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Medicine & Health RHODE ISLAND

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—♦—

Care of the Uninsured and Underserved Part 2

What's in a Name???

GOOD - authentic, honest, just, kind, pleasant, skillful, valid

NEIGHBOR - friend, near

ALLIANCE - affiliation, association, marriage, relationship

CORPORATION - company, business establishment

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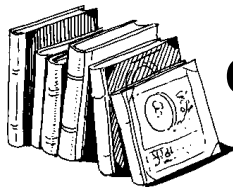
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ERRATUM: The November 2006 issue (volume 89, number 11) mistakenly included L. McTyeire Johnston, MD, among the authors of the ACP abstract: "Recurrent Clozapine Induced Cardiac Tamponade."

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Commentaries

Dreams In Neurological Diseases



“YOU’RE DREAMING,” IS A COMMON COMMENT. It usually means that you are wishing, or overly optimistic. It used to be used routinely for the Red Sox’s hopes to win a World Series; or these days to hope that your medical insurance rates won’t rise as your coverage plummets.

“Maybe I’ll win the lottery.”

“Dream on...”

As best I can tell, the study of dreams has not advanced much. While dreams played a huge role in the development of psychoanalysis, they seem not have been studied much in the past few decades. By this I mean the study of dream content. Understanding of the physiology of dreams has advanced greatly but what dreams “do” and what they “mean” has not.

In my field, **Parkinson’s disease (PD)**, dreams play a very important role. For one thing PD patients often develop vivid dreams when they start taking their PD medications. Sometimes the dreams are so realistic that if they have that sort of dream they may wake up thinking that it happened. When the family hears, “Did the fire department get everyone out of the burning house down the street?” after what seemed to them a normal, uneventful night, they will often become worried about confusion and impending dementia.

Nightmares too occur in PD, as they do throughout the population. Sometimes they occur because of the medications, and sometimes they simply become more vivid, hence more terrifying, abetted by the medications.

About one-third of men (about 1/15 of women) with PD develop REM sleep behavior disorder. In normal REM (rapid eye movement) sleep, we are paralyzed except for our eye and breathing movements. This is when the bulk of our dreaming occurs. People with REM sleep behavior disorder maintain their normal awake muscle tone during dream sleep. During certain types of dreams, typically

violent, they act out their dreams: kicking, punching and strangling their bedmates, punching furniture, jumping out of bed, causing the type of havoc you’d expect if you acted out a violent dream. Interestingly the dreams in which they hit their wives usually accompany dreams in which they are fighting people or animals which are attacking the wife. While the psychoanalytic meaning of this may be clear, its pathophysiology is not. It often precedes the onset of the motor dysfunction in PD and is unrelated to the medications used to treat it.

Post-traumatic stress disorder is another condition in which dreams are an integral part of the illness. People experience the same terrifying nightmare repeatedly, making sleep another battlefield in life.

An observation by a patient got me interested in another aspect of sleep. I gave a talk on non-motor aspects of Machado-Joseph Disease, an inherited spinocerebellar ataxia, at the annual meeting of the National Ataxia Foundation. During the question and answer session, a patient asked me why he was always normal in his dreams, meaning that he hadn’t yet developed his motor symptoms. These usually begin in the fourth or fifth decade. I told him that I had no idea about this, having never heard it before; and then I got the inspiration to ask the audience, full of people with a variety of ataxic disorders, almost all of adult onset, whether they too were only normal in their dreams. The response was about 30:1. Only a single person had dreams in which she was afflicted. The rest were normal.

That was interesting. I wondered if this was true with other adult onset disorders, so I asked the next 100 patients I saw with PD about their dreams. Many, of course, didn’t recall their dreams (we all dream although many think they don’t) but of those who did, only a small fraction dreamt they had PD.

In my way of thinking, these were not wish fulfillment dreams, with a single exception. In a wish fulfillment dream, there is great relief or joy in some dream outcome. Your lost dog is found, your friend’s cancer is miraculously cured, you get the job you’ve been wanting, etc. In my patients’ dreams they experience themselves as normal, not hampered by PD. There is so sense of relief, of being restored. The one wish fulfillment dream was of a person who dreamt he had PD! The PD got him out of the army, which allowed him to go home, with great joy.

I love making these sorts of observations. While I am not very creative, I think that I’m intellectually curious. So when someone, like the ataxic person in the audience, asks me a question about something I’ve never thought about, especially something a little bit oddball, I wonder about it. In this case the first question, which the ataxic patients answered was, “is it a general observation?” The next question was whether or not it extended to another disorder, which it did. I don’t know, of course, whether it is true of all adult-onset disorders, that the dreamers are normal in their dreams, but I assume that it is, although to induce from only two disorders, both neurological, is not a solid foundation.

The more interesting question is: does this mean anything? I don’t know. For one thing we don’t know if the observation reflects the dream or the recall mechanism. Maybe patients only recall particular types of dreams, just as the PD patients only enact certain dreams. Perhaps there is an innate censor that restricts recall.

Perhaps these *are* wish-fulfillment dreams. Perhaps the wish is not to be miraculously healed and restored, but simply to have a normal life, a life never touched by disease, not a “going back,” but a “never was,” a much better wish to have fulfilled.

— JOSEPH H. FRIEDMAN, MD

Profiling and Genetic Destiny

THE RICH VOCABULARY OF ANCIENT ROME included a word to describe the process of sketching or otherwise displaying the lateral outlines of some person or object. The word was *profile* and as a form of art it confined itself to the peripheral contours of the face, rather than its full portrait. Addison in 1702, for example, declared that the classical Roman art had decayed to such a degree that by the Third Century, its emperors were portrayed solely in profile.

A new art form eventually arose called silhouetting [named after Etienne de Silhouette, 18th Century French Minister of Finance]. It embodied the skillful representation of a person's facial profile incised from black paper and then placed against a contrasting white background. The American theater during the 1930s was blessed with the presence of three hugely talented siblings, the Barrymores: Ethel, Lionel and John. Newspapers often referred to John Barrymore, an extraordinarily handsome man, as "the great profile;" indeed, his noble facial contours richly deserved such a title.

A silhouetted profile becomes high art when people can readily recognize it as Napoleon or Elvis Presley or even Uncle Philbert. Accuracy and predictability became the criteria of perfection in graphic profiling. If a profile, which is little more than a hint of the full truth, can allow the observer to identify the subject with a high level of probability, the profile can be called successful.

Demographers, geologists and even economists gradually expanded the definition of a profile to include non-facial outlines; and, inevitably, it came to define the shape, artistic or not, individual, populational or even meteorological. Thus, gradually, the word profile was taken to mean a hazy outline evocative of fuller realities. In this altered sense sociologists, physicians and even police departments now employ the word profile.

Profiling of criminal behavior, or the potential for criminal behavior, is centuries old. It is tempting, if also naïve, to contemplate a list of visible characteristics which police might use to identify criminals, even potential criminals who have not as yet undertaken a life of crime. Jurisdictions have striven to create such a forensic profile for centuries. In 17th Century England, for example, Michael Dalton, a jurist, prepared a list of characteristics; e.g., whether the suspect's parents "were wicked," the suspect's nature [whether a "quarreler, a pilferer or bloody-minded"], whether idle or vagrant, his companions, and "whether he be of evil fame or report." Thus earlier profiling placed much responsibility on the intuitive judgment of the enforcers of law and tacitly accepted such guiding principles as guilt by association, the heritability of criminals and the association of unemployment with unlawful acts.

The 19th Century witnessed the first serious attempts to identify a genetic basis for criminal behavior. Cesare Lombroso, one of the founders of criminology, was convinced that certain facial characteristics predisposed an individual to crime, alcoholism and feeble-mindedness. Advocates of phrenology, the pseudoscience which attempts to associate cranial contour with

behavior, also believed that certain cranial bumps signified certain altered cognitive faculties and character traits.

In 1985 the **Drug Enforcement Administration [DEA]** issued guidelines for the identification of possible drug couriers. The profile included the age and ethnic characteristics of the probable contraband drivers. As a result, a disproportionate number of black and Hispanic drivers were stopped for alleged traffic violations as a means of ascertaining whether the vehicle was carrying drugs. This widespread practice, now called racial profiling, led to increased tensions between the police and communities of color. Racial profiling is now defined as the discriminatory police practice of suspecting individuals of criminal behavior based principally on their ethnicity, race or nation of origin.

The most egregious example of racial profiling on American territory took place in 1942 when 109,650 west coast residents of Japanese ancestry [70,000 of whom were American citizens] were forcibly removed from their homes and interned in "preventive detention" for the duration of the conflict with Japan. These actions were undertaken to abort acts of sabotage or espionage. Records of the Federal Bureau of Investigation, incidentally, contain no substantiated instances of verified espionage or sabotage by Japanese-Americans before or during World War II.

Medical profiling, on the other hand, would seem to be a safe practice since the only victims of potential bias in profiling might be the diseases themselves. Certainly triage profiling for diabetes would seem to be an ennobling effort. Thus, if a patient were to exhibit the triad of great thirst [polydipsia], excessive urination [polyuria] and unexplained weight loss, urgent steps should then be taken to determine the presence or absence of diabetes. Not everyone with these signs will be a diabetic, but sufficient numbers will indeed be in the early stages of the disease to justify the continued use of this profile.

In 1961 a genetic study of an otherwise normal 44 year-old male revealed him to possess an extra Y chromosome [the male sex chromosome]. This curious anomaly was then detected in about one in every thousand newborn males. Studies have since determined that such individuals – called supermales by the tabloids – are taller than normal, slower learners, more prone to facial acne and more easily frustrated than those with a normal complement of sex chromosomes. Still other social scientists have detected an increased aggressive tendency in the XYY syndrome males, and some people have even speculated that such individuals are more prone to engage in violent crime. More recent and more comprehensive studies have disputed this alleged association.

Science-fiction writers have envisioned a brave new world where each newborn's capabilities and destiny will be readily available to its parents on a computer-generated profile. But others believe that man, like Jacob Marley, has no destiny on this earth save the one he contrives for himself.

– STANLEY M. ARONSON, MD

Improving the Poor Outcomes of Today's Health Care

L. McTyeire Johnston, MD

Knowing is not enough; we must apply.

Willing is not enough; we must do.

— Goethe

Goethe prefaces the findings of the Institute of Medicine, in their studies to improve safety and outcomes for patients. His words are likewise applicable to these two *Medicine & Health/Rhode Island* issues.

October's issue focused on shortcomings in our delivery of health services. Starting with the adverse impacts of lack of insurance, articles spotlighted that many Rhode Islanders receive fragmented care, in a system with shallow understanding and application of patients' personal and cultural needs, with resultant outcomes in quality, access, and customer satisfaction that would embarrass any industry.

This issue's topics are more hopeful. The authors highlight successes:

- Tricia Leddy reviews the progress of RIte Care in improving access and outcomes for Rhode Islanders. Critical to these successes was the concrete vision at RIte Care's creation, and the political will to construct that vision.
- Dennis Roy discusses the multi-disciplinary model of Community Health centers, which have built systems of care reaching beyond office visits to address the spectrum of patients' needs. These successes should be no surprise—the Community Health Centers are governed by community-driven Boards of Directors.
- Reflecting the critical work on the front lines of patient care, Chris Campanile, MD, discusses changes in office operations to improve access and quality. There are lessons here about vision (what are we trying to do?), about teamwork (and the critical role of non-physicians), and about using measurement (are we doing what we want?).
- David Rochefort, PhD, analyzes health reform in Massachusetts. Noting that we best evaluate Massachusetts' individual design components and Rhode Island's established agency environment, he points out the public and political partnerships necessary to drive the innovation in policy.
- Christopher Koller, the state's Health Insurance Commissioner, asks "What Would It Take?" He challenges us to define the principles and make a plan, and names the necessary support from all constituencies—patients, providers, and policymakers.

These articles present strong rays of light that penetrate the otherwise bleak horizons of our health care system. There

is no doubt—the forces impeding a comprehensive system of comprehensive services are winning. As individuals, as employers, as policymakers, and as a State, we are losing the battle to control health care costs; as costs rise, purchasers respond by limiting coverage. As the situation gets more desperate, we risk making bad decisions that could lead to a more fragmented system serving fewer Rhode Islanders.

As background and understanding for facing these challenges, we need to appreciate the forces at work.

Impact of Unit Costs

The total costs of services are the simple product of unit cost and volume. Unit costs are increasingly uncontrollable—inflation, new technology, costs of new infrastructure (e.g., capital expansions at hospitals). More and more, unit cost growth consumes all the expense growth our system can tolerate. The result: the burden of cost control falls to the control of volume, of utilization—fewer services become the only answer to rising costs.

Competition as a double-edged sword

Competition can drive improvement and efficiency. However, a competitive system is also a fragmented one, losing the negotiating leverage that comes with all-or-nothing contracting. Competition also relieves us as a society of the responsibility to answer, "What product do we want?" To date, the enthusiasm for competition risks blocking a clear vision and concrete system delivery:

- In the commercial world, plans present variable cost-shifting strategies and therefore different barriers for patients to negotiate (the choice made, by the way, by employers, not patients);
- In the world of publicly financed health care, some approaches would foster a multi-model system without taking advantage of the leverage (in contracting and in performance outcomes) provided by a centralized approach.

Meeting the cost challenge by reducing coverage

In the face of overwhelming cost and limited vision, we miss the point (and responsibility):

- What in our system has value, and what does not?
- What should we spend our money on?
- Where is the tradeoff between cost-shifting and access?

Increasingly, we are at risk of consciously limiting access as the strategy to moderating health system costs. We are already seeing new trends emerge:

- employers no longer purchase insurance for their workers;

- Medicaid solutions are sought in reducing eligibility;
- The percentage of uninsured Rhode Island children has risen from 4.3% (2002) to 6.8% (2005).¹

These are daunting problems—daunting, but not hopeless. The authors in this issue cite successes. These successes occur at the front lines of the provider office, in the design of and commitment to comprehensive services as named by the community, in the State-level planning and implementation that has brought health care and quality outcomes to Rhode Island's children, and in the active struggles for vision at our State policy level. There *are* solutions, solutions that require us all to give a lot, solutions that will bring our patients better care.

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1. Rhode Island Kids' Count, August 29, 2006.

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RItE Care: Rhode Island's Success In Improving the Health of Children and Families

Tricia Leddy, MS

"Universal comprehensive coverage for all Rhode Islanders is a goal to be achieved over the course of several years."

Thus began a new Rhode Island law authorizing the RItE Care Program. Implemented in 1994 under a Medicaid 1115 Research and Demonstration Waiver, RItE Care had three goals:

Goal 1: To improve access and quality of care, health status, and health outcomes.

RItE Care established specific measures as markers of improvement in access and quality: lengthen the intervals between pregnancies, increase prenatal care, improve birth outcomes, improve childhood immunization/well child visit rates, decrease lead poisoning, and improve oral health. In 1994, there was a significant gap in these measures between individuals in Medicaid-enrolled families and individuals enrolled in employer-sponsored health insurance coverage in RI.

Goal 2: To reduce uninsurance among low-income children and families in Rhode Island.

The marker of success would be the number of uninsured children in RI, as well as RI's level of uninsurance overall. In 1995, Rhode Island ranked 25th in the country in uninsured children, with 12.5% of Rhode Island children without coverage.¹

Goal 3: To control the rate of growth in health care expenditures for enrollees in Rhode Island's Medicaid Program.

The marker would be the annual rate of increase in costs for RItE Care families, compared to the annual increase in the cost of commercial insurance coverage in the state. At that time, the state's cost for a child or family enrolled in Medicaid was increasing at twice the rate as that of families with commercial coverage.

THE BEGINNING

In 1993, a federal Medicaid Research and Demonstration waiver allowed Rhode Island to enroll all of the state's AFDC² families into licensed managed care health plans. The waiver brought in new federal Medicaid dollars to expand coverage to uninsured, low-income working families.

RItE Care began with 70,000 individuals - children and parents in single parent families, receiving cash assistance under the AFDC program. Between August 1994 and August 1995, all families enrolled in AFDC were enrolled in their choice of Health Plans. Initially, five plans participated: Neighborhood Health Plan of Rhode Island (NHPRI), a new health plan formed by the network of the state's community health centers; United Healthcare of New England (UHCNE); Blue Chip, Blue Cross of Rhode Island's HMO; Harvard Health Plan; and Pilgrim Health Care.

The state contracted with these plans, all accredited by the National Committee for Quality Assurance (NCQA), for a comprehensive set of benefits, focusing on primary and preventive care. Contracts specified quality and access standards which the state defined and monitored. The contracts provided financial incentives for meeting or exceeding performance standards in areas of quality and access, primarily using NCQA measures. Most significantly, the state required that each enrollee have a primary care physician, responsible for coordinating all his/her care.

