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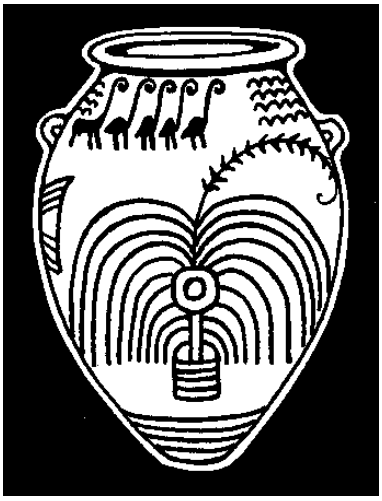
Commentaries

Inequity or Iniquity? Social Injustice and Medical Care



In their scholarly and illuminating book, *Social Injustice*, Levy and Sidel discuss the medical problems associated with "social injustice." One author makes the point that in the developed world two approaches to the delivery of health care have evolved. One is to consider health care a government obligation, while the other is to make the individual responsible for his/her own care. The underlying philosophy of the latter is that if one works hard enough things should take care of themselves.

Among all the developed countries, only the United States government fails to provide health care for its citizens, with the result that the rich in America have the best care in the world and the poor reap the harvest of their own problems.

As our country continues to divide into two increasingly disparate populations, the rich and the poor, one sees a parallel discrepancy taking place in health status. Our "average" health indices for the population are fair, not good, and when compared to average annual income, are rather poor. However, if one relates health to income for individuals rather than as averages, the picture is not only bleak, but getting bleaker.

Social Injustice is not an uplifting book, but neither is it an angry book. Its essays describes the health circumstances of various unfortunate groups: the poor, the displaced, the old, the uninsured, etc. The many facets of social injustice outlined in these essays are well known, and all have a powerful impact on physical and mental health. To me they seem a call to arms, requiring action of those in authority. But they do not seem to be a concern to our national leaders, other than, "how much will it cost for this incremental benefit," or the opposite, "how much can we save by reducing care without upsetting our constituencies?"

One of the most influential doctors in international public health is Paul Farmer, MD, a winner of a McArthur Genius Award, an infectious disease expert, a public health advocate and the subject of a popular book, *Mountains Beyond Mountains*, by Tracy Kidder. An important message I took home after hearing Dr. Farmer speak at Brown this year was that medical care, especially for the desperately poor, cannot be taken out of context. This is one of those obvious concepts that, while simple, cut to the heart of a problem. He described how he justified his financial requests to wealthy donors, be they individuals or corporations, for food and other sustenance items, pointing out that delivering medicine didn't make much sense if the recipients starved to death. Food, clothing, sanitation, etc. are necessary parts of health care. He presented a bundled care system that was not limited to paying the salaries of medical workers and funding clinics and medications. This is exactly the same point that underlies *Social Injustice*.

Gunnar Myrdal, the recipient of the 1974 Nobel prize in economics, lectured long ago that "people are sick because they are poor, and become poorer because they are sick", yet newspapers and other periodicals repeatedly describe, as if a new discovery, the close associations between illness, job loss, lack of health insurance, homelessness and recurrent generations of misery.

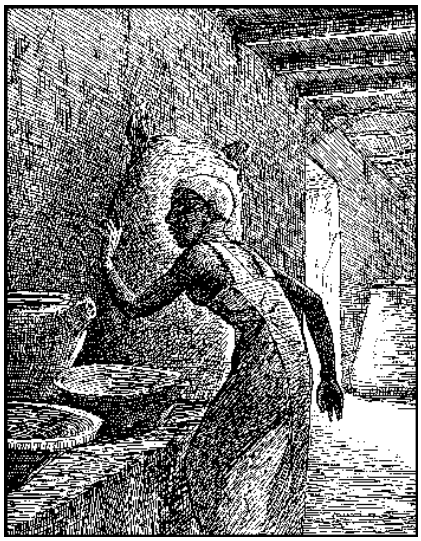
Louis Uchitelle has written about the connection between job loss and health in a book on the effects of lay-offs on American workers. He notes "There's a lot of mental health damage. The act of being laid off is such a blow to the self-esteem. Lay-offs are a national phenomenon, a societal problem—but the laid-off workers blame themselves."

We must acknowledge the size of the problem in order to state the obvious: poor nutrition must be remedied to fight tuberculosis; proper housing must be found for the homeless; affordable care must be provided for the elderly. Obsessive focus on short-term cost savings ensures that we fail to prevent, treat and cure as we shift the burden, at markedly increased cost to the future.

This issue of *Medicine & Health/Rhode Island*, and a sequel, cover territory similar to *Social Injustice*, focusing on health care in Rhode Island, the smallest state in the richest country in the history of the world. This is a small collection of papers, not a book, and is limited to health care, not all social injustice. It is a report on what is being done, what is not being done, and what needs to be done. The articles lead us to challenge the constraints imposed by a basic belief among those in power: that healthcare, not a constitutional right, is not and should not be a part of the American social contract.

Medical care is only one part of health care.

– Joseph H. Friedman, MD



Gregori Rasputin, AIDS and Victoria's Secret

St. Petersberg, Russia: The year 1904 was a troubling one for the Romanovs, who ruled Russia. The nation was caught up in a losing war with a newly emergent Japan. There was widespread economic inequity nationwide as well as unrest in the streets of Russia's major cities. And the royal family was without a male heir.

Tsarina Alexandra, Nicholas' wife, was about to give birth. The Peterhof Palace was awash in anxious expectation. The following note appears in Tsar Nicholas' diary for July 30, 1904: "An unforgettable great day for us, during which we were clearly visited by the grace of God. At 1:15 during the day Alix gave birth to a son, whom in prayer we have named Alexei."

The dynastic heir to the throne was apparently a healthy newborn. But by early September the royal joy turned to a profound grief as it became apparent that Tsarevitch Alexis was a victim of a hereditary bleeding disease. Many of Europe's royal families – in Russia, Spain and Germany – were related to each other, sharing a common grandmother in the recently deceased Queen Victoria of the United Kingdom [1819-1901]; and all of these families were touched by what historians have called the Royal Disease and physicians have named hemophilia.

Young Alexis matured although even negligible trauma caused extensive bleeding, especially into the joints such as the knee, resulting in excruciating pain, limited movement, and, eventually, joint deformities. By the time that Alexis was old enough to walk his activities became a constant source of anxiety for the family. Navy personnel were assigned to amuse him and thus curtail any form of athletics. His ailment was kept a secret and the general public caught only distant glimpses of him since the family rarely left the royal palaces.

Alexis' personal physician, Sergei Petrovich Fedorov knew that there was no meaningful treatment for this usually fatal disease. In despair, Alexis' parents resorted to prayer, amulets and nostrums of questionable merit.

In 1907 a charismatic monk from the depths of Siberia, Gregori Efimovitch Rasputin, visited the senior church official who was the Tsarina's personal confessor. Rasputin was introduced to the royal family and his magnetic charm and messianic fervor so captivated them that this marginally literate monk was given increasing authority in the affairs of Russia, including the personal counseling of the Tsarina and her ailing son. Rasputin believed that he, and only he, could stop the bleeding episodes in young Alexis. And, accordingly, the care of the royal heir was placed in his hands.

Rasputin had led a life of debauchery until his conversion in 1904 when he joined an obscure religious sect, the Khlysty, who taught that salvation could be achieved solely through repentance. Rasputin declared to those who would listen: "Only through me can you hope to be saved; and the manner of your salvation is thus: you must be united with me in soul and body. The virtue that goes out from me is the source of light, the destruction of sin."

Alexis' bleeding episodes continued despite Rasputin's claim that his willpower was sufficient to make the hemorrhages cease. Interference in the politics of the state finally caused a number of nobles to plan Rasputin's assassination. On December 15, 1916, he was poisoned with potassium cyanide and finally shot to death. The Romanov regime was overturned in the 1917 revolution; and in 1918, the tsar and his family, including 13 year-old Alexis, were shot to death.

Hemophilia is now shown to be caused by an abnormal gene on the X chromosome. Males have only one X-chromosome as part of their XY complement of genes while females have two X-chromosomes. If a male inherits the abnormal hemophilia gene, he will be a victim of this blood-clotting disease. If a female inherits the abnormal gene, she will not develop the disease [since she has another X chromosome to initiate the necessary blood-clotting mechanisms], but she will become a carrier of the disorder, imparting it to her male offspring; and, to making her female offspring carriers. Geneticists trace the trait that produced hemophilia in a number of European royal families to Queen Victoria. One son, Leopold, was gravely ill with hemophilia and died in early childhood. Two daughters, Beatrice and Alice, while healthy. were carriers of hemophilia; and they introduced the abnormal gene into the royal families of Germany and Spain. One of Alice's daughters Alexandra, Victoria's granddaughter, married Nicholas II; their son was the hemophiliac, Alexis.

Blood clotting [coagulation] is achieved through a complex cascade of biochemical and cellular elements. One of these chemical substances, factor VIII, is deficient in hemophiliacs, resulting in uncontrolled bleeding following negligible injury. Transfusion with normal blood, which carries factor VIII, may stop the bleeding temporarily. Scientists can extract factor VIII from large pools of human plasma, and the administration of concentrated factor VIII has become a life-saving intervention for hemophiliacs – but at a heavy price. Many hemophiliacs in the 1980s succumbed to AIDS or hepatitis because the HIV and hepatitis viruses had unknowingly contaminated the plasma pools used for the extraction of factor VIII. Since then factor VIII has been synthesized, thus obviating the hazard of contamination.

How long has hemophilia been known? Some two millennia ago, the Talmud tacitly recognized the hereditary nature of the ailment when it stated that circumcision of the newborn male was to be avoided if prior male siblings [or maternal cousins] had bled excessively as newborns.

