Johnson & Wales University Physician Assistant Studies Program Class of 2020

SPECIAL SECTION
PHYSICIAN ASSISTANTS (PAs)
GUEST EDITOR: ROBERT B. HACKEY, PhD

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named new president, COO at Kent

LARRY BROWN, MD  
appointed director of the Division of Child and Adolescent Psychiatry at Alpert Medical School

MELISSA RUSSO, MD  
named to international, national organizations

ELIZABETH LOKICH, MD  
joins Women & Infants Program in Women’s Oncology

ALLAN R. TUNKEL, MD  
named Senior Associate Dean For Medical Education

Michele G. Cyr, MD  
named Senior Associate Dean For Academic Affairs

Michael Garrity, DNP  
named President-Elect of Rhode Island State Nurses Association

CARE NEW ENGLAND  
anounces major expansion of orthopedics services

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receives 2018 Riesman Family Excellence in Teaching Award

Ilse Jenouri, MD  
named 2018 Outstanding Physician of the Year at Miriam

Robert Patterson, MD  
receives Miriam Hospital’s Charles “Bud” Kahn, MD, lifetime leadership award

Peter Monti, PhD  
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Congressman Joseph Kennedy  
named 2017 Southcoast Health–Hero for Health Award recipient

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Apathy is common. It may be normal, as in, “I don’t care about” something, or pathological, a syndrome often present as one of the cardinal features of depression, Alzheimer’s disease, Parkinson’s disease and a host of other disorders. Like most behavioral constructs, it is complex and difficult to understand, and has no objective markers.

Since I care for a large number of people with Parkinson’s disease, apathy is something I deal with every day. It is probably most noticeable to doctors in the form of lack of spontaneous speech. Apathetic PD patients generally keep quiet, even though the appointment with the doctor is for them. It is the spouse or the child who usually does the talking. The patient responds when the doctor says hello, and will answer questions when they are addressed to him, but often only after specifically asked to answer, waiting for the significant other to answer first. There are a few potential explanations for this, but apathy is usually part of the explanation. (I note in passing that there is the occasional patient, although severely dysarthric and almost unintelligible, who is exceedingly loquacious, even when not understood, and the opposite of apathetic.)

I once attended a small conference on apathy hosted by a drug company interested in developing a drug for the condition. Their interest was focused on schizophrenia, in which apathy plays a major role. Many non-psychiatrists, and certainly the lay public, think of schizophrenia as a disorder in which the afflicted have auditory hallucinations ordering them to do weird or dangerous things, and delusions, such as thinking their thoughts are controlled by aliens. And while hallucinations and delusions are, in fact, common in schizophrenia, these are part of what are considered the “positive” phenomena of the disorder, whereas the most devastating features are the “negative” symptoms, the reduced motivation, the reduced pleasure, the weak social bonding, the poor insight, and apathy. The positive symptoms are what respond best to antipsychotic drugs. The negative symptoms do not, so patients are generally only partially improved and often don’t feel better on their psych meds, and so may stop taking them. Apathy is a very central issue in many psychiatric problems, and, I learned at this meeting, for many in the Alzheimer’s world as well.

I learned that they consider apathy a serious problem. I, on the other hand, had developed a belief that apathy in PD isn’t necessarily a bad thing. My thinking was based on the fact that apathy generally develops hand in hand with dementia in PD, and that, although patients experience reduced enjoyment, they also have a blunted response to their losses. As apathy develops, the patient initially may not want to do the things he used to for entertainment. He may not care much about socializing, going to the movies, entertaining at home. The pleasure no longer offsets the effort. There is a drop in motivation. There is less interest in starting conversations, getting questions answered, or completing projects. The patient loses interest in what he watches on TV. This inexorably progresses to the point where he may not care if the TV is on or off, what is going on around him, or what’s for dinner. In the end, the only thing that provides pleasure is a visit from the grandchildren, and that for only a few minutes before the activity becomes overwhelming and uncomfortable. That is a tragedy. The persona of the patient has slowly been extinguished. The spark that made that person who he was is gone, and only a shell remains. On the other hand, this patient has been spared the suffering that the family is experiencing. The only person not devastated by these changes is the patient himself. He doesn’t care. Yes, he knows that he can’t figure out how to use the TV remote control, that he can’t drive, get to the bathroom on time, and forgets how many grandchildren he has, or their names, but it no longer bothers him. He
doesn’t get happy but he doesn’t get sad. Emotions are largely gone. The family suffers but the patient does not. He no longer grieves for his losses.

I always point this out to the family, and they seem greatly relieved to hear me tell them that they are probably suffering more than the patient. “He doesn’t care but you do.” I believe that they often have thought this themselves, but felt guilty to give voice to this insight.

I was surprised, then, when I mentioned to my colleagues, all in the schizophrenia or Alzheimer’s disease worlds, that I thought apathy had some positive aspects. They were aghast. I felt that they responded as if I had just suggested reinstituting haloperidol as a “chemical straitjacket” for obstreperous, demented nursing home patients (using drugs like haloperidol to make patients unable to move, and therefore unable to stand and fall, or to attack others). I’ve thought about this a lot and have not altered my thinking.

Apathy is more than lack of emotion. It encompasses lack of motivation, and therefore overlaps with fatigue, an amotivational syndrome. Fatigue, of course, is a common problem in daily life, and is increased in virtually all disorders, somatic and psychic, particularly depression. The only disorder I’ve been able to think of without an increase in fatigue is mania.

I think it is probably correct to regard lack of motivation and fatigue as major problems in all disorders, but I think it is equally correct to consider apathy a problem only when it is, in fact, a problem, not simply because it’s there. Some clouds do have silver linings.

Author
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Blue eyes, bleeding heart

ANANYA ANAND, ScB, MSc

He stared unswervingly at me. I touched his head, covered with fine reddish-brown hair, when I felt it— the “boggy” subgaleal hematoma I was mentally anticipating but thoroughly unequipped to handle emotionally.

Three weeks into my pediatric rotation with three more weeks and one more rotation to go before the culmination of an intense third year of medical school, I thought nothing could faze me anymore. Ten months of rotating through the core specialties had tested my resilience, and I thought I had made it to the other side relatively unscathed. Dealing with a patient whose abdominal sutures burst open, exposing all of his intestines. Handled. Giving a previously healthy patient a new diagnosis of ALS. Handled. I thought I had made it to the other side relatively unscathed. Dealing with a patient whose abdominal sutures burst open, exposing all of his intestines. Handled. Giving a previously healthy patient a new diagnosis of ALS. Handled.

Midway through the week, my residents asked me to accompany him to see a patient that would be transferred from the NICU to our floor. Baby J was a two-month-old who was brought to his PCP by his parents because of bilateral subconjunctival hemorrhages believed to be secondary to straining with bowel movements. At the visit, the PCP noticed that J’s head was swollen and he had a bruise to his left cheek. The parents were told to take J to the ER where a CT scan showed that he had three calvarial skull fractures and signs of a frontal lobe hemorrhagic contusion. In non-medical speak—J had been violently abused. There was evidence that not only had he been shaken, he had impact injuries, ultimately receiving a diagnosis of “Non-accidental trauma” [NAT].

When I heard J’s history, I was livid. When I walked into his room, stared into his eyes and placed my hand upon his head, tactually perceiving what had been radiographically described, I began seething. It was unfathomable to me how anyone could brutalize a defenseless baby, let alone their own. As I checked J’s reflexes and performed his physical exam, he reached for my index finger. The second his tiny hand gripped my finger I experienced what felt like the entire gamut of human emotion. Anger, sadness, pity, love, tenderness, confusion—each emotion hit me like waves of a raging ocean slapping down a helpless swimmer. I picked J up and held him close to me and began to sob.

That night, my emotions still running rampant, I called my mother who held him close to me and began to sob. I can only hope and pray that he will be treated with the unconditional love, kindness and understanding that we all deserve. But one thing is certain—his blue eyes had pierced into my very being and left an indelible mark.

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9. Brazil
10. China

FAGA’ALU, AMERICA SAMOA

Students from the Bryant University Physician Assistant (PA) Program Class of 2019 take a break from their clinical duties at LBJ Tropical Medical Center in American Samoa to view the Journal. Shown left to right are: Ida Apel, Alison Migliori, Emma Pennock, Kasey Cameron, Andrea Ferraro, Kat Ashe, Allison Malo, and Taylor Laramee. The students have been in American Samoa since May and will each complete two five-week rotations in required specialties, including: Inpatient Internal Medicine, Obstetrics & Gynecology, Pediatrics, General Surgery, and Emergency Medicine.

Wherever you may be, or wherever your travels take you, be sure to check the Journal on your mobile device, and send us a photo: mkorr@rimed.org.
NEW BEDFORD, MASS.
Sarah Stevens, RIMS Office Manager, pauses to view the Journal while visiting the “Grand Panorama of a Whaling Voyage ‘Round the World”, an 1848 painting that is 8.5 feet high and 1,275 feet long, currently displayed in the Kilburn Mill by the New Bedford Whaling Museum [bottom photo]. The painting accurately represents the details of whale hunting, sailing vessels, and the world ports they visited.

[Above] This dramatic section of the panorama depicts the deadly 1847 eruption of Pico do Fogo, the 7000-foot-high volcano in Cape Verde.

[Right] Whale carcasses were lashed to the ships with chains while crews worked around the clock slicing strips of blubber, weighing a ton each, which were then cut into smaller pieces and cooked in large pots to render the oil.
Kenneth S. Korr, MD, visited Chihuly Garden and Glass in Seattle in July. The galleries, glass house and gardens opened in 2012 and contain one of the largest collections of the multi-media artist’s work. The Tacoma, WA, native, who earned an MFA from RISD in 1968, where he established the glass program and taught for more than a decade, creates works of art in glass, neon, ice, acrylic, paint, charcoal and polyvinyl with the goal of transforming the perception of color, light and form.
As the Physician Assistant [PA] profession celebrated its 50th anniversary in 2017, the number of PAs authorized to practice in Rhode Island continued to grow rapidly. As of June 2018, the Rhode Island Department of Health reported that more than 550 PAs currently hold an active license to practice in RI. Notably, 111 (20%) of the state’s PAs first obtained their license between January 1, 2017 and May 31, 2018.

Rhode Island is now home to two PA training programs. The state’s first PA program, established at Johnson and Wales University (JWU) in 2012, graduated its first class of 23 students in 2016, and a second class of 24 students in 2017. Bryant University’s program, established in 2014, graduated its first class of 29 students in March, 2017. Students from each program excelled on the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on the Certification of Physician Assistants; 100% of first-time takers from JWU passed the PANCE in both 2016 and 2017, and 97% of first-time test takers from Bryant graduates passed in 2017. Both programs are highly selective, accepting roughly 5% of all applicants.

Early conversations about PAs in Rhode Island

Protecting the public, rather than expanding the supply of allied health providers, framed early deliberations about licensing PAs in Rhode Island. Following the lead of the American Medical Association (AMA), the Rhode Island Medical Society (RIMS) supported the general notion of PAs practicing under physician supervision. In 1970, John Farrell, the executive secretary of RIMS, presented a report to the RIMS House of Delegates on the AMA Congress on Health Manpower held in October 1970. The AMA report encouraged states to amend existing medical practice acts “to broaden the authorization for delegation of functions” to physician’s assistants, nurse midwives, nurse practitioners, and other non-physician providers. The report recommended that “a proviso should be included that the delegate is authorized to perform under appropriate supervision functions warranted by his education, demonstrated ability, and training... State medical associations are encouraged to support such amendments.” By embracing the AMA’s recommendations, Rhode Island adopted a wait-and-see approach to PA licensure, in contrast to North Carolina, where physicians and policymakers collaborated to draft model legislation to regulate PAs in 1970. The Allied Health Professions and Services Committee recommended “that the House of Delegates request a moratorium on licensure of any additional health occupations in Rhode Island until such long-range solutions are developed.” The committee’s recommendation, however, did not “preclude amendment of existing licensure laws to permit expanded functions.”

In the absence of a regulatory framework, no physician assistants practiced in Rhode Island in the early 1970s. By early 1972, the Medical Society’s Allied Medical Professions and Services Committee reported that it had received local inquiries “concerning the licensing of a Physician Assistant.” Although Committee members discussed PA programs and scope of practice, RIMS did not press for legislation to license PAs in Rhode Island. Interest in licensing PAs in Rhode Island continued to grow among PAs during the early 1970s. By 1975, Dr. George Meissner reported that the Allied Health Professions and Services Committee received inquiries from recent PA graduates interested in practicing in the state.

The evolution of PA legislation and regulation in RI

Physician Assistant practice in Rhode Island was authorized by the General Assembly with the passage of S-2384, “An Act to Facilitate an Increase in Medical Manpower Through the Use of Physician Assistants” on June 4, 1976. This bill – Chapter 274 of the Public Laws of 1976 – defined the criteria for licensing and regulating PAs in Rhode Island. The new law established “a framework for the development of a new category of health manpower to be known as the physician assistant” and defined the scope of PA practice. S-2384 sought to “encourage the more effective utilization of the skills of physicians by enabling them to delegate health-care tasks to qualified physician assistants where such delegation is consistent with the patient’s health and welfare.” The new law took effect on January 1, 1977. The Medical Society first accepted PAs as affiliate members in 1978. Although the legislation paved the way “for innovative development of programs for the education of physician assistants,” it would be four decades before the first class of PAs graduated from a training program based in Rhode Island.

Physicians in Rhode Island – and the Medical Society in particular – engaged in a lively and spirited debate about the autonomy and supervision of PAs during the 1980s. In 1982, the General Assembly took up the issue of updating
the licensing framework established in 1976 with a new legislative proposal – H82-7695 – that authorized PAs to provide “patient services” broadly defined. The bill immediately sparked controversy within RIMS, which included PAs as members. Since the passage of Rhode Island’s initial PA licensure bill, the concerns about a shortage of physicians in the 1970s had dissipated. In the wake of a sobering report by the Graduate Medical Education National Advisory Committee in 1981, projections of a physician shortage were replaced by growing concerns about an oversupply of doctors. At the Jan. 20, 1982 meeting of the Medical Society’s House of Delegates, Dr. Albert Tetreault presented a resolution that declared:

“Whereas there is no shortage of Physicians in the State of Rhode Island; Whereas the level of clinical medicine rendered by physicians to their patients is always superior to any diagnosis and prescribed treatments delegated to or performed by non-physicians. Be it resolved that the practice of Medicine in Rhode Island by non-physicians outside of the hospital setting is not in the best interest of patients and should not be justified except under life-threatening circumstances. Be it further resolved that the Rhode Island Medical Society urgently pursue all legal channels to immediately curtail existing practices and those extensions of privileges conferred on licensed non-physicians that sanction future abuses.”

After a lively debate at the March 24, 1982 RIMS meeting, the assembled delegates rejected the resolution to oppose the bill by a margin of 24-19. Several physicians present expressed their opinion that “PAs are well-trained and are assets to the health-care delivery team” and that “PAs, as members of the Society, deserve its support.” Furthermore, physicians also noted “PAs have attempted to work with the Society, while other paraprofessionals seeking legislation have not done so.” Thus, RIMS suggested that with appropriate revisions, it could support the bill. Delegates charged Dr. Walter Cotter with the task of preparing revisions for legislators to consider before voting on a final version of the bill. In a letter to the House of Representatives, Dr. Cotter noted that the original legislation was “unclear and might leave the physician assistant exposed to a hazard of less than our best medical care.” In particular, the House of Delegates recommended that “it is better to delete the words patient services and substitute the following: Those certain services in which he is trained.” By carefully circumscribing PAs scope of practice, the amendment recognized the generalist nature of PA education. As Dr. Cotter noted, the suggested amendment protected the “patient, the supervising physician, and the physician assistant” for the PA could not be “assigned tasks for which he is not trained or given responsibilities outside of his field of expertise.” The May 1982 newsletter of RIMS noted that, “in a special session of the Rhode Island Medical Society House of Delegates held May 3, 1982, a motion was unanimously voted that the

Society go on record as supporting a bill in the Rhode Island General Assembly, H82-7695-A, ‘An Act Relating to Physician Assistants.’”

The success of the Medical Society in amending the content of the PA legislation in 1982 underscored the political influence of physicians over health policy issues at the General Assembly and reinforced the primacy of physicians in the PA-physician relationship. As Drs. Mario Tami and Albert Tetreault observed in the June 1982 RIMS newsletter, physician lobbying “made certain that the composition of the physician assistant legislation which was signed into law was acceptable to the Rhode Island Medical Society House of Delegates.” As RIMS President Dr. Charles Shoemaker noted in 1984, “during the past ten years, the Rhode Island Medical Society has devoted considerable time and energy to blocking efforts by non-physician health providers to expand their professional roles and privileges...Previous years have seen testimony from the Society against chiropractors, physician assistants, and other groups who attempted to extend their practice privileges by legislative fiat. The primary focus of our concern has been to protect patients by requiring adequate training and experience for all providers of medical care. Yet each year, we find ourselves cast in the role of the establishment fighting the underdog and being accused of protecting our own financial interests.”

By the early 1990s, however, the scope of PA practice expanded to include writing prescriptions and medical orders. The statutory framework governing PA practice can be found in Chapter 5-54 of the Rhode Island General Laws (2012). Under Section 5-54-4, “a physician assistant may perform medical services when such services are rendered under the supervision of a registered physician. Such supervision shall be continuous but need not be in the personal presence of the supervising physician or physicians.” The Rhode Island Department of Health is responsible for developing rules and regulations to govern the licensure, scope of practice, supervision, and professional conduct of PAs, as outlined in the Department’s Rules and Regulations [216-RICR-40-05-24].

Where do PAs practice?
Although the architects of the PA profession originally envisioned it as a way to address the shortage of primary care providers, the proportion of PAs choosing careers in primary care continues to decline over time. This trend is even more pronounced in Rhode Island, as fewer than one in five PAs (18.8%) pursued primary care as their area of practice in 2015; nationally, 28.5% of PAs worked in primary care settings. While some PAs described primary care as “part of the profession’s DNA,” a majority of PAs have pursued specialty careers since the late 1990s as “robust nonprimary care career opportunities draw the majority of new PA trainees.” This trend, however, reflects the availability of job openings. More than 2/3 of job postings for PAs in 2014 were
in medical specialties; only 19% of available positions were in primary care.\textsuperscript{14} Unlike nurse practitioners, who can practice independently in 20 states, the role and scope of practice of PAs are defined by supervising physicians.\textsuperscript{18} Today, fewer physicians opt for careers in primary care, as more recent graduates opt for careers in surgical or medical specialties over time.\textsuperscript{16} Thus, it naturally follows that fewer opportunities will exist for PAs to pursue careers in primary care settings. In addition, both salary considerations and working conditions also shape the appeal of specialty careers versus primary care practice for new PA graduates. PAs practicing in primary care settings saw an average of 73 patients per week, compared to 63 patients per week for non-primary care PAs.\textsuperscript{17} In addition, the mean base salary of primary care PAs was $91,309 in 2014, compared to $99,608 for PAs practicing in other settings.\textsuperscript{17} A 9% salary differential, coupled with a higher patient load, does little to improve the appeal of primary care for recent graduates.

The growing utilization of PAs in Rhode Island in surgical and medical specialties reflects the flexibility of PA education and training. As Reamer Bushardt and Ruth Ballweg observed, “a generalist education with clinical and interpersonal skills that translate across myriad practice settings has powered PA adaptability.”\textsuperscript{18} PAs acquire new skills over time as they gain experience through supervised practice and their practice setting and specialization can evolve over time. This adaptive and evolutionary quality of PA education limits the appeal of formal credentialing or specialty certification of PAs. As the president of the American Academy of Physician Assistants argued in 2006, “We will do everything we can to defend the flexibility of this profession – to move from specialty to specialty while at the same time protecting the patient.”\textsuperscript{15}

References


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Creating Rhode Island’s First PA Program

GEORGE BOTTOMLEY, DVM, PA-C

Rhode Island’s first physician assistant (PA) program at Johnson & Wales University graduated its inaugural class of physician assistant students on May 21, 2016. These twenty-three students and students in the Class of 2017 (all of whom in both classes passed the Physician Assistant National Certification Examination on their first try) raised the profile of the physician assistant profession in the State of Rhode Island. Over half of these new PAs took positions in Rhode Island. The following describes how the vision of Johnson & Wales University became a reality.