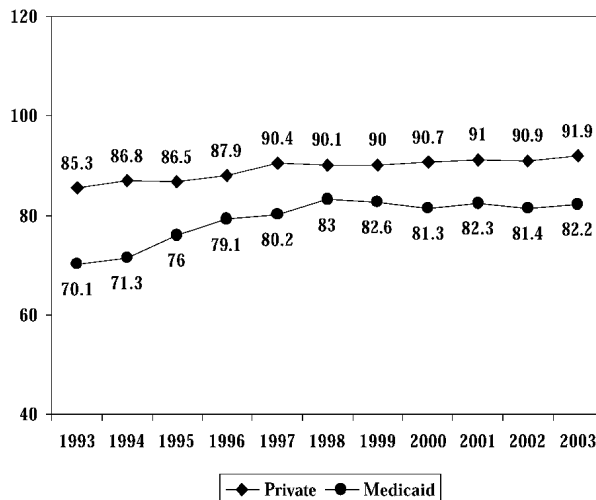
The state would meet the goals of the RItE Care program through two basic components of the federal waiver:

- The 70,000 enrollees in AFDC, who had Medicaid coverage but had difficulty obtaining services, were transitioned from Medicaid fee-for-service to a RItE Care plan.
- RItE Care's waiver allowed the state to expand coverage to the state's uninsured, low-income working families.

THE FIRST TEN YEARS

In 1994, RItE Care began with pregnant women and preschool children enrolled in Medicaid. By 1999, through a series of incremental expansions approved by the federal government, the state legislature and the governor, eligibility expanded to cover all uninsured

Percent of Women who Received Adequate/Adequate+ Prenatal Care by Insurance Status 1993-2003



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 - (n=149,305)

children and parents in low-income, working families. By 2000, an additional 35,000 children and parents, who were previously uninsured, had enrolled in RItE Care.

At the same time, federal welfare reform changed the rules for AFDC: the number of Rhode Islanders receiving cash assistance dwindled from 70,000 to less than 35,000. Maintaining health insurance coverage through RItE Care enabled families to move to employment, since these jobs rarely offered health coverage.

Between 2001 and 2004, 5000 children with special health care needs, including children in state foster care, were transitioned from Medicaid fee-for-service to RItE Care. These children received care management services, which were not available in fee-for-service Medicaid.

RItE CARE NOW

RItE Care covers 126,000 enrollees—12% of Rhode Island's population. More than 70,000 are children—one third of all children in Rhode Island. While almost all of RItE Care's initial 70,000 enrollees in 1994 received cash assistance, now more than three quarters are working families, living at or near the poverty level, who are not offered health insurance coverage at work, for whom RItE Care coverage is

their only "public" benefit, and who, if not for RItE Care, would be without insurance.

RItE Care covers 126,000 enrollees—12% of Rhode Island's population.

As the nature of the enrollees has changed—from families primarily on cash assistance to families who are primarily working—RItE care instituted copayments:

- Working families above 150% of the federal poverty level (\$24,900 for a family of three) are required to pay a monthly premium between \$61 and \$92. A total of 12,000 enrollees, less than 10% of the program's enrollment, are above 150% of the poverty level and are required to pay this monthly premium.
- Any family eligible for RItE Care who is offered health coverage at work is required to enroll in that coverage. Through the creation of "RItE Share" in 2001, state and federal funds under the RItE Care waiver can be used to help eligible families pay the monthly premium

charged by their employer. There are currently 6000 RItE Share enrollees—these families are enrolled in insurance at work, receive help paying their monthly premium instead of enrolling in RItE Care, and the state saves approximately \$2.2 million annually.

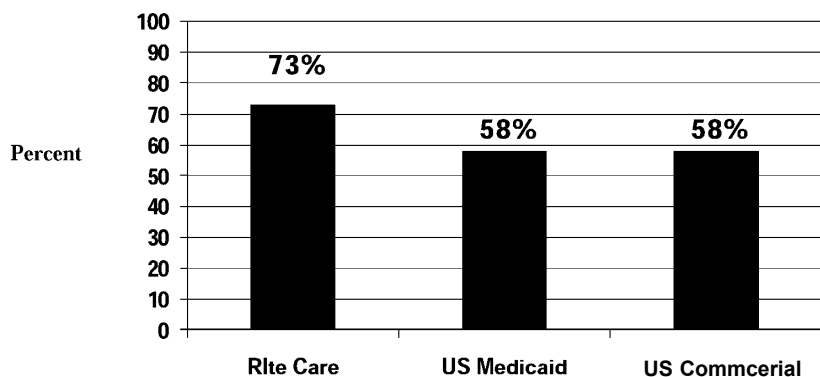
The state and federal government, the enrolled families, and often the family's employer now share responsibility for health insurance. These changes have slowed RItE Care's enrollment growth, while ensuring that families with access to employer-sponsored coverage can remain in or enroll in coverage at work.

Fundamental Changes to Medicaid's Health Care Delivery System

Although the program required health plans to include traditional safety net providers in their networks, the program expanded to include all the providers in the plans' networks, and ensured that each individual had a primary care physician. RItE Care plans increased physician reimbursement from the fee-for-service Medicaid rates, and tripled primary care provider participation (from 350 physicians pre-RItE Care to over 900 physicians post-RItE Care). Within RItE Care's first year, the number of physician visits went from an average of two per year per enrollee to almost five visits per year.

With the increase in care provided by community-based physicians came a reduction in both inpatient hospital days and **emergency department (ED)** visits. The federal waiver requires RItE Care to limit program expenditures to no more than a 6% increase annually per enrollee, using pre-waiver Medicaid expenditures for the AFDC population as the baseline. In fact, when both physician reimbursement rates and physician visits increased significantly in RItE Care's first year, the total program expenditures remained within the prescribed limit of the waiver. The dramatic reductions in both ED use and preventable inpatient stays essentially "funded" the increased investment in community based physician services. This was the program's intent.

Annual Well Child Visits RIte Care vs. US Medicaid vs. US Commercial Insurance Ages 3 to 6



Source: 2004 HEDIS measures reported to NCQA by Health Plans

Pay for Performance results in "America's Best Health Plans" recognition

In 2005, *US News and World Report* ("America's Best Health Plans") ranked Medicaid health plans, using NCQA HEDIS scores. All three of Rhode Island's RIte Care Health Plans placed among the top six among all health plans in the nation participating in Medicaid managed care.³ In 2006, they placed in the top four.

Since 1998, health plan contracts have had a pay-for-performance component based on improvements in HEDIS and other performance measures (e.g., member services, preventive services, clinical care, and chronic care management). Because RIte Care-participating plans are NCQA-accredited, the State has access to the HEDIS® data for the plans' RIte Care population, as well as for their commercial population, and uses these and other measures to track, measure, and reward exemplary performance. There has been significant and steady improvement over the seven years that the performance measures have been in place in virtually every measure for all three plans.⁴

The Commonwealth Fund⁵ highlighted RIte Care: "Rhode Island's experience illustrates that much can be done to improve quality as well as efficiency through relatively modest quality improvement initiatives."

NATIONAL RECOGNITION

Many articles have cited RIte Care's success in expanding access to the uninsured, improving access and quality of care, while maintaining the per person annual rate of inflation at about half the inflation rate for commercial insurance.⁵

- In 2001, DHS received a Purchaser Award from the National Health Care Purchasing Institute for the program to recognize DHS' "value purchasing" management philosophy.
- In 2003, the National Health Policy Forum at The George Washington

University reviewed RIte Care and RIte Share: Doing It RIte: Exploring a Decade of Health Care Innovation. They reported:⁷

"The RIte Care program has been widely heralded as a success and an illustration that not all managed care is alike. Ongoing evaluations of the program have found increased enrollee access to primary care, specialty services, and improved health outcomes. And 97% of enrollees indicate that they are satisfied with RIte Care."

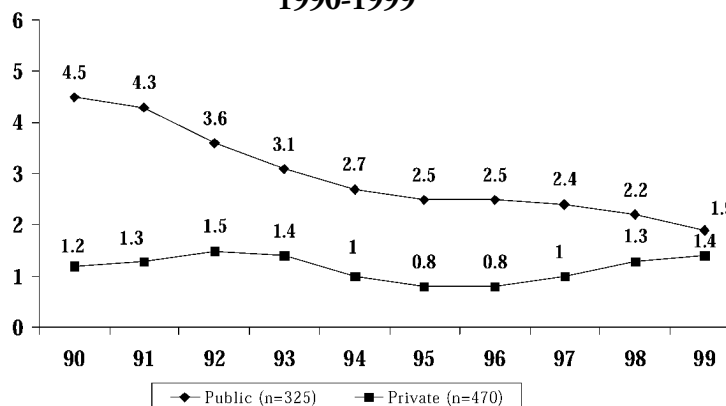
ENROLLEE SATISFACTION

- Since 1996, between 95% and 97% of enrollees reported that they were very satisfied or satisfied with the services of their "regular doctor";
- During that same time, between 96% and 98% of RIte Care enrollees reported that, overall, they were very satisfied or satisfied with RIte Care;

In the 2004 enrollee survey:

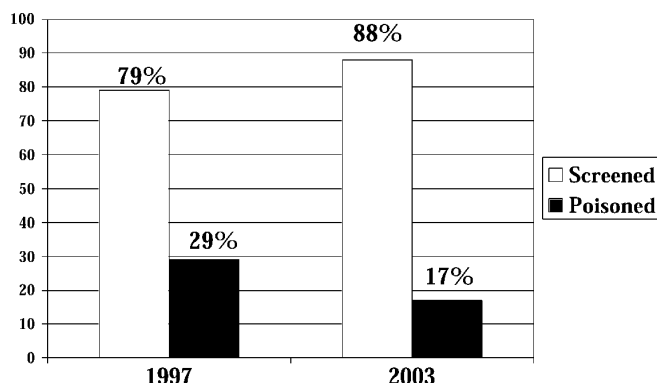
- Almost 82% of respondents report that they (or their child) saw their doctor the same day they called for an appointment when sick;
- 97% of respondents said they were seen either the same day or the next day;
- 93% of respondents reported that

Rhode Island's Postneonatal Mortality Rate Declines for Publicly Funded Births Rhode Island Postneonatal Mortality by Insurance Status 1990-1999



Data Source: Medicaid Research & Evaluation Project
Center for Child & Family Health, Department of Human Services
Linked Birth Death File 1990-99, Division of Family Health, Department of Health (n=905)
Deaths per 1000 births to Infants 0-364 days - 3 year moving average

Lead Poisoning Rates Decline as Lead Screening Rates Improve In Rite Care Two Year Olds 1997 vs. 2003



1997: Kaufmann, R. B., et.al., "Elevated Blood Lead Levels and Blood Lead Screening among US Children Aged One to Five Years: 1988 – 1994," *Pediatrics*, 106(6), 2000.

2003: O'Haire, C., et.al. *Lead Screening and Lead Poisoning in Medicaid and Commercially Insured Children Enrolled in the Same Managed care Organization*, American Public Health Association Poster Session, 2003.

they had seen their regular doctor within the past 12 months;

- Almost 92% of respondents said they were either very satisfied or satisfied with reaching their regular doctor during evenings, nights, weekends, and holidays; and
- Nearly 95% of respondents said they were very satisfied or satisfied with getting a referral to a specialist.

SUCCESS IN ACHIEVING ALL THREE PROGRAM GOALS

Goal 1: Rite Care has Improved Access, Quality and Health Outcomes

"Rhode Island has the best record in the country at providing women with prenatal care. Credit goes to its Rite Care program, which has improved children's health generally. The key to this managed

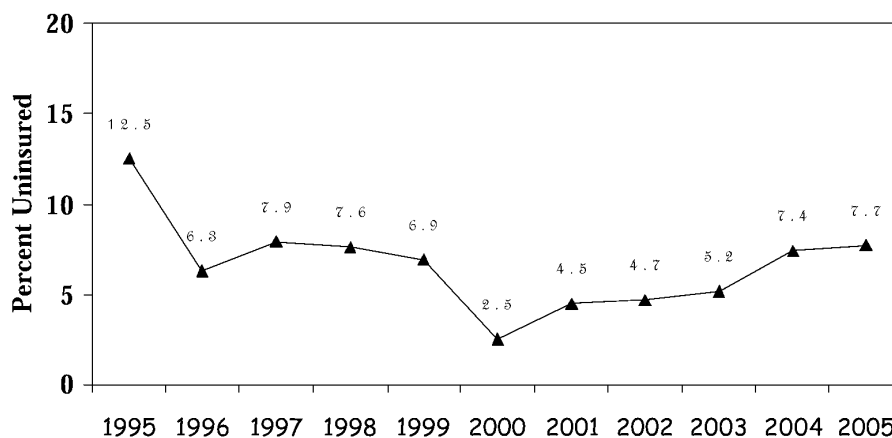
care effort comes in setting standards for provider performance and then following up to see that they are met. Attention to pre- and post-natal care results in lower infant mortality."

– *Governing Magazine*⁶

Rite Care has improved prenatal care

- Adequacy of prenatal care improved for pregnant women on Medicaid/Rite Care, from 70% in 1993 (pre-Rite Care) to 82% in 2003 (Rite Care), narrowing the gap between women with public and with private health coverage in Rhode Island.
- The percentage of pregnant women on Medicaid who smoked during pregnancy decreased from 33% in 1993 to 20% in 2003.
- Short interbirth interval (i.e., less than 18 months) is associated with low birth weight. The number of women on Medicaid waiting at least 18 months between births increased from 58% of pre-Rite Care (1993) to 72% post-Rite Care (2003), closing the gap between women with public and with private health coverage in Rhode Island.

Percent Uninsured Rhode Island Children (under 18) 1995-2005



National Ranking 25th 2nd 1st 2nd 3rd 1st 3rd 2nd 2nd 9th 12th

Data Source: Medicaid Research and Evaluation Project, RI Access Project
US Bureau of the Census, Current Population Surveys 1994-2004 (September estimates)

Numbers of well-child visits also increased. In 2004, 79% of the children between the ages of 3 and 6 enrolled in RIte Care had timely well child visits. This compares favorably to the rates for Medicaid-enrolled children nationally (58%) as well as to the rate for children enrolled in commercial health plans across the nation (58%).

Infant Mortality Rate Reduced Significantly

Infant mortality data point to RIte Care's success.⁷ From 1990 to 1999, the infant mortality rate declined 36% for infants born in RI with public insurance, from 10.7 deaths per thousand births to 6.8 deaths per thousand births. The gap between the publicly insured infant mortality rate and privately insured infant mortality rate was reduced, from a gap of 4.3 deaths per thousand births in 1990 to 1.5 deaths per thousand births in 1999.

The infant mortality rate combines neonatal mortality, deaths within the first 28 days after birth, and post neonatal mortality, deaths from 29 days to one year. The neonatal mortality rate can be influenced by access to specialized neonatal intensive care. In fact, technology and other improved access to such care have served to improve neonatal infant mortality rates across the nation over the last decade.

Neonatal mortality for Rhode Island infants with public insurance decreased 23%, from 6.2 deaths per thousand births in 1990 to 4.8 deaths per thousand births in 1999.

Postneonatal mortality is considered a measure of access to pediatric care.⁸

The postneonatal mortality rate for Rhode Island infants with public insurance decreased more sharply, by 57%, from 4.5 deaths per thousand births in 1990 to 1.9 deaths per thousand births in 1999.

This sharp decline in postneonatal infant mortality is not reflected in the rest of the nation, and can be assumed to be due to improvements in access to pediatric care. The causes of death include SIDS, congenital anomalies, infections, and prematurity.

Lead Poisoning is Reduced Significantly

In 1997 Brown University researchers studied two year-olds enrolled in Rite Care: 79% received timely screening for

lead poisoning, a rate dramatically higher than those published in national surveys.⁹ The study also showed an alarming result: 29% of the children screened had blood lead levels that were considered lead-poisoned by the Centers for Disease Control and Prevention (CDC), a rate that was significantly higher than national reported rates of childhood lead poisoning (at 8.6%).¹¹

The dramatic reductions in both ED use and preventable inpatient stays essentially "funded" the increased investment in community based physician services.

Today RIte Care children with lead poisoning are enrolled in "Lead Centers." Located in urban areas, Lead Centers ensure that the family receives help in creating and maintaining a lead-safe environment in their home. In 2003, Brown University researchers conducted a new study on RIte Care two year olds. The already high timely lead screening rate of 79% increased to 88%. The rate of lead poisoning plummeted from 29% to 17% .

Goal 2: RIte Care Reduced Uninsurance in Rhode Island

By 2000, RIte Care had reduced uninsurance among Rhode Island children and families. In 2002 Rhode Island had the second lowest rate of uninsured in the nation, surpassed only by Vermont.