And so this rare disease, affecting about one male child per 10,000 births, has wended its way through history, affecting the sons of both peasants and kings. The nature of the genetically determined deficit has been discovered in the last century and a safe, efficient additive now halts its hemorrhagic ravages. Uncontrolled hemophilia, along with Rasputin and the royal houses of Europe, is now confined to history books.

– Stanley M. Aronson, MD

Learning From Poor Outcomes in Today's Health Care

L. McTyeire Johnston, MD

> *"The past decade has witnessed major advances in health promotion and maintenance… In glaring contrast, increasing poverty and increasing costs of medical services have created an ever-growing population of underserved patients… Tragically, the major failure of the health system is untreated patients, not untreatable diseases."*
>
> – March 1993

Little has changed since the quote appeared in this journal in 1993. Some Rhode Islanders receive care that is, by all measures of access, quality, and patient satisfaction, superb. Others don't. The reasons for those failures are complex, the roots varied, and the solutions debated, but one thing is clear—gaps in care are growing.

What *has* changed is our understanding that successful care can be measured; those measurements are not encouraging. While we can measure the process of care (e.g., use of tracking tools for diabetes), we do not meet outcome goals (e.g., glycohemoglobin targets). We have evidence-based guidelines that work – many patients do not receive them. We understand system characteristics (e.g., from medical information management to appointment access) that, if implemented, improve our outcomes, but aside from billing operations our offices look just like they did a decade ago. All the guidelines, all the measurements, all the goals are for naught if we fail to deliver improved outcomes to our patients.

Successful outcomes for patients include access, quality, and patient satisfaction – how are we doing today? How can we do better tomorrow?

Access: Health Care for Some

Although by no means sufficient, health insurance is necessary for access to comprehensive care. This is *very* old news, yet:

- Only 65% of Americans are insured throughout the year. [1]
- In Rhode Island, 13.8% of adults are uninsured. [2]
- Over 40% of uninsured Rhode Island adults report being unable to see a doctor due to cost. [2]
- The working class is suffering the most rapid descent into the ranks of the uninsured. [3]
- In 2004, Rhode Island's hospitals provided 37% more (net, $21.5 million) in charity care than in the previous year. [4]
- Uninsured adults with chronic conditions are seven times more likely than insured counterparts to lack a usual source of health care. [5]

Avoiding the discussion of what system is necessary to deliver access to care, national policy leaders remain stuck on cost-shifting strategies, strategies that are problematic to providers and patients, protective of payers, and promote growth of the ranks of the un- and under-insured. For some reason, we accept that our society's need for comprehensive and quality health services will be delivered by the "market," thinking that such a Darwinian approach will deliver the perfect system and forgetting that only the economically fittest survive.

Of most concern: all our energy talking about costs diverts us from the *sine quo non* in healthcare: there is no health care without access.

Quality: Falling Short of Goals

The list of poor outcomes is long:

- Less than 60% of people, from 12 communities over 2 years, received recommended treatments. [6]
- Self-reported fair or poor health is twice as likely in uninsured compared with insured Rhode Islanders. [2]
- Local HEDIS results and national benchmarks document that less than 60% of adolescents receive preventive services.
- Almost half of uninsured adults with chronic conditions forego needed medical care or medications. [5]
- Patients too often turn to emergency rooms for non-emergency care, and in those settings receive care that is technically thorough, yet incomplete (the physician examines vital signs, but doesn't ask where—or whether—the patient works).
- Even higher income (>/+ $75,000/household) uninsured adults fall short of meeting cancer screening goals. [7]

The reasons for these disturbing performances are complex. Some failures are rooted in lack of understanding and acceptance of evidence-based guidelines. Others are rooted in inability to change practice patterns. Apathy is an barrier, driving lack of interest in change of practice patterns. One thing is certain: most energy for change is consumed by business, not service, demands.

Satisfaction: Who's the Real Customer?

Forward-thinking insurers are talking about "consumer-driven care." While some use the rhetoric to mask cost-shifting strategies, others truly embrace the concept of an informed patient making informed choices. We have learned that:

- Rigid appointment systems may present barriers, not opportunities, to care.
- There is untapped potential in improved provider-patient communications afforded by new technologies.
- Survey instruments can quantify patient satisfaction with clinician communication, office staff performance, and perceived quality of health care. These instruments are rarely a routine component of office operations.

Meantime, our practice structures have evolved to envision patient service in brief, episodic, one-on-on encounters between provider and patient. We live within rigid appointment systems where

low DNKA rates, not patient needs and expectations, are the goal. We successfully address our own lifestyle needs with larger groups, scripted office hours, and hospitalist services.

When we or our family are forced to become patients ourselves, we confront the barriers inherent in today's system of service. Perhaps we should be patients more often.

Learning from Today's Gaps

If good outcomes reflect good care, we must accept that poor outcomes reflect poor care. All the well-referenced guidelines and processes are only rhetoric if patients do not benefit. We have a health care system that falls far short of potential, a system of bimodal opportunities and outcomes. At best, our system tolerates poor outcomes; at worst, our system produces them. And we as providers increasingly view ourselves as powerless, along for the ride.

This and a subsequent issue of *Medicine & Health/Rhode Island* will attempt to bring focus, and to stimulate vision: how can the system move to better care?

- This month's issue will spotlight gaps institutionalized in our system: the impact of lack of health insurance, the huge complexities faced by safety net providers striving to bring quality care to disenfranchised Rhode Islanders, and the basic failure of our system's design and delivery to communicate with and serve the ever-changing demographics of Rhode Islanders.
- A subsequent issue will address learning, moving from gaps to improvements: when Rite Care started, what problems did it target for change? How can we address the depth and breadth of services needed to manage chronic illness? How can health care delivery go deeper than acute, chronic, and preventive care to address dental, social, and survival needs of Rhode Islanders? And finally, how can we as a profession and as a State, move towards better outcomes, and better care?

...all our energy talking about costs diverts us from the *sine quo non* in healthcare: there is no health care without access.

We have dedicated professionals, we have deep technology and resources, yet our patients face service gaps and poor outcomes. Too many patients lack access, quality treatment, providers they trust. As a profession, we do care. But perhaps our approach needs an attitude adjustment, in order that we push system leaders to focus on patients first. Hopefully, these two issues of *Medicine & Health/Rhode Island* will trigger improvements.

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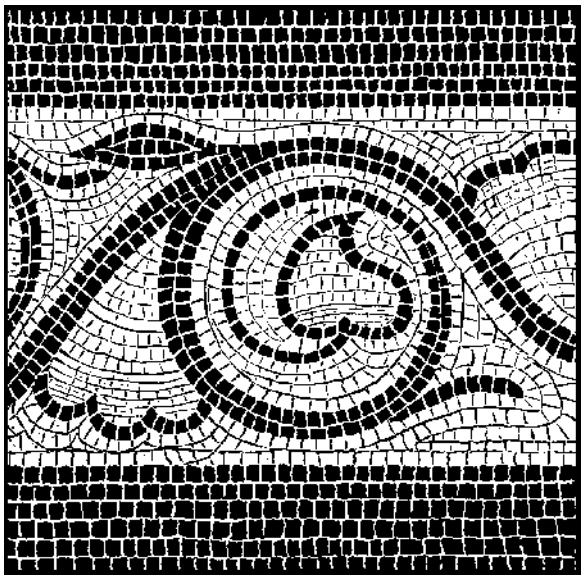

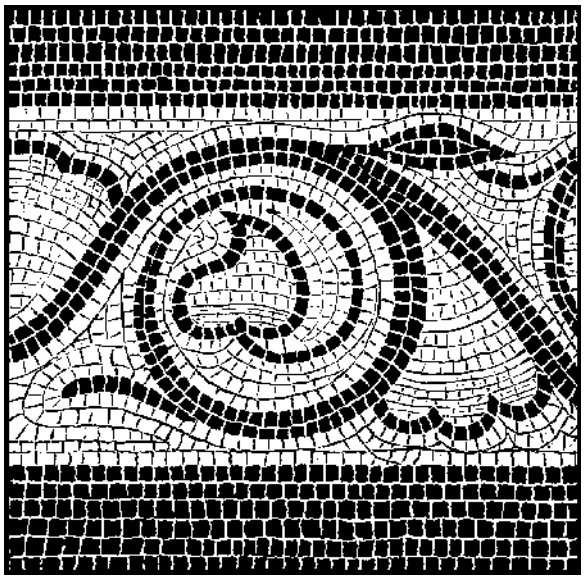

Health Outcomes and Health Insurance:
A Review of Recent Evidence

Patricia Nolan, MD, MPH

The high cost of health insurance dominates policy discussions. Only after that issue is resolved does the discussion turn to health outcomes. Can we use the evidence to focus on health outcomes rather than segmenting our policy debate by addressing costs and payments? Does lack of health insurance lead to poor health? If so, how can we assure that reforming health insurance will lead to better health outcomes? Assuring the health of all should be a very important public policy question for the United States and for Rhode Island. Solutions should drive decision-making about improving health outcomes through public and private investments in health care and health insurance. If we know that lack of health insurance leads to poor health, our policies and investments should be based on that knowledge.

Wise policy decisions are based on the best available answers to these questions. Each time the state or the nation makes budget decisions about health insurance coverage for the vulnerable, we should be explicitly examining the impact on the health status of those affected. The same is true when we look at tax policies for businesses and individuals providing health insurance and at specific coverage mandates in the state's insurance laws.

What is the evidence? In the past decade a substantial body of evidence has been assembled to answer these questions. This paper reviews evidence about the relationships among health insurance coverage, access to medical care services, and health outcomes.

Methods

The literature was searched through PubMed, using as criteria health insurance and health outcomes, and was limited to work published in 2000 or later, in English, with abstracts. Particular attention was given to review articles concerning health and health insurance in the United States, but non-reviews were included if the abstract indicated that they addressed disparities in health outcomes or access to medical care services.