Johnson & Wales University (JWU) was founded in 1914 in Providence, Rhode Island. Today the Providence Campus is the largest of the four Johnson & Wales University campuses, with more than 8,500 students from all 50 states and more than 60 countries. The university’s mission statement defines its purpose – Johnson & Wales University…an exceptional education that inspires professional success and lifelong personal and intellectual growth. All of JWU’s degree programs embrace a professional and practice-based model of student learning. The idea of offering an M.S. in Physician Assistant Studies reflected the university’s history and mission.

JWU has deep experience in delivering professional programs, including degree programs focused on health and wellness in culinary nutrition, dietetics, and applied nutrition. The success of these programs led administrators to explore other potential programs in the health professions. In 2009, JWU leadership began to explore such programming in the health care area and for the reasons discussed below, attention on physician assistant studies quickly became a focus. JWU then engaged the services of an experienced consultant in PA education to consider facility, faculty, clinical training needs, and to become familiar with the Accreditation Review Commission for Physician Assistant Education (ARC-PA) standards and processes (http://www.arc-pa.org/).

Existing physician assistant programs in New England were located in the Greater Boston area, Connecticut, or Maine. At the time, Rhode Island was one of only two states in the United States without a PA program. Administrators believed the program would have market viability. The concentration of health care providers in Southern New England, and Rhode Island in particular, provided ample clinical training sites for JWU students. This perception was confirmed during preliminary clinical site development work. A Physician Assistant Advisory Committee visited local hospital systems to explore interest in supporting the program and the potential availability of clinical training in the area. In addition, university officials held meetings with the Hospital Association of Rhode Island, the group that coordinates clinical sites for the state’s nursing programs, to explore clinical training possibilities.

Creating a PA program in Rhode Island had the additional benefit of reducing the financial burden of PA education for Rhode Islanders and encouraging program graduates to stay in the area to practice. If students could continue to live at home with parents or their families, the stability of their living situation and resulting savings could reduce their debt burden, thus allowing graduates to potentially choose a practice area in primary care that is traditionally a lower paying opportunity. Demand for additional licensed physician assistants was – and remains – strong. The U.S. Bureau of Labor Statistics (BLS) data at the time showed an estimated 30% increase in need through 2020. Current BLS data projects that PA employment is projected to grow 37% from 2016 to 2026. A market research study completed for JWU by the Educational Advisory Board (EAB), a well-known higher education research organization, also projected that demand for PAs in Southern New England would increase by 8.8 percent from 2010 to 2012. At the time, there was (and still is) an acute need for primary care practitioners in Rhode Island.

The Provost’s Council and the University Dean’s Committee both enthusiastically supported the development of a high-quality program in this area in 2010. The notification of intent to apply for Accreditation-Provisional was completed and approved by the University Provost and President. Subsequently, an application for Accreditation-Provisional was submitted and the ARC-PA set the date of June 6-7, 2013 for the site visit. A seven-year financial model was developed for the program by the Assistant to the Provost. In October 2012, JWU purchased a two-story, 18,000 square-foot brick building at 157 Clifford Street as the future home of the program. I was hired to lead the program through the process of curriculum design and the three-step accreditation process, as well as to manage its full launch and ongoing operations. As a native Newporter and URI graduate, I had a long-standing interest in developing a PA program in Rhode Island. PAs from the RI Academy of Physician Assistants
and the Rhode Island Medical Society – of which all RI PAs are also members – wholeheartedly supported the initiative and proved instrumental in galvanizing support from the healthcare community. Meetings occurred with leaders from every Rhode Island hospital group, large group practice, and community health center, with insurance and pharmaceutical industry representatives, with the RI Department of Health and Board of Licensure; with RI congressional representatives; and with representatives from every college and university in RI.

JWU developed articulation agreements with Providence College (PC) and the University of Rhode Island (URI) that guarantee an interview if the student meets specific undergraduate course and experiential (direct patient care) hours. These requirements are above the minimum course and GPA requirements which allow a student to qualify for consideration through our usual process. We worked with URI and PC pre-professional health advisors to develop these requirements, knowing the rigor of the courses URI and PC students take gives us confidence that they will succeed in our program.

New models of health care delivery, such as the patient-centered medical home, call for a team-based approach from providers, so it makes sense that the education of those professionals include elements of that teamwork. To advance that principle, on March 27, 2013, JWU's Center for Physician Assistant Studies and Brown University’s Alpert Medical School signed a memorandum of understanding to explore possible collaborations. The leadership of the Alpert Medical School recognized the impact that physician assistants have as part of the interprofessional health care team. “The new model of health care is patient-focused, IT-driven, and team-based,” said Dr. Edward Wing, then-dean of medicine and biological sciences at Brown. “Alpert Medical School is fortunate to partner with JWU to explore interdisciplinary training opportunities with its physician assistant program. This new collaboration makes good sense as we work toward expanding the entire health care workforce.”

Construction work on the building began in fall 2012; the new Center for Physician Assistant Studies was completed in early 2014.

The mission of the Physician Assistant Studies program at JWU is to educate students to become collaborative practitioners with the respect, empathy and trust inherent to patient-centered, humanistic health care. This statement emphasized the team-based, interprofessional, patient-centered approach so vital to high quality healthcare. The JWU PA program forged a relationship with the Arnold P. Gold Foundation to bring their experience in the humanistic aspects of patient care to our program. The mission statement informs everything about the program, from the architectural design of the Center that intentionally emphasizes community, to the structure of the curriculum that de-emphasizes competition and emphasizes patient-centeredness and provider self-care, to the recruitment of faculty and staff and the qualities of students we accept into the program. During the development of the program, the curriculum designers used the Physician Assistant Competencies developed by the American Academy of Physician Assistants. In addition to the ARC-PA Standards, JWU also employed the Physician Assistant National Certification Examination (PANCE) blueprint, and prior experience to determine the necessary depth and breadth of the curriculum.

The JWU PA curriculum is a comprehensive course of study designed to prepare students for entry into clinical practice. The didactic portion consists of 51 weeks (60.5 credit hours) of rigorous instruction and study in all areas of medicine as a means to prepare students for the 49 weeks and 43.5 credits of clinical training they will receive during the second year of the program. This is consistent with the national average of 52.7 weeks and 63.8 credit hours for the didactic phase and 51.1 weeks and 44.5 credit hours for the clinical phase. Students apply through a centralized application service. Minimum requirements include a completed undergraduate degree with a minimum undergrad cumulative GPA and BCP [biology, chemistry, physics] GPA of 3.0. Required courses are in anatomy, physiology, biology, chemistry [all with labs], English, math, and the behavioral sciences. Students must have a minimum of 250 hours of direct patient care as well as experience in shadowing a PA. GREs are required. Since the start of the program, students chosen for interviews have GPAs and patient care hours significantly above the minimums.

Physician assistant programs are based on a medical model and all new and developing programs are required to award a master's level degree. The Summer semester of the didactic phase provides basic science foundation for the Fall and Spring modules. Summer courses are coordinated such that when a body system is being taught in the anatomy lecture and cadaver lab (Applied Anatomy), the same system is being taught in the history and physical examination course [Patient Care]. Basic modules are also taught in microbiology, immunology, cell physiology, genetics, and pharmacology.

The following semesters contain the clinical preparatory sciences courses in Clinical Medicine, Pharmacotherapeutics, Diagnostics Skills, and Patient Care. These courses run longitudinally in the Fall and Spring but are presented in module format, starting with the clinical medicine, pharmacotherapeutics, diagnostic skills, and patient care associated with the HEENT system and progressing through cardiology, pulmonology, and so on. Students are immersed in a body system for one, two, three, or more weeks, tested on the content and move on to the next module. Toward the end of the didactic year, students revisit each system in the context of a specific population in their women’s medicine, pediatric, geriatric, general surgery, and emergency medicine modules. Topics in behavioral medicine, public health to
emphasize the social determinants of health, evidence-based research, ethics, and professional practice are included in a year-long course on Professional and Health Policy Issues. Approximately sixty percent of the lecturing is done by PA faculty, all of whom are certified and continue to work clinically. The balance is taught by adjunct faculty, largely from the RI medical community and many of whom are also Brown affiliates.

JWU's rich history in the areas of nutrition and the culinary arts provides students with a unique “Cooking for Health & Wellness” course as part of the didactic year curriculum. Students are taught everything from knife skills to the choice of ingredients, to the hands-on preparation of healthy meals in the kitchens of our Cuisinart Center for the Culinary Arts. This course is also coordinated with their module: during the endocrine module, for example, students learn about food substitutions and preparation of meals for the diabetic patient.

The clinical year begins with Introduction to Clinical Practice that provides students with hands-on experience in skills that include splinting and casting, suturing, immunizations, venipuncture, and instruction at the Lifespan Simulation Laboratory. The clinical year consists of nine five-week rotations across all primary care disciplines (family medicine, internal medicine, and pediatrics), in addition to surgery, emergency medicine, behavioral medicine and women’s health. This provides students with direct experience in varied disciplines of medicine, in a variety of settings to include inpatient, outpatient, emergency department and surgical environments, as well as opportunities to interact with patients across the life span in acute, emergency, chronic and preventative encounters. In addition, each student is required to complete a master’s paper and presentation that combines scholarly activity with clinical practice by encouraging students to use evidence-based medicine to investigate a clinical question. Students have hands-on experiences in the above-listed settings. They work with MDs, PAs, NPs, and others on the team and under the supervision of the preceptor perform patient evaluation/diagnosis, develop treatment plans, counsel patients, etc. In the clinical year, following each clinical rotation students take a specific standardized examination developed by the national PA Education Association for each area...family practice, internal medicine, emergency medicine, etc. Preceptors also complete an evaluation for each student. Prior to graduation, each student completes a Master’s Project which includes an objective structured clinical examination (OSCE) using the standardized patient program at Brown, takes a summative examination, and prepares a presentation based on a clinical question and using evidence-based medicine principles learned during the program. Graduation from an accredited program qualifies them to sit for the PA National Certification Examination developed by the National Commission for the Certification of PAs. Thereafter to maintain certification, all PAs must accrue 100 hours of CME every 2 years and take a re-certification examination every ten years.

From the start, the Rhode Island Academy of Physician Assistants (RIAPA) and the Rhode Island Medical Society (RIMS) leaders and membership were overwhelmingly supportive advocates; representatives participated in ARC-PA site visits, served as lecturers and clinical preceptors, and participated as members of our Admissions Committee. Clinical preceptors and employers of our graduates tell us they like our students because they are “smart and kind.” Today, over half of the students who have graduated from our program currently practice in Rhode Island.

References

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Becoming a PA: Reflections from Johnson & Wales University Students

ARIANA AFRICO, BS; ALYSSE PAZIENZA, BS; MATTHEW J. DACOSTA, BA; KAYLA DENIS, BS

INTRODUCTION
This collaborative student-authored piece features the perspectives of four different students in both the didactic and clinical years of the Johnson & Wales University (JWU) PA program. These student vignettes present a snapshot of life as a PA student. Ariana Africo grew up in North Providence and earned her B.S. in Biology from the University of New England. She is a first-year student in the PA program. Matthew J. DaCosta is a second-year PA student and a National Health Service Corps scholar. Originally from New Bedford, MA, he gained experience in mental health and emergency medicine before PA school, he holds a B.A. in Psychology from the University of Massachusetts-Dartmouth. Kayla Denis is a second-year student who spent much of her childhood as a competitive gymnast. Born and raised in Swansea, MA, Kayla graduated from Northeastern University, and worked as a medical assistant in her hometown for five years, where she developed a passion for medicine and patient care. Alyssse Pazienza, a first-year PA student, is a native Rhode Islander who graduated from the University of Maryland with a B.S. in Kinesiology.

FIRST YEAR: ENDLESS POSSIBILITIES
ARIANA AFRICO, BS
To me, becoming a Physician Assistant is more than just getting to wear the white coat at the end of my program. It is about improving the gap in access and quality of healthcare for all. Physician Assistants are trained to provide high quality care to patients. We are able to perform a comprehensive history and physical, order and interpret lab tests and imaging, and prescribe medication. I take pride in our curriculum at Johnson & Wales University where we are taught to not only be well-versed and empathetic providers, but also how to take a humanistic approach to medicine. This is looking at our patients as more than just their ailments. It is treating the whole patient, not just the disease itself. It is about forming good relationships between the patient and provider as well as being sensitive to the values and beliefs of our patients to overall improve their care.

Being a PA is about taking a team-based approach to improve patient care. We must collaborate with our supervising physician and communicate well with our colleagues. While doing so, we must not forget to recognize that all health professionals play important roles on our healthcare team. This team-based approach optimizes patient care and improves outcomes.

PA school helped me find where my passion lies in the medical field. At the start of PA school I had my heart set on becoming a surgical Physician Assistant. During my second year, however, other specialties such as endocrinology and pediatrics also piqued my interest. At JWU, our clinical rotations can help solidify where our passion really lies by exposing us to several specialty areas.

We must never forget that medicine is a realm of endless possibilities. With so many intriguing specialties in the medical field, at some point in my career I want to be able to switch to a new specialty to further my knowledge and training. The beautiful thing about the Physician Assistant profession is that it is extremely versatile and will allow me to make the switch to a new specialty without additional schooling. Instead, we train extensively on the job to become proficient in the field. This aspect of the Physician Assistant profession is what made it stand out from other health professions to me. If doctors desire to switch specialties, they would have to get additional training through a fellowship or residency. Even if nurse practitioners desired to switch to a specialty that did not fall into the scope of their education, they, too, would have to supplement their education through additional schooling. Becoming a Physician Assistant not only gives me the ability to choose, but also the ability to change and grow. When I finally get to wear that white coat, I will wear it with pride because it will mean more to me than just the conclusion of my program. It will symbolize my career and passion coming together while I make a difference in the lives of my patients.

FIRST YEAR: COLLABORATION AND VERSATILITY
ALYSSE PAZIENZA, BS
“What do you want to be when you grow up?” was the million-dollar question when I was in high school. It wasn’t until I started college that I felt a compelling urgency to make a decision about what I wanted to do; yet, at that point in my life, I had no specific career aspirations. I just knew that I had an interest in science and helping people. It wasn’t until my freshman year of college that I heard the job title “Physician Assistant (PA).” I did a quick Google search and found that PAs have the ability to see, diagnose and treat patients under a doctor’s supervision. PA school would only require an additional 2-3 years of education following my undergraduate degree, and I would have the ability to switch specialties throughout my career. This lateral mobility and the flexible schedule that I would have as a PA seemed to fit
my goal of one day starting a family while maintaining my career. As I looked further, I found that PAs have a fundamental focus on the patient care aspect of medicine. I would be able to spend quality time getting to know my patients while effectively taking care of their medical needs.

“Let’s start an IV... Get the family on the phone... Hold compressions and check the rhythm.” I was now standing in a trauma bay at Rhode Island Hospital, watching as the trauma team worked diligently to save a patient’s life. Amongst the chaos, I felt a sense of admiration. It was evident that the patient was the central focus of the team’s work. While the attending physician called out instructions, the PA completed the exam and helped manage the patient’s airway while the nursing staff continued compressions and administered medications. This shadowing experience solidified my decision to become a PA. Whether in a trauma bay resuscitating a patient or in a primary care office creating a care plan, I would have the opportunity to be an integral part of a team and impact many lives.

During my shadowing experiences, I observed PAs perform an array of duties from reassuring patients and their families, to completing lumbar punctures, assisting with cardiac catheterizations and surgery. I realized that a PA’s abilities are far-reaching and encompass endless possibilities to be both autonomous providers and essential team members.

The PA profession encompasses everything I am already passionate about: medicine, humanism, and versatility. I am truly humbled to have the opportunity to be whatever my patients need during times of vulnerability. Whether adjusting a patient’s medications to enhance comfort, reviewing labs and imaging to confirm a diagnosis, or holding their hand while giving difficult news, I feel honored to join this profession. All of these values are also so intricately woven into the Johnson & Wales PA program, which made it an easy decision for me to pursue my education there. Each day, I am reminded of how important my role as a PA will be, not only as a member of the healthcare team, but as a human being who cares deeply for others.

SECOND YEAR: WE ARE HUMBLED
MATTHEW J. DACOSTA, BA

The transition into the clinical phase of PA training mimics a grayscale. The black and white hues of didactic medicine transform into real-patient scenarios, often muddled with gray areas. Amidst the novelty, we are humbled.

The challenges of clinical practice require a new mode of critical thinking. Independent of science and medicine; the human element can exhibit an unfamiliar variability. As echoed by our faculty, there is certainly great wisdom in the phrase “diseases don’t always read the book.”

Fortunately, all PA students possess a foundation of knowledge that improves with each encounter. Through independent study, preceptor guidance, and carefully listening to our patients, we begin to find some clarity.

During our journey of lifelong learning, we continue to derive lessons from the gray areas of medicine. Its ubiquity partially motivates clinical excellence. Regardless of what lies on the grayscale of our training, we truly find solace in the one aspect that underlies it all: the sacred relationships we share with our patients.

SECOND YEAR: DRINKING WATER FROM A FIRE HOSE
KAYLA DENIS, BS

There are many paths to choosing a career in medicine. I was drawn to the PA profession for many reasons, but particularly for the collaborative nature of PA practice. I thrive in team-based environments where the ideas and actions of many are stronger than that of one. This especially spoke to me given the evolution of modern medicine, where the idea of collaborative care via an inter-professional team of providers is of utmost importance. I was also intrigued by the fluidity in choosing a specialty and the option to change specialties without additional training. With my background as a competitive gymnast, I’ve always had a passion for orthopedics, but I loved the notion that I was not limited to a choice I made fairly early in my professional journey. Lastly, and most important for me, was the patient-centered and humanistic care that resides at the center of the PA profession.

Life as a PA student is difficult. There is just no other way to put it. My favorite analogy comes from one of my professors, who said, “PA school is like drinking water from a fire hose.” The amount of information presented in such a short period of time is intimidating and overwhelming, and despite all of our best efforts, some of it will pass by unabsorbed. But that is a key element of the medical profession in general. There really is no way to know everything about every disease or diagnosis. This is not only humbling but truly is the beauty of medicine. It takes a team of passionate, dedicated individuals to provide the type of care we all hope to provide. I think the same can be said about the path through PA school, where your friends and family are the essential support system helping to hold you up when the task ahead is daunting. I am forever thankful for the countless loads of laundry, grocery store trips, ready-to-bake meals, and family game nights that left me with one less item on my to-do list during late nights reading ECGs, and which also provided the mental decompression essential for success.

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PAs: From Training to Practice
ASHLEY A. HUGHES, MSPAS, PA-C

In 2014, Johnson & Wales University (JWU) enrolled its inaugural class of Physician Assistant (PA) students, making it the first Physician Assistant Program in the state of Rhode Island (RI). The program is now enrolling its fifth class under the direction of George Bottomley, DVM, PA-C. Since its inception, this Master’s degree program led and taught by certified PAs and local physicians, has addressed a shortage of health care practitioners in RI.

The program’s didactic phase begins in the summer, where four courses run simultaneously. Courses in anatomy, patient care, foundations of medicine and professional health and policy launch the students’ education. In the first week, students are introduced to the 24-hour access cadaver lab, assigned cadavers and are provided with dissection protocols. They then begin a year-long journey with them. Students are guided through detailed sequential dissections to identify clinically relevant gross, regional and surface anatomy by our Anatomist, Patricia Brady, who holds a PhD in biomedical sciences. Anatomy sequencing is coordinated with patient care courses. This harmonized learning aids students in integrating information between courses and in the practical application of anatomical knowledge for understanding of physical examination findings.

The cadaver lab is woven into the curriculum as an additional tool to supplement the understanding of medicine. For example, within the cardiology module, students return to the lab to identify cardiac pathology. As Faculty Assistant Professor Victoria Miller, MSPAS, PA-C, observed, “In the summer, the students begin the course with the eyes of an anatomist and return to the lab with the eyes of a pathologist.” Second-year students devote time in the lab to practicing procedural skills before entering the clinical year.

At the culmination of the academic year, students hold a closure ceremony where they gather with faculty to express their thanks for the year-long relationship and lasting gift of medical knowledge gained from their cadavers and the education the experience imparts. This event highlights the JWU Program mission of developing humanistic, respectful and empathetic PAs who will carry these values forward with them in their future careers.