Since 2000, as health care costs have risen, the level of uninsurance across all states has risen. Uninsurance among all Rhode Islanders had dropped from 12.9% in 1995 to 5.9% in 2000, the lowest in the nation. By 2005, level of uninsurance in RI was 11.8%. Uninsurance among children dropped from 12.5 % in 1995 to 2.5% in 2000, the lowest in the nation. By 2005, the rate of uninsurance in children had crept up to 7.7%, 12th in the nation. Without RIte Care,

Rhode Island's rate of uninsurance would be rising even more quickly.

Goal 3: To contain the growth of health care costs for Medicaid/RIte Care enrolled families

RIte Care has limited the annual growth in expenditures to no more than 6 % for each enrollee over the past 8 years, as required under the federal waiver. This 6% growth is less than half the double digit rate of growth experienced during this time by commercial health insurers. In the early 1990s, pre RIte Care, the situation was the opposite—the cost of covering Medicaid families was increasing at 8%, twice the rate of growth in the commercial market, which was then 4%. Among the ways RIte Care has limited expenditures:

- The newly created RIte Share offsets public costs by requiring eligible families to enroll in employer sponsored coverage whenever available,
- Monthly premiums paid by families over 150% of the poverty level
- Ensuring that RIte Care is always the "last payor," by identifying all opportunities for enrollees to be covered by commercial insurance, Medicare, etc.

But the most effective way that RIte Care has limited expenditure growth is the same method the program has used to improve access, quality and health outcomes—by following these basic principles of an efficient, high-performing health system:

- Ensure access to primary and preventive care, including timely access to community-based urgent care,
- Ensure that enrollees with chronic disease or other health conditions are identified promptly and receive ongoing chronic care management,
- Ensure that all care provided is evidence-based, and
- Ensure that all care is provided in the most appropriate, least restrictive setting.

*Governing Magazine*¹⁰ noted, in a reference to RIte Care:

"A few states have revamped their organization and management systems to ensure better access to

medical care and by keeping costs in control. Rhode Island stands out in this respect."

FUTURE CHALLENGES AND PLANS

Rite Care has plans for the future

Oral health care was not part of the health plan's contract, and remained in fee-for-service Medicaid—until now. Beginning September first, children are enrolling in Rite Smiles. Like Rite Care, children enroll in a dental plan, which will provide access to care through its provider network, focusing on primary and preventive care. United Healthcare's dental plan is enrolling Rite Care children under a contract with the state, beginning with 35,000 children age 6 and under.

Births to teens in Rhode Island outpaces every other New England state.¹¹ Of the 1200 teenagers each year who give birth, two-thirds enroll in Rite Care for themselves and their infants. Addressing this issue would help control Rite Care costs by controlling the program's growth.

The biggest challenge to Rite Care is beyond the scope and control of the program—the continuing escalation in the cost of health care.

Escalating health care costs hits Rite Care in two ways:

- With the limits imposed by the federal waiver and the state budget, health care costs that are increasing beyond the rate of inflation will create a structural deficit that has to be addressed each year by finding additional ways to offset program costs.
- The continued erosion of employer-sponsored health coverage will create a continual demand for Rite Care.

Addressing the escalation in the cost of health care will be critical for Rite Care's sustainability.

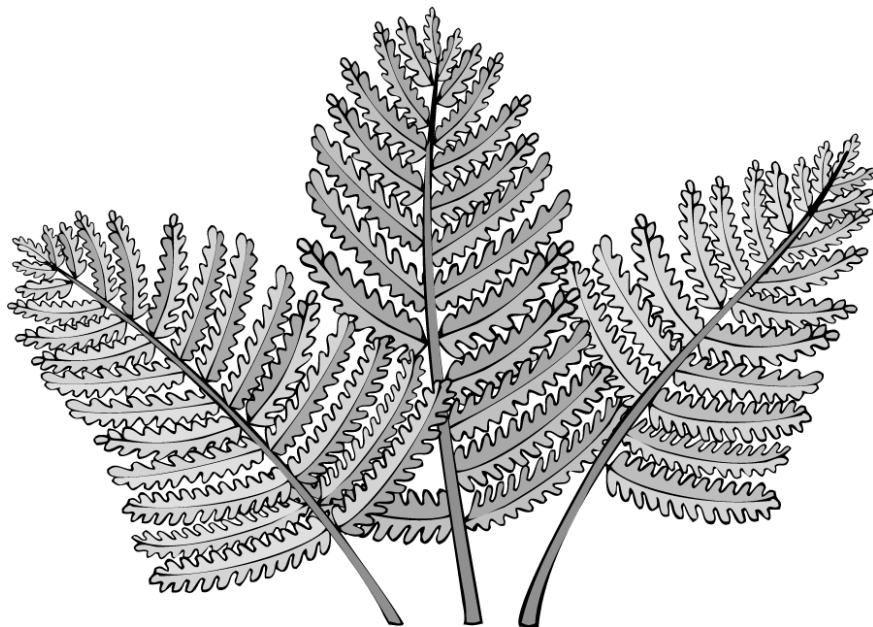
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Serving the Spectrum of Needs in Community Health Centers

Dennis Roy

RHODE ISLAND'S COMMUNITY HEALTH CENTERS have served as a safety net for our residents for close to forty years. The Health Centers' collective mission is to provide comprehensive health care to patients regardless of their ability to pay, thereby reducing disparities in care.

HISTORY

What is today a movement of over 1,000 health centers serving 15 million people began in December, 1965, in a small office in Boston's Columbia Point Housing Project, as a project of the Tufts Medical School. A rural health center in Mississippi along with urban centers in Chicago, Denver, Los Angeles and Providence, Rhode Island, (1968) followed.

From the beginning health centers were dedicated to providing accessible and affordable quality health care. Located in low income neighborhoods, the Centers involved patients not only in their health care but in the governing structure of the health center.

The Public Health Services Act established the community health center program. There are two types of community health centers, those that meet the qualifications for coverage and payment through Medicaid and Medicare, and those which also receive funding under Section 330 of the PHSA. Currently there are 1018 Section 330 health centers and 97 "look-a-likes" who received enhanced rates but no federal funding. All health centers must meet four basic standards to be deemed federally qualified:

1. They must be located in or serve a medically underserved community; one with a high proportion of low-income persons as well as a community with demonstrably elevated levels of death and disability from preventable causes.
2. They must offer a comprehensive range of primary health services as well as supportive services including translation and transportation.

3. They must adjust fees on a published sliding fee schedule and must provide services without regard for the patient's ability to pay.

4. They must be governed by a Board of Directors, a majority of whose members are center patients. This governing structure makes each health center unique, allowing for direct patient feedback regarding the quality of care.

The **Rhode Island Health Center Association (RIHCA)** is the Primary Care Association for all Community Health Centers statewide. Our organization represents 10 Federally Qualified Health Centers, the state's Health Care for the Homeless program and one island-based medical center, incorporating 33 locations including school based health centers and one mobile van.

WHO ARE THE PATIENTS?

In 2004 our centers served over 103,000 unduplicated patients. *This is nearly 10% of the total state population.* Our Health centers serve patients from every city and town in Rhode Island. In addition, they serve patients from the Pawcatuck/Stonington area in southeastern Connecticut, the Blackstone/Bellingham area in Massachusetts and the Attleboro/Seekonk area in Southern Massachusetts. Over 20% of our patients are uninsured; the number of center-patients without insurance rose by more than 3,500 in 2004 from the previous year. According to the 2004 Uniform Data System of the Bureau of Primary Health Care, 37% Health Center patients are best served by a language other than English. In Rhode Island, 35% of the health center population is reported as Hispanic, four times the percentage of the state's Hispanic population. Nine percent of the health center patients are reported as African-American, twice the state rate.

CHALLENGES: POVERTY, DISPARITIES

One in five Rhode Island children lives in poverty. According to the US census, childhood poverty in Rhode Island increased from 16.7% in 22000 to 21% in 2004, above the national rate of 18.4%. In parallel, the number of uninsured children in Rhode Island is also rising. According to the Rhode Island Kids Count Fact Book (2006 Rhode Island Kids Count Factbook) 5.8% of Rhode Island's children under age 18 are uninsured. This number has been increasing in the last few years.

The percentage of uninsured adults is 10.8%; this number is also rising. One reason for the increase in the uninsured rate is the institution of Rite Care/Share premiums. Another contributor is the decline in employer-sponsored insurance. According to the 2003 **Behavioral Risk Factor Surveillance System, (BRFSS)** the number of uninsured working Rhode Islanders rose from 7.6% to 8.3% between 2002 and 2003. This 1% increase represents 4,415 newly uninsured employed Rhode Islanders.

The **Rhode Island Public Expenditure Council's (RIPEC)** FY 2006 Medicaid Report, *A RX for Reform*, forecasts that Medicaid's growth will continue to create large structural problem in the state's budget unless a vigorous program of entitlement reform and cost containment is pursued. The projected national budget cuts will cut 10 million dollars in federal Medicaid funding to Rhode Island. In Rhode Island 10% of the population receive their health care at community health centers. Of the over 100,000 that receive services, 30,000 are uninsured; there is a real threat, to patients and to the solvency of Health Centers, that those numbers will grow.

COMBATING HEALTH DISPARITIES

Eliminating health disparities by 2010 is an important stated goal for the nation and the state. The Rhode Island

BRFSS has identified nine risk indicators for which significant racial and ethnic disparities exist: firearms in the home, binge drinking, lack of physical activity, obesity, tobacco use, unable to afford a doctor, no regular provider, fair or poor general health, and lack of health insurance. In Rhode Island the percentage of blacks, Hispanics and Asian and Pacific Islanders with no health insurance is more than twice the rate for whites. The 2004 BRFSS reports 20% of males and 9% of females have no regular provider. According to BRFSS, Rhode Island has one of the highest adult asthma prevalence rates in the country. Rhode Island Department of Health reports that Rhode Island ranks fifth in the nation in the prevalence of asthma among adults (9.6% as compared to 7.7% nationally). Asthma is the number one chronic condition in children and the third ranked cause of hospitalization in children under fifteen. African American children are more likely than white children to suffer from asthma. Rhode Island Department of Health discharge database reports that the rate for asthma related hospitalizations was 7.8% for African American children vs. 2.9% for white children. Because the health center's African American population is twice the state rate, the need for asthma education for health center patients and staff is great.

The prevalence of diabetes in Rhode Island increased by 52% from 1996 through 2001. This increase was greatest among Hispanics/Latinos and people 45-64 years of age. Rhode Island's increase was reflected in an increase in diabetic patients at the health centers. In 2001 diabetes contributed to the death of 759 residents of Rhode Island.

WHAT ARE THE SERVICES?

Rhode Island's Community Health Centers provide a wide spectrum of services, including:

- Adult Medicine
- Pediatric and Adolescent Medicine
- Family Medicine
- OB/GYN
- Lab services
- Radiology
- Pharmacy
- Substance Abuse Counseling
- Hearing Screening

- Mental Health Counseling
- Vision Screening
- Health Education
- Nutrition Counseling
- Dental Care
- Family Planning
- Healthcare for the Homeless
- HIV: Primary Care and Support Services
- School Based Program
- Food Pantry
- Transportation Assistance
- Case Management/Disease Management

Within this set, Community Health Centers put special focus on those aspects of care often under-represented in traditional service systems: Oral Health, Mental Health, and Social Service.

ORAL HEALTH NEEDS

In Rhode Island, a number of factors contribute to the shortage of dentists. Many dentists are aging and few individuals are establishing new practices in Rhode Island; this in part is due to the fact that Rhode Island has no dental school. Those who are practicing limit their number of Medicaid patients, in part because of the low Medicaid reimbursement rate. In addition, Medicaid in Rhode Island does not cover all oral health care services. This dental challenge is greatest for Rhode Island's nursing home residents. Annually there are approximately 11,750 Medicaid recipients in Rhode Island nursing homes but in a two year period from 2001-2002, only 29% received any dental services. Low reimbursement is a primary reason. Oral health disease is the top chronic disease facing children. Rhode Island Health Centers have acted as a safety net by establishing full service practices throughout the state and by establishing school-based portable dental operations. In addition, three health centers have partnered, (East Bay Community Action Program, Comprehensive Community Action Program, Thundermist) to create "The Molar Express" in conjunction with Ronald McDonald House Charities to bring a fully operational mobile dental vehicle to local elementary schools this fall to provide comprehensive oral health services..

Eight centers in our network pro-

vided over 27,500 visits for over 11,600 Rhode Islanders in 2005. We are ready to continue our critical role in providing access as the State of Rhode Island unfolds its new dental benefits manager program. In fact, Community Health Centers will be a critical element in the success of this program as they have been in the success of Rite Care.

Community Health Centers are creating solutions to the lack of oral health access for nursing home residents. A consortium of health centers including EBCAP has replied to the Department of Human Services request for dental services for nursing home residents.

MENTAL HEALTH NEEDS

The Rhode Island Department of Health's BRFSS (2004) states that 34.6% of adults in Rhode Island report having poor mental health. In 2004, Rhode Island's health centers treated 4,000 patients for depression, with an average age of 38 years. Some Rhode Island Health Centers have co-located mental health providers within their practices, a service that shows promise for the future in concentrating patient care under one roof. At EBCAP, we are working closely with East Bay Mental Health and Newport County Mental Health. Our providers, using a screening tool for mental health concerns, can refer patients to on-site clinicians for further diagnosis and follow-up. EBCAP uses federal health center grant funds to support screening and treatment.

SOCIAL SERVICES FOR PATIENTS

In 1991 the Department of Health began the Family Resource Counselor program at health centers and some hospitals to screen pregnant women for public benefits. In 1998 the Department of Health and the Department of Human Services collaborated to expand the **Family Resource Counselor (FRC)** Network to include assisting with the Rite Care application.

In 2006, the network consists of almost 60 individuals located at all health centers including school based health center sites, most hospitals and one community based organization. The network is managed by the Rhode Island Health Center Association through a contract with the Department of Human Services. The Family

Resource Counselors screen and refer patients to public benefit programs and assist patients with the RIte Care/Share (Rhode Island's Medicaid program) application.

Family Resource Counselors are available for all health center patients as well as the general public. They receive referrals from the Department of Human Services, the Department of Health and the three health plans. They speak six languages, in addition to English; Spanish, Portuguese, Cambodian, Creole, French, and Cape Verdean.

Community Health Centers employ social workers. For example, EBCAP provides a full array of social services ranging from Head Start for children, **Women, Infants and Children Program (WIC)**, assistance with heating bills in the winter and case management services for seniors, the homeless and teens. Community Health Centers are experienced in combining primary health, oral health, mental health and social services to the patient at one site.

OUTCOMES/PERFORMANCE MEASUREMENT

All Health Centers have achieved **Joint Commission on Accreditation for Health Care Organizations (JCAHO)** accreditation and are committed to patient safety and quality improvement, as evidenced by participation in state and national quality collaboratives.

To address the needs of patients with chronic diseases, 80% of our centers participated in Health Disparities Collaboratives for asthma, diabetes and depression. These Health Disparities Collaboratives, initiated in 1999, are intended to address the reality that racial and ethnic minorities suffer disproportionately from health problems, including infant mortality, asthma, cancer, HIV/AIDS, and diabetes. The Collaboratives bring together health center teams for 12 to 16 months, under the guidance of national experts, to effect rapid improvements in care for patients with chronic conditions.

Goals include improving the skills of clinical staff, ensuring that care is comprehensive and proactive, and effectively educating patients on self-management of their conditions.

Health Disparities Collaboratives and JCAHO accreditation mark Community Health Centers' drive to integrate quality goals and performance measurement into daily work. 2005 HEDIS rates indicate that the Health Centers surpass others in the provider network of NHPRI for childhood immunization and testing and screening for patients with diabetes. Nine health center sites have re-worked their appointment systems to deliver Open Access. Yearly the CHCs assess the satisfaction of our patients with our services.

As state lawmakers think about how to provide services to Rhode Island's increasingly diverse communities, community health centers are poised to lead the way. Health centers are experts in delivering high quality health care, but they also know their patients and have developed proven methods of managing the chronic diseases which affect their patients' lives.

A COMMUNITY RESOURCE

All health centers are engaged with the Department of Health Center for Emergency Response and Preparedness. Since 2004 all 12 health center organizations meet with HEALTH under RIHCA leadership to develop emergency preparedness plans that include surge capacity, and meeting the needs of clients who have both medical and behavioral needs. Rhode Island Health Centers have a prominent place in State planning for pandemic flu. All the health centers are actively engaged in training their clinical and non clinical staff to address response and each is organizing their own incident response teams. Examples of community service during past health crises follows:

- In October 1996 when a true outbreak of meningococcal disease occurred in Northern Rhode Island,

health centers were an integral part of the mass vaccination campaign targeting 2-29 year olds. This mass campaign assisted in stopping the outbreak.