In addition, the Institute of Medicine's Committee on the Consequences of Uninsurance has issued a series of reports on health insurance in the United States. The second report in the series, *Care without Coverage: Too Little, Too Late*,[1] addresses the relationship of health insurance coverage to health outcomes, and its findings are included in the evidence presented here.

Information from the Rhode Island Department of Health web site was used for Rhode Island data. These data come from surveys conducted by the department, particularly the **Behavior Risk Factor Surveillance System (BRFSS)** and the 1999 Survey of Employers on Health Insurance Coverage.

Results

The Rhode Island Experience with Health Insurance Coverage

The Rhode Island Department of Health's 1999 Survey of Employers on Health Insurance Coverage[2] found that 79% of employers with 3 or more employees offered group health insurance. Of those employers, 98% paid some or all of the premium. Of the employers offering health insurance, 88 % offered family coverage options. In companies offering insurance, 77% of employees were eligible for coverage. Part-time employees were much less likely to be eligible (32%) than were full-time employees (92%). This study has not been repeated.

Data on the health insurance coverage of adults in Rhode Island are collected through the BRFSS, providing a consistent database for identifying trends. In 2004,[3]10% of adults aged 18 through 64 reported being uninsured for all or part of the year, compared with 11% in 1999. Males were more likely to be uninsured (13% in 2004) than females (7% in 2004). Sources included private, employer-based and public insurance programs, including Medicaid and Medicare. (Note that those over 65 years of age are likely to be insured through Medicare and are not included in the survey data.)

In an analysis of insurance coverage of Rhode Island adults aged 18 to 65 based on the 2001 RI Health Interview Survey and the 2003 US Census Bureau Current Population Survey, the RI Department of Human Services estimated[3] that coverage was declining. In the 2001 Health Interview Survey, 9.4% of adults reported lacking health insurance; in the 2003 Current Population Survey, 14.1% reported lacking it.

Using BRFSS data (2004), the RI Health Department and the RI Department of Human Services found that uninsured adults reported poorer general health status and lower use of screening for breast cancer, cervical cancer, colon cancer, and prostate cancer than insured adults.

Health Insurance and Health Status

Jack Hadley's literature review[5] examined:

1. The relationship between health insurance status and the outcomes of specific diseases or conditions,
2. The relationship between medical care use and mortality, and
3. The relationship between health insurance status and general mortality, morbidity and/or health status.

I have used his framework to summarize the findings from the evidence set in this paper. Hadley's standard for conclusions on these relationships is the weight of the evidence. He assessed the quality of execution, the methods used (controlled trials, natural experiments, time series, etc.), the magnitude of effects, and the consistency of the direction of effects. He included a table displaying the features and findings of the reviewed articles.

Health Insurance Status and Outcomes of Specific Diseases and Conditions

The weight of the evidence relating health insurance status and disease outcomes is strong and consistent. For specific conditions, particularly hyperten-

sion and heart attacks, cancer, trauma, ruptured appendix, diabetes, and pregnancy, being uninsured or becoming uninsured results in worse outcomes. [5] These findings are consistent and of significant magnitude, even though being uninsured is measured at one point in time and disease outcomes are measured over several years. (Table 1)

The Institute of Medicine Committee on the Consequences of Uninsurance (2002) reached similar conclusions from its literature review and the shared experiences of its members. They found that adults in late middle age (45 to 64 years of age) and adults with low incomes are susceptible to deteriorating health if they lack or lose health insurance. Short-term, there is evidence of worsening of high blood pressure and of the ability to walk or climb stairs. Longer term, those with heart attacks, cancer, trauma, and HIV infection had a 25% higher risk of dying if they lacked health insurance.

Access to prevention and early detection services is compromised by not having health insurance. Bigby and Holmes[6] noted that women increase their use of mammography when they become eligible for Medicare. Women without insurance and women on Medicaid have more advanced disease at first diagnosis of breast cancer and have a lower survival rate than women with private insurance. (For a low-income woman not otherwise eligible for Medicaid, a diagnosis of breast cancer will make her eligible.)

Hwang et al [7] found that people with multiple chronic health conditions had higher out-of-pocket costs, whether or not insured. They were vulnerable to losing access to medical care and preventive care if out-of-pocket costs increased.

Mayberry et al[8] found greater racial and ethnic disparities among the uninsured and Medicaid populations compared to privately insured groups. Among persons of color with diabetics and HIV, studies showed decreased access to needed care to be associated with lack of health insurance.

...having no health insurance reduces access to medical care and increases the risk of poor health outcomes.

Medical Care Use and Mortality

The evidence assembled by Hadley addressing the relationship between medical use and mortality is from older literature. In spite of differences in the studies, all but one, a cross-sectional study of cancer mortality rates in 1970, found that medical care use reduced mortality rates. Taken as a whole, although the magnitudes of effect vary among population subgroups and among mortality measures, the effect magnitudes fall in the range of a 1% to 2% decrease in mortality associated with a 10% increase in *per capita* medical care use.

An ample literature addresses the effect of health insurance status on access to medical services. Greenwald *et al.*[9]conducted a telephone survey of employed adult Latinos in California.:75% of employer-insured persons and 72% of Medi-Cal recipients had a definite place of care, while only 45% of uninsured persons did. Compared to 12% of the employer-insured and 39% of the Medi-Cal enrollees with a definite place of care, 51% of the uninsured had a public or community clinic as their definite place of care. Emergency departments were the definite place for care for 3.5% of the uninsured, 2.4% of Medi-Cal enrollees, and 1.8% of the privately insured Latinos. Critically important is the finding that 31% of the uninsured Latino respondents reported they could not get needed care because of costs, while 6% of employer-insured and 18% of Medi-Cal enrollees could not afford needed care.

Starfield and Shi[10] examined the access of children and their families to a consistent source of first-contact care providing person-focused care over time and coordination of additional care when needed (a medical home). They found that health care insurance in the US increases the likelihood of having a medical home but does not guarantee access to this important source of medical care for children.

Health Insurance Status and General Mortality, Morbidity and/or Health Status

The literature on the relationship between health insurance status and general mortality is less robust. Studies consistently point to increased age-specific mortality among the uninsured.[10] Mayberry et al.[8] also found that access to private insurance is a major predictor of successful pregnancy outcomes.

Taking into account the more robust evidence that access to medical care improves all-cause mortality outcomes and the strong evidence that having health insurance improves access to medical services, we can strengthen our confidence in the more limited evidence that not having health insurance leads to increased age-specific mortality. Furthermore, there is a substantial degree of qualitative consistency

Table 1. Health Insurance Status and Health Outcomes for Specific Conditions

Condition	Health Outcome	Strength of Evidence
Hypertension	Uncontrolled hypertension Increased mortality	Strong
Heart Attacks	Increased in-hospital mortality	Substantial
Cancer	Late-stage diagnosis	Strong
Trauma	Less treatment Higher mortality	Substantial
Ruptured Appendix	Increased risk of rupture	Strong
Diabetes	Uncontrolled blood glucose levels	Substantial
Pregnancy	Adverse outcomes for newborns	Strong

Sources: IOM report[1] and Hadley[5]

[1] *Care without Coverage: Too Little, Too Late.* The Institute of Medicine, 2002.
[5] Jack Hadley, Sicker and Poorer The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health Work, and Income. *Medical Care Research and Review*, 2003, v 60(2 supp):3S 75S.

Table 2: Per Capita Health Care Spending among Industrialized Nations, 2002

Nation	Per Capita Spending in PPP* $	Health Spending in % of GDP**
OECD[1] median	2,193	8.5
US	5,267	14.6
Switzerland (next highest)	3,446	11.2
Canada	2,931	9.6
Australia	2,504	9.1
UK	2,160	7.7

Source: Anderson[i]

* Purchasing Power Parity dollars
** Gross Domestic Product
Organization for Economic Cooperation and Development with thirty industrialized nation members
[i] Anderson GR *et al*. Health Spending in the United States and the Rest of the Industrialize World. Health Affairs. 2005, v 24(4):903-914.

across studies showing lack of health insurance has a detrimental effect on general mortality and on the outcomes of numerous diseases and health conditions.

Discussion

The policy debate about health care in the United States centers on insurance, focusing on costs and how to pay them rather than on health outcomes and how to achieve them. The high cost of health insurance is seen as a major impediment to insuring everyone, and, as this review of the literature shows, having no health insurance reduces access to medical care and increases the risk of poor health outcomes. In centering the debate on the *cost* of health insurance, rather than on the *cost-benefits* of health care, there is a risk of excessively segmenting the debate.

In the *American Journal of Bioethics*, [11] Richard Lamm notes,

> Government must look at the big picture, and weigh and decide access and benefits together, and then integrate health care with all those other necessary governmental functions… But by segmenting the governmental obligations… [we repeat] the error that has kept the pressure in the United States off of government to achieve universal coverage.

Clearly costs are important in our policy debate. Anderson[12] compared the *per capita* spending of industrialized nations in 2002 in "purchasing power parity dollars" and as a percent of gross domestic product. Expressed as purchasing power parity dollars, the US spent $5267 *per capita* on health care, while Switzerland spent $3446, Canada $2931, Australia $2504, and the median for the industrialized nations was $2193. (Table 2) Americans pay through a complex system in which evidence shows that lacking health insurance is a significant contributor to poor health outcomes. In advocating for health policy, we should be examining the impact on health outcomes that result from payment system policies.

...selecting patients based on coverage and benefit policies, runs counter to professional ethics...