The remainder of the students’ didactic education is designed for synergistic learning by presenting course material in a module specific format. The fall and spring semesters run for 16 weeks and each semester contains module information delivered over 1 to 4 weeks’ time. The length of each module varies based on the National Commission on the Certification of Physician Assistants (NCCPA) content blueprint organ areas to ensure adequate coverage of material by the completion of the didactic year to best prepare students for both clinical rotations and the Physician Assistant National Certifying Examination (PANCE). Modules consist of Dermatology, HEENT, Hematology, Cardiology, Pulmonology, Musculoskeletal, Renal, Urology, Neurology, Endocrinology, Infectious Diseases, Gynecology, Obstetrics, Gastroenterology, Surgery, Pediatrics, Geriatrics and Emergency Medicine. Each module contains clinical medicine lectures along with associated diagnostic skills, patient care, pharmacology lectures and problem-based learning cases, where students apply what they have learned in the module to clinical scenarios. This method of delivering medical education, allows students to learn, synthesize, and apply their knowledge in real time.

To better emphasize lifestyle changes as a way to manage disease, Assistant Professor Mallory Sullivan, MSPAS, PA-C, coordinates the highly regarded “Food as Medicine” course. Students collaborate with PA faculty and JWU chefs in the industrial kitchens where they learn how to use food as medicine. This trailblazing course links clinical medicine with patient care and nutrition. Students work to design and implement meal plans for a specified set of health conditions. They learn how proper nutrition can prevent illness as well as how to tailor nutritional education delivered to patients based on health problems, dietary restrictions and cultural needs. “Food as medicine” is designed to arm the PA with the tools to empower patients with the knowledge necessary to maintain their own nutritional wellness and this course achieves that objective.

PA education at JWU aims to develop generalist health care practitioners capable of working in dynamic, team-based environments. By introducing team-based care early in education with interprofessional events, students have opportunities to collaborate with other health care professionals to augment their understanding of the role of other professions in health care delivery. The students also learn leadership skills, communication skills, and strategies to create patient-centered clinical care plans. JWU PA students work alongside Respiratory Therapy, Occupational Therapy, Physical Therapy and Nursing students in patient encounters.
with community volunteer patients and simulation lab exercises. Assistant Professor Rebecca Simon, MS, who holds a master's degree in Occupational Therapy, coordinates interprofessional events. These experiences optimize the understanding of each specialty's role in patient care and facilitates collaboration between all parties for benefit of comprehensive and fluid patient care.

The second year of the JWU PA program curriculum is managed by Assistant Professor Kelli Kruzel, MSPAS, PA-C, who works diligently to place students in nine, five-week clinical rotations that provide the students an opportunity to practice skills they have learned. Core rotations in family medicine, internal medicine, pediatric medicine, women's health, behavioral and mental health, surgery, emergency medicine and two elective rotations, afford students a well-rounded clinical experience that prepares them for entry-level clinical work.

Physician assistants are educated in the medical model and typically begin their clinical careers upon graduation. PAs work in association with a supervising physician. The relationship between PA and supervising physician is one of joint practice. PAs can examine, diagnose and treat patients independently provided that the care delivered falls within the scope of practice of both PA and supervising physician. The role of the supervising physician is to provide professional guidance and support to the PA on medical care plans on a case-by-case basis. This relationship requires mutual respect and trust and places the patient at the center of medical care. Each state has its own regulations regarding the level of supervision a PA requires to practice medicine. The Rhode Island Department of Health Rules and Regulations for the Licensure of Physician Assistants states, “The constant physical presence of the supervising physician or physician designee is not required. It is the responsibility of the supervising physician and physician assistant to assure an appropriate level of supervision depending on the services being rendered.” Rhode Island state law further states, “The supervising physician or physician designee must be available for easy communication and referral at all times.” Each pairing of supervising physician and PA should have a written supervisory agreement clearly outlining this agreement. There is flexibility in the supervisory relationship based on the experience of both supervising physician and PA and office or hospital medical staff laws.

What makes the PA profession unique is the ability of practicing PAs to transition from one field of medicine to another when the desire to make a change presents itself. While this can be challenging and requires additional self-paced and employer required learning, it is entirely possible for the generalist-trained PA. PAs train and receive their board certification in general medicine, rather than in the care of a defined patient population, which provides a broad and solid foundation of medicine applicable to the care of patients in different clinical settings. Additionally, post-graduate training programs exist and serve the purpose of providing in-depth training to new graduates or PAs switching fields. This feature alone makes the profession appealing to many. For some, it is also an exciting and rewarding aspect of the profession for the practicing PA to incorporate areas of interest into their active clinical careers or follow a non-clinical trajectory. For example, physician assistants may maintain their full-time patient care work and decide to become involved in research. They may elect to be part of a research team and incorporate their knowledge into study design and implementation, data analysis or become a contributing author to a published article.

PAs often participate in departmental projects and hospital-wide polices as key stakeholders given their presence and function in multidisciplinary care teams. Insight into patient care and hospital inner workings also presents opportunities for PAs to advance to positions within hospital administration. This presents a new and challenging area of practice for PAs with a passion to improve hospital delivered patient care and PA responsibilities. For example, Denni Woodmansee, PA-C, acting Director of Physician Assistant Services for the U.S. Department of Veterans Affairs, has been effective in creating policies to be more inclusive of PAs and to appropriately widen the scope of PA practice within the Veteran's Administration.

Physician assistants may become involved with one of the four major national PA organizations: the American Academy of Physician Assistants (AAPA), the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), the National Commission on the Certification of Physician Assistants (NCCPA) or the Physician Assistant Education Association (PAEA). The AAPA advocates for the PA profession on a local and national level. NCCPA is the only certifying body for physician assistants. PAs involved with NCCPA assist with ensuring that physician assistants meet professional standards and these core values and knowledge set are adequately assessed for in the NCCPA certifying examination. The work of the ARC-PA is geared towards reviewing current and new physician assistant programs to make certain they are meeting or exceeding previously identified professional, academic and clinical standards for newly graduating physician assistants.

The highly respected U.S. Public Health Service (USPHS) also enlists PAs as Commissioned Corps Officers and assigns them to areas of greatest need. In turn, they serve needy populations within the United States, while becoming part of a medical deployment team to offer medical care of persons affected by natural disaster or illness outbreak. Rear Admiral Michael Milner, one of the highest-ranking PAs in the USPHS, highlights the extensive ways in which PAs can contribute to medicine and public health. Rear Admiral Milner's career included managing public health programs in Rhode Island and five additional states, working for the Department of Homeland Security, becoming...
Chief Professional Officer for the Health Services Office and acting as Chief PA consultant to the Director of the Indian Health Service (IHS).

PAs work in a multitude of environments. This flexibility extends to work outside of the United States. Due to the predicted physician shortage and challenges with providing accessible and affordable health care, the need for advanced care providers on the global scale has been recognized. The model of education provided to PAs in the US serves as a benchmark for other countries to establish similar programs in their home locales to give rise to semi-autonomous clinical workers with the potential to address current health care delivery obstacles. Recently, the United Kingdom began the National Physician Associate Exchange Program, employing U.S.-certified Physician Assistants in the United Kingdom in an effort to expand the role of Physician Associates working with the National Health System in England. Canada, Australia, New Zealand, Northern Ireland, Scotland, the Netherlands, Germany, Ghana, Afghanistan, Liberia, Israel, Saudi-Arabia, India and Taiwan have already begun training and graduating physician assistants/physician associates. This list does not include those countries that have established their own version of an advanced practice provider that is not necessarily given the title of physician assistant or physician associate. The increasing presence of PAs around the globe has opened the door for international clinical work within those countries that welcome certified US physician assistants to be part of the clinical team.

The areas of interest and career paths discussed here are not completely representative of the pathways available to PAs; however, they represent a small portion of the wide variety of possibilities that exist for PAs today. With the projected growth of the PA profession comes an expanding pool of clinical and non-clinical jobs that will allow PAs to offer expertise, education and guidance as valued members of health care teams in the United States and abroad.

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Why Hire a PA?
SYDNEY FONTAINE, BS; CHRISTINA RAMIREZ, BS

The Physician Assistant (PA) profession is growing rapidly and was recently cited as the third best job in America in 2018.¹ PAs partner with physicians to improve patient-centered and integrated care and add value to their respective clinical teams. Their presence in a practice increases access to high quality care, which improves both productivity and revenue for practices and their respective physicians.² To gain a better understanding of why physicians choose to incorporate PAs into their practice, we examined the experience of a small primary care practice and a larger orthopedic group in Rhode Island. Physicians and PAs in each setting provided a practical, hands-on perspective on how they define PA roles, negotiate clinical autonomy, and coordinate care with other members of the practice. We interviewed Dr. John K. Czerwein, Jr. and PA Benjamin Javery of The Center for Orthopaedics, Inc. (CFO) as well as Dr. Herbert J. Brennan and PA Kimberly Masood of Brennan, Cronin, and Peters: Internal Medicine practice (BCP) to obtain perspectives about PA roles and contributions in different settings.

Practices typically consider adding a PA when rising demand exceeds their ability to provide quality care to all their patients.³ Physicians may recruit additional physicians, or hire a Nurse Practitioner (NP) or PA. Bringing an additional physician into a practice is often less cost-effective than adding non-physician practitioners because a new physician would receive a larger salary and often own a share in the practice.⁴ While NP and PA roles can overlap, there are key differences between the two professions. NPs are trained using a nursing model, focusing on health promotion, disease prevention, and counseling.⁵ PA education was shaped by several prominent academic physicians, who recognized that medical corpsmen returning from the war in Vietnam had strong, but underutilized clinical skills.⁶ Before entering PA school, applicants must complete between several hundred to 2000+ hours of direct patient care experience, providing future PAs with a hands-on approach to patient care before beginning their studies. “The intensive PA curriculum is modeled on that used in medical schools.”⁷ In a typical 27-month program, PA students must complete over 2000 hours of supervised clinical practice in a wide variety of settings that includes rotations in family medicine, internal medicine, general surgery, pediatrics, obstetrics and gynecology, emergency medicine and psychiatry.⁷ In contrast, the Executive Director of the New Hampshire Nurse Practitioner Association noted that “NPs approach patient health care by looking at the patient as a whole, by looking at their social needs as well as their medical needs. They bring a more holistic approach to treating the patient.”⁸ “This holistic philosophy leads NPs to ‘function as a combination of a patient educator and a social worker.’”⁸ These differences in education make it more likely for PAs to specialize, while NPs are more common in a primary care setting.⁹

HIRING A PA
At the Center for Orthopedics (CFO), “We did consider a nurse practitioner as a possible hire, but based on the research we did, we felt that a physician assistant would be more advantageous in the operating room.” PAs are exposed to multiple surgical specialties during their required rotations, and their curriculum, akin to medical school, reflects a more “disease specific” orientation. In contrast, more than 90% of NPs train in primary care, and NPs are more likely to choose careers in primary care settings.⁹ In this context, the Center for Orthopedics’ decision to hire a recent graduate of a PA program filled an important need for the practice to add a colleague who would be ready to assist in surgery rather than spending most of his time in the clinic. One of the most challenging problems for CFO was managing surgical patients in Providence while also seeing patients in the outpatient clinic in Johnston. Surgeons in the practice perform surgeries at Our Lady of Fatima Hospital and also see patients for outpatient visits in Johnston. Providing continuity of care proved difficult due to the distance between sites. The use of a PA “reinforces continuity for patients when their usual provider is not available” and has “decreased stress” and “significantly reduced [the surgeons’] workload.”¹⁰ As the American Association of Surgical Physician Assistants noted, “surgical PAs can be indispensable in an office setting, performing about 80% of the tasks normally performed by physicians,” including preoperative exams, post-op wound checks, and the removal of sutures, staples and drains.¹¹ In hospital settings, PAs can order labs, imaging studies, EKGs, and necessary medications.¹¹ This team-based patient-centered care helps patients build relationships with the entire team of providers knowing that they will always have available support and consultation to discuss treatment plans and track progress.
PAs may also play a vital role in primary care settings. The continuing shortage of primary care physicians creates significant challenges for practices seeking to expand their ability to meet patient demand. The primary care practice of Drs. Brennan, Cronin and Peters (BCP) faced difficulty meeting the rising demand of their patients. The partners considered hiring a new colleague to manage their increasing volume of patients and the challenge of providing same-day visits for patients. Since unscheduled appointments are difficult for primary care practices to balance, hiring a PA expanded the ability of the practice to see more patients without further overextending the physicians. Most practices face pressure to shorten the length of patient appointments to accommodate more patients. Recent estimates predict a shortage of between 4,300 and 43,000 primary care physicians nationally by 2030. Hiring a PA allowed BCP to uphold their patient-provider relationships while increasing availability. As a recent graduate, BCP felt she was a good addition to the care team because they could mold her skills to fit the practice’s patient care philosophy.

Hiring a PA rather than a partnering physician often makes financial sense for a practice, as the salary difference between physicians and PAs in primary care is roughly $89,000. For an internal medicine practice such as BCP, Dr. Brennan noted that either a PA or an NP offered effective options. NPs are growing in primary care because they can be independent providers; 20 states (including Rhode Island) grant NPs “full practice authority” to diagnose and treat patients without physician supervision. The proportion of PAs choosing careers in primary care has steadily declined since the mid-1990s because a majority of job postings for PAs were in surgery (28%), emergency medicine (12%), or other specialties. Nevertheless, PAs represent an excellent option for primary care practices since they are trained as “generalist clinicians who are ready to practice medicine in collaboration with a physician.” Although BCP chose to add a PA to meet the needs of a growing practice, Dr. Brennan believes the PA and NP roles can be interchangeable if the applicants are “properly trained” for their respective setting.

SCOPE OF PRACTICE

In Rhode Island and 19 other states, NPs are licensed to practice independently; in other states, their scope of practice varies widely. Unlike NPs, PAs must practice under a supervising physician. The nature of this supervision, however, is defined by each physician and PA independently. PAs acquire new skills over time as they gain experience through supervised practice. “Upon graduation, a PA is an adaptable provider. Akin to a stem cell, the PA has the flexibility to move into any specialty practiced by a supervising physician.” The ability to change specialty or area of practice as a PA is possible because of a PA’s relationship with his or her supervising physician. More than 50% of PAs practice will work in more than one specialty during their career.

As one PA at the Center for Orthopaedics noted, staying in Rhode Island allowed him to have many “freedoms provided such as no restriction on prescribing different classes of medication and flexibility with regard to physician supervision.”

The PA role is defined by negotiated autonomy with their supervising physician. The Department of Health’s rules and regulations for the licensure of physician assistants specify that “Physician assistants practice with physician supervision. Physician assistants may perform those duties and responsibilities consistent with the limitations of §5-54-8 of the Act, including prescribing of drugs and medical devices, that are delegated by their supervising physician[s].” The PA’s level of autonomy, in turn, depends on the “experience, training and preferences of all providers on the team, the needs of the patient population and the level of trust the physician has with the PA.” Dr. Czerwein noted that a PA’s scope of practice can expand over time. For example, during his first six months at the Center for Orthopaedics, the PA’s responsibilities in the operating room went from observing to assisting on some cases, to first-assisting in surgery. Dr. Brennan’s description of a PA’s role and negotiated autonomy focused on the patient. When a PA is first hired, he or she needs to acclimate to the specific clinical setting, as primary care treatment modalities vary widely. As PAs adjust to their new roles, their “clinical acumen” also grows, which gives the supervising physician confidence in how the PA is fulfilling his or her new role.

FINANCIAL CONSIDERATIONS

The PA profession continues to expand; the number of PAs in practice is expected to grow 38% between 2012 and 2022. Many factors contribute to a student’s decision to become a PA rather than applying to medical school. PAs represent a cost-effective option for growing physician practices. The 2016 Statistical Profile of Certified Physician Assistants by Specialty Annual Report states that Surgical Subspecialty PAs made an average of $113,496 while Primary Care PAs made an average of $95,928. In contrast, according to the Medscape Physician Compensation Report, orthopedic physicians made on average $489,000 while family medicine physicians made an average of $209,000 in 2017. These large pay gaps, especially in surgical subspecialty like orthopedics, can offer a compelling case to hire a PA.

CONCLUSION

The experience for both the Center for Orthopaedics, Inc. and Dr. Brennan, Cronin and Peters’ Internal Medicine practice demonstrates how PAs can improve the efficiency of different practice settings. The PA profession was designed for flexibility, adaptability, and negotiated autonomy. In a rapidly changing health care system, PAs can increase work productivity, reduce physician stress, and support a team-based, patient-centered model of care while presumably maintaining or increasing quality of care.
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Babesiosis and Lyme Disease in a 68-year-old man

NICHOLAS MUSISCA, MD; HARRY VANDUSEN, MD’21; ALYSSA MIERJESKI, MD; WILLIAM BINDER, MD

Case Reports from the Alpert Medical School of Brown University Residency in Emergency Medicine

HARRY VANDUSEN: A 68-year-old man presented to the emergency department from his physician’s office with a chief complaint of fatigue, shortness of breath and night sweats. A chest X-ray at the physician’s office was normal.

The patient’s symptoms started approximately one month earlier and his doctor had diagnosed him with the flu. He initially felt better after a course of oseltamivir but his symptoms returned approximately 4 days prior to coming to the ED. The patient described profound fatigue and shortness of breath with minimal activity in addition to night sweats, chills and nausea. He denied any recent rashes, insect bites, abdominal pain, cough or weight loss. He traveled to Florida approximately 1 month prior, but had not been outside of the U.S. He had no history of smoking but admitted to social alcohol use. The patient lives with a dog and cat, both of which had been fully vaccinated. He had a history of Lyme disease in the early ’90s that presented with severe joint pain. Medical history also included osteoarthritis and benign prostatic hypertrophy.

On exam, he had normal vital signs and appeared non-toxic. He had no scleral icterus and his cardiopulmonary and neurological exams were normal. He had mild, left, upper-quadrant (LUQ) tenderness. He had no calf swelling or tenderness, and there were no rashes or insect bites.

DR. ANDREW NATHANSON: The patient appears well but reported new onset fatigue and shortness of breath, as well as night sweats. What were your concerns?

DR. NICHOLAS MUSISCA: The differential diagnosis of fatigue and shortness of breath is large. In the emergency department vague symptoms and a non-focal physical exam are a frequent and difficult presentation requiring a heuristic approach. Our initial strategy was to rapidly rule out immediate life-threatening problems and then gather additional data. Given the patient’s age and the frequency of acute coronary syndrome presentations to the ED, a cardiovascular cause was briefly considered, as ‘atypical’ symptoms such as fatigue, malaise, and dyspnea are common findings in older patients. While the ECG is not a particularly sensitive test for coronary artery disease and acute coronary syndrome (ACS), it is portable, inexpensive, non-invasive, and can provide significant information quickly. Our patient’s ECG was normal.

DR. MARK GREVE: The patient had night sweats. Did you pursue an infectious or hematologic/oncologic cause of the patient’s illness?

DR. ALYSSA MIERJESKI: The difficulty in interpreting night sweats is the lack of a standardized definition published on the topic. However, causes of night sweats are well documented and include autoimmune disorders such as rheumatoid arthritis and giant cell arteritis, as well as cardiovascular, endocrine, neoplastic and infectious causes. Additionally, numerous medications, including selective serotonin reuptake inhibitors (SSRIs) have been associated with night sweats. As we had no obvious cause of the patient’s complaints from his history or physical exam, we obtained a series of labs tests, including a CBC, chem 20, troponin, and a D-dimer.

DR. DAVID LINDQUIST: What were your lab results?

DR. MIERJESKI: The patient had a number of laboratory abnormalities. The WBC count was 2.9 x 10^9 with 34% segmented neutrophils and 11% bands. The hemoglobin and hematocrit were 10.7 g/dl and 32.4%, respectively, and the platelets were 77,000. The patient had a mild transaminitis (AST 62 IU/L, ALT 59 IU/L), his alkaline phosphatase was mildly elevated at 138 IU/L, and his D-dimer was 2,374 ng/ml (normal < 250). A urinalysis and a troponin were both negative.

DR. ELIZABETH NESTOR: The patient had a number of lab abnormalities, of which the elevation in the D-dimer is particularly striking. Did you pursue the cause of the elevated D-dimer? Furthermore, he was pancytopenic and had a significant percentage of bands.

DR. MUSISCA: The D-dimer is a fibrin degradation product and is generated from cross-linked fibrin. An elevated plasma concentration of D-dimer indicates recent or ongoing intravascular blood coagulation, and consequently it is a nonspecific finding. Taken in conjunction with the patient’s
dyspnea, however, we felt it was prudent to obtain a pulmo-
nary embolism (PE) protocol CT scan. The scan was negative
for a PE but did demonstrate a prominent liver and spleen.