- In February of 2003 Rhode Island experienced its worse fire in history, the Station nightclub fire. Health Center directories were delivered to the Department of Human Service's command center for DHS staff to assist in making referrals to health centers. Many Family Resource Counselors volunteered to help. In 2005 when hurricane Katrina evacuees were moved from the Gulf Coast to Middletown, health centers provided medical and dental care as well as prescription needs and food pantry services for these displaced individuals. Again, the Family Resource Counselors volunteered. All the evacuees (200+) were managed by staff of East Bay Community Action Program.

Because health centers are in 28 locations across the state, we are positioned to be an effective and efficient system to meet the daily needs as well as the emergency needs of Rhode Islanders.

Since 1965, Community Health Centers have provided care for people who are uninsured, under insured or participating in Medicaid-based programs.

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RHODE ISLAND'S COMMUNITY HEALTH CENTERS:

Blackstone Valley Community Health Center, Thundermist Health Centers, Providence Community Health Centers, Wood River Health Services, Northwest Health Center, CCAP/Family Health, Crossroads Rhode Island, East Bay CAP, Tri Town Health Center, Chad Brown Health Center, Block Island Health Services and Bayside Family Healthcare.

Opportunities For Improved Quality and Access In the Office Setting

Chris Campanile MD, PhD

QUALITY IMPROVEMENT 101 WAS NOT OFFERED after Pathology in our second year of medical school or as a fourth-year elective. Nor was it part of our residency curriculum. Physicians are trained to elicit a history, examine, assess and plan, patient by patient. We know the course and outcome of individual patients, but we seldom know how we're doing caring for the entire population of patients we see. We strive to implement evidence-based guidelines for our individual patients but are generally not aware of our performance in satisfying such measures for our entire patient-population.. We are not accustomed to practicing Population-Based Medicine.

OUTSIDE OF OUR OFFICES: THE BROADER CONTEXT FOR QUALITY IMPROVEMENT

In the hospital setting, accreditation organizations such as the JCAHO (Joint Commission on Accreditation of Healthcare Organizations) are strong outside motivating forces. To oversee physician performance, the Federal government created **Professional Standards Review Organizations (PSRO)**, established by the Social Security Amendments of 1972. The **Health Care Financing Administration (HCFA)** administered **Peer Review Organizations (PRO)**, whose stated purpose was to "curb the growth in expenditures for health care" and "assure the quality of care delivered." The law allowed sanctions, including lack of payment for services. These approaches often dismayed physicians, who complained of: inaccurate and incomplete data, differences in judgment regarding individual patient care, limited evidence-based data on which to set performance targets, and inadequate tools to achieve these targets. The measures also were viewed as largely about cost containment and as taking a punitive rather than supportive approach to quality.

The **Centers for Medicaid and Medicare Services (CMS)** replaced

PROs with **Quality Improvement Organizations (QIO)** to promote care in the Medicare and Medicaid populations. The physician office setting is one of four areas of focus, along with home health, nursing homes, and hospitals. Statewide quality organizations compete for the QIO contract for their state. A contract runs for 3 years and is termed a **Scope of Work (SOW)**. Quality Partners of RI is the QIO for Rhode Island. We are currently in the 8th Scope of Work, which emphasizes **health information technology (HIT)**, chronic illness care, and cultural competency in providing care to diverse populations.

In the outpatient setting **Community Health Centers (CHCs)** were among the first practices to adopt formal QI programs. CHCs fall under the **Bureau of Primary Health Care/Health Resources and Services Administration (HRSA)** of the Department of Health and Human Services. Those CHCs which are 'federally qualified' regularly submit a grant to receive funds to offset care given to un- and underinsured patients. The clinical portion of these grants requires the submission of data on a number of health measures and the CHC's plan for improvement. In addition, CHCs have been required to participate in **Health Disparities Collaboratives**, a HRSA initiative beginning in 1998 with involvement from the **Institute for Healthcare Improvement (IHI)**. These Collaboratives seek to improve chronic illness care for diabetes, depression, asthma, and cardiovascular disease.

THE FRAMEWORK FOR IMPROVING QUALITY

The **RI Department of Health (RIDOH)**, and in particular, the **Diabetes Prevention and Control Program (DPCP)**, have been instrumental in bringing the **Health Disparities Collaborative** model to a wider array of practice settings in Rhode Island. For years the DPCP ran a Collaborative-like

QI diabetes program called **CHIP (Community Health Improvement Program)** for CHCs and some hospital-based clinics. Driven by a desire to spread this model of chronic care improvement and collaborative learning, the **RI Chronic Care Collaborative (RICCC)** started in the spring of 2003. This program is based on the national **Health Disparities Collaboratives** that had previously been run only with CHCs. This included adopting the **Chronic Care Model (CCM)** developed by Dr. Ed Wagner and colleagues at the **MacColl Institute for Healthcare Innovation**² as well as the rapid cycle **Improvement Model** and the **IHI's Learning Model**. What the RICCC created, for the first time, was a Collaborative composed of CHCs, hospital-based clinics, and private practices. By doing this, the RICCC promoted the spread of a chronic illness care program from CHCs to private practices.

Dr. Don Berwick and the Institute for Healthcare Improvement developed **The Collaborative Learning Model**. It is composed of four conferences that take place over the course of a year: 3 Learning Sessions and an Outcomes Congress. In the original CHC Health Disparities Collaboratives these Learning Sessions might take place over 2 to 3 days. The RICCC, in deference to the smaller private practices now participating, has modified these conferences to take place during evening and half day sessions. The Outcomes Congress occurs at the end of the yearlong cycle of training. Government, health, academic and business leaders are invited to the Outcomes Congress. The Learning Sessions are supplemented by monthly conference calls, an email listserve, and site visits by RICCC faculty. The time intervals between Learning Sessions are termed **Action Periods**. During this time practice teams innovate, test, and implement improvements into their model of care.

BEYOND THE FRAMEWORK: DOING THE WORK

The Improvement Model is based on the work of Shewart and Demings,¹ (the **Plan, Do, Study, Act (PDSA)** cycle):

- *Planning* refers to identifying an area that needs improvement. With discussion among staff who are familiar with the related process(es), reasons for poor performance are listed. Based on these, a specific innovation is planned. An example from the RICCC involves the goal of having patients with diabetes remove their shoes and socks before their provider enters the exam room.
- The innovation (*Do*) is as follows: signs will be posted in the exam rooms of Dr. E; starting tomorrow, Dr. E. will note whether the next ten diabetes patients she sees has shoes and socks off. Dr. E. does this and notes that the sign was not particularly prominent and also was not in the appropriate language for some patients.
- The group met again for twenty minutes a few days later to review (*Study*) the data. Four out of 10 patients had shoes and socks off when Dr. E. entered the exam room. Dr. E. passed along her observations about the signs.
- *Act* involves one of three options: toss out the idea because it appears to have no merit, modify the idea and test again, or implement the idea because it appears optimal or nearly so. This group decides to change the signs, making them more prominent, with Spanish and Portuguese versions.

The cycle continues. The next round of testing resulted in 7 or 10 patients with shoes and socks off. The next innovation was to have the medical assistant verbally remind the diabetes patients to take off shoes and socks (this depended on the success of some parallel testing which ensured that the M.A. knew the reason for each patient's visit). This round of testing resulted in 10 out of 10 patients with shoes and socks off by the time Dr. E. entered the exam room.

The **Chronic Care Model (CCM)** has as its premise the need to redesign one's approach to chronic illness care to effect significant improvement. The CCM began as a pilot at Group Health Cooperative in Puget Sound and grew to involve over 70 'best practices.' The ultimate goal of the Model is a productive interaction between an 'informed, activated patient' and a 'prepared, proactive practice team..^{3,4} Six components comprise this Model:

1. Health System – Organization of Health Care. All levels of the organization beginning with medical and administrative leadership must support this model. Ideally this vision is reflected in the mission statement of the practice and incentives are based on quality of care.

2. Delivery System Design. Physicians are encouraged to work with ancillary staff and mid-level providers as a team, each member having a defined role. More complex patients may require a case management style that incorporates other professionals (e.g., nutritionists, mental health providers, social workers). In addition, alternative formats for the patient encounter, such as group visits, should be considered.. Increasingly, physicians must be cognizant of patients' cultural backgrounds.

3. Clinical Information Systems. Data-driven improvement allows a physician to know which patients need follow-up appointments, laboratory studies or visits to other specialists,. and to have a snapshot summary of the patient's clinical status at the time of the visit.

4. Decision Support entails embedding this information into daily clinical practice. It also means sharing these evidence-based guidelines with patients as well as integrating specialist expertise into the primary care of the patient.

5. Self-Management Support refers to preparing and empowering patients to manage their health care. Emphasis is placed on the patient's central role in disease-manage-

ment. Physicians must become skilled in brief clinical interventions ; e.g., motivational interviewing and facilitating the patient's passage thru the 5 A's: Ask, Assess, Advise, Assist, and Arrange, originally developed as part of smoking cessation programs.⁶⁻⁸ This component of the model sets it apart from routine care of chronic conditions.

6. Community Resources makes physicians aware of potentially helpful resources in the community. For key programs the physician or practice is encouraged to create a more formal partnership. For example, a physician might partner with a senior center which has exercise classes. The practice might create a 'referral' form that is given to the patient with information on the senior center.

The CCM has been implemented in Rhode Island through the Chronic Care Collaborative. The RICCC has now completed two full cycles of the Learning Model and began the 3rd year last May. This has involved 30 practice sites composed of a mixture of private practices, community health centers, and hospital-based outpatient clinics and a total of over 2500 patients. The average A1c for the entire population is 7.6% while the proportion of patients with blood pressure at goal (<130/80) is 41% and LDL-cholesterol at goal (<100) is 63%. These comprise the outcome measures. Some of the process measure performance are as follows: proportion with documented retinal eye exam: 27%, annual renal function screening via urine microalbumin/creatinine ratio: 50%, and pneumovax administration: 61%. Eight of nine measures showed improved over the past two years.

Though the Chronic Care Model assists with improving outcomes related to visits for chronic illness, a more basic question is: How easy is it for patients to be seen when they want, especially if that entails a same-day visit? Many practices are implementing Open Access Scheduling,^{10,11} (also called "advanced access" or "same-day scheduling") Patients with same-day access usually make fewer emergency room visits and after-hours phone

calls. Patient satisfaction surveys indicate that patients appreciate this model. Several practices in Rhode Island have implemented Open Access Scheduling and an open access 'collaborative' run through Quality Partners of RI has completed its first year.

Two measures used to gauge the success of Open Access Scheduling are no-show rates and 3rd next available appointment. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. Capitol Hill Health Center, a participant in the QPRI Open Access Collaborative, reduced the no-show rate in its pediatric clinic from 24% to 8% over a nine month period. The number of calendar days until the 3rd next available appointment dropped from sixty to zero.

Health Information Technology is so critical to quality improvement that it bears further mention. The need for almost real time reporting of data on large groups of patients makes an **electronic health record (EHR)** essential. An EHR must not only facilitate documentation and transmission of information but also act as an interactive database able to provide customized reports instantly. In Rhode Island, a grant from the **Agency for Healthcare Research and Quality (AHRQ)** is funding the effort to create a Community Health Information Exchange through which health data will be shared by approved entities. The construction of this network has spurred other groups such as RI Primary Care Physicians Corporation and EHR Rhode Island to assist physicians in selecting and purchasing EHRs which are compatible with the larger connectivity work occurring through the AHRQ grant. In addition, QPRI administers **DOQ-IT (Doctor's Office Quality Information Technology)**, a CMS program designed to assist practices in choosing an EHR. Most importantly, health plans have begun to demonstrate that they also value the implementation of EHRs in doctors' offices: BCBSRI recently initiated Quality Counts, a four year program which rewards physicians first for using an EHR that produces clinical reports and ultimately for demonstrating improvement in 10 health measures.

PRACTICAL SUGGESTIONS: THE HILLSIDE QUALITY IMPROVEMENT PROGRAM

Creating a quality improvement program in a practice requires less financial resources than sheer will. The needed ingredients are: a clinical champion, a QI assistant, an administrative representative such as an office manager, an electronic health record or a stand alone patient registry or at least an electronic scheduling/billing module that includes diagnosis codes, a forum to share results with other physicians and staff, and regular meetings of the quality group. At Hillside Avenue Family & Community Medicine, the quality improvement group consists of 4 people: myself, the physician operating officer, a QI assistant, and the operations manager. Our QI assistant has generally been a college graduate interested in a career in health who is in a transition year.

The major components of the QI program at Hillside divide into two categories: a chronic care QI program which operates as part of the RICCC as described above, and a system to contact patients who are due for chronic illness follow-up visits or for regular preventive care visits. The RICCC QI program focuses on diabetes and uses a standalone registry written in Microsoft Access called **CDEMS (Chronic Disease Electronic Management System)**. Once a diabetes visit has occurred, an email is sent to the QI assistant. She takes the updated information from the patient's diabetes summary table in the EHR and enters it into the CDEMS program, located on a network drive available to all Hillside users. The QI assistant also generates the monthly data reports and Excel graphs required by the RICCC and posts this information in a common area so that all staff can view the results.

Importantly, for measures that are not showing improvement, the QI assistant will generate a list of patients who lacked the marked activity; e.g., annual retinal eye exam, and contact these patients. Measures that continue to fail to improve are discussed at QI meetings. Out of that discussion comes an agreement to test an innovation that is predicted to improve outcomes. For example, the PCP may fax a memo to the eye care specialist to facilitate documen-

tation of eye exams.

In this type of disease-based QI work it is essential to report performance data monthly. To ascribe an outcome to a given intervention, regular measurement will provide data directly before and after that intervention. The trend over time will make up for what might otherwise be a statistically insignificant change.

The addition of a nutritionist to our diabetes care team has been integral to the success of this program. We have encouraged our nutritionist to attend collaborative learning sessions and to become skilled in motivational interviewing techniques.

I believe that if we are to improve the care of patients with chronic illness we need a 'chronic disease educator' on the health care team. This person would have basic knowledge of several of the most common chronic illnesses and also have extensive training in the techniques of motivational interviewing. Such a person would spend 30 to 60 minutes with the patient, right before or after the physician-visit. This person's training would be part of a nationally accredited program and their services would have an ICD-9 or CPT code that would be reimbursed by payers.

The other major thrust of the Hillside QI program consists of contacting patients who have CHF, COPD, DM, HTN, or asthma, and have not been seen in the previous four months. We also target pediatric and adult patients who have not been seen for an annual physical exam within the past year. To generate these reports we use our scheduling/billing software. Our front desk staff will make two phone calls and mail one letter.

At Hillside we also use this work to generate volume especially during a relatively slow season such as the summer and early Fall. We have estimated the return on our investment in this work by tabulating the cost of the staff doing the work against the projected collections for the appointments generated and have found that this work easily pays for itself. Regular meetings are essential if a QI program is going to produce results. There should be a regular time every one to two weeks. At Hillside the four of us meet for 30-60 minutes most Tuesday mornings.

MOVING FORWARD

If physicians undertake the task of establishing a quality improvement program in their practice, the most difficult part of this work will not be discovering more efficient and satisfying ways of doing things in your office. These improvements will be self-evident after sufficient testing. Much more daunting is the Diffusion of Innovation,¹² i.e., convincing your fellow clinicians and support staff that any new method is worth implementing throughout the practice.

Many professional societies offer assistance to physicians interested in starting a quality improvement program. The American Academy of Family Physicians' website has a section on quality improvement.¹³ The seven year cycle of recertification of the American Board of Family Practice now requires that all physicians complete a Performance in Practice Module which is in essence a quality improvement project.

I urge all physicians to add a quality improvement program to their practices to be well positioned for the time when performance data will be expected and rewarded.

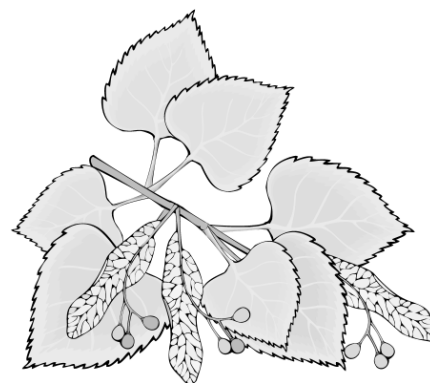
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Is Health Reform In Massachusetts a Model For Rhode Island?