Physicians encounter the issues of health insurance coverage in a variety of ways, ranging from the highly personal—"Will I be paid a reasonable fee for this service?"—to the highly professional – "How can I assure that this patient receives needed medical care?" Thus physicians cannot be disinterested in the outcome of the policy debate. Professional ethics require physicians to be fully aware of their complex interests. Solutions that benefit physicians may penalize patients. There are intense and competing pressures for limited resources, so that it is possible to fill a practice with "paying patients" and crowd out those with no insurance or other payment sources. As Moran[13] points out in his "revisionist history" of our health care dilemma, health care insurance has created demand for health care, priced at close to zero at the point of care, [that] is virtually unlimited.... In such a marketplace, lack of insurance is clearly a catastrophic problem, since many products and service that are available…bear prices that are very high relative to the income of a typical citizen.

The public view, that medical resources are infinite, compounds the physician's dilemma: 51% of the general public "refused to set any monetary limit…on what should be spent in an attempt to save a life."[14] In this environment, where prices are high, options are many, and resources for many patients are insufficient, physicians must "triage" patients. The medical profession "recognizes only urgency, need, efficacy and equality as appropriate principles for … 'clinical justice'."[15] Serving patients in a system focused on insurance costs, making medical decisions and selecting patients based on coverage and benefit policies, runs counter to professional ethics, and distracts from professional focus on the benefit of coverage to patient outcomes.

Conclusions

Review of the evidence on the relationship between insurance coverage and health outcomes demonstrates the following:

- Lack of health insurance drives poor health outcomes
- Health outcomes of the uninsured are substandard compared with outcomes of insured populations.
- In the current environment, we direct our efforts to work on insurance costs, and health needs run a poor second.
- The results are poor care and poor health for the uninsured.

Society expects physicians to exercise professional judgment in providing care even though they have conflicts of interest between personal and professional roles. The weight of the evidence is that having health insurance in the United States is associated with better access to

medical care. Lack of health insurance and loss of coverage are associated with poor health outcomes and higher rates of mortality and sickness. Public policies that promote access to coverage to achieve equitable health outcomes are supported by the weight of the literature-based evidence.

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Homelessness and Health

Ivan S. Wolfson, MD

Much has been written on the impact of homelessness on health status, especially the increased prevalence of chronic medical illness.[1] Our experience in Rhode Island reflects the national trends. Our patients face two groups of barriers: those that are universal, and those that are homeless-specific. The universal barriers confront any uninsured patient, but homelessness renders them more formidable. The homeless-specific barriers relate to problems of mental health, substance use disorders and homelessness itself.

Who are the homeless in Rhode Island?

In 2003-2004, over 6000 Rhode Islanders stayed at shelters. Of these, 25% were under the age of 13. Lack of income, housing costs, and domestic violence were the three main reasons people gave for seeking emergency shelter.[2]

The homeless are mostly uninsured. In a 2005 survey of 52 consecutive homeless patients at Crossroads, we found that 71% were uninsured. Of the 29% with insurance, over 85% were on **General Public Assistance (GPA)** Medical. This state-funded program offers limited benefits, compared to private insurance or Medicaid.

The homeless disproportionately suffer from mental illness and substance use disorders. In our survey, 81% of patients had a major mental illness and 69% had a substance-use disorder. Over 50% had co-occurring major mental illness and a substance-use disorder.

Providing services for homeless individuals

The universal needs of homeless individuals are fairly straightforward: accessing primary care, obtaining medication, labs and diagnostic testing, and referral.

Accessing Primary Care

At our clinic in downtown Providence, one primary care doctor sees patients only three half days per week (due to our limited grant funding). A volunteer nurse practitioner runs a women's clinic one half day per week. Three volunteer psychiatrists each contribute two sessions per month. A second nurse practitioner, newly hired. divides her 24 hours between triage, medication refills and primary care. This adds the equivalent of approximately 2 more half days per week. Because of our limited funding and limited ability to bill for our services, there is a huge unmet need for care that we cannot begin to fulfill. This translates into long waits for new appointments, and over-booked follow-up appointments. Overbooking leads to crowded waiting rooms; due to the high prevalence of psychiatric disorders, many of our patients find the long waits and overcrowding intolerable.

Labs/diagnostic tests

Over the ten years of our Health Care for the Homeless grant, we have arranged with a number of local institutions to provide free laboratory and diagnostic testing for our patients. Without this service (as well as our ability to provide medications), we would not have a primary care clinic. Imagine not being able to check a creatinine, A1c or lipids on a diabetic patient or a anticonvulsant level on a patient with a seizure disorder.

The barrier for our patients lies in the intake regimen for the free tests. Crossroads patients who need a diagnostic test, except blood tests, must apply for free care at the institution giving the service. That means meeting with a social worker, filling out forms and providing documents, not all of which are readily available. Most, but not all, patients get approved, but the process is a barrier.

Medications

For uninsured patients we use a combination of sample medications and indigent patient program medications.

This medication system still imposes barriers for our patients:

1. Most of our patients receive indigent patient program medications through pharmaceutical companies. While on-line applications have streamlined the process, we still employ a staff person (at 20 hours a week) to complete the paperwork and tracking.
2. Because we do not have a pharmacist, I, or another licensed provider, must check every bottle of medication before it is dispensed. All medications must be logged in as well as out. We must label each bottle and track lot numbers and expiration dates. Again, this is time-consuming.
3. Due to our patients' precarious social situations, we give only enough medication until the next appointment. And we make that next appointment sooner than one might in another setting. Medications get lost or stolen. Our usual follow-up time is four to eight weeks. The upshot is that our follow-up slots are filled quickly and we end up overbooking. In addition, any missed appointments (a frequent occurrence) result in patients either running out of medication or having to come in for a refill. If an appointment is not available, which is often the case, the patient must go though a triage process to receive his/her medication.
4. We often make prescribing decisions based on availability; e.g, we might switch ace-inhibitors every few months. We may be out of ramipril, which was working fine, but now have only quinapril. Or the dose is 10 mg, and we have only 2.5 mg tablets. Now we must dispense 240 tablets for two months. This gets to be burdensome for a patient on six different medications. Worse yet, if an antibiotic is not available, we may have to write a prescription, which the patient can take to one of the social service agencies that provides prescription assistance.

Referrals

At Crossroads, we rely mainly on the Lifespan system for referrals. The clinic system there is overwhelmed with referrals. Under a two-tiered system, uninsured and under-insured patients are

treated in the clinic system, while those with private insurance see the same doctor, but in a private office. For the homeless. this system leads to longer waits, crowded offices, rushed appointments, and more difficult telephone communication than in the private office.

Communication between specialty clinics and Crossroads is problematic. We cannot dictate a referral note (which in private practice might bring a formal consult note in return). We use the system of faxed, paper referrals set up for the community health centers, leading to inconsistent follow-up.

Rhode Island Hospital provides a great deal of high quality free service. Like any large hospital system, however, it can be difficult to negotiate for even the savviest patients. For the homeless, with their myriad mental health issues and feelings of being marginalized, this adds another barrier.

Behavioral Health Needs and Lack of Treatment Resources

The homeless disproportionately suffer from mental illness and/or substance use disorders. Traditionally, the mental health care system and the substance abuse treatment system have not only been separate, but at odds about philosophies of treatment, priorities and the use of medication. While this dichotomy is changing, the legacy of old divisions permeates both systems.

Access to Community Mental Health Services

The community mental health center system was created to take care of patients who might have been institutionalized in a different era, and those who cannot function in the community without significant support. Very few Crossroads' patients meet either criterion.

One burdensome issue is that of "engagement." If one is to receive services at a mental health center, one must engage, that is, keep appointments. Patients are generally discharged after a certain number of missed appointments, usually three. We all understand the financial challenges created by "no-shows." We also understand the critical role motivation plays in making and maintaining change.

For homeless persons, however, there are two problems related to "engagement" criteria. First, complex appointment-counting can lead to errors: more than a few patients have told me that a rescheduled appointment went into their record as a "no-show" and was counted against them as reason for discharge. Second, this system leaves little room for flexibility. This "engagement" rule should not to be applied to these patients, for whom the ability to keep appointments is one of those functions that they cannot manage without support. Ironically, this is where many of our homeless patients really do meet the mental health center criteria; and being discharged from mental health services due to lack of follow-through perpetuates problems.

Our patients suffer from major depression, post-traumatic stress disorder, panic disorder, generalized anxiety disorder.

Homelessness and behavioral health needs provoke an endless cycle: the inability to maintain housing is not only an economic issue but also reflects a deeper lack of "adult living skills;" i.e., the ability to pay bills on time, keep appointments, fill out bureaucratic forms. Similar to a patient with mild dementia who can function adequately while in familiar settings and routines, any disruption, such as the loss of a spouse or being hospitalized, brings rapid deterioration. While many of our patients get by when they have housing and a more structured environment, when they are thrown into the chaos of homelessness, they often lose any previous ability to multi-task.

Complexity of Behavioral Health Problems

Our patients suffer from major depression, post-traumatic stress disorder, panic disorder, generalized anxiety disorder, to name a few. Some have personality disorders. Many have psychotic symptoms. They are victims of domestic violence and sexual assault. They have been emotionally, physically and sexually abused (the percentage of women we see who have been sexually abused leaves one speechless). They have substance use disorders. Is it any wonder that they miss appointments, forget to take their medication, or fail to bring forms to the welfare office?

I remember being surprised when a patient told me that in the past month he had not applied for GPA (as we discussed), had not gone for fasting blood work, and did not let anyone know he had lost his medication. Instead, he had looked at two apartments. He told me, "I can only focus on one thing at a time." I did not see why all of these things could not have been done in a month. I came to realize that I need to assess my patient's priorities (housing, in this case) and not impose my own (medication compliance). The real lesson of that discussion was this: many homeless patients can do only one thing at a time.