In regards to the bands, the patient did not meet systemic
inflammatory response syndrome (SIRS) criteria, although
his pancytopenia was suggestive of a broad hematologic
dysfunction.

**DR. MATTHEW KOPP:** To summarize, the patient appears
nontoxic, has pancytopenia with a predominance of bands, a
mild elevation in transaminases, and appears to have a large
liver and spleen partially visualized on a PE CT. What were
your concerns at this point?

**DR. MIERJESKI:** The patient’s symptoms appeared to
develop rapidly and while a neoplastic process such as
lymphoma was within the differential, we were concerned
about an infectious disease. The patient did not have an
upper respiratory infection, and his chest X-ray was normal,
making pneumonia unlikely. He did not appear to have a
genitourinary infection. Endocarditis was within the dif-
ferential, although the patient did not have a murmur and
did not exhibit any of the Duke criteria for the diagnosis of
infective endocarditis. Numerous viruses – HIV, CMV, EBV,
and others – can cause HSM and pancytopenia. Additionally,
and due to the endemicity of tick-borne illness within our
region, tick-borne illnesses must be considered. We sent a
thin and thick smear for parasites, as well as lyme, ehrlichia,
and anaplasma titers. The smear was positive for intraeryth-
rocytic parasites, consistent with babesiosis (See Figure 1.).
He had a parasitemia of 0.26%.

**DR. ELIZABETH SUTTON:** How common is babesiosis? Is
it likely that the patient’s initial symptoms over one month
ago were consistent with babesiosis?

**DR. MUSISCA:** Babesiosis is a zoonotic red blood cell para-
sitic infection transmitted by the tick, *Ixodes scapularis*. It
was first identified by Victor Babes in 1888, but was not rec-
ognized in humans until 1957, and not noted in an immu-
nocompetent individual until 1969. During the present
century, the prevalence of tick-borne illnesses has escalated,
and babesiosis has become an increasingly recognized dis-
ease in the northeast and upper Midwest states, and also has
a worldwide distribution. While there are over 100 species
of babesia, most infections in the US are due to *B. microti*.

Clinical manifestations of babesiosis can range from a sub-
clinical disease to severe and fulminant illness. While most
patients are symptomatic within 1–6 weeks of a nymph tick
feeding, parasitemia can exist silently for months to years. More
commonly patients report symptoms similar to our
patient – gradual, nonspecific flu-like complaints including
chills, sweats, headaches, nausea, myalgias, anorexia, and
occasionally a non-productive cough about 1–6 weeks after
a nymph tick feeding. Transmission from a tick is usually
in the spring or summer months when the nymphs quest
for a blood meal. Many patients do not recall a tick bite.
Additional avenues of infection include blood transfusion,
and rarely transplacental transmission from a mother to the
neonate. Laboratory abnormalities can reveal pancytope-
nia, elevated transaminases, and an increased total bilirubin
due to hemolysis.

**DR. JESSIE WERNER:** How is the diagnosis made?

**DR. WILLIAM BINDEr:** Diagnosis of an acute infection is
made through detection of Babesia parasites on Giemsa or
Wright stained thin and thick blood smears. The trophozoites
can appear as pleomorphic ring forms, and rarely tetrads of
merozoites can arrange to form a Maltese cross pattern. PCR
can be used to detect low-grade Babesia microti infection
and is more sensitive than light microscopy. Serology can
also be utilized to detect antibodies and confirm the diagno-
sis. A travel history is important in patients with findings
of intraerythrocytic parasites as the ring forms can resemble
those of *Plasmodium falciparum*. As autochthonous malaria

![Figure 1. Trophozoites noted on giemsa stain smear. This patient had a low (0.26%) parasitemia.](image-url)
is rare in the U.S., and has not been detected in New England in over 70 years, we felt confident that the trophozoites were consistent with Babesia.12

D R. VICTORIA LEYTIN: How was the patient treated?

D R. MIERJESKI: Our patient was symptomatic but not unstable, and fell into the category of mild to moderate disease. Mild to moderate disease is treated with atovaquone and azithromycin for 7 to 10 days. Alternatively, patients can be treated with intravenous clindamycin and quinine for 7 to 10 days, although this regimen tends to have more adverse side effects.

Immunocompromised individuals – patients with HIV, on immunomodulators, a history of hematologic malignancies, and those with splenectomies – are at higher risk in developing severe and fulminant disease. While the treatment regimen for severe disease is also clindamycin and quinine, the treatment duration is often increased to 6 weeks due to increased chance of persistent disease. There are also several alternative regimens including atovaquone-proguanil; atovaquone, clindamycin and doxycycline; and atovaquone, azithromycin and doxycycline. In patients with severe disease who have greater than 10% parasitemia, exchange transfusion is an important therapeutic adjunct.11

D R. ANGELA JARMAN: What was the patient’s outcome?

D R. MIERJESKI: Although this patient had several laboratory abnormalities, overall he appeared very well with no overt contraindications to outpatient treatment. Antibiotics were initiated in the emergency department, and he was eventually discharged home on oral antibiotics with outpatient follow-up scheduled in 48 hours. The following day, the patient’s Lyme titer also came back positive, and doxycycline was added to his treatment regimen. The patient has done well and after several months was back to his baseline.

D R. OTIS WARREN: How frequently do multiple organisms occur in an *Ixodes scapularis* tick?

D R. MUSISCA: Concentrated cases of babesiosis are seen in Lyme-endemic parts of the country. While Lyme disease is much more commonly seen as an isolated infection, dual infection is not uncommon. The organisms responsible for either Lyme disease, babesiosis, or human anaplasma may occur in over 20% of *Ixodes scapularis* ticks, although it is rare to find all 3 of these organisms present together.10,13

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Dermatomyositis Developing Post Neoadjuvant Chemotherapy and Lumpectomy

DANIEL E. WONG, BA; EDELVA WILLIAMS, MD; SARITA WARRIER, MD

ABSTRACT
Dermatomyositis is an idiopathic inflammatory myopathy known to occur as a paraneoplastic syndrome. The course of dermatomyositis is commonly reported to mirror the course of the malignancy. Here, we report a case of dermatomyositis that developed in a patient after lumpectomy and completed chemotherapeutic treatment.

KEYWORDS: dermatomyositis, breast cancer, chemotherapy, paraneoplastic syndrome

INTRODUCTION
Dermatomyositis is an idiopathic connective tissue disease characterized by inflammatory myositis and characteristic skin lesions. The disease bears a strong association with malignancy: approximately 15–30% of patients with dermatomyositis have an underlying malignancy, and dermatomyositis patients have an 5–7 times increased risk of developing cancer compared to the general population.1,2 However, numerous previous reports of paraneoplastic dermatomyositis have observed the disease evolving in parallel with cancer.3–6 Here we present a case of dermatomyositis that developed in a patient with invasive ductal carcinoma of the breast after six cycles of neoadjuvant chemotherapy and right lumpectomy.

CASE PRESENTATION
A 48-year-old woman with a history of grade III breast cancer treated with neoadjuvant chemotherapy and lumpectomy presented with two months of facial and arm swelling, dysphagia, and erythematous rash involving the face, chest, and arms. The symptoms initially developed two weeks after her 6th cycle of taxotere, carboplatin, trastuzumab, and pertuzumab. She first visited her oncologist, who suspected her symptoms to be either a side effect of chemotherapy or an allergic reaction. At the time, she received diphenhydramine, topical steroids, and short courses of oral steroids, which provided only transient improvement in her symptoms. On admission to the hospital, she was afebrile and hemodynamically normal with bilateral arm pitting edema and an erythematous facial rash [Figure 1]. She had full strength of all extremities. She had a WBC of 12.1 K/µL and unremarkable serum chemistries. Her presentation was thought to be suspicious for superior vena cava syndrome, but chest computed tomography (CT) showed no evidence of venous occlusion. Bilateral arm ultrasound was negative for deep vein thrombosis. Creatinine kinase was 819 IU/L (normal 20–165 IU/L), aldolase 9.1 U/L (normal ≤ 8.1 U/L), and antinuclear antibody was reactive at 1:1280 with a speckled pattern. Further evaluation with an arm MRI revealed edema with enhancement of skin, subcutaneous tissues, and multiple proximal muscles consistent with dermatomyositis [Figure 2]. A skin biopsy was consistent with dermatomyositis, with vacuolated immune complex deposition at the dermal-epidermal junction. Muscle biopsy showed
perivascular and interstitial lymphocytic infiltration, indicating an inflammatory myopathy. The patient was started on azathioprine and a prednisone taper, and her symptoms improved over several months.

**DISCUSSION**

Dermatomyositis is an idiopathic inflammatory myopathy with classic cutaneous manifestations, including Gottron’s papules, heliotrope rash, and the shawl sign. The condition has a strong association with malignancy, with lung, ovarian, and breast being the most common types. Out of the dermatomyositis cases diagnosed in breast cancer patients, 71% present with stage III or IV breast cancer. Recent work shows that the underlying mechanism of dermatomyositis is likely immunological, with over 70% of patients found to have disease-specific autoantibodies. Diagnosis is typically made with muscle biopsy, electromyography, and muscle magnetic resonance imaging. Glucocorticoids are considered the mainstay of management. Steroid-sparing immunosuppressive therapies confer therapeutic benefit in addition to relieving steroid burden, and intravenous immunoglobulin is used in severe cases. If cancer is present, cancer cure is expected to lead to symptomatic improvement. Many have reported that with complete remission of cancer, the physical manifestations of dermatomyositis either diminish or disappear completely. In a study by Cox et al, dermatomyositis patients who underwent resection of tumors were found to have resolution of their symptoms.

Treatment is monitored clinically for improving muscle strength and resolution of cutaneous symptoms. A fall in creatinine kinase levels is generally seen initially in the recovery course, followed by a more gradual return of muscle power. This case displays an unusual presentation of dermatomyositis that evaded immediate diagnosis due to a few atypical characteristics. She had no weakness and the serum elevations of muscle enzymes was modest. Most accounts of malignancy-associated dermatomyositis describe the two disease processes occurring simultaneously. Interestingly, this patient presented with symptoms after six cycles of neoadjuvant chemotherapy and tumor excision. The patient had physical exam findings that did not bear similarity to the typical cutaneous findings associated with dermatomyositis. Indeed, limb edema is a rare finding in adult dermatomyositis, and Milisenda et al reported 14 only cases up until 2014. Her symptoms appeared resistant to repeated courses...
of steroids and developed two weeks after a cycle of chemotherapy. For these reasons, the diagnosis of dermatomyositis was not immediately entertained. The patient’s presentation initially raised the possibility of angioedema, allergic reaction, steroid-induced myopathy, or a previously undiagnosed autoimmune process unmasked by chemotherapy.

**CONCLUSION**

This case reinforces the importance of maintaining a high suspicion for dermatomyositis in a patient with cancer history presenting with widespread skin rashes, even in the setting of completed treatment. Though paraneoplastic dermatomyositis is known for its temporal association with malignancy, a presentation such as this one demonstrates an atypical time course.

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Bubbles in the Brain: A Rare Complication Following Transthoracic Echocardiography
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ABSTRACT
With nearly 700,000 cases every year, ischemic stroke represents the third leading cause of death in the United States. Nearly thirty percent of all ischemic strokes are due to embolism. A standard component of every stroke work-up at most institutions, echocardiography is vital not only for diagnosis but also for prevention and treatment of cardiac sources of embolism. Visualization of right-to-left shunting is often contrast-enhanced with micro bubbles created by mixing saline with air, a so-called “bubble study.” We present a case of an 89-year-old woman who suffered cerebral air embolism and massive infarction following a routine bubble Transthoracic Echocardiogram.

KEYWORDS: bubble study, echocardiography, ischemic stroke, embolism, stroke

An 89-year-old woman with Peripheral Vascular Disease and Limited Scleroderma presented to the hospital with two weeks of progressively worsening burning leg pain and swelling and was admitted for cellulitis. On exam, she was found to have bilateral erythema of her lower extremities with clear drainage and was started on intravenous antibiotics. Initial laboratory workup was only significant for leukocytosis of 18,700. During the course of her hospital stay, she also became short of breath and was hypoxic with evidence of cor pulmonale. Transthoracic Echocardiogram (TTE) showed impaired left ventricular relaxation, severe right heart failure (rVdd 48mm), severe pulmonary hypertension (rVSP 92mmHg) and severe tricuspid regurgitation (TrPGmax 82mmHg).

Thirty minutes after receiving intravenous furosemide, she developed generalized left-sided weakness. The stroke team was activated although the patient’s neurological exam was unremarkable for any focal deficits, and tissue plasminogen activator was not administered due to her rapidly improving symptoms. No acute changes were seen on an emergent head computed tomography (CT) scan. Decreased diffusion in the right precentral gyrus consistent with ischemia-induced left hemiparesis was later appreciated on Magnetic Resonance Imaging (MRI) (Figure 1).

A stroke work-up was initiated with normal carotid ultrasound, lipid panel and A1c. The patient was treated with clopidogrel, atorvastatin, and heparin throughout her hospitalization, and no arrhythmias were noted on telemetry. Three days later, a bubble TTE was performed as part of the workup that identified both an intrapulmonary right-to-left shunt (RLS) and a small patent foramen ovale (Figure 2). Approximately twenty minutes later, the patient was unable to move any of her limbs against gravity, had a left visual field defect, mild facial droop, and dysarthria.

Figure 1. Diffusion impairment on MRI
Axial brain DWI showing right precentral diffusion impairment.

Figure 2. Echocardiogram of Valsalva maneuver performed during bubble study showing numerous bubbles in the left heart (yellow ellipse) indicating RLS.
CASE REPORT

without aphasia or sensory deficits. Computed Tomography Angiogram revealed diffuse foci of right-sided intracerebral air embolism (Figure 3) with no evidence of large vessel occlusion. Tissue plasminogen activator was not administered due to the potentially increased risk of hemorrhage in recently infarcted tissue. MRI demonstrated bilateral diffusion restriction pattern consistent with massive ischemic stroke (Figure 4). The patient had severe neurological damage and the family did not want to pursue any further workup. The patient was transitioned to inpatient hospice and died the subsequent day.

DISCUSSION

The 2016 Appropriate Use Criteria by the American Society of Echocardiography recommends performing TTE or transesophageal echocardiography (TEE) as initial tests to evaluate suspected cardiovascular sources of embolism, especially in patients for whom therapeutic management depends on the findings. Intra-cardiac shunting can be determined sometimes using color Doppler although agitated saline or bubble studies are known to yield higher results. These tests are performed at the end of TTE when it is necessary to rule out RLS. Recent advances in medicine have enabled closure of RLS through percutaneous devices.

Alternative imaging methods include bubble transcranial doppler (TCD), which can detect a RLS by visualizing bubbles in the middle cerebral artery through the temporal bone window. Bubble TCD is limited by the absence of the temporal window in some patients and the inability to distinguish intracardiac and extracardiac sources of embolism. Paradoxical embolization with neurologic symptoms following bubble TCD in patients with RLS and congenital heart disease has been noted previously, although the frequency has not been described.

A 2009 case series by Romero and colleagues of bubble-study-associated cerebrovascular accidents included two cases of transient ischemic attacks and three cases of ischemic stroke. All patients were female, and all experienced symptoms within five minutes of their respective bubble studies. Four of the patients had a bubble TTE and one had a bubble TCD. While protocols vary among institutions, either bubble TTE or bubble TCD can be used to detect RLS and involve similar injection formulations. In response to this series, a prospective consecutive case series was conducted in 2010 by Tsivgoulis and colleagues to estimate the rate of cerebrovascular accidents in bubble TCD. Of the 508 patients who underwent bubble TCD, none had a stroke within twenty-four hours.

In our case, bubble TTE was ordered following the recommendation of the stroke team to evaluate for intra-cardiac thrombus, RLS, and any structural defects. Twenty-four minutes elapsed between bubble TTE and the onset of stroke symptoms, more than the five minutes of previous cases, but well within the twenty-four hours allotted by Tsivgoulis and colleagues to report these events. All twenty-four minutes can easily be accounted for by the preceding TTE as well as the transport time from the echocardiogram lab back to the patient’s room during which symptoms may have been present but not appreciated.

At many institutions, TTE is the initial form of cardiac imaging for stroke work-up due to its low cost and non-invasiveness compared to TEE. In addition, TEE was not indicated in our patient as TTE already showed evidence of patent foramen ovale as well as intrapulmonary RLS and would not have changed management. A bubble study is usually done at the end of TTE to exclude RLS.

To investigate further, we compared the procedure at our institution with those of other institutions. A TTE without bubbles is first performed. 2 mL of air is agitated with 8 mL

Figure 3. Figure 3: Air emboli on CT
Axial brain CT showing multiple foci of air emboli (yellow ellipse).

Figure 4. Interval change in diffusion impairment on MRI
Axial brain DWI showing increased diffusion impairment (yellow arrows) consistent with region of air emboli. Superior slices showed that the diffusion impairment extended bilaterally.
of normal saline. The solution-containing syringe is then connected to the patient’s IV port via Luer lock and injected vertically to avoid injecting large bubbles. The study is then repeated with a Valsalva maneuver, for a total volume of injected air of 4 mL. Additional injections may be necessary if the first attempt is not definitive.

Given that bubbles are seen in the brain during bubble TCD, it should not be surprising that bubbles may also be found in the brain during bubble TTE. In general, the bubbles used in either modality are too small and short-lived to occlude cerebral vessels. While a 2 mL bolus of air is sufficient to cause an arterial embolism in a 7 kg macaque, the volume necessary to have the same effect in a human is likely significantly greater. As all cases of bubble-study-associated cerebrovascular accident reported here have been in females, smaller size may be a risk factor. Additionally, this patient’s study was marked as “technically challenging” and may have required multiple injections. Although other institutions inject only 1 mL of air compared to our hospital’s 2 mL, the incidence of bubble study-associated cerebrovascular accident is so low that the relative risks of different protocols cannot be meaningfully compared. Due to this rarity, the mechanism by which cerebrovascular accident develops after bubble study is not understood. In the case of bubble TCD, previous research has hypothesized that neurologic symptoms may be related to the shunting of chemical factors other than microemboli.

**CONCLUSION**

While a previous case series has linked bubble studies to ischemic stroke temporally, our case is the first to provide direct radiographic evidence of air embolism with spatially concordant infarction. One limitation of our report is that the exact cause of death was unknown as there was no autopsy performed. Cor pulmonale and severe pulmonary hypertension could have also contributed to the patient’s death in addition to the severe neurologic damage. Another limitation is that the bubble TTE was technically challenging and the patient refused further images. Hence the exact magnitude of the intrapulmonary RLS and PFO could not be ascertained. In conclusion, even though the incidence of cerebral air embolism following bubble studies is exceedingly rare, it is important for all providers to be aware of this complication and its potentially fatal consequences.

**References**

2. Heart Disease and Stroke Statistics—2010 Update [Internet]. Ahajournal.org. 2010 [cited 22 May 2017]. Available from: http://circ.ahajournals.org/content/121/7/e46.full#sec-61

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Community Health Workers in Rhode Island: A Study of a Growing Public Health Workforce
BRADY DUNKLEE, MPH’18; DEBORAH GARNEAU, MA

ABSTRACT
Community Health Workers are gaining recognition as a valuable, newly emergent public health workforce. This article describes a qualitative study that generated a snapshot of Community Health Worker employment in Rhode Island, gathered collective wisdom and stakeholders’ perspectives about how to pay for a community health workforce, and highlighted promising opportunities to grow and sustain the field. This article summarizes the study’s findings, and discusses its implications. The full report is available at: http://www.health.ri.gov/publications/reports/CommunityHealthWorkersInRhodeIsland.pdf

KEYWORDS: Community Health Workers, CHWs, Community Health, Public Health Workforce, Community Health Worker Funding

BACKGROUND
Community Health Workers (CHWs) have gained increasing attention in the United States for their potential to improve population health outcomes, particularly by addressing disparities among underserved groups, while reducing costs and improving access to healthcare.1–4 “Community Health Worker” is an umbrella term that may include job titles such as Outreach Worker, Peer Advocate, Patient Navigator, Community Health Educator, and Promotor(a) de Salud.2,5,6 CHWs often share lived experience, language and culture with the groups they serve, and build patient and community capacity to improve health through activities such as outreach, community education, informal counseling, social support and advocacy. For the Rhode Island Department of Health, “Community health workers are frontline, public health professionals who often have similar cultural beliefs, chronic health conditions, disability, or life experiences as other people in the same community.” A CHW might help a patient set and pursue a behavioral goal through motivational interviewing, accompany a patient to an appointment, advocate with a landlord to remediate mold, provide social support to someone with a new diagnosis, or explain a medication regimen in culturally and linguistically appropriate terms. A growing body of evidence supports CHWs’ effectiveness in addressing the social, economic and environmental determinants of health.7–11 A number of studies have also demonstrated cost effectiveness or cost savings as a result of these public health interventions.12–15

The CHW workforce in Rhode Island has gained recognition among stakeholders in state government, healthcare, social service and higher education in recent years. In 2016, the Rhode Island Department of Health developed certification standards for CHWs with a broad spectrum of RI CHWs through the Rhode Island Certification Board. A certification grandparenting period for CHWs ended in late 2017, and regular certification procedures are in effect, making Rhode Island one of a growing number of states to offer certification.16 Certification requires 70 hours of classroom training aligned to state standards, 1,000 hours of work experience, 50 hours of supervision, and a portfolio demonstrating experience and competence. 217 CHWs have been certified through this process to date. Several major projects in the state support CHW positions and/or workforce development, including the multiagency, CMS-funded State Innovation Model Test Grant (SIM),17 the Executive Office of Health & Human Services’ Healthcare Workforce Transformation Initiative,18 the Care Transformation Collaborative of Rhode Island (CTC-RI),19 and Rhode Island College’s Healthy Jobs RI initiative funded by the department of Labor & Training’s real Jobs RI program. The Rhode Island Department of Health (RIDOH) has supported CHW expansion and professionalization as a partner in these initiatives, and in its signature Health Equity Zone (HEZ) programs.