David A. Rochefort, PhD

WHEN GOVERNOR CARCIERI ANNOUNCED his fiscal year 2007 budget in February, health care cuts figured prominently in the plan to control expenditures. Recommended reductions in RItE Care and Medicaid, Rhode Island's primary public programs for providing health insurance for low-income families, amounted to \$43 million. Nearly 7,000 enrollees would have become ineligible for continued coverage. Reacting to the governor's proposal, an eclectic group of community, labor, health, and mental health groups joined forces to block the changes.¹ Ultimately, the General Assembly rejected most proposed cuts, but the episode dramatized the severity of the state's health care financing problems while highlighting the program changes that loom on the horizon.²

Against this backdrop, Massachusetts has adopted major new health insurance legislation. Len Nichols of the New America Foundation has written, "Everyone interested in solutions to our health system's problems (and who isn't?) is looking to Massachusetts in the wake of its recent landmark legislation."³ According to supporters, the new law will bring Massachusetts close to universal coverage by a combination of new requirements on businesses and expanded government involvement in the insurance marketplace.

To what extent does the Massachusetts approach present useful strategies for policymakers and health reform advocates in Rhode Island? This article addresses that question.

HEALTH INSURANCE PROBLEMS IN RHODE ISLAND

According to the Robert Wood Johnson Foundation, "No one report card exists on how the United States is faring on health insurance coverage. However, one thing is certain: the number of uninsured is rising."⁴ Latest estimates by the US Census Bureau put the total number of uninsured in the country at 46.6 million for 2005, up from 45.3 million in 2004.⁵ This figure represents 15.9% of the population. An increase in health insurance

costs, the decline of employment-based coverage, and eligibility limitations within public programs have all contributed to growth of the uninsured.

Although the situation in Rhode Island looks better than in many states, a parallel reduction in health insurance coverage has taken place here. In 2004-05, the uninsured reached 11.4% of the Rhode Island population.⁶ This statistic, the highest percentage since the mid-1990s, caps a worsening trend that began after the state's uninsured bottomed out at 6.2% in 2000. Whereas Rhode Island had the lowest uninsurance rate in the nation that year, by 2004-05 it was tied for eleventh place; Massachusetts, at 10.7%, held seventh position.

Not all population groups in Rhode Island are equally likely to face coverage problems. Males, residents between the ages of 18 and 34, low- and middle-income earners, the unemployed, Hispanics, and those living in core cities are disproportionately affected.⁷ The comparatively favorable insurance status of children and women reflects, in large part,

the RItE Care Medicaid managed care program, Rhode Island's State Children's Health Insurance Program (SCHIP), and RItE Share, a premium assistance program to help low-income working families obtain coverage through their jobs.

Although most Rhode Islanders still receive health insurance through employment, there have been extensive reductions in coverage of this type similar to changes nationally. The share of the Rhode Island population covered by employment-based health insurance fell from 70% in 2000 to 62% in 2004.⁸ The most rapid decline occurred within the small business community. In addition, enrollees are facing higher premiums, deductibles, and copayments.⁹

Health care costs in the United States are the highest in the world and continue to rise, raising questions about the sustainability of the current system. In Rhode Island, health care spending, climbing steadily over recent decades, is higher on a per capita basis than for the US as a whole. In 2004, Rhode Islanders' personal health care expendi-

Figure 1
Uninsured as Percentage
of Total Population
2004-05

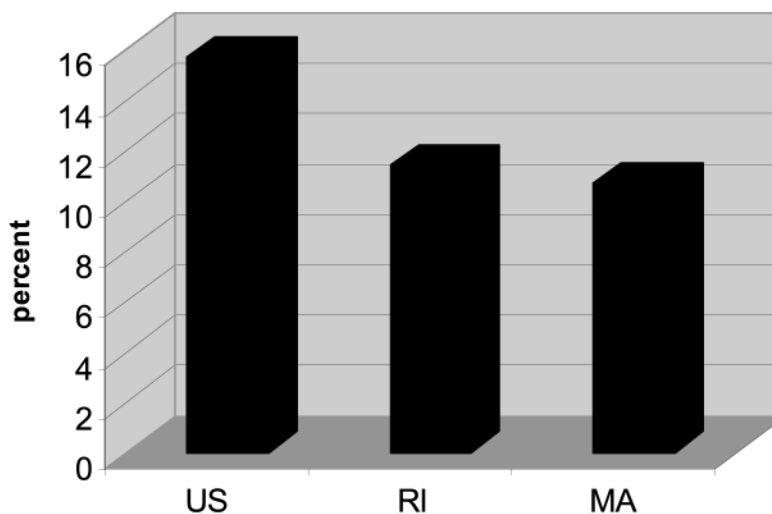
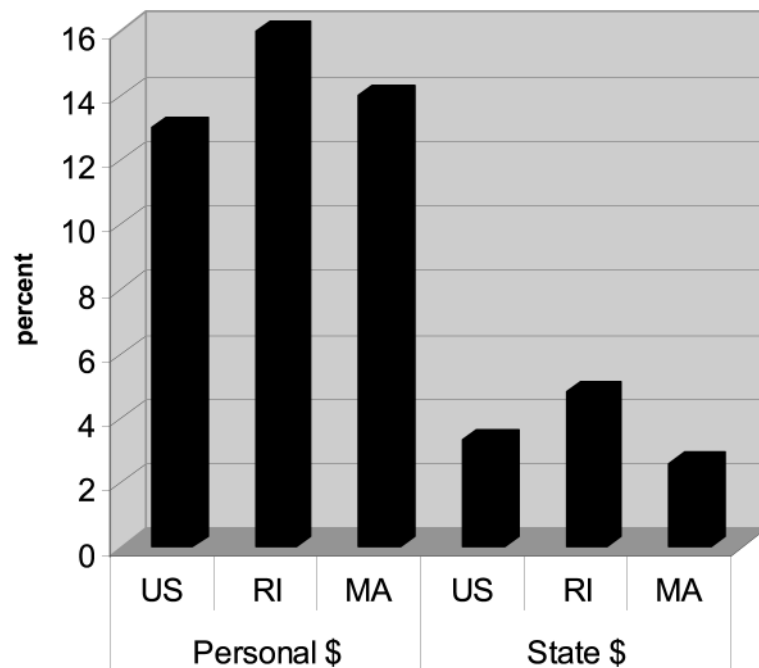


Figure 2
Personal Health Expenditures (2004)
and State Health Expenditures (2003)
as Percentage of Gross State Product



tures accounted for 16% of Gross State Product; the share is 13% nationally.¹⁰ Rhode Island's spending level results from an annual growth rate of 8.5% between 1980 and 2004. Family premiums for people insured through their jobs now average more than \$10,000 in Rhode Island.

Spending for Medicaid, which is projected to reach \$63.5 million next year, now absorbs more than 20% of the state budget. In September, Governor Carcieri, working with the Rhode Island Expenditure Council, charged a new Study Group with improving the efficiency and effectiveness of the program.²

In November 2002, researchers from the Boston University Health Reform Program concluded there was already enough spending on health care in Rhode Island to make coverage available to all, if only the existing system would be reformed.¹¹ Yet there has been little agreement on the best direction for change. Proposals have included malpractice litigation, single-payer health care, and employer mandates. A "Fair Share Health Care Act" requiring large companies either to contribute a minimum

amount to their employees' health insurance or pay into a state fund did not pass the legislature this year, despite support from the Lieutenant-Governor.

One bill that did pass, The Health Care Affordability Act of 2006, is meant to reduce the cost of insurance for low- to moderate-income individuals, small businesses, and the self-employed, but the law falls far short of comprehensive reform. Significantly, lawmakers inserted a provision creating a Task Force to study "the applicability of the Massachusetts Health Care Reform Plan to Rhode Island" with a reporting date no later than June of 2007.¹²

UNDERSTANDING THE MASSACHUSETTS HEALTH REFORM LAW

The Massachusetts health reform resulted from a combination of problems, pressures, and possibilities.¹³ Although federal and state estimates differ, both agree on a sharp increase in the number of uninsured in the Commonwealth during the early part of this decade. Health insurance costs in Massachusetts are also among the highest in the nation: yearly

premium increases of 10% or more in private health plans are the norm.

Massachusetts' governor, with Presidential aspirations, was intent on establishing a reputation for domestic policy successes. Legislative leaders also recognized health coverage as a priority. An initiative by the Blue Cross Blue Shield Foundation of Massachusetts, Roadmap to Coverage, maintained focus on the uninsured.

Yet these conditions alone might have been insufficient to elicit a legislative solution were it not for two additional forces. The federal government threatened to withdraw \$385 million annually under the state's Medicaid waiver unless Massachusetts came up with a new way to finance services for its uninsured.¹⁴ And a coalition of religious and community groups introduced a ballot initiative to put the health coverage issue before voters. The implications were clear: if Massachusetts policymakers failed to adopt meaningful reform, there would be serious consequences.

Contentious debate characterized discussions of the new legislation. Powerful groups representing business, the health industry, and consumers monitored developments while competing to influence the specification of benefits and responsibilities. Wisely, however, major stakeholders avoided the legislative stalemate that could have arisen had they approached the law-making process as a zero-sum contest between their interests and those of other participants. By November 2005, four main options from Governor Romney, the House, the Senate, and the Massachusetts Affordable Care Today! campaign held the spotlight.¹⁵ Their provisions differed with respect to program size, mandated employer costs, individual coverage requirements, and the role of Medicaid. Even as the legislative endgame was underway in spring of 2006, the Governor and legislative leaders remained at odds over state funding for the new program and proposed business costs.

The final package that emerged in April embodied a compromise of government interventionism and market-based incentives.¹³ A new "Health Insurance Connector" was established to make low-cost insurance products available to small businesses and individuals. Employers with more than 10 employees who fail to provide coverage will be subject to an as-

assessment of \$295 per employee per year. Eligibility changes in MassHealth, the state's Medicaid program, expanded coverage for children up to 300% percent of the poverty level. For low-income individuals and families falling in the gap between public and private sources, policymakers created the "Commonwealth Care Health Insurance Program," providing sliding-scale subsidies for the purchase of insurance. Plans offered through Commonwealth Care will be without deductibles, and enrollees below the poverty level will not pay premiums. A new requirement also expands availability of "cafeteria plans" enabling the purchase of health insurance with pre-tax dollars.

One of the most innovative—and widely discussed—elements of the Massachusetts health reform is an "individual mandate." Beginning in July 2007, all residents must acquire coverage through either an employer, MassHealth, or self-purchase. For the latter group, the Health Insurance Connector will define affordability standards as well as the features of health plans that will be offered for sale to the uninsured. The penalty for not complying with this individual mandate, if "affordable coverage" is made available, will be an increase in state income taxes equal to loss of the personal exemption in 2007, and one-half the cost of the lowest available insurance plan premium after that.

The Massachusetts law also revamps the state's Free Care Pool, increases reimbursements for hospitals and physicians, and merges the non-group and small-group insurance markets. The most noteworthy part of the new program, however, will be its impact in expanding coverage. Once fully in place within three years, the plan is projected to cover 515,000 of the currently uninsured, bringing the uninsured population in Massachusetts to below 1%.¹⁶

When Governor Romney signed the health care bill into law, the *Boston Globe* described it as a moment "widely praised as historic for the state and seen as a big boost to Romney's presidential aspirations."¹⁷ Health policy expert Paul Ginsburg (in the *New York Times*) predicted: "It's definitely going to be inspiring to other states... They found a way to get to a major expansion of coverage that people could agree on."¹⁶

Less than a month after the signing of the bill, Rhode Island lawmakers scheduled a special hearing to begin reviewing the lessons of the Massachusetts experience.

A SOLUTION WITH STRENGTHS AND WEAKNESSES

Politics, Not Policy

Conflicting views and interests notwithstanding, health care reform in Massachusetts was made possible by a shared bipartisan commitment from Democratic legislative leaders and a Republican governor. At the same time, the process of policymaking was, in important respects, an open one, in which business, labor, hospital, professional, and consumer groups were consulted. The final legislative package combined new mandates on employers as well as individuals.

When John McDonough, executive director of the Boston-based advocacy group Health Care For All, spoke with Rhode Island lawmakers last May, he stressed compromise as the major lesson of the Massachusetts reform.¹⁸ Writing subsequently in *Health Affairs*, McDonough emphasized that the Massachusetts experience is valuable "more as a political blueprint and less as a policy blueprint."¹³

For Rhode Island, in which the health policy process has often been marked by a combative relationship between the Democratic legislature and Republican governor, this point is essential. Finding a successful path to reform will depend on mutual accommodation and inclusiveness.

The Cost Question

At the root of unease about the Massachusetts plan is a fear that costs will soon outdistance revenues, making it necessary for policymakers either to retrench on the program's objectives or find additional funding via higher taxes, higher employer assessments, and/or increased consumer contributions.¹⁷ Already, the state's financial commitment under the law is targeted at \$125 million annually in general revenues. A large proportion of remaining costs is to be covered by the special Medicaid waiver monies obtained by Massachusetts. For Rhode Island, which has a higher level of uninsurance than Massachusetts and no equivalent supplemental federal Medicaid payments, the funding requirements of a program with this de-

sign would be daunting. One answer is to fashion a bill that couples coverage expansion with tough cost-containment provisions—something the Massachusetts law does not do—but this will increase the political obstacles to reform.

Finding the Right Administrative Model

The central administrative mechanism of the Massachusetts health reform is the Commonwealth Health Insurance Connector, a new authority whose functions range from helping to rewrite the regulation of private insurance plans, to approval of new low-cost low-benefit products for young adults, to supervising the purchase of insurance by individuals eligible for public subsidies. It is too early to assess the Connector's complex work. A significant effort at transparency seems to be underway through regular public notices and open meetings. As expected, staffing demands, internal organization, basic data-gathering and analysis, and drafting of rules have dominated the Connector's first few months.

A current controversy, however, concerns the affordability of rates announced by the Connector for enrollees between 100 and 300% of the poverty line. Commented one health policy analyst from Tufts University, "for too many people, the numbers just don't add up."¹⁹ This worrisome development has occurred closely in tandem with Governor Romney's weakening of the enforcement of the \$295 assessment on businesses that don't pay a "fair and reasonable" contribution to their employees' coverage.²⁰ Now there is discussion as to whether the state's insurance mandate will require parents to buy plans that cover their children.²¹ Taken together, decisions on these matters could limit the scope of coverage achieved in Massachusetts.

The lesson to be underscored here is that administrative operations as well as policy design are pivotal in maintaining the balance of interests within health reform. Rhode Islanders need to consider carefully which bureaucratic model—the Massachusetts example, or some other allocation of implementation responsibility—would prove most advantageous in view of this state's established agency environment. Creating specialized bureaucracies is a tempting strategy for concentrat-

ing expertise and authority in executing new public functions. Yet the risks include high start-up costs, problems of coordination with other government departments, and capture by outside groups.

W(h)ither Employment-Based Coverage?

According to the *Boston Globe*, premium increases for the four major private health insurers in Massachusetts are expected to exceed 10% for 2007—the seventh straight year of double-digit inflation in health insurance costs.²² Many employers are likely to restrict benefits and/or impose higher deductibles, copayments, and premiums on employees.

This same scenario has been playing out in Rhode Island. Small wonder, then, that Governor Carcieri identified halting the “continued erosion of employer-sponsored health insurance” as a primary goal of his current health policy agenda.²³ However, the Massachusetts health plan does little to address this problem. On the one hand, the Connector will help make lower-cost insurance products available for small businesses, but on the other the merger of small-group and nongroup markets is expected to raise small-group premiums.¹³ Further, the \$295 employer assessment could prove too meager to prevent a disinsurance movement among business-owners who direct employees to the Connector rather than continue to provide coverage on their own.²⁴

Nor does the Massachusetts plan halt the cost-sharing increases in private insurance. It may even exacerbate the trend by limiting benefits in the nonsubsidized plans offered through the Connector. The basic dilemma of our market-based health system remains: those lowest on the political and economic totem pole are expected to absorb the burden of cost-shifting. The result has been increasing levels of “underinsurance.” To the extent that Rhode Island addresses this problem through regulation and other means—the emphasis in the state’s 2006 health law on prevention and wellness is a possible contribution—it would have lessons of its own to export.

CONCLUSION

Would the Massachusetts model work in Rhode Island? The question is difficult to answer, not least because it is still far from clear how well the program will work

in Massachusetts. As health care advocate John McDonough and his associates have written, “Give Massachusetts time to implement, and revisit what we have achieved by 2009. Then let’s talk.”¹³

Yet Rhode Island may not have the luxury of waiting for results elsewhere before having to act. As measured by key coverage and spending indicators, Rhode Island’s health system faces a predicament even worse than the one in Massachusetts, and major cuts in public programs are under consideration. The Massachusetts example may be very useful *now* for its inspirational value.

As to whether the structure of the Massachusetts approach should be adopted in this state, it seems a question best answered through evaluation of individual design components, rather than as a thumbs-up-or-down for the program as a whole. The Massachusetts health plan is a social experiment, and its pieces are not so closely interlocked they can’t be tampered with. Once Rhode Islanders decide on *what* they want to accomplish—in terms of such aims as universality, cost-containment, and market intervention—the *how* should come more plainly into view.