The ability to track literally dozens of short, medium and long-term goals in our brains, constantly rearranging and re-prioritizing and acting accordingly, is something we take for granted. We learn these life-skills from our family, from school (to graduate high school requires a good bit of these skills), from holding a job and being in stable relationships. Our patients often lack these skills. Treatment often needs to proceed at a slower pace.

Our patients suffer disproportionately from substance use disorders. The difficulty accessing treatment, lack of adequate treatment, stigmatization of substance abusers by the public, marginalization by the medical community, and allocation of resources towards detoxification rather than treatment, are among the many, well-documented barriers our patients face. We are diligent about assessment of substance use. We address with patients the impact of substance use disorders on their health and their ability to obtain and maintain housing as well as the need for treatment concurrent with any other medical or behavioral health treatment they are receiving. We believe that a respectful, non-judgmental attitude towards substance use is the most effective.

Beyond being a primary care clinic treating the usual host of chronic conditions, inadequate community care renders us a *de facto* clinic for the treatment of mental health and substance use disorders. We would prefer that our patients receive behavioral health, substance abuse and co-occurring disorders treatment in a specialized center, with individual and group counseling and psychiatric services. But

these services are available in limited quantities. We offer counseling, as we are able. We prescribe psychiatric medications when indicated. And we try to link patients with other sources of treatment and support either with appropriate providers and/or community groups such as AA or NA.

Homelessness as a Risk Factor

The last major barrier is the most obvious. Simply put, "homelessness creates health problems: it also simultaneously makes health care difficult to obtain,"[3] The correlations between housing status and health are so strong and so clear, that adequate housing must be seen as a public health issue. Some health problems lead to homelessness, homeless leads to certain health problems and worse yet, homelessness complicates treatment of many illnesses.[4] Unfortunately, mental illness and substance use disorders suffer in all three of these scenarios. Also, those with mental illness or substance use disorders are more likely to have chronic medical conditions.[1]

Consider this illustrative case.

A homeless diabetic patient must: a) find refrigeration for insulin; b) adhere to a controlled, regular diet while eating at soup kitchens and shelters; c) cope with hypoglycemia without ready access to food, d) carry syringes while living on the street. One patient chose not to check his blood sugars or take insulin because he felt that if people knew he was diabetic he would be assaulted for his syringes. When he left the shelter to stay with friends periodically, his glucose control improved.

Medication compliance is another challenge for the homeless patient. Once-daily dosing is obviously best, but patients do fairly well with morning and bedtime dosing. Anything beyond that becomes problematic. The reasons go beyond mere forgetfulness, although this affects those with mental health and substance use disorders more than it might otherwise. Patients do not like to carry full bottles of multiple medications. Some patients choose to have their medications locked up the shelter for safekeeping. This can lead to missing doses if patients are not there at the right time. Incarceration, even overnight, can disrupt medication management. Medications in possession of a patient upon arrival are often not returned. This in part due to the fact that medication would be held at the prison in Cranston and patients may be released directly from court in Providence. They would then have to go back to Cranston to retrieve their medication.

The lack of respite care is another barrier. Most shelters close in the morning, evicting patients for the day. Anyone needing to keep a foot elevated, or to recover from gastroenteritis or influenza, will be hard pressed to find a place to lie down for the day. Interferon treatment for Hepatitis C, also with greater prevalence in this population, is difficult to sustain without a stable living situation, and is therefore often not offered.

...even with medical coverage, the homeless would still face barriers...

Where do we go from here?

The obvious answer is that we need universal health coverage. But even with medical coverage, the homeless would still face barriers described. Greater availability of mental health and substance abuse treatment is needed. But this treatment also needs to have the flexibility to meet the needs of those who do not fit into traditional treatment models.

The experience of many working with the homeless had been that getting these patients housed was often not a sustainable solution. Patients who were medically compromised, psychologically unstable or abusing drugs or alcohol, would be unable to maintain employment, quickly fall behind on rent and soon find themselves homeless again. Many felt that patients had to get "tuned-up" for housing: patients had to be stabilized before they should be offered housing. But stabilization while homeless is extremely difficult. The debate has moved forward to the "Housing First" movement. Put simply, becoming housed removes many of the barriers to adequate medical and mental health/substance abuse treatment. With improvement in these critical areas, many will be able to maintain housing and some will return to work. Programs must be supportive. By combining housing with health and social service supports, it has been possible to reduce costly ER and hospital usage, improve health outcomes and maintain housing.[1] This "supportive housing" approach was discussed recently in *Million–Dollar Murray* by Malcolm Gladwell in *The New Yorker.*[5]

Any positive impact we have made at Crossroads has been due to partnerships with city, state and federal government, with community organizations, with medical, mental health and substance abuse treatment centers, with local schools of pharmacy, nursing, and medicine as well as with many others. If any of the "solutions" I have suggested (universal health coverage, greater mental health and substance abuse treatment and expansion of supportive housing programs) are to occur at the levels needed, it will only be with more of these types of collaborations.

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The Rhode Island Free Clinic:
Access to Health Care for the Uninsured

Lisa Smolski, MPA

Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. Millions do not now have protection or security against the economic effects of sickness. And the time has now arrived for action to help them attain that opportunity and to help them get that protection.[1]

President Harry Truman's words are as relevant today as they were in 1948. Despite Medicare and Medicaid, which extended health insurance to the elderly, the disabled, and eligible people with low incomes, the United States has yet to achieve universal coverage.

Fewer and fewer people have health insurance. While health care spending in the United States has risen by 40% since 2000, health insurance premiums have grown by more than 60%.[3] At the same time, the **consumer price index (CPI)** has risen 9.7%. The numbers of workers who received medical insurance through their employer has dropped from nearly 70% in the late 1970s to approximately 50% today.

Rhode Island's rate of uninsured rose from 6 to 11% during the period 2000 to 2004,[5] despite the state's nationally recognized Rite Care program. Our state experienced the nation's twelfth highest increase (4.5%) in percentage of uninsured non-elderly adults.[6] There were 113,920 uninsured Rhode Islanders in 2004.[7] Fifteen percent of Rhode Island's adult non-elderly citizens have no medical coverage.[7]

Without Insurance: "I'm stuck in the middle"

These are the words of a self-employed Rhode Island Free Clinic patient who can't afford to purchase health insurance. Public opinion polls conducted by the Kaiser Family Foundation and Harvard School of Public Health in 2000 showed that, while more than 80% of the uninsured were workers or their dependents, 59% of the public believed the uninsured were unemployed or related to people who were unemployed.[8] In Rhode Island in 2004, only 17% of the uninsured were in jobless families. Among the 83% of the uninsured in working families, 67% of those workers worked full time.[7]

In our state, where 94% of all employers are small businesses,[9] the impact of rising health costs has profound effects:

- Between 1997 and 2003, the average commercial health insurance premium doubled in cost.
- In 2003 only 50% of private employers with fewer than 10 employees offered health insurance.[9]
- The *2005 Rhode Island Employer Health Insurance Survey* revealed that the average annual cost of a family's health insurance premium now equals the total annual income of an individual earning minimum wage.[5]

The uninsured are[11]:

- Three times more likely (47% vs 15%) to postpone seeking care because of cost;
- Four times as likely (37% vs 9%) to not get health care when they need it; and
- Nearly three times as likely (23% vs 8%) to be contacted by a collection agency about overdue medical bills

Rhode Island Free Clinic: Increasing Capacity of Our State's Health Care Safety Net

Bruce Becker, MD, a Rhode Island Hospital emergency room physician, and Stephanie Chafee, RN, MBA, an HIV nurse, founded **Rhode Island Free Clinic (RIFC)**. They envisioned a community-based response to expand the capacity of our state's health care safety net. Discussions began with colleagues in 1997 and RIFC opened as a pilot project in June 1999. It is the state's only free clinic devoted exclusively to providing free medical care to uninsured adults.

For more information on the Free Clinic, see www.rifreeclinic.org

> I believe the Free Clinic is a blessing from God. If it wasn't for you, I don't know what would have become of me and all the others like me who do not have medical insurance or the money to buy medicine. Thank you.
>
> -D., RIFC patient

The Free Clinic is an independent, non-profit organization supported exclusively by charitable donations. Its mission is to:

> *…offer high-quality medical care and preventive health services to individuals who do not have health insurance or cannot afford to purchase those services. Toward this goal, the clinic will be staffed by volunteers and will also serve an educational role for trainees in health care fields, providing services under the supervision of clinicians from leading academic institutions in Rhode Island.*

Patient Care

Beginning 1999, RIFC provided services to walk-in patients one night each week in a 500 square foot space donated by AIDS Care Ocean State on Broad Street in Providence's south side. As more volunteers came forward a second night was added to the weekly schedule. These two weekly (Tuesday and Thursday) primary care clinic nights remain the Free Clinic's core service and a gateway for other care. On that foundation, new monthly clinics have been added:

- Podiatry clinic (2001);
- Women's health clinic (2002);
- Inter-disciplinary diabetes and health maintenance clinics (2003);

- Collaborative mental health services and uninsured artists clinic (2004); and
- Pre-employment physical exams and cardiology clinic (2005).
- Most patients receive free medications, supplied as donated samples or through pharmaceutical company patient assistance programs.

The Free Clinic has provided care to nearly 1,700 unique patients (9,000 visits) since opening. Today, more than 500 adults are active patients whose care is being managed across primary care and internal specialty clinics, as well as across the Free Clinic's network of referrals to donated or low cost diagnostic and specialty services. The number of patient visits grew by 42% to 1803 in 2004 and by another 28% to 2,312 in 2005. The value of free patient visits provided on site (excluding free medications) was $443,394 in 2004. Free on-site visits in 2005 were valued at $683,263, with an additional $643,032 provided in free medications. *On-site services provided to patients at no cost were valued at $1,325,295 in 2005*(valued at standard Medicare billing rates and medication costs through an online pharmacy.)

