoned by the Germans for hoarding a few potatoes.

Sports were his ticket to a scholarship at the University of Missouri where, as a linebacker, he played for Dan Devine in Mizzou’s Orange Bowl years.

After completing a residency in Orthopedic Surgery at MU in 1972, he was awarded a fellowship by the Swiss AO Foundation. During the year in Switzerland, he fell in love with skiing and moved to Jackson Hole, WY.

For more than 25 years, Ken patched up or reconstructed everyone he could. His goal was to send them back into action. Nominated by surgical peers, he was listed for years in The Best Doctors in America. His patients came from all over the country. Life was full. He skied with the incomparable JH Ski Patrol, he kayaked, and he climbed. He rarely saw a risk that he didn’t want to take. He pioneered the repair of the ACL ligament of the knee. He was a US Ski Team doctor and taught at AO trauma courses stateside and in Europe. He was a Professor of Orthopedic Surgery at the University of Missouri, KC and a guest professor at Baltimore Shock Trauma. He won residents’ awards for Best Teacher. He ran a trauma fellowship program from Jackson. He wrote articles, contributed to books, lectured, performed operations for surgical teaching videos and served as an editor for The Journal of Orthopedic Trauma.

In 2001, Ken and Sandra moved to Providence, RI to be closer to their daughter Christine – a resident in Psychiatry at Brown – and her young children. There he worked as a consultant to companies developing biomaterials for orthopedic trauma. He was an Adjunct Professor of Engineering at Brown, advising biomedical post docs. He was a co-founder and board member of Nanova Biomaterials.

He volunteered at the Rhode Island Free Clinic, treating patients right until the end. He had a great and generous heart.

He leaves behind Sandra, his wife of 53 years; his daughter, Christine Rayner, MD, and her husband, Sarah Kincaid; Sarah’s daughter, Emerson; and his adored grandchildren, Alice and Oliver Rayner. They had him when they needed him most.

No date for a memorial has been set. If you are inclined to be missed by his patients and all who knew him as well as his loyal dogs Rufus and Lilly. ❧

JAMES B. SOUTHARD, MD, 75, died January 21, 2018 at Miriam Hospital, Providence. He was the beloved husband of Jean M. (Clauss) Southard.

Dr. Southard was a graduate of Taft Academy, Watertown, Connecticut, and Boston University, where he earned a Nursing Degree and Doctorate of Medicine. Upon graduation, he became an anesthesiologist at several hospitals, including in Connecticut at Hartford Hospital and Charlotte Hungerford Hospital, and in Rhode Island at the former Lying-In Hospital, Notre Dame Hospital, Roger Williams Medical Center, and Our Lady of Fatima Hospital, before retiring. A U.S. Army veteran, he served during the Vietnam War as an operating room technician, stationed in Würzburg, Germany.

He was a member of the Lincoln Council, Knights of Columbus, the American Medical Association and the Rhode Island Anesthesia Association. He enjoyed hockey, regularly playing in men’s leagues at the Smithfield Municipal Ice Rink.

Besides his wife, he is survived by one daughter, Sharon Southard of Boston, Massachusetts; three sons, Matthew Southard (Rebecca) and Nathaniel Southard (Carrie), both of Northfield, Connecticut, and James P. Southard of Boston, Massachusetts; two step-daughters, Tamara A. DiRobbio (David MacDonald) of Albion, and Alicia J. Sullivan (Michael) of Woonsocket; two step-sons, Christopher C. DiRobbio (Sheila) of Cumberland, and Michael J. DiRobbio (Amanda) of Framingham, Massachusetts; five grandchildren, Elizabeth, Benjamin, Hayden, Avery and Riley, and three step-grandchildren.

In lieu of flowers, contributions in his memory to the ALS Association - Rhode Island Chapter, 2374 Post Rd #103, Warwick, RI 02886, or to the Alzheimer’s Association - Rhode Island Chapter, 245 Waterman St #306, Providence, RI 02906 would be appreciated. ❧