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What Would It Take?

Christopher F. Koller, MPPM, MA

IN THE PARABLE OF THE BOILED FROG, the cold-blooded amphibian sits in a pot of hot water on the stove, ignorant of the rising temperature until it is too late.

Many observers maintain our medical care system is bobbing in a pot of rising costs and the resulting increased number of uninsured citizens - similarly unaware of the dangers that are rising. When, they ask, will the pot boil over and our system collapse?

Even if the imagery is overheated—after all, there are states with uninsured rates that are double Rhode Island's—the number of uninsured here is twice what it was five years ago and there seems to be renewed interest in tackling this persistent issue: how can a country as wealthy as ours not insure everybody? The passage of ambitious legislation in Massachusetts raises the question for Rhode Island: What would it take to guarantee for all Rhode Islanders some basic health care and a protection against medical catastrophes? What would it take to include all the Rhode Islanders who are outside the health insurance pool but are the ones getting soaked?

IT WOULD HAVE TO PRIORITIZE THE PROBLEM

Appeals to cover the uninsured can be made on justice: it is unfair for a moral society to live with so much inequity. After all, uninsured people are sicker than those with insurance, they postpone medical care and presumably suffer more, and—if uninsured long enough—die earlier.¹ Medicaid and Medicare were established based on this principle; and, according to this thinking, it is time to update governmental programs to reflect today's social reality of more uninsured.

Appeals to social justice often have limited effect in the US. Culturally we tolerate a fair amount of inequity in exchange for freedom and the hope of hitting it big. The second approach is more utilitarian: a large uninsured population imposes great social and economic costs on the rest of us - treatment costs borne by the insured and economic costs in lost productivity.² These costs are real but elusive to document: capturing and applying them

to finance an effort cover the uninsured is difficult. Maine's Dirigo Health Plan is built on such an effort, and its success is by no means assured.

If the costs are hard to capture, then the appeal to justice is probably stronger. Rhode Island, with its traditionally strong sense of cultural and social solidarity, is amenable to this appeal. Affordable health insurance is becoming a middle class problem. Massachusetts' legislation could inspire some productive sibling rivalry and collaboration. Yet even with the prioritization of health insurance for all, how would this be accomplished in a socially, politically and economically feasible fashion?

IT WOULD HAVE TO TARGET THE UNINSURED POPULATION.

Rhode Islanders' uninsured population resembles that in other states.³ The uninsured in RI are most likely to be:⁴

- Young (57% are between the ages of 18 and 34)
- Working (63% work for wages) and
- Poor (50% have incomes less than \$25,000)

While the number of Rhode Island companies offering health insurance has not eroded much over the last six years (smaller companies are consistently less likely to offer it), the number of employees able to afford their employers' offering has.⁵

The implications are that any efforts targeting these people will have to take into account their limited ability to pay, their relatively young (and healthy) status, and the inability of the privately funded, employer-based system to give them affordable, useful options.

IT WOULD TAKE A VISION

Imagine a set of rules for health insurance with a commitment to universal coverage. That sounds like an expansion of what works—Medicare. That beleaguered program has provided medical security for all elders, balanced a common set of benefits with the ability to buy up to a more comprehensive package—

with administrative costs 80% less than those of commercial health plans.

Applied to the commercial and uninsured population, a Medicare-for-all plan would replace (at least for some) employer-based health insurance with Federal financing, paid for by payroll and employer taxes with means-testing for lower income populations. Like Medicare it would offer a choice of plans, with the ability to buy supplemental coverage. By eliminating the tie to employer-based health care, it would acknowledge the reality of a mobile workforce and create a level playing field for employers.

Such a vision has its limits. Patients currently with private health insurance would surrender a choice of benefit plans for the certainties of health coverage and a government bureaucracy. Employers would be either invited or commanded to throw in the towel on buying health care benefits and trust that the government could do it better. Providers would accept broader Medicare-like fee setting in exchange for administrative simplicity. States would have to wait for change to emerge from Washington—a daunting prospect.⁶

An accommodation to this vision would capitalize on rather than refute the rise of consumerism and individualism in our culture. Commercial health insurance would look a lot like auto insurance. Individual purchasers empowered by the Internet and shrewd benefit plans, and goaded by an obligation to buy health insurance, would make informed choices, based on the cost and quality of their options. Patients would take more responsibility for the preventive equivalent of oil changes. Providers would respond to consumer pressures by offering specialization, cheap pricing and better service for commodity items—patients would come to "Trust the Midas touch." Rare and expensive high-end services, like collision work, would be negotiated between insurers and regulated providers.

There are limits to this accommodation as well. Unlike auto insurance, society would insist on public subsidization of the purchase of health insurance or a set of publicly funded providers for low

income citizens. Also, the moral and epidemiological consequences of neglecting preventive health services are a lot higher than not changing your oil: we find it easier to junk someone's house or car than their body. But our cultural schizophrenia demands both maximum benefits coverage and maximum treatment choice, with little consideration of price.

IT WOULD TAKE SOME PRINCIPLES

Any policies to expand health insurance would start with some collective commitments. In Rhode Island, they might look like the following:

1. *Universal right*: as obvious as it sounds, any proposal must begin with a fundamental social commitment to the requirement of universal coverage for every citizen.
2. *Universal obligation*: everyone contributes—at the point of care, at the premium level and in taxes. There is no free loading for either individuals or employers. Individuals have some cost sharing at the point of care so cost-sensitive decisions are made.
3. *Limited right*: As with Medicare, everyone would have to buy into a core benefit package. This package would have to be cheap enough for young, healthy and lower income people: built on primary and preventive care, generic drugs and catastrophic hospitalization. Everyone could buy more coverage if they could afford it, but the social commitment would be to the conditions to promote a healthy life, not a guarantee of coverage to treat any condition or to sustain any hope for physical survival.
4. *Mercy trumps responsibility*. As appealing as it may be to penalize every bad habit through insurance premiums, that road ends with older and sicker people paying a lot more—thus defeating the pooling effects of insurance. We do charge more for sixteen year olds to drive and for sky divers to buy life insurance and we should probably charge you more if you smoke and choose not to exercise, but insurance is also about randomness: bad

things happening for no good reason. Health insurance in particular is about spreading the financial burden of ill health: no matter how much you smoke your disease should not render you destitute. Besides, public health measures like public smoking laws and direct consumption taxes have proven more effective at reducing smoking incidence than an indiscriminate premium surcharge.

5. *Lots of choice*: Americans have consistently shown a willingness to pay more, and accept more inequality, in exchange for more choices of doctor and of health plan. Any design would have to allow for this.
6. *Let the Government do (more of) it*. Employer-based health insurance continues to erode in the face of rising costs. Without requiring it, there would need to be a mechanism for employers to meet their obligations by ceding money and responsibility to the Government, to avoid instances like large retail firms where employees flock to Medicaid. By evolution and intent, as it purchases more, the Government assumes a greater role in regulating the medical care system. Similarly, advocates of universal coverage must acknowledge that to be politically feasible the delivery system and at least some of the financing system must stay private—at least initially—and thus more fragmented and more costly.
7. *Fix the tax code*. Employee health care benefits are not taxed; employers reduce their tax liability with every dollar of insurance coverage purchased. But when individuals buy health insurance for themselves, they do it with after tax dollars. These incentives need to be corrected.

8. *Let the states try it*. National reforms will be glacial in pace. Political consensus is easier to reach at the local level. States, citing Oliver Wendell Holmes, can be “the laboratories of innovation” and Rhode Island—with its RItE Care program, and history of provider quality report-

ing—has shown an appetite for innovation in health policy. In a universal coverage model, states would have to be:

- Rule-makers – to level the playing field for individuals, employers and providers.
- Market-makers – to negotiate with private health plans on behalf of others without that leverage.
- Financiers – to maximize federal Medicaid payments and use taxing authority to subsidize care for those who cannot afford it.

9. *Underlying costs must be addressed and the delivery system changed*. Our fragmented, specialty-heavy medical delivery system is partially responsible for poor quality and high costs. Any reforms should promote better information exchange to reduce duplication, more cost awareness for ambulatory services, more consumer responsibility and stronger primary and preventive care.
10. *Most importantly: don't let the perfect be the enemy of the good*. The greatest challenge would be the termination of a basic benefit. There remains a huge gap between the health benefits we want and what we can afford. Economists typically suggest that it is unsustainable for a family to spend much more than 10% of gross income on medical care expenses. For the market rate of \$1100/month for a family policy and an employer contribution of 50%, that would require an annual income of \$66,000. If more money is not found, the cost of the package must be reduced; part of that must come from reduced benefits. No budget is unlimited.

IT WOULD TAKE A PLAN

Visions, by their nature, are great leaps forward. Any variant of the visions articulated here could involve a massive reallocation of funding from employers to individuals and the state or federal government. It would signify an acceptance by the public that health care is a public

good and entrust more of its financing to a political process and public administration—neither of which enjoy great popularity today.

So it would take pragmatism to get from here to there. That is why the plan passed this spring by the Massachusetts legislature has attracted such attention. It consists of the following elements:⁷

1. Employer mandate (*Vetoed by Governor Romney but over-ridden by the legislature*) Businesses would be required to insure employees or pay a contribution to the state for those who do not purchase health insurance. The state, through a new agency, will take a stronger hand in negotiating benefits and prices with private health plans on behalf of small employers.
2. Individual mandate. When the program is fully implemented, every Massachusetts resident would have to show—on their tax filing—proof of insurance coverage.
 - a. Low income families would have access to an expanded Medicaid program, possibly with a more limited set of benefits than currently.
 - b. Young residents could stay on their parents' coverage until age 25, or purchase special, reduced benefit packages through the state purchasing agency.
 - c. Employed individuals could purchase their benefit through the same agency using pre-tax dollars, with a subsidy if their income was low.

This program's success will hinge on money. Under threats of federal cuts, Massachusetts is moving large amounts of Medicaid money which previously went directly to providers into insurance subsidies. Even if the money "works" initially, will this program create a larger budgetary obligation for the state, with no ability to control medical cost trends in the future?

A second success factor will be the effect on small businesses. Will the "Commonwealth Connector"—the state's new purchasing entity—succeed in negotiating with health plans, reducing

the rate of medical inflation and forging a consensus on the balance between expanded benefits and cost?

Finally, the legislative artfully avoids defining what constitutes affordable health insurance in terms of price and comprehensiveness. It remains to be seen how consensus will be developed.

A program such as Massachusetts' could be developed in Rhode Island. Key elements might include:

1. Employer and individual obligations—in a voluntary market, we will not achieve full insurance. A sizeable group of people buy auto insurance only because they must.
2. Requirement of a basic benefit package—less comprehensive than the current commercial standard.
3. Increasing the age of covered dependents.
4. An active Government purchasing and regulatory role for those who can't negotiate with health plans themselves, building on the success of RIte Care and history of small employer group regulation.
5. Subsidies for low income populations who cannot afford even the basic plan, funded as much as possible through Medicaid.
6. Building a common platform on the foundations of RIte Care and our existing small group and individual regulations. This would permit some standardization of marketing and enrollment in certain markets to reduce administrative costs.

IT WOULD TAKE CAREFUL THOUGHT TO OVERCOME OBSTACLES

Not surprisingly, there would be conditions to such a program.

The money. Covering Rhode Island's 110,000 uninsured is a \$500 million annual challenge at commercial rates of coverage and payment. Financing is a greater concern than in Massachusetts, because there is no bolus of existing Medicaid funds. Sources include Federal payments for new Medicaid eligibles, existing payments for uncompensated care, savings

from benefit limitations and design, and more payments from the currently-uninsured, their employers, and the taxpayers.

Sustainability. With medical trend rates at two-three times inflation, any new program should dampen the trend, not accelerate it, particularly since the state would be liable for future expense increases for the subsidized portion of the program. The tools used by large purchasers—aggressive plan negotiation to limit administrative costs and profit, and benefits redesign that demands more patient responsibility—should be employed. The state would have to negotiate aggressively with large health plans on behalf of those who can't, set standards for information and quality, and possibly even negotiate provider rates. Health information technology would have to deliver on its promise of reduced duplication and administrative costs.

Political Resistance. The establishment of a program like this would depend upon a political mandate that wins over the voices of resistance—those who believe they would lose in the new system. The line of putative losers would be large: patients fearing loss of choice; advocates fearing the loss of consumer protections and benefit coverage; tax payers and employers fearing new financial obligations; providers and insurance brokers fearing loss of autonomy and revenue, insurance companies fearing loss of profits. At the core would be institutional resistance to the unknown: the unforeseen outcomes could be worse than the status quo.

Who would advocate for such a program? Certainly the uninsured themselves—but poor young people have not been bases of great political power. Uncompensated care providers—hospitals, community health centers and other physicians—would see their burden greatly lightened. Employers who struggle to provide health insurance should welcome both the increased options available to them, and a set of common rules to eliminate unfair advantages enjoyed by some businesses that pay for less health care. Absent leadership, a viable plan and skillful advocacy, this may not be enough to overcome resistance. The linchpin may end up being people obligated and activated to purchase health insurance under an individual mandate—who would

exert a strong force for reform and change. Any calls for mere subsidization of our current unaffordable structure should be resisted.

The inequities posed by the uninsured exert a moral claim on the community. Moral claims in a civil society are translated and prioritized through the political process. "In the end", says Princeton economist Uwe Reinhardt, "Efforts at health care reform are exercises in the economics of sharing."⁸ Sharing is hard to do, even harder to legislate. However, Rhode Island has assets. Our small size is an advantage: there is a strong fabric of social solidarity resulting from our sometimes-too-intimate-sense of community; and as visiting policy makers repeatedly tell us, it is possible to develop "line of sight trust" on issues of common importance.

The number of uninsured will increase until we believe it is in our individual and collective interests to act—even at the risk of the unknown, of failure and certainly with compromises and, yes, sharing. Has that time come in

Rhode Island? The almost one in eight Rhode Islanders without insurance believe it is past time. The workers who watch the rising costs of their health benefits eat up their wages believe that something must be done. Legislators who struggle to balance a budget in the face of rising Medicaid and personnel health costs believe that something must be done.

Like the number of uninsured, the temperature in the frog's pot is increasing—and the number of people willing to act on the challenge of the uninsured may well be too.

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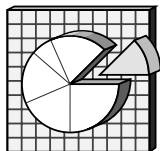
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Utilization of Hospital Emergency Departments, Rhode Island 2005

Karen A. Williams, MPH, and Jay S. Buechner, PhD

RECENT CHANGES TO LICENSURE REGULATIONS IN RHODE ISLAND required hospitals to report emergency department (ED) visit and observation data to the Department of Health routinely beginning in 2005. ED data in particular provide a wealth of information on special populations (e.g., the uninsured) and conditions seen primarily in the outpatient setting. Preliminary data on ED utilization are presented here, with special focus on the disparities between the insured and uninsured populations.

METHODS

Under licensure regulations, the eleven acute-care general hospitals and two psychiatric facilities in Rhode Island report to the Department of Health a defined set of data items on each emergency department visit beginning with visits occurring January 1, 2005. The data include patient-level demographic and clinical information. This analysis covers ED visits occurring January 1 - December 31, 2005 and is limited to ED visits not resulting in admission to the hospital. ED data reported by the two psychiatric hospitals consist of visit data for patients receiving an unscheduled psychiatric evaluation that did not result in an inpatient stay. Due to complexities in the manner in which hospitals record ED data, the data presented here are subject to change as methods to distinguish ED visits that result in inpatient admission at acute-care facilities from those that do not are improved. Diagnoses are coded in ICD-9-CM,¹ and were grouped as for published national data.² Expected source of payment reported as "self-pay" was used as a proxy for uninsured in this analysis. Comparative data for inpatient stays were

produced by analyzing the data on inpatient discharges also reported by the state's acute-care hospitals.

RESULTS

In 2005, there were 382,243 ED visits not resulting in an inpatient stay to Rhode Island's acute-care general and psychiatric hospitals. Of these, the highest proportion of visits was to Rhode Island Hospital (26.1%), followed by Kent County Memorial Hospital (12.3%). (Table 1) The two psychiatric hospitals reported the lowest volume, together comprising less than 1%.

Females accounted for more than one-half (55.4%) of all ED visits and for the majority of visits within each age group except 0-14 years, where males comprised 54.1% of the visits. For both males and females, approximately one-half of the visits were among those ages 15-44, a younger pattern than the inpatient population, where 41.1% of admissions are of persons ages 65 years and older.