Patients come from nearly every city and town in the state, although the majority (72%) live in Providence. While most of the Free Clinic's patients come from the state's core cities, a fair number are from Barrington, East Greenwich and other locations typically not regarded as towns where the State's uninsured reside. RIFC's patient population is 55% female, and relatively evenly divided between the ages of 19 and 65, with a small number of elderly who are not eligible for Medicare. Pediatric services are not offered; patients must be at least 19 years old.

Free Clinic patients do not represent the state's uninsured population. However, they do reflect the site's inner-city location and the fact that minorities, particularly Hispanics, are far more likely to be uninsured. The majority of patients (65%) are Hispanic, followed by non-Hispanic white (15%) African American (12%) and Asian (3%). Five percent self-report as "Other." Spanish is the primary language of 56% of patients, 29% speak English as their primary language and 15% speak other languages.

Seventy percent of patients self-report incomes below the federal poverty level. (Income documentation is not required to access services.) Forty-two percent of patients are employed full or part-time, including 3% who are self-employed. Other patients describe themselves as unemployed or not in the labor force.

On educational attainment, 67% have a grade school or high school education; 20% have college degrees; and 13% report vocational or other education level.

Many patients are coping with chronic diseases that are most effectively managed with regular primary care. Forty one percent have hypertension; 28% have diabetes. Often these diseases are out of control when a patient first enters the clinic. New patients' conditions may have been recently stabilized in a local hospital emergency room. Lack of access to reliable primary care makes these patients especially vulnerable. Many are embarrassed by their lack of insurance, as though this status marked a personal failing when, in fact, the system has failed them.

"Andrea" worked in a daycare center that did not provide health insurance, and "aged out" of her health insurance on her 20th birthday. Andrea has mild depression, asthma, and seasonal allergies and was unable to afford care or medications. She turned to RIFC for help. She sees the Free Clinic's volunteer providers regularly, follows their multiple treatment plans for her conditions, and receives free medications through the efforts of RIFC volunteers and a pharmaceutical company Patient Assistance Program. Andrea's goal is to become a Head Start teacher and finally acquire employer-based health insurance.

Most of our patients are reluctant to go to a hospital emergency room. They fear the cost and impersonal service. They also fear being "trapped" into expensive tests, costly medications and referrals. For them, the emergency department is a place of last resort.

Many Free Clinic patients are aware of the **community health centers (CHCs)** but report they cannot afford the sliding scale fees. Even if on-site services are affordable, patients cannot pay for the diagnostic and specialty tests and services to which they might be referred from their CHC provider. Medication costs are also a concern.

The larger issue is the inadequate capacity of a broken system to provide the uninsured with primary care. Hospitals and CHCs reputedly serve the uninsured. However, the numbers of uninsured adults receiving ongoing primary care at hospital-based clinics is very small, probably less than 15,000 according to an informal survey conducted by RIFC. In 2004, according to the Rhode Island Health Center Association, the CHCs served approximately 23,000 uninsured individuals.[13] Some physicians are expanding access through fee-for-service programs set up directly with uninsured patients through their practices.[14] These programs fall short of serving the nearly 114,000 Rhode Islanders without health insurance.

Opportunities and Challenges of Providing Free Care to the Uninsured

RIFC models the best and highlights the worst of our health care system. The Free Clinic and its patients are coping with challenges that make the fragile and fragmented nature of our health system glaringly obvious. However, widespread community support coupled with a lack of third-party reimbursement offer opportunities to develop patient-focused programs and services that can translate into better care. Recent examples include:

- *collaborative management model for mental health care*. A lack of mental health resources, particularly those which did not pose significant linguistic and cultural barriers, led RIFC to develop on-site mental health services integrated with primary care. Early results have shown that communication between providers and patients' ability to schedule multiple appointments in a single evening has led to better compliance, greater patient and provider satisfaction and improved outcomes;
- *focus on patient education and healthy lifestyles in a culturally competent environment*. Patient visits

need not be limited to 15-minutes. Providers take the time they need for a visit; patients feel they are listened to. Time for communication is particularly important at a site where many patients do not speak English (many volunteers are interpreters) and teaching is embraced. Nutrition programs and cooking demonstrations led by registered dieticians are popular with patients, their family members and volunteers.

- *opportunities for research*. RIFC's patient population and expansive programs can provide data on methods to improve health outcomes for its specific patient panel—a population, i.e., the uninsured, about which there is little literature concerning best practices. With a two-year strategy grant from Rhode Island Foundation, the Free Clinic has implemented a patient tracking database to provide information on program effectiveness and patient outcomes. The Clinic is in the early stages of developing research protocols and building on its academic relationships to include research opportunities that can benefit the Free Clinic's patients and ultimately, other vulnerable populations.

Growing for the Future

RIFC turns away, on average, ten people each day five days a week. Approximately ten new patients enter the practice monthly through primary care clinic walk-in day; afterward all visits are by appointment. RIFC is in the early stages of collaborating with Ocean State Ethics Network to determine the most ethical and equitable way to provide access to new patients given the Clinic's limited capacity.

Since its 1999 beginnings, the Free Clinic rapidly outgrew its 500 square foot donated space and moved to another Broad Street location in the larger Hindle Building, in January 2003. Having outgrown that site, RIFC is building a permanent home on the 6,500 square foot third floor of Hindle.

Design of the new space was completed with extensive input from volunteers. Construction of the new clinic, and associated fundraising for construction, endowment and program is underway There will be seven examination rooms and five rooms for individual counseling (mental health, medication, or other needs). Teaching space will be available for patients and their family members as well as students and health professionals. A cooking demonstration area will allow RIFC to build on its healthy lifestyle programs. Internet access will be available in every work area, as the Free Clinic moves toward an electronic medical record system with eClinicalworks software donated through Rhode Island Quality Institute and EHRRI.

In this larger space, RIFC will build upon the lessons learned while it increases capacity:

- *retain the warm and welcoming environment* that makes the Free Clinic a unique experience for all involved, whether as patient, volunteer or staff. The personal care is remarkable to all who experience it, making patients more compliant and leading to improved outcomes.
- *recruit more volunteers* to provide care to greater numbers.
- *continue building external relationships for donated services* to provide more of the uninsured with access to a broader array of care and medications.
- *generate charitable donations* that undergird our expansion and continued operations.
- *continue to advocate for the uninsured,* educating our leadership and the public about this continuing crisis.

The Free Clinic is not a solution to the crisis of the uninsured, but part of the safety net that must be strengthened. There are national and international models from which we can draw and others who share our goal of breaking down barriers to care – until the vision of President Harry Truman and so many others is realized.

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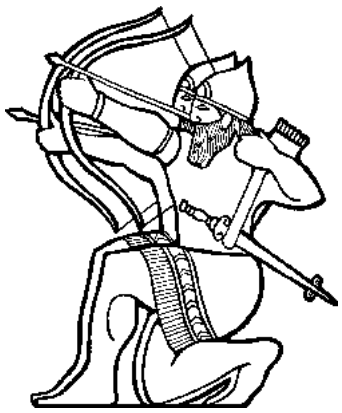

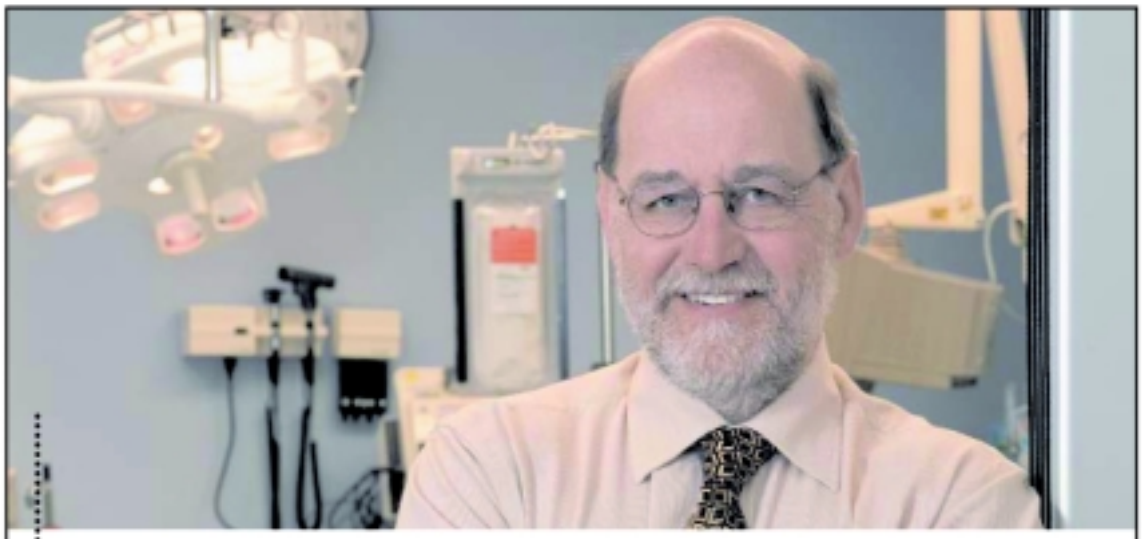

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A Multi-cultural Approach at the Foundation of Medical Practice

Pablo Rodriguez, MD

The demographic changes in this country during the last decade have created a growing number of health disparities and unequal treatment[1] among racial and ethnic minorities. These inequalities have happened in spite of increasing investments in a system that every year consumes a larger percentage of our **Gross Domestic Product (GDP)**. Healthcare, far from being a right, has become a commodity, and access to services a prime determinant of outcomes.