In 2017, RIDOH carried out a study of the CHW employment landscape in the state to understand, document and build on the field’s momentum.

METHODS
The Rhode Island CHW Employment Study, conducted over several months in 2017, asked a series of questions of 39 key informants with direct knowledge of the training, employment, deployment, and activities of CHWs in Rhode Island, in 24 in-person and 1 telephone interview. Of the 25 interviews, 18 represented employers, while seven represented other stakeholders, such as funders and educators. The group of key informants, identified by RIDOH staff, was selected to be representative and diverse, but not exhaustive. Interviews
were structured around a set of essential questions, but took the form of open-ended conversations, focused on CHW roles, funding, and sustainability. Essential questions included: 1) Where do CHWs work? What do they do? 2) Who gets CHW services? 3) How are CHWs funded? 4) How are CHWs trained and sustained? 5) How can the CHW workforce grow? Participants defined “Community Health Worker” for their own context, but were prompted with the American Public Health Association (APHA) definition and a list of job titles commonly listed under the umbrella term “Community Health Worker.”

Interview notes were ordered and assembled to generate a narrative of key takeaways from each interview, then sent to interviewees for review and revision. Revised narratives were analyzed as a whole to create a thematically organized report. The report was then shared with key informants for a second round of revisions. Key findings were developed using the authors’ and key informants’ interpretation of relevance and significance to the field at large.

RESULTS
Where do CHWs work? What do they do?
Rhode Island CHWs work in settings that range from small, community-based organizations to large health systems. Medical settings employing CHWs include Federally Qualified Health Centers (FQHCs), hospitals, health systems, and clinics. Several insurance carriers employ CHWs directly. A Community Health Team model integrating CHWs on interdisciplinary teams is expanding with support from initiatives focused on health system transformation, including the State Innovation Model Test Grant and the Care Transformation Collaborative of Rhode Island. Many CHWs also work in organizations that combine social and health services, or primarily offer social services. Several Community Action Programs (CAPs) employ CHWs. Some CHW programs are geographically focused, while others target particular populations or health conditions. During the study period, the Rhode Island Parent Information Network (RIPIN) employed the largest number of CHWs of any organization in the state, and Lifespan was the largest employer that employed CHWs.

Who gets CHW services?
Most CHWs work with people with high levels of social need and health risk. Employers and payers use several tools to assess need and risk, including proprietary systems. HIV/AIDS organizations use a comprehensive acuity assessment. Two population-focused programs provide CHW services to all clients of specific prevention and education programs.

How are CHWs funded?
No one has found the “magic bullet” solution to financial sustainability for CHWs, and in Rhode Island they are funded through a broad array of sources and methods. The majority of the funding comes through time-limited philanthropic or categorical public grant funding (“soft money”), rather than payments that are built into health plans or core operating funds. Such “soft” money includes significant investments in health system transformation, and public grants and contracts for health and social services, in addition to philanthropic support. Community Action Programs (CAPs) employ CHWs with social services funding. Some grant funding targets specific health conditions or populations. Payers support CHWs on a fee-for-service basis only in extremely limited settings and situations, but support through alternative payment mechanisms like capitation is gaining ground. Several larger organizations fund CHWs through core operating funds. Funding for CHW workforce development is also supporting trainers and employers.

How are CHWs trained and sustained?
CHWs and their employers need more than financial resources to sustain them. Interviewed employers identified key factors including certification and continuing education, administrative infrastructure, hiring procedures, integration onto teams, workplace supports, a career ladder, a professional community building a clear CHW role and identity, and evaluation as important resources for a sustainable workforce.

How can the CHW workforce grow?
Interviews with employers and stakeholders, indicated a growing consensus in the field. There is momentum building among employers, payers and government for expanding the CHW workforce. Employers are using innovative strategies to support CHWs. Pay-for-value approaches hold more promise than fee for service models. Training and workforce development resources are available. Employers and CHWs may learn from each other’s practices related to workplace supports and evaluation.

DISCUSSION
Key informants and opinion contributors were unanimously positive about the value of CHWs for healthcare and public health. Healthcare providers and administrators cited CHWs’ impacts on previously intractable patients and problems. Payers described CHWs’ effectiveness in areas of high social and economic need, and with patients with multiple chronic conditions and behavioral health needs. Social service providers and community-based organizations highlighted the benefits of CHWs’ shared experience, language, culture or status with clients, and the impacts of lay workers on the social determinants of health. Policy stakeholders saw CHWs advancing the Triple Aim, and taking a prevention approach focused on the roots of public health problems. Community Health Workers themselves emphasized...
the benefits of personal connections with patients, and the health outcomes driven by these relations.

Most participants expressed a belief that the CHW field has gathered momentum for growth in Rhode Island. Newly available credentialing through the CHW certification process was described as both evidence for, and a source of statewide momentum. The recent expansion of Community Health Teams across Rhode Island, and the fact that major payers and health systems directly employ CHWs also contributed to a sense that this workforce is expanding in size and positive reputation.

Viewpoints varied on how to pay for this momentum. While the bulk of resources currently supporting CHWs come from grants, funding sources used by interviewed organizations included general operating funds, funding derived from capitation arrangements, and fee-for-service billing for high-risk patients covered by a Medicaid MCO. Most interviewed participants who commented on payment believed that focusing on expanded fee-for-service billing might incentivize the wrong services, and run counter to the broader shift towards value-based-payment and accountable care. However, capitation-based support for CHWs would need to account for differences in the distribution of social need that CHWs address. There may be new opportunities for Accountable Care Organizations, particularly Rhode Island’s Medicaid Accountable Entities, to develop approaches that financially sustain this workforce at scale.

Participants identified concerns about integrating and sustaining CHWs effectively and equitably. One concern was how to integrate CHWs into clinical practice when they may have lower levels of formal education, and emergent or undefined professional roles. Inter-professional Community Health Team models serving multiple primary care practices are one high-profile solution: CHWs work cooperatively on teams with licensed professionals, rather than embedding in only one PCP. Several organizations described workplace supports they offer, including flexible scheduling for those with medical and family needs, and integrated LICSW support to help manage stress and grief deriving from work with high-risk patients. Concerns about the potential for racial or cultural tokenism and pay inequity were also noted.

There are many opportunities for further study. This project made no attempt to quantify the CHW workforce in the state. Labor market analysis of Rhode Island CHWs can provide a clearer picture of the workforce’s size, working conditions, growth and attrition. Studying the effect of certification on labor supply and demand may offer opportunities to improve training and career pathways and ensure professional working conditions. Effectiveness, quality and implementation research of CHW programs in health services can help develop the evidence base, and continuously improve these interventions. Cost effectiveness studies will be of particular interest to Accountable Care Organizations with new pay-for-value arrangements and population health accountabilities that may be efficiently and effectively addressed by CHWs.

The Rhode Island Department of Health remains committed to its support of Community Health Workers in the state. In the words of Nicole Alexander-Scott, MD, MPH, Rhode Island’s Director of Health, “Health begins in our homes, schools, jobs, and communities. As trusted members of the community, Community Health Workers play an essential role in addressing the social, economic, and environmental factors that contribute to the health of Rhode Islanders. They also help connect community members with high-quality, culturally competent health and social services. The Rhode Island Department of Health is proud to support these vital members of our healthcare workforce.”

Acknowledgments

The authors wish to thank all the study participants who generously agreed to be interviewed without compensation, and Rhode Island’s Community Health Workers for all their good work for health, care and equity.

References


Authors
Brady Dunklee, MPH, Boston University School of Public Health (2018), conducted this study for the Rhode Island Department of Health in 2017.

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

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<tr>
<th>VITAL EVENTS</th>
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<th>Number</th>
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<td>Live Births</td>
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<td>939</td>
<td>11,548</td>
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<td>Deaths</td>
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<td>Marriages</td>
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<td>Divorces</td>
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<td>20+ weeks gestation</td>
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* Rates per 1,000 estimated population  
# Rates per 1,000 live births

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<th>Underlying Cause of Death Category</th>
<th>REPORTING PERIOD</th>
<th>JUNE 2017</th>
<th>12 MONTHS ENDING WITH JUNE 2017</th>
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<th>Number (a)</th>
<th>Rates (b)</th>
<th>YPll (c)</th>
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<tr>
<td>Diseases of the Heart</td>
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<td>2,368</td>
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<td>Malignant Neoplasms</td>
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<td>169</td>
<td>2,263</td>
<td>214.2</td>
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<td>Cerebrovascular Disease</td>
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<td>453</td>
<td>42.9</td>
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<td>Injuries (Accident/Suicide/Homicide)</td>
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<td>68</td>
<td>882</td>
<td>83.5</td>
<td>13,785.5</td>
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<td>COPD</td>
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<td>49</td>
<td>509</td>
<td>48.2</td>
<td>415.0</td>
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</table>

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

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

July 2, Monday
Meeting with American Cancer Society regarding legislation
Meeting with Special Legislative Commission to Study All Aspects Involved in Changing the Start Time of Rhode Island’s Public Schools

July 3, Tuesday
RIMS Physician Health Committee: Herbert Rakatansky, MD, Chair
Meeting with Congressman Cicilline to present AMPAC contribution: Peter Karczmar, MD, RIMPAC Treasurer

July 10, Tuesday
Governor’s Overdose Prevention and Intervention Task Force/Harm Reduction Workgroup

July 11, Wednesday
Board of Medical Licensure and Discipline
Governor’s Overdose Prevention and Intervention Task Force: Sarah Fessler, MD, Past President
Meeting with DRFIRST regarding electronic prescribing

July 12, Thursday
Meeting with Blue Cross Blue Shield of RI: Bradley Collins, MD, President and staff
Neronha Campaign for Attorney General fundraiser

July 13, Friday
Meeting with Massachusetts Medical Society regarding legislation

July 16 Monday
RIMS Board of Directors Meeting: Bradley Collins, MD, President

July 17, Tuesday
Presentation to HealthCore (Health Career Opportunities Reimagined) at Warren Alpert Medical School

July 19, Thursday
Harm Reduction Coalition Meeting, RIMS Offices

July 20, Friday
Diabetes Prevention Conference Call, Department of Health

July 25, Wednesday
Meeting with Prevent Opioid Abuse (POA) regarding legislation

New England Charter Medicine Academy

July 30–31, Monday–Tuesday
AMA Advocacy Resource Center State Legislative Round Table: Steve DeToy, Board Member, RIMS Director of Government and Public Affairs
It’s a new day.

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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.
URI College of Pharmacy ranked 11th in nation in federal research funding

Ranking places URI second among all pharmacy colleges on East Coast

“Many of our faculty members are in the middle, the primes, of their research careers and they’re really hitting their stride,” Larrat said, noting he expects the College will maintain the momentum going forward. “These successful, seasoned researchers are also mentoring our younger professors, whose new research funding isn’t even reflected in the 2017 rank. That’s what makes this sustainable.”

A committee of researchers, led by professors Navindra Seeram, Kerry LaPlante, Bongsup Cho and Angela Slitt meet regularly to strategize research efforts and target grant funding. LaPlante recently held a grant writing workshop, helping researchers from the Colleges of Pharmacy, Nursing and Health Sciences as well as the R.I. Idea Network of Biomedical Research Excellence program to improve their grant applications. Slitt is chairwoman on the URI Council for Research Grants Program, serving as a university-wide advocate for grant funding.

The funding fuels critical research in such areas as drug development, cancer treatment and prevention, health outcomes, neurological health and the use of natural ingredients like maple syrup in maintaining health, among a host of other important subjects. The benefit to the community of such scientific breakthroughs is obvious, but the grant funding also helps the College continually improve its educational offerings, Larrat said.

“We harp on our students to make a difference, and they see our faculty members doing just that,” he said. “Being able to take salient discoveries from the research labs and bring that work into the classrooms is of benefit to our students; it makes us better teachers, and it makes our students better scientists and health providers. And the access to work in those labs is incredibly valuable to our students. And it is translated into helping the patients we all serve.”

URI College of Pharmacy Professor David Rowley works with student Zoe Perkins in a research lab in Avedisian Hall in Kingston. [URI Photo/Patrick Luce]
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Health dept., Kent sign consent agreement after patient medical errors
Kent has committed $1.7M to improvement plans

The Rhode Island Dept. of Health and Kent Hospital entered into a consent agreement on June 22, 2018. [http://health.ri.gov/discipline/hospitals/KentConsentAgreement201806.pdf]

The agreement was the result of an investigation into “deficiencies relating to the verification of procedure site/side” incidents involving four patients. These included, according to the agreement:

“1. On 12/6/2017, Patient #1 underwent a re-excision of the right breast which was performed on the wrong area of the breast.

“2. On 3/14/18, Patient #2 underwent an incision on the left abdomen for a nephrectomy which was intended to be done on the right abdomen.

“3. On 4/10/18, Patient #3 underwent insertion of a catheter with use of a guidewire that was subsequently found to be retained in the patient following the procedure.

“4. On 5/20/18, Patient #4 underwent insertion of a catheter with use of a guidewire that was subsequently found to be retained in the patient following the procedure.”

JAMES E. FANALE, MD, president and CEO, Care New England, and RAYMOND O. POWRIE, MD, FRCP(C), FACP, interim president, Kent Hospital, issued a joint statement regarding the RIDOH agreement:

“Kent Hospital and Care New England (CNE) are firmly committed to addressing the issues put forward by the Rhode Island Department of Health today. There is no greater issue on which we focus than patient safety and quality of care.

“We take the matters raised in these findings very seriously and, from the very beginning, self-reported all of these events to the RI Department of Health. We are grateful to the RI Department of Health and the Centers for Medicare and Medicaid Services (CMS) for their careful review, assessment, and guidance to enhance our own internal reviews.

“Specific to the findings highlighted in today’s agreement, Kent Hospital and Care New England have begun an active and aggressive improvement plan that is resulting in a complete and thorough review of our safety culture and practices, hospital-wide education, retraining, and recommitment to a level of excellence that will be unsurpassed. Much of this work and financial investment already began prior to the findings issued today and includes disciplinary action, policy and procedure review, competency assessment, auditing of compliance with policies and protocols, and prospectively maintaining a constant state of renewed diligence towards adherence and compliance.”

Kent has implemented a 100-day turnaround plan that Kent voluntarily initiated in March after the second incident and which was, according to the agreement, “subsequently expanded to address URFOS [unintended retained foreign objects] and overall hospital procedures to ensure patient safety and compliance…”

As part of the agreement, Kent has committed at least $1.7 million to implement its year-long plan. The hospital also has agreed to hire an independent monitor by August 1st to oversee compliance with the agreement.

RIDOH announces consent agreement with Rhode Island Hospital over patient medical errors
RIH to invest a minimum of $1M in improvement efforts

The Rhode Island Department of Health (RIDOH) and Rhode Island Hospital have entered into a consent agreement, in lieu of regulatory action, that will result in the healthcare facility implementing a series of system improvement measures over the coming year.

The agreement follows a review by RIDOH of four reported incidents involving Rhode Island Hospital patients during February and March 2018. The incidents involved patient identification and procedure verification.

According to the consent agreement, the incidents included:

“1. On 2/21/18, Patient ID#2 underwent a computed tomography angiography of the brain and neck intended for another patient.

“2. On 2/26/18, Patient ID#1 was not correctly identified and as a result underwent an angiogram intended for another patient.

“3. On 3/12/18, Patient ID#3 underwent a surgical vertebroplasty on Patient ID#3’s C-6 which was intended to be done on C-7.

“4. On 3/16/18, Patient ID#8 underwent a mammogram of the right breast intended for another patient.”

“Whenever preventable errors occur in hospital settings, it is essential that we scrutinize those errors carefully and that facilities make the systems changes needed to ensure that they do not occur again,” said Director of Health NICOLE ALEXANDER-SCOTT, MD, MPH.

The steps to be taken by Rhode Island Hospital outlined in the consent agreement include:

• Requesting and implementing the recommendations of the national hospital accrediting body, known as the Joint Commission, and putting in place process improvement methodologies developed by the Joint Commission.

• Conducting facility-wide training on patient identification and procedure verification.

• Scheduling a series of meetings with community emergency medical service (EMS) leadership and emergency department staff (among other staff) to identify opportunities for improvement related to patient identification.

• Submitting to RIDOH policies and procedures related to access to electronic medical records, with a focus on policies related to the number of patients records a user can access simultaneously.

• Hiring an external compliance organization to provide monitoring and oversight for at least one year.

Rhode Island Hospital has agreed to invest a minimum of $1 million in these and other improvement efforts that RIDOH required through this consent agreement.
Newport Hospital kicks off emergency department expansion campaign

NEWPORT – Newport Hospital recently launched its public campaign to expand its emergency department by announcing a $3-million gift from the van Beuren Charitable Foundation and a $1.5- million challenge grant from the Alletta Morris McBean Charitable Trust. Both foundations are longtime supporters of the hospital and Aquidneck Island charities.

The hospital’s $12.5 million construction project is needed to better meet Aquidneck Island residents’ needs as well as the demands put on the hospital by the growing summer tourism industry.

The construction will nearly double the number of treatment and exam rooms, critical to keeping wait times low, improving patient privacy and advancing the ED’s best practice models. Treatment rooms will increase from 17 to 29 and include a new behavioral health section and a four-bed observation unit.

“It’s time that the expertise and compassion our caregivers provide are complemented by a healing environment that is spacious, modern and comfortable for patients and families,” said CRISTA DURAND, president of Newport Hospital. “We are thrilled that the van Beuren Charitable Foundation and The Alletta Morris McBean Charitable Trust are so committed to helping Newport Hospital provide the very best in care when our patients need us the most.”

HOPE H. VAN BEUREN, founder and chair emerita of her family foundation, said, “Our mission is to invest in the quality of life and quality of place of Aquidneck Island and surrounding communities. The hospital is most important for the betterment of the community and the Foundation recognizes that the Emergency Department must be expanded to address Aquidneck Island’s growing health care needs.”

“It is our pleasure to once again partner with Newport Hospital on a project so critical to the families of Aquidneck Island,” said DONALD CHRIST, chair of The Alletta Morris McBean Charitable Trust. “We hope our challenge grant will engage community members in a campaign that truly is near and dear to everyone on the island.” The Trust will match every donation to the project up to $1.5 million in total.

To date, the hospital has raised $10 million during a “silent phase” of the campaign, receiving gifts from individuals and other organizations. Future fundraising efforts will include a broad outreach to community members throughout Newport County to engage their support for Newport Hospital.

The last significant renovation to Newport Hospital’s emergency department was made 20 years ago. At the time, the space could accommodate 22,000 patient visits annually. Today, the same emergency department is 30 percent over capacity, managing 33,000 patient visits per year. The island’s aging population and significant growth in tourism during the summer – a time when ED patient volume swells by 40 percent – have significantly stretched resources.

“Strain on health care access – seasonal or not – is not sustainable. Newport Hospital is committed to providing exceptional care in a timely manner year-round,” said Durand. She added that the renovated emergency department will factor in future growth, and could accommodate as many as 40,000-plus visits annually.