The largest proportion of ED visits were covered by private insurance, with Blue Cross comprising the largest proportion overall. (Figure 1) Medicaid managed care, primarily Rite Care, was the second leading payer, with 19.1% of visits. Expected source of payment among ED visits was distributed differently than among hospital inpatients. For example, Medicare, which accounts for the largest proportion of inpatient admissions (45.4% in 2004), accounted for only 15.2% of ED visits. Additionally, 14.4% of ED visits were uninsured, compared to only 3.1% of inpatient stays and 4.9% of inpatients admitted through the emergency room.

Insurance status varied by age group and sex. ED visits for those ages 15-44 accounted for the greatest proportion of visits by far, with 48.3% of ED visits among the insured and over three-fourths (76.1%) of the uninsured visits. For both males and females, the youngest (ages 0-14) and oldest (ages 65+) age groups had the lowest proportion of uninsured visits. The differ-

Table 1.
Number of Emergency Department Visits by Hospital,
Rhode Island 2005

Hospital	Number of ED Visits	Percent of Total
Rhode Island	99,741	26.1%
Kent County	47,060	12.3%
Landmark	41,191	10.8%
Miriam	30,576	8.0%
South County	27,674	7.2%
Newport	25,937	6.8%
Saint Joseph	25,086	6.6%
Westerly	22,616	5.9%
Memorial	22,254	5.8%
Women and Infants	21,981	5.8%
Roger Williams	16,193	4.2%
Butler	1,847	0.5%
Bradley	87	0.0%
Total	382,243	100.0%

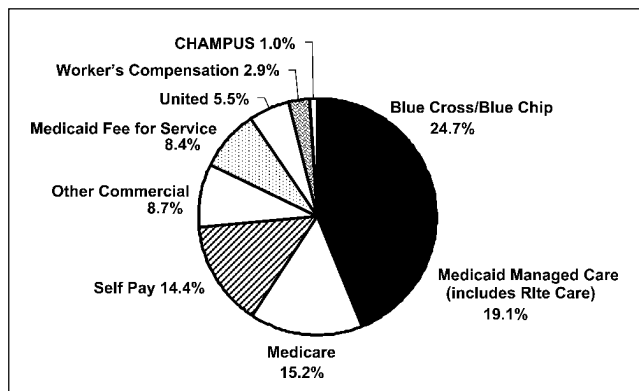


Figure 1. Emergency department utilization as percent of all visits, by expected source of payment, Rhode Island, 2005

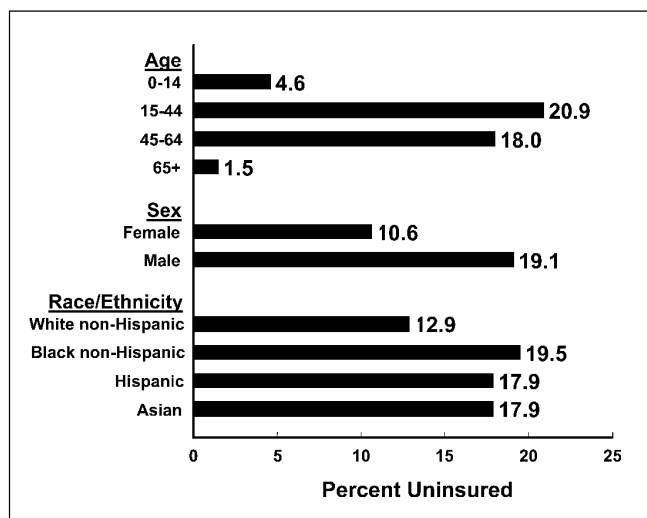


Figure 2. Emergency department visits as percent uninsured, by age group, sex and select race/ethnicity groups, Rhode Island, 2005

ence in insurance status by sex is greatest for those ages 15-44. Overall, one in five visits in this age group are uninsured, but 30.1% of males are uninsured compared to 14.4% of females. (Figure 2) Overall, 19.1% of visits by males were uninsured, compared to only 10.6% of visits by females. (Figure 2)

Among ED visits, insurance status also varied by race and ethnicity. Seventy-four percent of ED visits were by White Non-Hispanic persons. The next largest race/ethnic group was Black Non-Hispanic, accounting for 9.1% of all ED visits. Persons identified as White non-Hispanic had the lowest proportion of visits without insurance (12.9%). (Figure 2) The proportion without insurance was much higher for minority groups—19.5% for Black non-Hispanic, 17.9% for Hispanic, and 17.9% for Asian.

Injury and poisoning was the leading first-listed diagnosis category overall for both the insured and uninsured, comprising almost a third (29.9%) of all ED visits. (Figure 3) The second leading diagnosis category was symptoms, signs, and ill-defined conditions, which accounted for 18.5% of all visits, followed by diseases of the respiratory system (9.0%). The most notable differences by insurance status were for mental disorders and for complications

of pregnancy, childbirth and the puerperium. Mental disorders was the third leading category among the uninsured ED visits (9.9%), but ranked only seventh for those insured (4.8%). Complications of pregnancy, childbirth, and the puerperium accounted for 4.9% of insured ED visits, but only 1.4% of uninsured visits.

DISCUSSION

Emergency department data are a rich data source for examining trends among the uninsured and disease conditions specific to outpatient settings. Utilization patterns in the ED differ from patterns seen for inpatients with regards to patient characteristics, health insurance and disease conditions.

A significant proportion of ED visits by both genders are uninsured. Not surprisingly, lack of insurance is highest for males age 15-44, where the uninsured represent almost one-third of visits. This disparity in insurance status by age and sex highlights the need for improving insurance coverage among this group.

Few differences in disease conditions between the insured and uninsured populations were identified based on broad diagnosis categories. However, the proportion of persons seeking care in hospital EDs who are uninsured is much higher than the proportion uninsured among inpatients, including those admitted through the ED, giving rise to the question of whether the uninsured may be using the ED largely for non-emergent conditions. More detailed analyses of the diagnostic information in the ED database are planned to investigate the use of emergency departments for such conditions, with particular regard to insurance status. In the longer term, linking ED data to aggregate population-based survey data on access to primary care and usual sources of care will be pursued, with the expectation that the additional information may help to explain the utilization patterns identified from the ED database.

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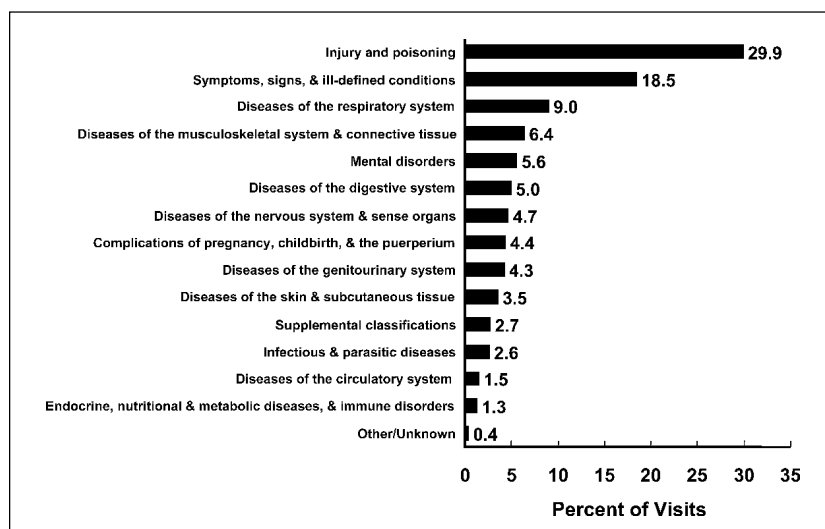
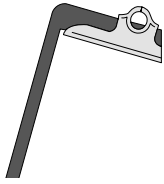


Figure 3. Emergency department utilization as percent of visits, by first-listed diagnosis category, Rhode Island, 2005

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Rhode Island Public Health Training Program: Market Survey Findings

Karine Tolentino, MPH, and Robert Marshall, PhD

IN MARCH 2001 THE ROBERT WOOD JOHNSON FOUNDATION asked the Institute of Medicine to develop recommendations for how public health education, training, and research could be strengthened to meet the future needs to improve population-level health. Because of the ecological approach to public health and the numerous institutions and agencies that play important roles, the IOM report, *Who will keep the public healthy*, (2002), addresses its recommendations widely to a variety of public health-related sectors. It seems a reasonable step to extend that framework to professionals in the many community-based organizations that carry out critical roles in state and local public health activities.

Brown University Program in Public Health and the Rhode Island Department of Health (HEALTH) received an educational grant from Pfizer, Inc. in December 2005 to develop a Public Health Training Program (PHTP) for professional staff in the business, government and not-for-profit sectors of Rhode Island. To assure project success, it is important to minimize barriers to participation among the target audiences by identifying and addressing concerns; by determining their high priority training topics; and by noting preferences for scheduling, training "credit" and cost. One of the first steps in this process involved conducting a market survey and using those results to inform the design and implementation of the PHTP activities. This paper summarizes the key findings of the survey.

BACKGROUND

Only the Brown University Master in Public Health (MPH) offers accredited, graduate public health training in Rhode Island. Yet, due to various reasons, such as workday class schedules, this program may not meet the needs of many full-time employed health-related professionals in Rhode Island. Both Brown and HEALTH believe that public health training can lead professionals and other community leaders to a better understanding of the dynamics of population-based health issues in the state.

The PHTP is a collaborative project established to improve collaboration and promote training experiences in public health topics for personnel in the state and local government, business, non-profit community organizations and healthcare. As one of the first tasks during the planning phase, the PHTP surveyed key informants, including executives and administrators in each of the target sectors in order to determine the specific interest of the intended audience.

METHODS

The investigators selected 46 executives and administrators in major Rhode Island community organizations during February-March 2006. These included business executives (Vice President-level) in banking, insurance and manufactur-

ing firms, Executive Directors of community human service agencies (including those serving minority populations), senior-level hospital administrators (Presidents, Department Directors, state and municipal agency officials (Division Directors, Human Resource Executives) and representatives of professional organizations (Presidents, Executive Directors, etc.). The source information for key informants came from the Public Health Directory—the Department of Health's electronic data base for routine and emergency communication with key contacts in minority agencies, hospitals, businesses involved in the worksite wellness program, members of licensed health professional boards, occupational safety groups and municipal officials (water, sewage, public works), in addition to others. The Directory contains 160,000 contacts (including all licensed health professionals) in 200 categories. Department of Health program staff recommended prospective respondents from within categories of interest to ensure broad participation at a high level across all the target organizations. Investigators mailed personal requests to selected respondents and followed up by telephone.

While some of these organizations and professions, especially the health-related ones, may be required to offer or undergo certain public health related training, such as universal precautions, food safety or hospital incident command, there is no requirement, *per se*, for training in broad-based public health subjects, such as epidemiology or economics of health care, which are addressed here.

The data collection instrument included four main sections: the responding executive's own personal interest in public health training ("self assessment"); the respondent's assessment of whether or not the organization's policies and practices would encourage participation by employees in public health training ("organizational assessment"); an assessment of the perceived interest of professional employees within the organization, based on the executives' own experience ("employees assessment"); and, finally, general information about the organization and its workforce. Investigators used Epi-Info (version 3.3.2) and STATA 8.0 for data analysis.

RESULTS

A total of 43 executives and administrators responded to requests for interviews (completion rate of 93%). Overall, the majority of participants (67.4%, $n = 29$) had a graduate degree while (27.9%, $n = 12$) had an undergraduate degree. Organizations' size ranged from less than 50 to more than 500 employees.

Table 1 shows the level of interest in public health training, preferences for training scheduled, type of credit and the willingness to pay for training—according to the self, organizational and employee assessments. Respondents said that they,

Table 1: Level of interest in public health training, preferences for training schedule, type of training credit and the willingness to pay for training, based on respondents' self-assessment, their assessment of organizational policies and practices and their assessment of other profession employees' interests and preferences. (Percentages in parentheses.)

Total n = 43*	Self-Assessment	Organizational Assessment	Employees Assessment
Interest in public health training			
Yes	36 (83.7)	41 (95.4)	
Moderate interest			30 (69.8)
High interest			7 (16.3)
Very high interest			6 (14.0)
Preferred schedule of training			
Workday	20 (55.6)	33 (80.5)	---
Weekday evening	8 (22.2)	3 (7.3)	---
Multi-day	4(11.0)	1 (2.4)	---
Preferred type of credit for training			
First Choice			
No official credit necessary	10 (27.8)	1 (2.4)	3 (7.0)
CME/CEU	11 (30.6)	21 (51.2)	21 (48.8)
Graduate credit	3 (8.3)	7 (17.1)	6 (14.0)
Certificate/letter	8 (22.2)	8 (19.5)	7 (16.3)
Second choice			
Undergraduate credit	1 (2.8)	10 (24.4)	8 (18.6)
Willingness to pay for training			
< \$100	26 (72.3)	17 (41.5)	37 (86.1)
\$100-\$500	9 (25.0)	7 (17.1)	5 (11.6)
> \$500	1 (2.8)	6 (14.6)	---
Entire cost of training	---	9 (22.0)	---

* Total N may not add up due to skip patterns

individually, their organizations and their professional employees are interested in public health training. Preferred topics ranged widely from health economics to environmental health, obesity and emergency preparedness. When asked about their own personal interest, 83.7% of respondents valued public health training. Nearly all of the respondents (95.4%) indicated that their organization would promote or encourage participation, by employees, in public health training. Most respondents (69.8%) thought that professional employees within their organization have a moderate interest in public health training, while 16.3 % and 14.0% reported high and very high interest, respectively.

Workday is the preferred schedule of training for both respondents (55.6%) and organizations (80.5%). Only a few preferred multi-day trainings. Approximately 30% of respondents prefer **continuing education** (CME/CEU) credits, while 27.8% are interested in public health training not requiring certification. According to respondents, continuing education is the preferred type of credit for both organizations (51.2%) and professional employees (48.8%), with some preference for graduate and undergraduate credit. Only about 1 in 5 wanted certificates or letters of completion.

The largest percentages of individual respondents (72.3%), organizations (41.5%) and professional employees (86.1%) are willing to pay only \$100 or less for training. This finding is consistent with responses from 40 participants in other PHTP

trainings held during August 2006 concerning access to RI public health data. Ninety percent of respondents (mostly from community-based organizations) were only willing to pay up to \$20 for course registration fees. In this study about 40% of companies (mostly larger ones) have tuition assistance available. In an average year, 44% of organizations devote less than \$10,000 for professional development or continuing education training.

DISCUSSION

Results indicate a high level but diverse pattern of interest in public health training topics among professional employees in the government, business and not-for-profit sectors. Most key informants identified access to continuing education as an important incentive for their professional employees and the organization for which they work. There is a strong interest in making undergraduate and graduate public health training more available to professionals and other employees. Executives expressed strong personal interest

in public health training mostly to enhance their knowledge and work performance, not necessarily requiring incentives or certification.

Based on these preliminary findings, we conclude that there are two key markets for public health training in Rhode Island: 1) undergraduate and graduate public health training for employees of business, government, community-based organizations and 2) continuing education for public-health related professionals. Over the next few months, the PHTP plans to explore these various markets further and collaborate with partner organizations to promote opportunities for public health training throughout the state.

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Images In Medicine

Colonic Intussusception in an Adult

John A. Pezzullo, MD

A 37 year-old man presented to the emergency department with intermittent colicky mid-abdominal pain, episodes of nausea and vomiting, and bright red blood per rectum. Laboratory analysis was unrevealing, and the patient was normotensive and afebrile. On physical examination, there was tenderness to palpation in the mid abdomen and the left upper quadrant without rebound. The abdomen was otherwise soft and non-tender. Past medical history was benign, and there was no significant family history. A **computed tomographic (CT)** study of the abdomen revealed a 5 cm mid-colonic mass with intussusception of the hepatic flexure suspicious for primary bowel carcinoma. The remainder of the CT examination was negative. The patient was admitted to the surgical service for exploratory laparotomy, which confirmed the colo-colonic intussusception due to a large intraluminal and partially intramural mass. A right hemicolectomy was performed. On histology, the mass was revealed to be a large benign colonic fibroma with mild intramural invasion.

Adult intussusception is rare, accounting for 5% of all intussusceptions, and nearly equally involves the small bowel and colon. In contradistinction to the pediatric population, 90% of adult cases have a demonstrable cause, and 65% of these cases are due to neoplasia. Malignant tumors are more common than benign tumors in the colon; the reverse is true in the small bowel. Isolated colonic fibromatosis in the adult is extraordinarily rare with less than 15 case reports in the medical literature. Extracolonic and enteric fibromatosis may be seen in cases of Gardner's Syndrome, which was not present in this case.