This country is more linguistically diverse now than at any time since the early 20th century. By the year 2000 approximately 47 million people over the age of 5 spoke a language other than English in the home. This segment of the population had grown by 38% in the 1980s and by 47% in the 1990s.[2]

In Rhode Island, the US Census (2004) estimates that almost 20% of the population over 5 years old speak a language other than English at home. Latinos are the largest ethnic minority group in the state; as a group they experience some of the greatest disparities in health and healthcare access.[3] They are the least likely group to have insurance and the most likely to experience other barriers to care by virtue of a different language and culture. A large number of Latinos are non-citizens and many have limited English proficiency, all of which limit access to health.

However, to define the lack of access to healthcare as a lack of insurance trivializes a personal social interaction, and misrepresents health care as a mere transaction between individuals and institutions. Specifically, the presence of insurance coverage does not guarantee access and therefore may not improve health outcomes, especially for those experiencing linguistic and cultural barriers to care. In this article we will explore some of the barriers experienced by **limited English proficiency (LEP)** patients and suggest strategies to surmount those barriers.

Language, Citizenship, and Jobs

The development of public policies that could address the " access" barriers experienced by Latinos requires a good understanding of the role that citizenship status and language play on the interaction between this population and the healthcare system. Non-citizen minorities who do not speak English are more likely to be uninsured than other minorities or white English-speaking citizens, even when corrected for income levels. Compared to white English-speaking citizens, non-citizen Latino adults who speak English are two times as likely to lack coverage (55% vs. 28%), and non-citizen Spanish-speaking Latino adults are almost three times as likely to be uninsured (72% vs. 28%).[4]

Although immigrants have a high rate of labor participation, they often have jobs that do not offer health insurance, or offer it at too-high rates.

Of the 57% of Latinos without job-based coverage, 4% purchase private coverage, 27% obtain Medicaid, 4% receive other public coverage, and 66% remain uninsured.[5] Even when insurance is offered at work, Latinos have a lower take-up rate: 76% of men sign up for insurance compared with 85% of white men.[5]

Although immigrants have a high rate of labor participation, they often have jobs that do not offer health insurance, or offer it at too-high rates. Only 43% of Latinos receive health insurance coverage at work compared with 73% coverage of non-Hispanic whites. Approximately 87% of uninsured Latinos come from working families, and citizenship status, regardless of work, is a strong determinant of coverage. According to a Kaiser Family Foundation study,[6] 27% of Latino US citizens are uninsured; 35% of naturalized and 44% of legal immigrants are also not covered.

The Face of Patients: Access and Care

Uninsured individuals have decreased access to preventive care, which translates into more chronic and costly conditions once a visit to the hospital becomes inevitable. Nowhere is this more evident than during pregnancy. Early prenatal care is the most cost-effective intervention in preventing low birth weight babies, prematurity and costly care in the neonatal intensive care unit and beyond.

Rhode Island has taken the progressive path of covering all pregnant women and children regardless of citizenship status. RIte Care, begun in 1994 through a 1115 Medicaid waiver,[7] has covered parents of RIte Care-eligible children (up to age 18) with income under 185% of the **Federal Poverty Level (FPL)** , children under age 19 with family income under 250% of FPL, and pregnant women with family income under 350% of FPL.

The CDC[3] has documented other disparities in preventive services between Hispanic and non-Hispanic populations:

	Hispanic	Non-Hispanic
Ever had a mammogram	84.7	90.3
Sigmoidoscopy or colonoscopy within previous 5 years	32	40
Cholesterol screening within 5 years	70.4	77.8
Pneumococcal vaccination, adults >= 65 yrs	44.9	62.4

Access disparities also persist between insured Latinos and whites.[5] According

to the **Medical Expenditure Panel Survey (MEPS)**, which sampled the medical expenses of households, managed care insured minorities, particularly Hispanics, reported barriers to care more frequently than did non-Hispanic Whites. Compared with other racial or ethnic groups, Hispanics more frequently reported difficulties obtaining care, going without needed care, and not being assured that family members could get needed care. Nearly one third of Hispanics reported not having a usual source of care. They were twice as likely as non-Hispanic whites to report long waits for care and that their provider failed to listen to them and provide them with needed information.[8] We must distinguish between "potential access," which is limited by financial barriers such as insurance and family income, and "realized access," which is defined by the quantity of healthcare actually received. In the latter, language, degree of acculturation, and citizenship status gain the most attention.

Safely Navigating the System: Health Care in Another Language

Healthcare in America is strongly influenced by the dominant culture. In the last few decades care has become increasingly fragmented, and navigation through the system has become complex even for those who know the language and have grown up in this culture. Once you add limited English proficiency to the equation, you have all the elements for diminished access, regardless of insurance coverage.

Effective communication between providers and patients is essential for the delivery of quality care, and patient satisfaction, compliance and health outcomes improve as communication improves.[9] Language barriers between patients and providers may result in excessive testing, poor understanding of medication side effects and provider instructions, decreased use of primary care, increased use of the emergency room and inadequate follow up. Hispanic populations not only have increased prevalence of diabetes, but they also have poorer glycohemoglobin performance and more retinopathy attributable directly to poorer health literacy and language barriers.

According to a nationwide survey[9] by the Commonwealth Fund, once Latinos get access to the healthcare system they have more difficulty than non-Hispanic whites and African Americans understanding what doctors tell them and comprehending written information. Moreover, Latinos are more likely than other groups to have limited choices about where to go for care and are less satisfied with their doctor interaction. Spanish-speaking Latinos had the most difficulty of any group comprehending prescription bottle instructions and written health information even after controlling for income, educational level and insurance status.

...healthcare in the cross-cultural context requires a level of knowledge and flexibility that is seldom learned in school...

Lack of understanding generates lack of confidence: only 43% of uninsured Spanish-speaking respondents reported a "great deal" of confidence in their physician compared to 54% across all ethnic and racial groups. Insured whites reported a 70% confidence in their provider. The need for quality medical interpreters is great and unfortunately there are only a handful of programs available. This is unfortunate because the costs of health care services are higher for **limited-English-proficiency (LEP)** patients who don't have interpretative services.

Interpreters and bilingual providers have a positive impact in the health care of LEP patients because such patients see doctors more often, use more preventative services and have higher satisfaction rates.[10] Too often family members or untrained bilingual staff are called upon to translate, a practice fraught with errors such as omitting, adding or substituting information. Most problematic for this population is to have minor dependents be the interpreters because of the breached confidentiality. In California such practice has been prohibited. In Rhode Island the legislature (2001) required every hospital in the state to provide qualified interpreters and /or bilingual clinicians for LEP patients; and children under age 16 have been banned as interpreters for anyone. Neighborhood Health Plan in association with area hospitals launched "Su Salud," funded by the Robert Wood Johnson Foundation. "Su Salud" hopes to find a cost-effective way of training and deploying medical interpreters by creating a claims reimbursement mechanism at the health plan. This is the nation's first fee-for-service reimbursement mechanism for interpreter services. While early results are too limited to arrive at meaningful conclusions, everyone involved is convinced of its intrinsic value.

The Deeper Challenge: A Multi-cultural Approach as the Foundation for All Care

Finally and most importantly, while barriers such as language and insurance may be difficult to overcome, they are nonetheless surmountable with the proper financial investments. A deeper and more difficult conversation surrounds the issue of culture and how cultural differences add critical dimensions that must be addressed if we are to bring our patients optimal outcomes.

For example, the primacy of individual patient autonomy is generally seen as the most appropriate and enlightened characteristic of a health care system. However, dealing with needs of Latino and other cultures within this context highlights complex challenges. In some cultures, patients will abandon perfectly competent and caring providers simply because they were given a choice of therapy as opposed to receiving the culturally-expected, traditional paternalistic view where doctor knows best. While it is important not to compromise your principles and to practice within the accepted community norms, healthcare in the cross-cultural context requires a level of knowledge and flexibility that is seldom learned in school.

Cultural competence has become the new buzzword in medicine. Unfortunately it puts the issue in a box as if it was a skill that could be acquired by reading a book or attending a lecture. Dr. Janelle Taylor,

describing our learning experience in medical school and residency, has spoken of the institutional culture of medicine which systematically fosters static and essentialist conceptions of "culture" as applied to patients.[11] In other words, separating cultural competence curricula from the "real" competencies of medicine assumes that they are somehow distinct, perhaps mutually exclusive. When medical students fail to see the value of learning how to approach the practice of medicine from a multi-cultural point of view, their teachers are failing. As one student said after a course in social and cultural awareness, "It's all very nice to talk about it in theory, but ultimately it makes no difference."[12] Dr. Taylor explained: "Physicians' medical knowledge is no less cultural for being real, just as patients' lived experiences and perspectives are no less real for being cultural".

Working with multicultural populations is a challenge but some of the most rewarding experiences in medicine come from arriving at a proper diagnosis when nothing is like it seems. Our learning in this area is lifelong and the influx of Latinos into this country presents the medical establishment with an unique opportunity to transform not only our approach to patients, but our vision of the world. The end result will be fewer disparities, less cost and a healthcare system responsive to the needs of the entire population. I have a dream.

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Health By Numbers
Rhode Island Department of Health • David Gifford, MD, MPH, Director of Health
Edited by Jay S. Buechner, PhD

Refugee Health In Rhode Island

Thalia Julme, Carrie Bridges, MPH, and Peter R. Simon, MD, MPH

The Office of Minority Health at the Rhode Island Department of Health formally initiated a Refugee Health Program in August 2004 with support from the Department's Tuberculosis Program and community-based refugee resettlement agencies. The goal of the program is to ensure that refugees enter into a comprehensive system of care that adequately responds to their unique health care needs. The Rhode Island Refugee Health Program works with **voluntary resettlement agencies (VOLAGS)**, state programs, and medical and social service providers to perform three core functions:

- Coordination of care,
- Education and training, and
- Surveillance and epidemiology.