The physical transformation will include a four-bed behavioral health unit, providing patients more privacy and dignity. Visits by patients with addiction and/or mental health issues have increased by 17 percent during the last three years and now represent eight percent of all emergency room visits.

A “clinical decision unit” will also be added, and is considered a national best practice. These four rooms will be for patients who need extended emergency department treatment and observation but may not require admission as an inpatient, lowering the total cost of care.

Other highlights of the project include:
- Three triage spaces for arriving patients, compared to one.
- A lounge and waiting area for patients waiting for tests and their family members.
- Dedicated workstations in each treatment space to facilitate bedside registration and documentation, and ultimately reduce wait time.
- Space that is geriatric and pediatric friendly

The existing emergency department will remain operational throughout the construction, which is expected to begin in July and be completed by September 2019.
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Rhode Island recognized nationally for top immunization rates

The Centers for Disease Control and Prevention (CDC) celebrated Rhode Island for having immunization rates that are among the highest in the country for several vaccines in different age groups at their most recent National Immunization Conference.

“Our tremendous immunization success is directly attributable to the dedication of Rhode Island’s healthcare provider community, including doctors, school nurses, pharmacists, and community partners, as well as to KIDSNET, a statewide health information system that helps children be as well vaccinated as possible,” said Nicole Alexander-Scott, MD, MPH, Director of the Rhode Island Department of Health (RIDOH).

The CDC’s annual National Immunization Conference brought together more than 1,500 local, state, and federal officials to explore science, policy, education, and planning issues related to immunization and vaccine-preventable diseases. Rhode Island received four individual awards:

- The highest flu vaccination coverage rate in the nation among children six months to 17 years of age during the 2016–2017 flu season (74%);
- The second highest flu vaccination coverage rate in the nation for adults during the 2016–2017 flu season (51%);
- Outstanding immunization rates for the vaccines routinely administered to adolescents. For example, among adolescents, Rhode Island had the highest HPV (Human papillomavirus) vaccination rate for males and females, the highest meningococcal vaccination rate, and the second highest Tdap vaccination rate. Tdap protects people against tetanus, diphtheria, and pertussis;
- Outstanding immunization rates for each of the nine vaccines routinely administered to children 19 to 35 months of age, such as measles, mumps, and rubella (MMR) vaccine, rotavirus vaccine, and Hepatitis A vaccine.

In addition to preventing the health effects of many vaccine-preventable diseases, vaccines substantially reduce disease-associated healthcare expenses. According to a CDC study published in 2014, childhood vaccines prevented 21 million hospitalizations nationally and resulted in savings of $295 billion in direct medical costs nationally between 1994 and 2013.

The data were collected using the National Immunization Survey, which is a CDC program that generates vaccination estimates through calling randomly selected phone lines and following up with people’s healthcare providers (if permission is granted). The rankings above are best estimates. Data are not collected on every individual, so the true vaccination rates (and therefore rankings) could be slightly higher or lower. Vaccination rates in Rhode Island and other states are evaluated against Healthy People 2020 goals, which are national health targets set by various federal health agencies, including CDC.

An additional factor in Rhode Island’s immunization success is its Universal Vaccine Policy. This Universal Vaccine Policy allows healthcare providers to order all vaccines from the state for children from birth through 18 years of age, and most recommended vaccines for adults, at no cost.

Complete immunization data are available online.
Survey reveals a mix of health behavior trends in RI youth

Survey shows data trends in the areas of sexual activity, drug use, smoking, and mental health

Results from a comprehensive youth health survey released recently suggest that middle and high school students in Rhode Island have made improvements in health behaviors over the past 10 years in many areas, including seat belt use, sexual activity, and alcohol and illegal prescription drug use. However, through the survey, the voices of Rhode Island youth revealed some concerning trends, including trends related to mental health, e-cigarette use, and marijuana use.

The Youth Risk Behavior Survey is a collaboration between the Centers for Disease Control and Prevention (CDC), the Rhode Island Department of Health (RIDOH), the Rhode Island Department of Education (RIDE), and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The survey, which is administered every two years, is implemented through anonymous questionnaires in Rhode Island public schools. These most recent data were collected from January 2017 to May 2017. The data are used to help policy makers, school administrators, social service workers, and public health professionals understand trends in the health behaviors of young people across the state and to create health-related policies that will impact those behaviors. By participating, schools make sure their students’ voices are heard and can get resources with the support needed to help solve pressing challenges, like student stress, substance abuse, and bullying.

Rhode Island YRBS data overview

Examples of health behavior improvements

- Tobacco, illegal prescription drug, and alcohol use: 5% of middle school students have ever tried cigarette smoking, down from 16% in 2007. In 2017, 6.1% of high school students currently smoke, a decline from 15% in 2007. 7% of high school students reported having ever misused a prescription drug, a decrease from 14% in 2011. The percentage of high school students who currently drink alcohol was almost cut in half in 10 years (43% in 2007 to 23% in 2017).
- Driving: High school students who reported that they rode with a driver who had been drinking decreased from 28% in 2007 to 14% in 2017. In 2007, 14% of students reported rarely or never wearing a seat belt when riding in the car driven by someone else. This decreased to 7% in 2017.
- Sex: The percentage of middle school students who have ever had sex decreased from 15% in 2009 to 8% in 2017. The percentage of high school students who have ever had sex decreased from 46% in 2007 to 36% in 2017.

Some concerning trends

- Mental health: 23% of middle school and 29% of high school students were so sad or hopeless almost every day for two weeks or more that they stopped usual activities. 12% of Rhode Island high school students considered suicide in the past year in 2007, compared to 16% in 2017. In 2017, 14% of high schoolers said they had made a suicide plan in the past year. The percent of high school students who reported attempting suicide in their lifetime increased from 9% in 2007 to 11% in 2017.
- Smoking electronic cigarettes: 16% of middle school students have ever tried e-cigarettes and 6% currently use e-cigarettes. 40% of high school students have tried an electronic vapor product, and 20% have done so in the past 30 days.
- Marijuana use: Rates of marijuana use have not decreased in the last 10 years. In 2017, 23% of Rhode Island high school student smoked marijuana in the past 30 days, the same percentage from 2007. 9% of middle school and 37% of high school students report having ever used marijuana.

Examples of health disparities

- Mental health: The prevalence of sadness and suicide risk behaviors are two to four times higher among students who identify as lesbian, gay, or bisexual, compared to their heterosexual peers. Mental health issues were more common among female and Hispanic high school and middle school students. In addition, students with disabilities had a significantly higher rate of sadness and four times the prevalence of suicide ideation and suicide attempts compared to students without disabilities.
- Bullying: 17% of students were bullied on school property, and 14% were cyber-bullied in the past year. Students who identify as lesbian, gay, or bisexual [31% for both types of bullying] and students with a disability (30% at school, 25% cyber) experienced bullying at higher rates than their peers. Hispanic and Caucasian high school students were more likely to be bullied at school and online, compared to African American students. Female high school students experienced higher rates of cyber-bullying than males.
- Smoking: 34% of students who identify as lesbian, gay, or bisexual have ever smoked cigarettes, compared to 18% of students who identify as heterosexual. 52% of students who identify as lesbian, gay, or bisexual have ever used e-cigarettes, compared to 39% of students who identify as heterosexual. The rate of current...
cigarette smoking and e-cigarette use is higher among Caucasian high school students, compared to African American students. Current e-cigarette use is higher among male high school students than females.

- Marijuana use: Hispanic middle school students had a higher prevalence of use than Caucasian students. Males were more likely than female middle school students to try marijuana before age 11.
- Physical activity: 32% of students with disabilities were physically active for at least 60 minutes five days a week, compared to 44% of students without a disability.

Additional Youth Risk Behavior Survey data on other health trends are available online. Only statewide data are available. (Data are not available by city and town.) However, comparisons between Rhode Island and other states are available online.

Lifespan makes $400,000 payment in lieu of taxes to Providence, increasing health system’s PILOT payments to $3.6 million

PROVIDENCE – Lifespan made a $400,000 payment in lieu of taxes last week to the City of Providence. The PILOT payments from the state’s largest health system to the city now total $3.6 million over the last seven years.

Lifespan also annually contributes more than $1.2 million in taxes to Providence on property either owned or leased by the health system. Its workforce is an economic engine for the city and state and has grown by nearly 25 percent from 2009 to nearly 15,000.

Providence Mayor JORGE O. ELORZA said Lifespan’s collaborative efforts and investments in Providence are essential to the continued growth and success of Providence.

“We continue to look for ways to work collaboratively with our anchor institutions, including our health care partners. I thank Lifespan for their continued support of the City of Providence and look forward to working with them as we move our city forward together,” said Mayor Elorza.
The Miriam Hospital has been awarded a $9.1 million grant from the National Institutes of Health to fund new and continuing initiatives at its Providence/Boston Center for AIDS Research (CFAR), a collaboration between the Lifespan health system, Brown University and Boston University/Boston Medical Center.

The five-year grant supports a major new relationship between two prominent universities: Brown University in Rhode Island and Boston University in Massachusetts, along with their affiliated medical centers, Lifespan and Boston Medical Center. The relationship significantly enhances the substantial resources and expertise of the Providence/Boston CFAR.

The grant also reflects a timely new emphasis of CFAR to address the relationship between HIV and substance use disorder – just as public health officials are seeking to curb the nation’s deadly and costly opioid epidemic. Each of the participating academic institutions operate NIH-funded HIV and alcohol research centers.

Based at The Miriam Hospital, the Providence/Boston CFAR has secured continuous NIH funding since its founding in 1998 by former infectious disease chief Charles C. J. Carpenter, MD, and this year it’s celebrating its 20th anniversary. The new funding is an acknowledgment that HIV/AIDS continues to pose a serious threat around the world and that the center produces valuable multidisciplinary research to help battle the disease.

Along with the new emphasis on substance use disorders, the Providence/Boston CFAR maintains a special focus on women, MSM [men who have sex with men], at-risk youth, and individuals in the criminal justice system. Its research is aimed at preventing and treating the disease here in the United States and in highly pandemic regions around the world including, sub-Saharan Africa, South Asia and Central Europe.

“This is very exciting,” said SUSAN CU-UVIN, MD, director of the Providence/Boston CFAR and an HIV physician at The Miriam as well as a faculty member at Brown’s Warren Alpert Medical School and the School of Public Health. “CFAR is devoted to translational research. Its primary goal is to improve the lives of people with HIV/AIDS. There is no reason to do this if it doesn’t reach the people who need it – in Rhode Island, Massachusetts and all around the world. “

She continued, “It’s not a science grant. It’s a service grant to support investigators to become researchers in the HIV/AIDS field. If you’re tied to a clinic, there’s no way you can do research. The grant allows us to attract young people who are promising investigators. We have the resources and mentorship they need.”

Currently, CFAR investigators have secured over $30 million in NIH-funded research in addition to $18.6 million from non-NIH sources, and $3.8 million in institutional support from the collaborating institutions for the next five-year cycle. The center provides services to over 250 faculty members from participating sites including international collaborators and those in Providence and Boston.

“The funding allows Brown faculty and trainees to continue to interact with our colleagues in Boston on cutting-edge HIV/AIDS research,” said JACK A. ELIAS, MD, senior vice president for health affairs and dean of medicine and biological sciences at Brown University. “CFAR is central to the HIV/AIDS research at The Warren Alpert Medical School because it provides critical funding for basic science, clinical, translational, and behavioral studies and for the training of new investigators.”

“Collaboration is the hallmark of HIV research and education, and this support reinforces the successful partnerships between our institutions,” said BESS MARCUS, dean of the School of Public Health at Brown University. “Because of the expertise of researchers in biology, medicine and public health, HIV has gone from a deadly infectious disease to a chronic illness that affords those afflicted with the chance to live a longer life. Continued work alongside our talented partners will lead to further advances in testing and treatment, and most importantly, improvements in the outcomes for people living with HIV/AIDS.”

Dr. Cu-Uvin praised Boston University/Boston Medical Center for their participation and said the Boston institutions bring invaluable expertise and resources to CFAR. The new collaboration could potentially leverage even greater funding from NIH in future grant cycles, she said.

SANDRO GALEA, MD, DrPH, the Robert A. Knox Professor and dean of the School of Public Health at Boston University, said, “I am delighted to partner with Brown in this award. This is consistent with our strategic direction as a school and I am much looking forward to seeing how this award will create more opportunities for science and scholarship by our faculty, bridging the two schools.”

KAREN ANTMAN, MD, dean of the Boston University School of Medicine and provost of the medical campus, said, “We are looking forward to substantial progress in HIV research with this important new NIH funded regional collaboration.”

“The expertise of HIV/AIDS and substance use disorders among CFAR partners will allow for the advancement of treatment and research at the intersection of these critical public health issues,” said Boston Medical Center President and CEO KATE WALSH.
Legislative Round-up

Hospitals now required to offer flu vaccines
to patients 65 and over
Legislation that requires hospitals to offer influenza vaccinations to their inpatients who are 65 and over has been signed into law.

The new law requires the policy to be in effect during flu season, between Oct. 1 and March 1 of each year. The vaccine will be offered unless contraindicated, and contingent upon the availability of the vaccine, in accordance with the latest recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Medical consent to minors for prenatal,
delivery and postnatal care
A new law now allows minors to consent to medical care involving pregnancy. The law provides that any person, including, but not limited to, a minor who is pregnant, may give effective consent for medical, dental, health and hospital services relating to prenatal, delivery, and post-delivery care.

Dr. Emily White, a Rhode Island obstetrician, gave committee testimony, saying, “Teenage pregnancy is never an ideal situation, but it does happen. And when it does, we want to make sure these young women receive the best medical care. Because of the current law, there can be many barriers to these young women receiving timely and appropriate care.”

Dr. White proceeded to give examples, such as pregnant teens in labor who cannot be given appropriate anesthetic because they have to wait sometimes hours for their parents to be reached to give consent.

With the passage of this legislation, Rhode Island joins 37 other states that already allow the consent of a minor in prenatal and delivery care.

New laws empower patients to curb possibility of opioid addiction
Gov. Gina Raimondo has signed two pieces of legislation that empowers patients to curb the possibility of opiate addiction.

The first law gives patients the option of only partially filling their prescription for painkillers. It allows a pharmacist to dispense a partial fill of a Schedule II controlled substance at the request of either the patient or the prescriber.

Under the provisions of the legislation, subsequent fills would have to be dispensed at the same pharmacy where the original prescription was partially filled, and the total quantity dispensed could not exceed the total quantity prescribed. After 30 days, the prescription expires.

The second law establishes a procedure for individuals to file a revocable voluntary non-opiate directive form with the patient’s licensed health care practitioner. The form indicates to all practitioners that the patient would not be administered or offered a prescription or medication order for an opiate.

The Centers for Disease Control published guidelines for the prescribing of opioids for chronic pain. Among the agency’s recommendations are limiting the dosage and coming up with a plan to mitigate the risk of addiction. While the CDC’s guidelines are a set of voluntary recommendations aimed at health providers, some states have begun to explore how to combat the crisis through legislation. Last year, Massachusetts passed comprehensive legislation based on the guidelines, including the creation of a non-opiate directive form.

Bill requiring insurers to cover mastectomies signed
Legislation to ensure that mastectomies are covered by insurance in Rhode Island has been signed into law. Rhode Island law has set some requirements about what insurance coverage for mastectomies must cover since 2005, but stopped short of actually requiring that insurers cover the procedure.

The new law eliminates provisions that allow insurers not to cover mastectomies, and also eliminates provisions that say they are allowed to require deductibles and copayments.

New law establishes additional home-based care option
Legislation to create a new long-term care option for seniors and people with disabilities has been signed into law by Gov. Gina M. Raimondo.

The legislation establishes in Rhode Island the “independent provider” model of at-home care, which allows consumers to hire and manage caregivers of their choice while the state takes on certain responsibilities, such as setting caregivers’ wages, qualification standards and hours.

By increasing both availability and quality of at-home care options, the new law’s ultimate goal is to move Rhode Island toward greater use of care in the community rather than in nursing facilities, since at-home care is both more comfortable and satisfying for consumers and less expensive than nursing facilities.

Currently around 77 percent of Medicaid funding for long-term services and supports goes to nursing facility care rather than community-based care. Those who use community-based care generally go through agencies or find, hire and manage a caregiver on their own. This bill would create a third option.

Two new laws will increase Narcan availability
Two bills passed by the General Assembly to help prevent opioid overdose deaths through increased access to Narcan have been signed into law.

The first bill requires the Department of Health to develop and distribute best practices guidelines for “co-prescribing” naloxone when also prescribing an opioid to patients who are at an elevated risk of overdosing. It requires the development of strategies for practitioners in non-pharmacy settings to prescribe and dispense naloxone while ensuring health insurance reimbursement.

The second bill amends the state’s Good Samaritan law to allow police and medical personnel to provide naloxone with instructions for its use to individuals who are at substantial risk for an overdose, or a family member or friend.
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VA Mindfulness Study underway for veterans with chronic pain

PROVIDENCE – Researchers at the Providence VA Medical Center are investigating how mindfulness-based care benefits veterans who suffer from chronic lower back pain.

“This work is an important step towards improving outcomes of this and other related mind-body interventions, by helping to understand how they work in the brain,” said DR. BENJAMIN GREENBERG, associate director of the VA Center for Neurorestoration and Neurotechnology, which is located on the Providence VAMC campus.

Use of the therapy continues to grow as VA and other health care organizations seek alternatives to opiates and other medications for managing chronic pain.

The purpose of the study is to learn how the brain changes in response to mindfulness training by enrolling 30 veteran participants who will receive eight weeks of mindfulness training in weekly two-hour sessions.

“We will look at the EEG and MRI data alongside disability rating scales,” said Dr. Greenberg. “We think the data will change in predictable ways that can help providers refine their use of mind-body therapies to treat not only chronic back pain, but a wide range of issues.”

One cohort of veterans has run through the eight-week mindfulness course and the study is currently running a second cohort.

Dr. Benjamin Greenberg, associate director of the VA Center for Neurorestoration and Neurotechnology, left, and Dr. Armin Zand Vakili, a psychiatry resident, demonstrate using an electroencephalogram to record brain activity with Hannah Swearingen, a health science specialist, at the Providence VA Medical Center recently.

[PROVIDENCE VA MEDICAL CENTER PHOTO BY WINFIELD DANIELSON]

Women & Infants in trial to evaluate performance characteristics for high-volume, non-invasive prenatal testing platform

PerkinElmer, Inc., and Women & Infants Hospital are collaborating to evaluate an innovative test method using the Vanadis® NIPT system, which is under development and not available for clinical use in the United States.

Non-invasive prenatal testing (NIPT) using cell-free DNA (cfDNA) has become the standard follow-up procedure for women classified as high risk following traditional prenatal screening and other national guidelines indicating risk for aneuploidy. Unlike existing NIPT technologies which require more complex platforms such as sequencing or microarrays, the Vanadis NIPT platform is the first of its kind designed to simplify screening for trisomies 21 (Down syndrome), 18 (Edwards syndrome) and 13 (Patau syndrome). This cost-effective, high-throughput scalable platform measures fetal chromosomal trisomies in maternal plasma by labeling and counting specific cfDNA fragments using imaging – removing the costly and data-intensive steps required for sequencing or microarray solutions.

The VALUE [Validation of a Lower Cost Aneuploidy Screen] study is funded through a contract with Women & Infants Hospital, but the design, implementation, analyses and reporting is the sole responsibility of the study staff at Women & Infants. The research study aims to test samples from approximately 2,650 women, most from an average risk pregnancy population, with additional high-risk cases added to determine performance characteristics such as detection rates and false positive rates. Turnaround time, associated costs, fetal sex determination, and quality metrics will also be examined. Women & Infants will serve as the primary study center and laboratory site.

Fourteen enrollment sites across North America are currently participating in the VALUE study.

“We believe that it is important that prenatal screening be under local laboratory control rather than concentrated in a few large commercial laboratories. The Vanadis technology requires less upfront investment as well as non-specialized laboratory space and technicians. It has the potential to be as efficient as current next generation sequencing offerings, yet could be cost-competitive with current serum-based screening,” said GLENN PALOMAKI, PhD, associate director of the Division of Medical Screening and Special Testing at Women & Infants Hospital and professor in the Department of Pathology and Laboratory Medicine at The Warren Alpert Medical School of Brown University.
Rhode Island expands access to Hepatitis C treatment for Medicaid patients

CRANSTON – The Executive Office of Health & Human Services (EOHHS) and advocates for patients with Hepatitis C (HCV) announced a change to the state’s Medicaid policy that will increase access to life-saving treatment for people living with the virus.