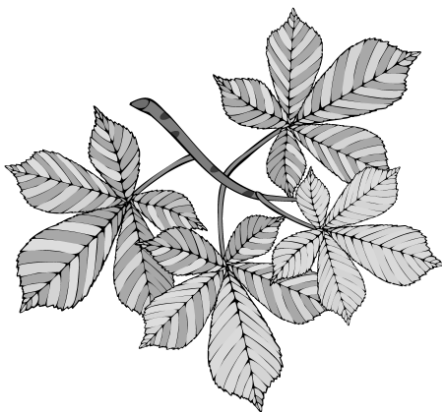
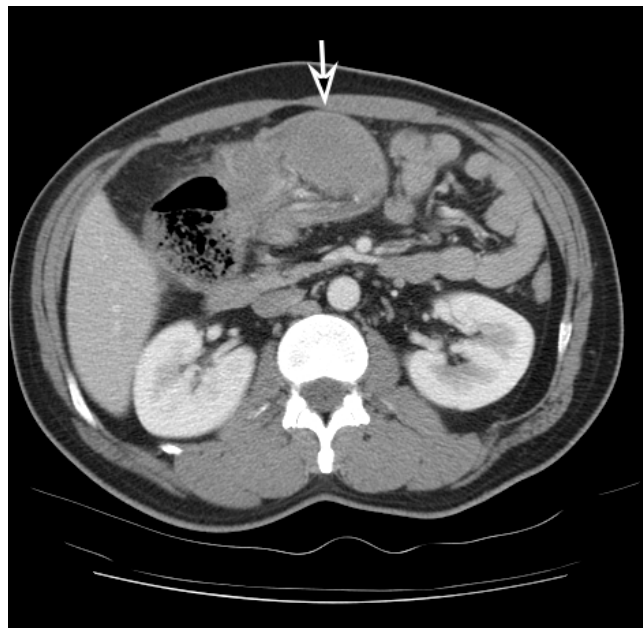
John A. Pezzullo, MD, is Assistant Professor of Diagnostic Imaging, Brown Medical School.

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Choi SH, Han JK, et al. Intussusception in adults. *AJR* 2004; 183: 691-8.

CORRESPONDENCE:

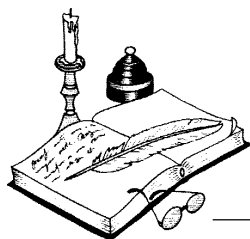
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Physician's Lexicon

The Vocabulary of Disaster

MEDICINE, IN ITS INFINITE FLEXIBILITY, contends with small problems, medium-sized problems and even crises. The lexicons of disaster, however, are rarely unique to the profession. Physicians and lay folks alike tend to use the same words when confronted with overwhelming calamities.

The word, disaster, for example, is a descendant of the Italian, *disastrato*, meaning from a star but interpreted as meaning born under an ill-fated star. The Italian word, in turn, is derived from the Latin, *astrum*, meaning star; and the prefix, *dis-*, means deprived of or something negative.

Crisis is from a Greek word meaning a putting apart or sometimes a judgment. The Latin, *criticus*, means to understand or to judge. In medicine, the word has come to mean an abrupt change in the progress of an acute disease and thus we have a malarial crisis, an Addisonian crisis, a febrile crisis and, of course, an identity crisis.

Catastrophe is derived from a Greek word meaning a twisting downward or an overturning. The prefix, *cata-*, is Greek signifying a downward or disintegrating quality as in words such as catabolism, cataclysm, catalyst, catatonia, cataract [a waterfall, and later, a waterfall-like opacity descending over the human ocular lens], catamenia and even catalog [a breakdown of many words.] The root, *strophe*, means a twisting or turning, as in words such as apostrophe, Dystrophy, on the other hand, is from a Greek root, *trophe*, meaning growth.

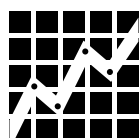
Pestilence is derived from the Latin, *pestis*, meaning plague-like. The psalmist wrote: "Thou shall not be afraid for the terror by night; nor for the arrow that flieth by day; nor for the pestilence that walketh in darkness." The word, pest, has come to mean an annoyance, a bane, even a scourge.

Plague comes indirectly from the Latin, *plaga*, meaning to strike or to wound. Derivative English words include apoplexy, paraplegia and complain.

Influenza is from the Latin, *influentia*, meaning the capacity to affect other things by intangible means; and inferentially, it refers to the ability of the stars to control human destiny. The Italian phrase, *influenza di freddo*, meaning of the cold, is the origin of the English name given to the respiratory infection.

And finally, the word, apocalypse. The word is derived from the Greek meaning to reveal or to uncover as it is used in the final, apocalyptic book of the New Testament, *The Revelation*. The Greek root, *calypso*, means to cover, to hide. In Greek mythology, Calypso, the sea nymph, was daughter of Atlas who lived on the island of Ogygia. It was she who captured Odysseus and hid him as prisoner of love for seven years.

— STANLEY M. ARONSON, MD



RHODE ISLAND DEPARTMENT OF HEALTH
DAVID GIFFORD, MD, MPH
DIRECTOR OF HEALTH

VITAL STATISTICS

EDITED BY COLLEEN FONTANA, STATE REGISTRAR

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

Underlying Cause of Death	Reporting Period			
	December 2005	12 Months Ending with December 2005		
	Number (a)	Number (a)	Rates (b)	YPLL (c)
Diseases of the Heart	285	2,971	277.7	4603.0
Malignant Neoplasms	205	2,324	217.3	6,206.5**
Cerebrovascular Diseases	38	482	45.1	780.0
Injuries (Accidents/Suicide/Homicide)	45	433	40.5	6,212.0
COPD	32	535	50.0	482.5

Vital Events	Reporting Period		
	June 2006	12 Months Ending with June 2006	
	Number	Number	Rates
Live Births	1,116	13,145	12.3*
Deaths	736	9,708	9.1*
Infant Deaths	(6)	(99)	7.5#
Neonatal Deaths	(4)	(81)	6.2#
Marriages	776	7,155	6.7*
Divorces	225	3,141	2.9*
Induced Terminations	434	4,827	367.2#
Spontaneous Fetal Deaths	43	1,027	78.1#
Under 20 weeks gestation	(41)	(962)	73.2#
20+ weeks gestation	(2)	(65)	4.9#

(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 1,069,725

(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.

* Rates per 1,000 estimated population

Rates per 1,000 live births

** Excludes 1 death of unknown age



MEDICAL MALPRACTICE TOPICS

INFORMATION FOR RHODE ISLAND PHYSICIANS FROM BABCOCK & HELLIWELL

Vicarious Liability The Risks of Working with Others

John Tickner, CPCU, President, Babcock & Helliwell

Medical malpractice insurance policies normally include coverage for "vicarious liability," which protects you if you are sued for the wrongdoings of your staff. In addition, under a form of vicarious liability called "joint and several liability," you could be held liable for the medical decisions and acts of a partner, even if you were never personally involved in the patient's treatment.

Even with insurance protection, no doctor wants to be involved in a malpractice claim. It can disrupt the practice, cause personal stress, and—if successful—damage your reputation. You can reduce the vicarious liability risk presented by your staff through careful hiring and with ongoing training and education. While you cannot eliminate vicarious liability altogether where a formal partnership or group exists, one way to reduce the risk is to require that all physicians in the group carry the same limits of liability. It is also a good idea to have coverage with the same professional liability carrier, since this provides control of the direction and quality of defense where there are competing and even conflicting interests in the case.

There is another type of vicarious liability that you may not know about. It is common for solo practices and medical groups to decrease their overhead expenses by making space available in the office for another physician. However, you or the group could be found liable for any malpractice on the part of an independent physician if it can be shown that a patient reasonably believed that this physician was a member of your practice. Legally, this is called an "ostensible" (apparent or perceived) partnership.

To reduce your risk of being brought into a suit for the malpractice of an independent physician sharing office space, carefully consider the potential consequences of practicing alongside a doctor whose risk exposure you may ultimately be forced to share. Though you might be totally innocent of any negligence, a plaintiff's attorney will try to show that at

least part of the alleged harm was the result of your acts or omissions.

Where such an arrangement makes sense, look at your practice setup from your patients' perspective. Could a patient perceive that you are practicing in a partnership or corporate setting? Keep things separate to clarify the true situation for your patients. There should be separate signs, billing systems, telephone numbers, business cards, and stationery. If you use the same waiting room, post a notice stating that you're not partners and not responsible for each other's care. Include the same notice on office forms. Avoid seeing each other's patients on a regular basis, and create a formal billing arrangement for overhead expenses—including office staff.

Perhaps the best way to avoid vicarious liability is to set up the practice as a professional corporation. That way, the PC would be held liable for the negligence of an individual physician employee. Another option is to form a limited liability partnership or corporation under which each doctor-partner is personally liable only for his own negligent acts, or for those by others under his direct control or responsibility. However, there are serious tax, insurance, and other issues related to both PCs and LLPs. It is important to discuss these options with your accountant, attorney, and insurance agent.

A final note

On behalf of the staff of Babcock & Helliwell, I want to wish you and your staff a happy holiday season and a prosperous new year.

John Tickner, CPCU, is president of Babcock & Helliwell, a privately held independent insurance agency established in 1892 that provides professional insurance-related services of all kinds. Babcock & Helliwell is an agency for ProMutual Group, New England's largest medical malpractice insurance provider and the second largest provider in Rhode Island.

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THE RHODE ISLAND MEDICAL JOURNAL

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Issued Monthly under the direction of the Publications Committee

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NINETY YEARS AGO, DECEMBER 1916

An Editorial, "The AMA Organizer in Rhode Island," reported that Dr. L.P. Van Dusen, the "official organizer" of the AMA, had spent the past six weeks calling on individual physicians, urging them to join.

A second Editorial, "Board of Health," commended the State Board of Health for: "...the efficiency and sanity of their attitude towards the epidemic of infantile paralysis which has struck terror to hearts of the parents of children throughout the areas afflicted. The sensible investigation of ...visitors to the state and their subsequent observation at their point of demarcation is in pleasing contrast to the rigid and therefore inefficient quarantine and uncertain control as instituted in neighboring states." The Editorial urged Rhode Island to hire a "trained sanitarian of the type exemplified by Gorgas of the Panama Canal."

A third Editorial, "Think it Over," urged members to consider merging the Providence and Pawtucket Medical Societies.

A fourth editorial, "Medical Meetings," recounted the last meeting, held at the School for the Feeble-Minded in Exeter, with an *ex tempore* talk by Dr. Ladd.

FIFTY YEARS AGO, DECEMBER 1956

Laurence A. Senseman, MD, discussed "Tranquilizing Drugs – Uses and Abuses for the Nervous Patient;" e.g., chlorprimazine, rauwolfia, serpasil, reserpine, azacyclonal, ritalin.

John E. Verna, MA, the Charles V. Chapin Fellow for Contagious Diseases at the Charles V. Chapin Hospital, contributed "Estimation of VI Antigen by a Direct Hemagglutination Test." He described the new test as "more sensitive for antigen detection than conventional hemagglutination."

Warren W. Francis, MD, and Robert R. Baldrige, MD, in "Arterial Grafting: Report of an Interesting Case," described the case of a 52 year-old woman admitted to Rhode Island Hospital "with a one year history of increasing bilateral claudication," primarily in the left leg. She was not diabetic. The first graft was found to be "occluded with thrombus." Another arterial hemograft shunt was inserted successfully.

An Editorial, "Doctor Draft," reported that the draft, which had been on the statutes for 6 years, would end in June. "...it will expire if the Congress amends the regular Selective Service laws to permit the service to make special calls for persons whose skills are needed by the armed forces. Such a special call would encompass physicians, but would not be limited to them. Such an amendment is now in process of drafting, but with the recent European and Near East strife a movement might get underway early in 1957 to continue the draft..."

TWENTY-FIVE YEARS AGO, DECEMBER 1981

The Journal printed "Reversible Neuropsychiatric Disease Related to Folate Deficiency," the first of a series of position papers in Neurology which will appear in the Medical Journal, produced by the Division of Neurology, Roger Williams General Hospital, and the Brown University Program in Medicine. The article concluded: "It is essential that folate levels be measured in the patient with diffuse cerebral dysfunction."

Edward A. Iannuccilli, MD, FACP, and Peter P. Yu, MD, discussed the 5 reported cases in "Adult Fibropolycystic Liver Disease and Symptomatic Portal Hypertension."

Frederick S. Fish, MD, and Francis H. Scola, MD, contributed "The Breast Cancer Detection Demonstration Project at Rhode Island Hospital," The authors analyzed the results from 1973 to 1979: of 700 patients screened, 95 were found to have biopsy-proved breast cancer.

Donald C. Williams, from the Rhode Island Department of Health, contributed "Assessment of Physician Supplies in Rhode Island in light of GMENAC Report." The Graduate Medical Education National Advisory Committee report suggested that the state would need more family practitioners, fewer general surgeons.

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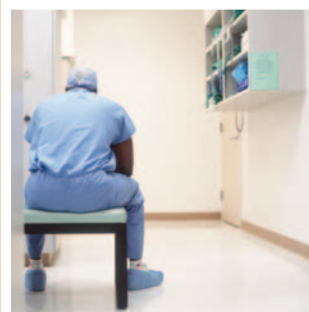
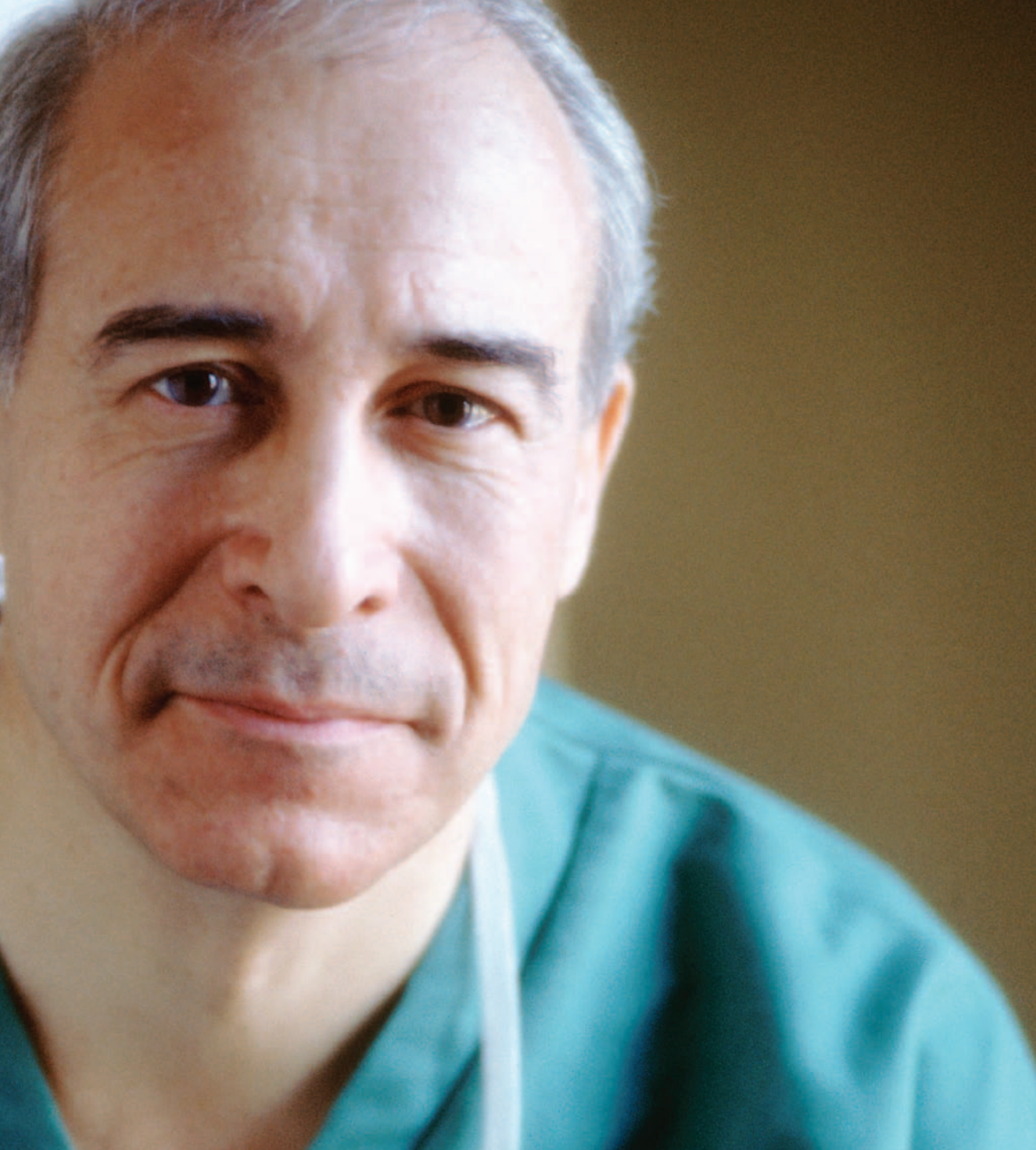
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