EOHHS and the Rhode Island Department of Health (RIDOH) worked with attorneys from Jones Kelleher, LLP, in conjunction with the Rhode Island Center for Justice, and the Center for Health Law and Policy Innovation of Harvard Law School and with other community partners to make this voluntary policy change. This occurred after the law firms notified Rhode Island officials on behalf of a Rhode Island Medicaid recipient who had been denied treatment for HCV that they were challenging the policy on her behalf and on behalf of other Medicaid patients. The new policy brings Rhode Island in line with federal medical necessity requirements for Medicaid.

Rhode Island’s new HCV policy, now in effect, removes previous Medicaid coverage restrictions for HCV treatment that permitted only those people with severe liver damage or cirrhosis to be covered. Under the new policy, any Medicaid beneficiary living with HCV and requiring treatment will be covered.

This expansion of access to treatment complements RIDOH’s efforts to prevent hepatitis C transmission through the ENCORE needle exchange program, administered by AIDS Care Ocean State, which provides services annually to over 500 clients. In addition, RIDOH funds community-based agencies to conduct rapid hepatitis C testing and link people to care. RIDOH has recently established a relationship with the RI Health Center Association to facilitate improvements in hepatitis C screening, diagnosis, and treatment in Federally Qualified Health Centers that serve low-income patients.

South County Hospital introduces daVinci Xi robot

South County Hospital introduced the latest member of its surgical team recently, the daVinci Xi robot, giving staff and visitors an up close look at robotic-assisted technology.

With the actual model used at South County Hospital for surgical procedures kept in the sterile environment of the operating room, a working demonstration model was brought in by the manufacturer, Intuitive Surgical. Throughout the day, anyone who was curious could sit in the surgeon’s chair and maneuver the robotic arms and attachments as the surgeons do. For this demonstration, daVinci was used to perform functions such as fold and unfold a five-dollar bill, manipulate rubber rings on and off finger-like protrusions, and pick up a coin from a plexiglass surface.

Marking its official introduction to the public, the daVinci robot was used to cut its own ribbon.

The daVinci Xi robotic arm assisted system was installed at South County Hospital in March. After technicians and operating room staff completed a thorough set-up and trial period with the system, the first surgical procedure on a patient was successfully completed on Thursday, May 31.

It will be used in a variety of urologic and general surgeries performed by chief of urology, Joseph Renzulli II, MD, and general surgeon, Joseph Brady, MD. Other members of the South County Health surgical team have already been selected to receive training to use the daVinci system.
Rhode Island Foundation awards $340K to 16 medical research projects

The Rhode Island Foundation is awarding nearly $340,000 in seed funding to 16 promising medical research projects. The grants are designed to help early-career researchers advance projects to the point where they can compete for national funding.

The Miriam Hospital received $16,000 for a project entitled “Defining Chronic Lyme Symptoms and Quality of Life to Develop Future Interventions.” The project will be led by research scientist SARA VARGAS, PhD. Rhode Island ranks fifth nationally in Lyme incidence, according to the Centers for Disease Control and Prevention.

The University of Rhode Island received $25,000 for “Correlations between Dietary Quality of Food Purchases and Diabetes Prevalence” led by MAYA VADIVELLOO, assistant professor of nutrition and food sciences.

The remaining research grant recipients are:

- Bradley Hospital was awarded $25,000 for “rTMS (sic) and EF Training for Working Memory Deficits in Adolescent Psychopathology” led by BRIAN KAVANAUGH, PsyD.
- Brown University was awarded $25,000 for “NMR Structure and Function Studies on Constituents of Promyelocytic Leukemia Nuclear Bodies” led by MANDAR NAIK, PhD.
- The Miriam Hospital received $25,000 for “Counting Kids; Enhancing Detection of Pediatric Tuberculosis in Ukraine” NATASHA RYBAK, MD.
- The Miriam Hospital received $11,458 for “A Pilot Study Exploring Powassan Virus Prevalence in Rhode Island” led by REBECCA REECE, MD.
- Rhode Island College was awarded $11,246 for “Understanding the Effects of Metabolism on Protein Folding and Aggregation” led by WILLIAM HOLMES, PhD.
- Rhode Island Hospital received $25,000 for “Novel Diagnostic Approaches to Delirium Detection in Patients with Acute Stroke” led by MICHAEL REZNIK, MD.
- Rhode Island Hospital received $25,000 for “Role of PKD in Right Ventricular Dysfunction Under Pulmonary Arterial Hypertension” led by BONG SOOK JHUN, PhD.
- Rhode Island Hospital was awarded $25,000 for “Challenges in Adolescent Transition to Adult HIV Care” led by SABINA HOLLAND, MD.
- The University of Rhode Island received $21,743 for “Identification of Extemporaneously Prepared Oral Anticancer Therapy Stabilities” led by BRITNY ROGALA, PharmD.
- The University of Rhode Island was awarded $12,321 for “Utilization and Adverse Perinatal Outcomes of P2Y12 Agents in Pregnant Women” led by XUERONG WEN, PhD.
- The University of Rhode Island received $24,911 for “Digital Electrochemistry: Ion-Selective Nanoparticles for Biomedical Analysis” led by JYEON KIM, PhD.
- The University of Rhode Island was awarded $24,914 for “Appropriate Care and Associated Outcomes in Women with Metastatic Breast Cancer” led by AMI VYAS, PhD.
- The University of Rhode Island received $25,000 for “Novel Biomimetic Inhalable Nanoparticles for Sustained Lung Cancer Drug Delivery” led by JYOTHI MENON, PhD.
- Women & Infants Hospital was awarded $16,259 for “Improving Obstetric Care to Underserved Rhode Island Women: Expanding the Role of Prison Health” led by ERIN CHRISTINE BROUSSEAU, MD.

A review panel made up of scientists and physicians assisted the Foundation in reviewing the proposals.
Rhode Island’s pain management regulations updated

*Updates focus on patient education, diagnosis code on prescriptions, and naloxone co-prescribing*

Rhode Island’s updated pain management regulations now require healthcare providers who are writing opioid prescriptions:

1. to have a conversation with their patients on the risks of taking an opioid prescription,
2. indicate the diagnosis code(s) on the prescription.
3. to co-prescribe naloxone to patients at higher risk or overdose.

The regulations apply to anyone who can prescribe a controlled substance including physicians, dentists, physician assistants, and advanced practice registered nurses (APRNs).

In communications about the regulation changes, Rhode Island Department of Health (RIDOH) officials also firmly reiterated to healthcare providers that effective, non-opioid pain management treatments are available with much less risk to patients, and that these treatments should be considered before opioids. These alternatives include non-prescription ibuprofen (i.e., Advil, Motrin) and/or acetaminophen (i.e., Tylenol), physical therapy, chiropractic care, acupuncture, massage, exercise, and cognitive behavioral therapy, among other modalities.

1. The regulations allow for patient education to happen either through a conversation with the patient or in writing. The patient education must include a conversation that includes:
   - Risks of developing dependence and the potential of overdose or death.
   - Risks related to the concurrent use of opioids and alcohol or benzodiazepines. (Benzodiazepines are sedatives, such as Xanax and Valium.)
   - The effect of opioids on one’s ability to safely operate any motor vehicle.

2. The requirement that healthcare providers include the diagnosis code on the prescription allows the pharmacists to understand why the controlled substance in being dispensed to the patient. Pharmacists are then able to use this information to have follow-up conversations with prescribers or patients to ensure that patients are being treated with the appropriate medication.

3. Prescribers must co-prescribe naloxone in these three different clinical scenarios:
   - When prescribing an opioid individually or in combination with other medications that is more than or equal to 50 morphine milligram equivalents (MMEs) per day.
   - When prescribing any dose of an opioid when a benzodiazepine has been prescribed in the past 30 days or will be prescribed at the current visit.
   - When prescribing any dose of an opioid to a patient with a prior history of opioid use disorder or overdose. Prescribers must also document in the patient’s medical record the medical necessity of prescribing an opioid to this high-risk individual and explain why the benefit outweighs the risk, given the patient’s previous history.
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Appointments

Rick Majzun, FACHE, named president and chief operating officer of Women & Infants

Rick Majzun, FACHE, has been named president and chief operating officer of Women & Infants Hospital, effective July 23, 2018. Majzun, who has more than 25 years of leadership experience, comes to Women & Infants from Barnes Jewish Hospital and St. Louis Children’s Hospital in St. Louis, MO.

The appointment of Majzun follows a year-long national search during which the search committee, led by Care New England Senior Vice President of Planning and Finance Gail Robbins, engaged physicians, staff, and management.

“With a demonstrated track record of success in hospital operations, including 10 years of leadership in an organization that, like Women & Infants, provides services to women and newborns, Rick is a perfect complement to the strong leadership team at Women & Infants Hospital and across Care New England,” said James E. Fanale, MD, president and chief executive officer, Care New England. “I look forward to welcoming Rick to our team, and I’d like to offer my sincere appreciation to the entire search team for their diligence in finding the perfect leader to join our organization.”

“I have long admired the reputation and care offered at Women & Infants Hospital and am excited to lead this preeminent organization,” said Majzun. “My family and I look forward to relocating to Rhode Island and enjoying all that this beautiful state has to offer.”

Majzun has been associated with BJC Healthcare since 1999, serving as regional director of BJC Medical Group, executive director of strategic planning and then vice president of strategic planning at BJC HealthCare, and vice president of strategic operations and planning of St. Louis Children’s Hospital.

Since 2013, he has served as vice president of operations at St. Louis Children’s Hospital and as vice president of the 212-bed Women & Infants Service at Barnes Jewish Hospital and St. Louis Children’s Hospital. Barnes Jewish is a 1,300-bed adult facility, and St. Louis Children’s is a 430-bed pediatric hospital.

During his leadership tenure, Majzun grew deliveries and neonatal intensive care unit admissions in a declining market; increased revenue, margin, and market share; improved major quality indicators; and achieved patient satisfaction goals. In addition, he worked with physician and nursing partners to create a process to align the cultures of three institutions.

A graduate of the University of Missouri-Columbia, Majzun earned a master of health administration at Washington University School of Medicine. He is a fellow of the American College of Health Care Executives (ACHE), from which he received the 2014 Service Award and the 2006 Early Career Healthcare Executive Regent’s Award. He was a 2011 Eisenhower Fellow and studied pediatric health care systems for five weeks in Kenya and Sweden, and was selected as a “40 under 40” in 2006 by St. Louis Business Journal.

Majzun serves in a number of roles for the Children’s Hospital Association, including a member of the Education Committee of the board of Trustees, a member of its Chief Operating Officer Steering Committee, member of the Editorial Advisory Committee, and member of the Annual Leadership Conference Advisory Committee. He has spoken before the National Association of Health Services Executives, the Children’s Hospital Association, the American College of Healthcare Executives, and the American Public Health Association.

Robert J. Haffey, MBA, MSN, RN, named new president, COO at Kent

Robert J. Haffey, MBA, MSN, RN, has been named president and chief operating officer of Kent Hospital, effective September 10, 2018. Haffey comes to Kent after serving as the president of Springfield, PA-based Delaware County Memorial Hospital, Taylor Hospital, and Crozer Keystone Health System Ambulatory Care Services since 2014.

Haffey’s appointment follows a national search led by Care New England senior leadership, physicians, staff, and management.

“With nearly 20 years of health care leadership experience, and a particular focus on quality in an acute care setting, Robert has a combination of skills and knowledge that stood out as we went through the process of selecting the right person for this important role,” said James E. Fanale, MD, president and chief executive officer, Care New England. “The diligence and hard work of our search team paid off, and we’re looking forward to Robert’s leadership at Kent as well as his role as part of the Care New England team.”

Dr. Fanale also expressed his thanks and appreciation to Raymond O. Powrie, MD, executive chief of medicine for Care New England, who is currently serving as interim president of Kent and chaired this search committee.

Haffey has been associated with Crozer Keystone Health System since 2012, serving as chief nursing officer for the five-hospital system before moving to his current role in 2014. His efforts during his tenure resulted in financial stability, recruitment of key specialty physicians, and an increased referral base. Haffey’s five years of bedside nursing experience also give him an important understanding of hospital operations. Crozer Keystone Health System was acquired by Prospect Medical Holdings, Inc. in 2016.

“I’m excited for the opportunity to lead the tremendous group of dedicated professionals at Kent Hospital who remain focused on providing the highest quality, safest care for the patients and families in the surrounding communities,” said Haffey. “The next few years are critical for the future of both Kent and Care New England, and I’m thrilled to be part of it.”

Haffey received his master of business administration in health care administration from Eastern University in St. Davids, PA, and his master of science in nursing from LaSalle University in Philadelphia, PA.
Dr. Melissa Russo named to international, national organizations

MELISSA RUSSO, MD, a maternal-fetal medicine and clinical genetics specialist in the Division of Maternal-Fetal Medicine at Women & Infants Hospital, has recently been named to a three-year term of the Genetics Committee of the American College of Obstetricians and Gynecologists; a three-year term on the Professional Advisory Board of the Marfan Foundation; and a nominated member of the International Research Society for Genetic Aortic Disease, the Montalcino Aortic Consortium, a consortium of prominent clinical, basic, and translational investigators around the world committed to diagnosing and managing aortic disorders and discovering their genetic causes and modifiers.

A magna cum laude graduate of Colgate University, Dr. Russo earned her medical degree from Georgetown University School of Medicine. She completed her residency in obstetrics and gynecology and fellowship in maternal-fetal medicine and clinical genetics at Johns Hopkins University.

Dr. Russo is board certified in obstetrics and gynecology, maternal-fetal medicine, and genetics. Prior to joining Women & Infants, she was at Texas Children’s/Baylor University in Houston, TX, where she was an assistant professor of maternal-fetal medicine and human and molecular genetics.

Her research interests include prenatal genetics, reproductive and pregnancy outcomes in women with connective tissue disorders such as Marfan syndrome and Loey-Dietz syndrome.

She is an assistant professor of obstetrics and gynecology at The Warren Alpert Medical School of Brown University.

Dr. Elizabeth Lokich joins Women & Infants Program in Women’s Oncology

Gynecologic oncologist ELIZABETH LOKICH, MD, has joined Care New England Medical Group and will be practicing at Women & Infants Hospital’s Program in Women’s Oncology. She is also an assistant professor of obstetrics and gynecology at The Warren Alpert Medical School of Brown University.

A graduate of Dartmouth College with a bachelor of art degree in molecular biology, Dr. Lokich earned a medical degree from The Geisel School of Medicine at Dartmouth. She completed a residency in obstetrics and gynecology at Dartmouth Hitchcock Medical Center and fellowship in gynecologic oncology at Women & Infants. Prior to returning to Women & Infants, Dr. Lokich worked at the University of New Mexico Comprehensive Cancer Center, where she was also an assistant professor of obstetrics and gynecology in the Division of Gynecologic Oncology.

Board-certified in obstetrics and gynecology and board-eligible in gynecologic oncology, Dr. Lokich is a member of the Society of Gynecologic Oncologists, American Society of Clinical Oncology, Association of Professors of Gynecology and Obstetrics, and American Congress of Obstetricians and Gynecologists.

Larry Brown, MD, appointed director of the Division of Child and Adolescent Psychiatry at Alpert Medical School

LARRY BROWN, MD, has been appointed director of the Division of Child and Adolescent Psychiatry at the Warren Alpert Medical School of Brown University and academic director of Bradley Hospital and Hasbro Children’s Hospital’s Division of Child and Family Psychiatry.

“Dr. Brown is well known to our community, having been with the division for more than 25 years. We are very fortunate to have him leading the integration of our academic and research missions with our outstanding clinical programs,” said DAN WALL, president, Bradley Hospital.

Wall said Brown brings to the position a long track record of teaching, from supervising child and adolescent psychiatry fellows to mentoring countless post-doctoral candidates and junior faculty over the years. Brown has also been overseeing an ongoing federally-funded research training program for more than 10 years. He is also co-director of the Lifespan Young Adult Behavioral Health Program, which he helped create.

A resident of Providence, Brown succeeds Gregory Fritz, MD.

Brown was director of the consultation-liaison service at Hasbro Children’s for 10 years in the 1990s and also served as director of outpatient services at both Hasbro Children’s and Bradley hospitals. His research in adolescent risk behavior and HIV and sexually transmitted disease prevention is internationally recognized. He has been the principal investigator on 20 federal grants totaling more than $29 million and has published more than 150 articles and book chapters about HIV/AIDS education and prevention.

Brown earned his medical degree from Columbia University College of Physicians and Surgeons and completed a residency and fellowship at Stanford University Medical Center.
Care New England announces major expansion of orthopedics services

Care New England Health System is expanding its orthopedics services with the addition of six new physicians to its Department of Orthopedic Surgery and Sports Medicine. The physicians, all members of the Care New England Medical Group, will practice out of Kent Hospital and see patients in Pawtucket and Lincoln and in Attleboro, MA.

The new physicians are Steven Blazar, MD, orthopedic surgeon and spine specialist; David Cicerchia, MD, orthopedic surgeon and spine specialist; Jonathan Gastel, MD, orthopedic surgeon and specialist in sports medicine and trauma; Steven Graff, MD, orthopedic surgeon and specialist in hand and upper extremity; Maher El-Khatib, MD, specialist in pain management; and Ana Mata-Fink, MD, orthopedic surgeon and shoulder and elbow specialist.

**DR. STEVEN BLAZAR** is board certified in orthopedic surgery, went to medical school at Boston University and was fellowship trained in spine surgery at Boston’s New England Baptist Hospital. Specializing in minimally invasive outpatient spine surgery, Dr. Blazar has more than 30 years of experience in adult inpatient deformity and reconstructive spine procedures from the neck to the low back. As the first spine surgeon in Rhode Island to implant an artificial disc, he has maintained his skills in the most advanced and evidence-based treatments for diseases of the spine. Dr. Blazar works collaboratively to incorporate a wide range of non-surgical services, including anesthesia pain management, non-narcotic medication trials, chiropractic, acupuncture, neuromuscular massage therapy, functional rehabilitation, and wellness behavioral intervention.

**DR. DAVID CICERCHIA** completed his medical and surgical training at Boston University, and a spine surgical fellowship at Boston’s New England Baptist Hospital. His advanced training and fellowship is in the surgery of the spine, which includes disorders of the cervical, thoracic and lumbar area, specializing in minimally invasive and robotic surgery as well as intra-operative computer navigation. Dr. Ciccheria is conservative in his approach, choosing to first exhaust the many non-operative treatments such as...
physical therapy, chiropractic, anesthesia pain management, non-narcotic pain medication, acupuncture, massage therapy, and functional rehabilitation.

**DR. JONATHAN GASTEL**, who is board certified in orthopedics and subspecialty certified in sports medicine by the American Board of Orthopedic Surgeons, has been practicing in Rhode Island since 1999. As a specialist in sports medicine, he has served as the orthopedic sports medicine team physician for Division I Bryant University since 2001, and previously as the Rhode Island College team physician. Dr. Gastel’s sports medicine and orthopaedic trauma training includes orthopaedic residency training at Brown University, sports medicine fellowship training at The Cleveland Clinic, and orthopaedic trauma fellowship at Brown University/Rhode Island Hospital. He received his medical education at the University of Rochester where he was honored by admission to the Alpha-Omega-Alpha Honor Society and graduated magna cum laude from Yale University. Dr. Gastel treats a variety of conditions that are both sports and non-sports-related involving the upper and lower extremities, a majority of which involve the knee and shoulder. He also treats a variety of injuries/conditions including the elbow, hip, and foot including tennis elbow, tendinitis, ankle sprains, and fractures.

**DR. STEVEN GRAFF** is board certified in orthopedic surgery. He attended medical school at the Columbia University College of Physicians and Surgeons, completed his internship in general surgery at Brigham and Women’s Hospital/Harvard Medical School, and his fellowship at The Indiana Hand Center. He began his orthopaedic practice in Rhode Island in 1994. He received a Certificate of Added Qualification in Hand and Microvascular Surgery from the American Board of Orthopaedic Surgery in 1997. This additional certification designates him as an expert in the various aspects of upper extremity surgery. While his practice incorporates seeing all aspects of orthopedic surgery patients in the office, his surgical practice is strongly focused on the upper extremity from just below the shoulder to the hand. Conditions that he treats include but are not limited to fractures, dislocations, significant ligament injuries, significant tendon injuries including complete rupture and laceration, tendonitis, all forms of arthritis, neurologic problems involving the upper extremity including nerve compression syndromes and nerve trauma, the evaluation and treatment of abnormal lumps and bumps in the upper extremity, infections, and nail disorders.

**DR. ANA MATA-FINK** is a board eligible orthopedic surgeon with subspecialty fellowship training in shoulder and elbow surgery. She attended medical school at Harvard University and finished both her residency and internship at Dartmouth-Hitchcock Medical Center. Dr. Mata-Fink has been practicing in Rhode Island since 2016, focusing on injuries and arthritis of the shoulder and elbow. Common conditions she treats include rotator cuff tears, shoulder instability, shoulder and elbow arthritis, and fractures. She has advanced training in conventional and reverse shoulder replacement, elbow replacement, and arthroscopic shoulder surgery.

Other providers include: **RAZIB KHAUND, MD**, director of sports medicine; **NORMAN KORNWITZ, MD**, specializing in total hip and knee replacement, arthroscopy, and fracture care; **PHILIP REILLY, MD**, specializing in sports medicine and arthroscopic treatment, particularly knee and shoulder; **ROBERT SHALVOY, MD**, executive chief of orthopedic surgery and sports medicine; **JESSICA MORSE, PA-C**, specializing in orthopedic surgery; and **RICHARD PELOQUIN, PA-C**, specializing in orthopedic surgery.

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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 surgical 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

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Fred Rotenberg, MD, receives 2018 Riesman Family Excellence in Teaching Award

Anesthesiologist FRED ROTENBERG, MD, has received the 2018 Riesman Family Excellence in Teaching Award, which recognizes a Miriam Hospital physician who teaches at The Warren Alpert Medical School of Brown University. Rotenberg serves as a clinical assistant professor of surgery (anesthesiology) at Brown. Medical school student Rachel Occhiogrosso nominated Rotenberg for the award.

“He took an interest in our personal and professional development and has years of wisdom to share. I particularly enjoyed his warmth and enthusiasm for working with medical students – a true gem of the Miriam Hospital,” Occhiogrosso wrote.

Rotenberg lives on the East Side of Providence, where he was born and raised.

He obtained his undergraduate degree from Washington University in St. Louis and master’s degree in pharmacology and toxicology from the University of Rhode Island. He earned his medical degree from the Warren Alpert Medical School and interned at The Miriam in 1981. Rotenberg completed his residency and fellowships at Massachusetts General Hospital. Rotenberg has been an attending anesthesiologist at The Miriam since 1986 and has taught Brown medical students for 32 years.

The award was presented at the annual meeting of The Miriam Hospital Medical Staff Association, held at the hospital on June 14.

The Riesman Family Excellence in Teaching Award was created in 2007 by a gift from the Robert A. and Marcia S. Riesman family to recognize excellence in teaching by a Miriam Hospital/Brown Medical School faculty member who is currently and actively involved in the education of medical students, resident physicians and other colleagues.

Ilse Jenouri, MD, named 2018 Outstanding Physician of the Year at Miriam

ILSE JENOURI, MD, MBA, FACEP, has been named the 2018 Charles C.J. Carpenter, MD, Outstanding Physician of the Year at The Miriam Hospital.

Jenouri has served as the medical director of The Miriam’s Emergency Department since her appointment to the position in July 2017. The Miriam Hospital Medical Staff Association sponsors the award, which is described as “the highest recognition that can be given to a member of our medical staff.” The award recognizes physicians for outstanding contributions to medicine, leadership, professionalism and patient care. Winners are nominated by their peers.

ALEX KEARNEY, MD, one of several physicians to nominate Jenouri, wrote that she has “been a champion for both patient care and physician/employee wellness. She is always working to make sure that patients are getting the best care possible and that physicians feel supported.”

“Dr. Jenouri has been a dynamic leader, keeping a positive attitude and supporting her colleagues, staff, and advocating for patients,” wrote another colleague ANDREW MUSITS, MD. “The new clinical decision unit has also opened under her leadership, allowing for a new avenue to better care for patients.”

VICTORIA LEYTIN, MD, added, “She assumed the leadership position with competence and grace. On a near daily basis, she is found walking the department, problem-solving, and making sure that all is running as smoothly as possible.”

Jenouri completed her residency in emergency medicine with The Warren Alpert Medical School of Brown University and joined the medical staff of The Miriam Hospital in 2002 as an attending physician. She served as the associate medical director of the ED for six years.

In 2018 and 2017, Jenouri was recognized as a “Top Doc” for emergency medicine by Rhode Island Monthly magazine. University Emergency Medicine Foundation presented her an “outstanding physician” award in 2013. In 2009, she was a recipient of a teaching recognition award from the Warren Alpert Medical School, where she is a clinical associate professor.

Jenouri is a graduate of the State University of New York Downstate College of Medicine and completed her residency in emergency medicine with The Warren Alpert Medical School of Brown University.

Jenouri was presented the outstanding physician award at the annual meeting of the Medical Staff Association, held at The Miriam Hospital on June 14.

The award is named after Charles Carpenter, M.D., who served as The Miriam’s physician-in-chief from 1986 to 1998 and became a leader in responding to the HIV/AIDS epidemic by establishing the hospital’s Immunology Center. He has served as director of the Lifespan/Tufts/Brown Center for AIDS Research (CFAR) and as a professor of medicine at Brown. He achieved widespread recognition for his work in treating diseases in developing countries and for training a generation of researchers in the field of international health.
Peter Monti, PhD, receives 10th Annual NIAAA Jack Mendelson Award

PETER M. MONTI, PhD, the Donald G. Millar Distinguished Professor of Alcohol and Addiction Studies, professor of behavioral and social sciences, and director of the Center for Alcohol and Addiction Studies in the Brown University School of Public Health, has been awarded the 10th Annual Jack Mendelson Award from the National Institutes on Alcohol Abuse and Alcoholism (NIAAA).

Each year, the award’s recipient is selected by NIAAA staff scientists and awarded to “an outstanding alcohol investigator whose clinical research makes a substantial contribution toward increasing our understanding of the effects of alcohol on health and well-being, and improving the diagnosis, prevention, and treatment of alcohol-related problems.”

Dr. Monti will deliver an Honorary Lecture on October 23, in Bethesda, Maryland.

Robert Patterson, MD, receives Miriam Hospital’s Charles “Bud” Kahn, MD, lifetime leadership award

ROBERT PATTERSON, MD, a vascular surgeon affiliated with The Miriam Hospital and a clinical professor of surgery at the Warren Alpert Medical School, is the 2018 recipient of the Charles “Bud” Kahn, MD, Lifetime Leadership Award.

The Miriam Hospital Medical Staff Association sponsors the award, which recognizes “a Miriam physician for their outstanding leadership over a lifetime of service” and who “exemplifies professionalism and leadership in a variety of ways, to include open communication, collaboration, cooperation, commitment, and integrity.”

Dr. Patterson completed his residency in general surgery at the Naval Regional Medical Center Portsmouth, and a clinical and research fellowship in vascular surgery at the University of Cincinnati. He is a Distinguished Fellow of the Society for Vascular Surgery and past-president of the New England Society for Vascular Surgery. He is on the editorial board of the Journal of Vascular Surgery.

He has been a practicing surgeon for close to 30 years and was nominated for the honor by many in The Miriam’s medical community, including Kristopher Davignon, associate chief of anesthesia for The Miriam and Rhode Island Hospital.

Davignon stated that Dr. Patterson “sees the whole patient. He takes time to understand their disease and communicate with other primary and consulting physicians about how best to proceed. Vascular disease is a multi-organ specialty and often vascular patients are complex and ill. It is clear that Dr. Patterson considers The Miriam Hospital his home.”

Tristen Chun, MD, a former Brown resident and 2019 vascular fellow said, “I think all the residents in our residency program would agree that he is a wonderful attending surgeon to work with both in and out of the operating room. He commands a tremendous amount of respect among us residents because of his expertise and experience in vascular surgery. He also gives respect to those around him, and he is one of the sincerest people you can find in medicine.”

The award, established in 2015, is named after Dr. Charles “Bud” Kahn, a retired endocrinologist who held leadership positions during his career at The Miriam. The award was presented at the annual meeting of The Miriam’s Medical Staff Association on June 14.

Amanda Morse, a Navy Veteran, watches her drive from an Ottobock sit-to-stand sporting power chair Monday, July 16, 2018, at the Button Hole Golf Course in Providence during the golf expo of the VA New England Healthcare System’s ninth annual Summer Sports Clinic, hosted by the Providence VA Medical Center and the Boston VA Health Care System. This was Morse’s first summer sports clinic. “This is amazing! We don’t get a lot of recreation,” she said. “It helps you realize you can still do the things you want to do.” More than 40 disabled Veterans traveled to Rhode Island for the special rehabilitation-related sporting clinic, which ran July 16 through 19, and featured adaptive sporting events including golf, archery, cycling, kayaking, sailing and deep sea fishing.

[PROVIDENCE VA MEDICAL CENTER PHOTO BY WINFIELD DANIELSON]
Recognition

Butler Hospital Foundation raises $80,000 to support Zero Suicide Initiative

PROVIDENCE – Butler Hospital Foundation raised more than $80,000 through sponsorships, ticket sales, and silent auction at A Masterpiece of Hope, hosted at the Providence Art Club on May 16. The gathering generated awareness for Butler Hospital’s services and research, and raised funds to support the launch of its Zero Suicide Initiative. Approximately 130 community members and Butler and Care New England clinicians, researchers, and staff were in attendance to honor Michael N. Matone as Corporation Member of the Year and Paul M. Cote with the Lila M. Sapinsley Community Service Award. The event was co-chaired by John Sinnott and Kelly Doern.

Matone has worked with the hospital for nearly two decades, serving as chair of the Butler Hospital Foundation in 2014 and 2015. He has participated in capital campaigns and fundraising events and is a strong advocate for Butler’s mission and services. Matone received the award at a board meeting earlier in the month as he was unable to attend the fundraiser.

Cote is a longtime supporter of Butler’s Memory and Aging Program (MAP), with which he became associated through his father’s battle with Alzheimer’s disease. He is also a volunteer member of the hospital’s Art and History Committee, and one of his paintings hangs in the hospital’s Arboretum. He hosts fundraising events to support MAP and the Alzheimer’s Association Rhode Island Chapter.

The Zero Suicide Initiative is a national effort to conceptualize suicide deaths as a preventable medical error in health care environments. Butler Hospital is taking initial steps to adopt a goal of zero suicide deaths in its inpatient and partial hospital treatment programs and for 30 days post-discharge.

It will take several years to implement employee education, evaluate new interventions, and establish a community safety network. Clinical and research teams will work together to develop data collection and measurement processes; to educate staff on an evidence-based suicide risk assessment tool; to define consistent language to frame suicide risk and related behaviors; to establish post-discharge communication protocols for patients’ primary care and other community-based providers for a stronger safety net; and to engage insurance companies in developing special payment models to cover the post-discharge care as part of a treatment plan.

Congressman Joseph Kennedy named 2017 Southcoast Health–Hero for Health Award recipient

NEW BEDFORD, MASS – Southcoast® Health announced that Congressman Joseph P. Kennedy, III, has been named the recipient of the 2017 Southcoast Health–Hero for Health Award.

The annual Southcoast Health–Hero for Health Award is presented to outstanding leaders who, through their work, advocate for optimal health and wellness in our region, state and country and thus exemplify the mission of Southcoast Health.

“Congressman Kennedy represents the true meaning of the Southcoast Health–Hero for Health Award,” said Keith A. Hovan, President & CEO of Southcoast Health. “He believes that access to quality healthcare is a right that belongs to every American. And he demonstrates that belief everyday, as he fights tirelessly for legislation that supports mental health care and substance abuse disorder treatment, and ensures that hospitals like Southcoast Health can serve the most vulnerable populations.”

Keith A. Hovan, President & CEO of Southcoast Health, presents Congressman Joseph P. Kennedy, III, with the 2017 Southcoast Health–Hero for Health Award.

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Michael N. Matone of East Greenwich, RI was awarded Butler Hospital Foundation’s Corporation Member of the Year.

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Kent Hospital receives Get With The Guidelines-Stroke Gold Plus Quality Achievement Award

WARWICK – Kent Hospital has received the American Heart Association/American Stroke Association’s Get With The Guidelines-Stroke Gold Plus Quality Achievement Award. The award recognizes the hospital’s commitment to ensuring stroke patients receive the most appropriate treatment according to nationally recognized, research-based guidelines based on the latest scientific evidence.

Kent Hospital earned the award by meeting specific quality achievement measures for the diagnosis and treatment of stroke patients at a set level for a designated period. These measures include evaluation of the proper use of medications and other stroke treatments aligned with the most up-to-date, evidence-based guidelines with the goal of speeding recovery and reducing death and disability for stroke patients. Before discharge, patients should also receive education on managing their health, get a follow-up visit scheduled, as well as other care transition interventions.

“Kent Hospital is dedicated to improving the quality of care for our stroke patients by implementing the American Heart Association’s Get With The Guidelines-Stroke initiative,” said ARSHAD IQBAL, M.D., chief of neurology and director of the Stroke Center at Kent Hospital. “The tools and resources provided help us track and measure our success in meeting evidenced-based clinical guidelines developed to improve patient outcomes.”

Kent Hospital additionally received the association’s Target: StrokeSM Honor Roll award. To qualify for this recognition, hospitals must meet quality measures developed to reduce the time between the patient’s arrival at the hospital and treatment with the clot-buster tissue plasminogen activator, or tPA, the only drug approved by the U.S. Food and Drug Administration to treat ischemic stroke.

Fatima receives stroke care achievement award

Fatima Hospital has received the American Heart Association/American Stroke Association’s “Get With The Guidelines” Stroke Silver Plus Quality Achievement Award.

Fatima earned the award by meeting specific quality achievement measures for the diagnosis and treatment of stroke patients at a set level for a designated period.

“Research has shown that hospitals adhering to clinical measures through the Get With The Guidelines quality improvement initiative can often see fewer readmissions and lower mortality rates,” said DAVID KOBIS, Fatima Hospital President.

Women & Infants Fertility Center awarded Ultrasound Practice Accreditation

Women & Infants Fertility Center has been awarded ultrasound practice accreditation in the area(s) of gynecologic ultrasound and first-trimester obstetric ultrasound by the Ultrasound Practice Accreditation Council of the American Institute of Ultrasound in Medicine.

Women & Infants Fertility Center achieved this recognition by meeting rigorous voluntary guidelines set by the diagnostic ultrasound profession. All facets of the practice were assessed, including the training and qualifications of physicians and sonographers; ultrasound equipment maintenance; documentation; storage, and record-keeping practices; policies and procedures to protect patients and staff; quality assurance methods; and the thoroughness, technical quality and interpretation of the sonograms the practice performs.

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1 www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm
South County Health President & CEO Louis Giancola to retire

Wakefield – After eighteen years serving as President & CEO of South County Health, Louis Giancola has announced his intention to retire to the board of Trustees. As the Board begins the process to select his successor, he will continue in his role to ensure a smooth transition.

“The decision was not an easy one because of my deep connection to the organization, staff, and the community,” said Giancola. “It has been my privilege and honor to be part of South County Health.”

Giancola’s contributions have led to significant improvements in South County Health’s ability to provide exceptional patient care while expanding the breadth and scope of healthcare and medical services into Washington County.

“Lou has made a generational impact on South County Health,” said Dennis Lynch, Chairman of the Board of Trustees, South County Health. “The legacy he leaves is one of a robust, financially stable, independent healthcare system delivering high quality care across Washington County and beyond. On behalf of the entire Board of Trustees and the entire community, we thank him and wish Lou every happiness going forward.”

Mr. Giancola was appointed to the role of President & CEO of South County Health in 2000. He previously served as Chief Operating Officer at Lahey Health and Women & Infants Hospital. His experience in healthcare dates back to 1969 when he helped establish community health centers in the West. He then served in several director capacities before coming to Rhode Island in 1992.

“I am blessed to be ending my 50-year career in a place, and among people, that I care for so deeply,” said Giancola. “While I am excited about my upcoming retirement, I remain fully committed to advancing South County Health and working alongside those who have made this such a special place.”
### Obituaries

**MICHAEL GARY EHRlich, MD**, passed away peacefully on July 21, 2018 at his home in Providence.

He attended medical school at Columbia University College of Physicians and Surgeons, from which he graduated Alpha Omega Alpha. After starting his career in New York City, he moved to Massachusetts in 1972 where he served as the Chief of Pediatric Orthopedics at Massachusetts General Hospital and an Associate Professor at Harvard Medical School for 18 years. For the next three decades he served as the Vincent Zecchino Professor and Chairman of Orthopedics at Brown University and Rhode Island and Miriam Hospitals. He also served as a Member of the Board of Trustees of the Lifespan Health System.

Over the course of his long and distinguished career, he was the recipient of countless honors and awards including the Milton W. Hamolsky, MD Outstanding Physician of the Year and the President’s Pursuit of Excellence Lifetime Champion Award in 2015. He recently became an Inaugural Fellow of the Orthopedic Research Society.

He was known for his tireless work ethic, signature bow ties, wry sense of humor and love of sailing. His legacy will live on through the countless students he mentored, the numerous medical teaching and research facilities that bear his name and the Michael G. Ehrlich, MD Endowed Chair in Orthopedic Research. He will also be remembered by the literally thousands of patients whose lives he touched as their physician.

He was predeceased by his wife of 50 years, Nancy Band Ehrlich, who was his partner in achieving his many accomplishments. He leaves behind his two sons, Christopher and Timothy, their wives, Sara and Isabella and five grandchildren, Charlotte, August, Julian, Harrison and June.

The Michael G. Ehrlich, M.D. Fund for Orthopedic Research has been established to support his lifelong passion and commitment to medicine. In his memory, contributions to the fund via the Rhode Island Foundation (www.rifoundation.org) would be greatly appreciated.

**CASIMIRO GIAMPAOLo, MD**, died on June 25, 2018, at the Philip Hulitar Hospice Center, Providence, after a 10-year battle with a rare disease, Primary Amyloidosis (AL), an acquired plasma cell disorder.

Dr. Giampaolo was born on March 27, 1943 in New York City. He is survived by his loving wife, Jo Ellen Mistarz, and daughter, Giorgina (Gina) Giampaolo, Providence; his brother Joseph (Eileen Koretz), New York City; and sister Mary (Frank) Lacava, Congers, NY; and many nieces and nephews.

Dr. Giampaolo practiced medicine for more than 45 years. He retired as Chairman, Department of Pathology, South County Hospital, Wakefield RI, where he served on the Executive Committee. After retiring in 2010, he continued a private pathology practice until 2016. Previously, Dr. Giampaolo served as Chairman, Department of Pathology, St. Elizabeth Hospital, Elizabeth, NJ; Associate Director of Pathology and Director, Pathology Residency Program, Mercy Hospital, Chicago; and Assistant Chief of Pathology, Boston City Hospital, among other positions. Dr. Giampaolo also worked as an Anatomic Pathologist at Walter Reed Army Medical Center in Washington, DC, where he served after being drafted and deferring for education, achieving the rank of Major.

Dr. Giampaolo particularly loved working with medical residents and students and sharing his knowledge. He held numerous academic appointments, including: Clinical Associate Professor of Pathology at University of Illinois School of Medicine, Associate Professor at Boston University School of Medicine, and at Mallory Institute of Pathology.

Dr. Giampaolo was an exceptional student who earned his medical degree at the University of Chicago and completed his residency at Harvard-affiliated hospitals in Boston. He earned his B.S. in mathematics, magna cum laude, at the University of Notre Dame, South Bend, IN. He ranked first in his class at Xavier High School in New York City. Dr. Giampaolo had an amazing memory and could recall virtually everything he had ever learned, although he would say that he could not. He continues to be an inspiration to his family.

In his memory, the family requests donations to be made to the Amyloid Research Fund at http://www.bu.edu/amyloid/donate/ at Boston University School of Medicine. Donations also can be mailed to: The Amyloidosis Center; 72 E. Concord Street, K503, Boston, MA 02118.

**DR. ALFREDO R. ESPARZa**, 85, died on July 1, 2018. Born in Mexico, he has been a Providence resident for several decades.

Dr. Esparza was the chief of Pathology at Rhode Island Hospital for many years. He was also an artist and a longtime member of the Providence Art Club.

He leaves a sister, Diana R. Esparza of Providence.

Donations in his memory may be made to the Cathedral of Saints Peter and Paul or to the Providence Art Club.