As defined by the Refugee Act of 1980, a refugee is a person who is outside of his/her country of origin and is unable or unwilling to return to that country because of the experience or legitimate fear of persecution on the grounds of race, religion, nationality, membership in a particular social group, or political affiliation.[1] Resettling a refugee to a third country is the final option after first offering voluntary repatriation to the refugee's country of origin and then attempting to integrate the refugee within the host country.

At the conclusion of 2004, there were approximately 9,237,000 refugees worldwide.[2] That year, the United States resettled 52,868 refugees, more than all the other countries that resettle refugees combined.[2] In federal fiscal year 2004 (October 1, 2003 – September 30, 2004), Rhode Island received 345 refugees, 0.65% of the national total. Generally speaking, states fall into one of three tiers for the number of refugees they resettle. RI is in the middle tier, with numbers in the hundreds. States like Minnesota, Florida, and Texas are in the top tier with thousands of refugees resettled annually. Other states like Alaska, Hawaii, and Delaware are in the lower tier, resettling fewer than 100 refugees per year.

The US Department of State and Department of Health and Human Services administer programs to assist refugees resettled in the United States. Benefits are offered to five federally recognized categories of people: refugees, asylees, Cuban/Haitian entrants, certain Amerasians, and victims of severe forms of trafficking. Collectively, these populations are referred to as refugees. Refugees resettle by joining family members or communities where VOLAGS have agreed to manage their case. Rhode Island has two participating VOLAGS: the Diocese of Providence and the International Institute of Rhode Island. VOLAGS deliver refugee reception and placement services as part of cooperative agreements with the Department of State.

Refugee Arrival Data

Rhode Island has welcomed more than 4,300 federally recognized refugees since 1980. Each year, the

Table 1.
Country of origin of refugees resettled in Rhode Island, October 1, 2004 – June 30, 2006

Country of origin	Number
Liberia	155
Thailand	37
Ivory Coast	22
Somalia	21
Ethiopia	16
Laos	16
Kenya	15
Ghana	12
Rwanda	10
Moldova	8
Sierra Leone	7
China	6
Burma	3
Burundi	3
Cambodia	3
Cuba	3
Guinea	3
Nigeria	3
Yemen	3
Philippines	2
Cameroon	1
Central African Republic	1
Eritrea	1
Russia	1
Total	**352**

Source: Rhode Island Refugee Program, Rhode Island Department of Health

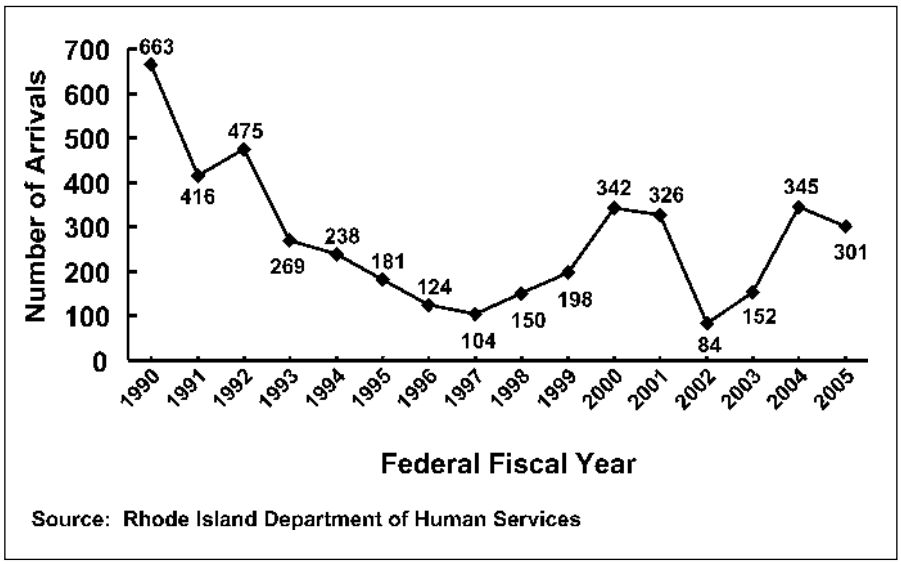

Figure 1. Total Refugee Arrivals in Rhode Island, by federal fiscal year, 1990-2005.

number of refugee arrivals fluctuates based on the stability in refugees' countries of origin, international affairs, and domestic resettlement targets, but in recent years, Rhode Island has become home to approximately 300 refugees annually. (Figure 1) In recent years, Rhode Island has resettled refugees from 24 countries, the majority of refugees coming from African countries. (Table 1)

Health Services for Refugees

All refugees approved for third country resettlement undergo an overseas medical examination before traveling to their new home, to ensure that they do not have medical conditions that would exclude them from eligibility to enter the United States. The results of that exam are forwarded to the refugee health program in the state where the refugee is being resettled.

The US Department of State requires refugee resettlement programs to facilitate a refugee health screening within 30 days of arrival in the United States, to verify the results of the overseas exam, identify any health condition that poses a threat to the individual's or public's health, and introduce the refugee into the primary care system. Following the initial screening, refugees should be accepted into ongoing primary care at that screening site or referred to another provider.

Under federal legislation, refugees are eligible for eight months of medical coverage from their date of entry into the country. In Rhode Island, refugees are enrolled in either RIte Care or Medical Assistance for the eight-month period. The refugee health screening is a covered expense under these programs. After the guaranteed coverage expires, refugees may continue to receive state health benefits if they meet the eligibility requirements promulgated by the state's Department of Human Services.

Table 2.
Medical conditions requiring follow-up identified among refugees resettled in Rhode Island, January 1, 2005 – June 30, 2006

Medical condition	Number
Oral Health	43
Vision	34
Prior treatment for tuberculosis	30
Hypertension	29
Heart	22
Ringworm and other parasites	17
Hernia	15
Trauma	12
Pregnancy	9
Obesity	8
STD in the past year*	7
Asthma	4
Bronchitis	3
Scoliosis	3
Unspecified skin condition	2
Hearing	1
Other	25

*including diagnosis of HIV

Source: Rhode Island Refugee Program, Rhode Island Department of Health

Health Conditions Identified Among Refugees

The Refugee Health Program created the Rhode Island Refugee Health Screening Form for healthcare providers to use at the initial health assessment to document immunizations, tuberculosis and infectious disease screening, physical exam results, and referrals for mental health, nutrition, and other health services. Instituted in January 2005, the form delineates the minimum standard for an initial health assessment of refugees resettled in Rhode Island and promotes uniformity of services across institutions. The screening components included in the form are based upon the recommendations of the federal Office of Refugee Resettlement[3] as well as screening and treatment recommendations issued by the **Centers for Disease Control and Prevention** (CDC).[4] The screening form and recommendations from the CDC can be found on the Refugee Health Program website.[5]

Health care providers who perform the domestic health assessment for refugees are asked to complete the RI Refugee Health Screening Form and submit a copy of the completed form to the Refugee Health Program. Table 2 presents data on refugee's health conditions identified on the overseas screening forms and the Program's screening forms for refugees resettled in Rhode Island between January 1, 2005, when the Program's form was instituted, and June 30, 2006.

Refugee Health Challenges

The diversity of the refugee population brings with it a host of opportunities and challenges for health care facilities. Most refugees will need translation and/or interpreting services. This is particularly important during the medical examination and follow-up. Although some refugees may speak English, sentence structure and vocabulary may be very different from American English. Accents may also make it difficult to understand or be understood.

Languages spoken by refugees resettled in Rhode Island include:[6]

Arabic	Burmese	French
Hmong	Krahn	Laotian
Liberian English	Maay Maay	Mandingo
Somali	Somali-Bantu	Thai

The National Standards for **Culturally and Linguistically Appropriate Services in Health Care** (**CLAS Standards**) provide mandates, guidelines, and recommendations for recipients of federal funding regarding the provision of culturally and linguistically appropriate services in healthcare settings. These standards were released in 2001 by the federal Office of Minority Health in response to Title VI of the Civil Rights Act. Of the 14 CLAS Standards, four (#4-7) are mandates enforceable by the Office of Civil Rights. The mandates speak to the issue of language access and require the provision of trained

interpreters and translated materials.[7]

Standard 4 – Qualified language assistance services

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5 – Notices to patients/consumers of the right to language assistance services

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6 – Qualifications for bilingual and interpreter services

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7 – Translated materials

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Conclusion

The Rhode Island Refugee Health Program is involved in coordinating care for refugees, providing education and training for refugees and health care providers, and performing surveillance of health conditions impacting refugees resettled in the state. As the Refugee Health Program continues, areas of focus include improving reporting of refugee health screening data, increasing access to culturally and linguistically appropriate services, and providing resources that assist health and social service providers provide comprehensive care responsive to the needs of refugees. For additional information about the Refugee Health Program, please visit its Rhode Island Department of Health webpage, http://www.health.ri.gov/chew/refugee/index.php.

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Thalia Julme, an undergraduate student at Brown University, is an intern at the Rhode Island Department of Health under an Undergraduate Teaching and Research Assistantship.

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Peter Simon, MD, MPH, is Assistant Medical Director, Division of Family Health, and Clinical Associate Professor, Departments of Community Health and Pediatrics, Brown Medical School.

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The Rhode Island Health IT e-Newsletter Project Update

The State and Regional Demonstration in Health Information Technology Project, also known as the AHRQ Health IT Project is a 5 year, $5 million dollar demonstration project that was awarded to the Rhode Island Health Department by the Agency for Healthcare Research and Quality in 2004 and will continue until 2009. Rhode Island is one of 6 states to be part of this demonstration project. The contract will plan, develop, implement, and evaluate an electronic "backbone" to facilitate interoperability and sharing of patient data between hospitals, physician offices, labs and other healthcare providers.

The Rhode Island Health Information Exchange project continues to make great progress. Since our last update the RI Department of Health has begun further work on security and privacy in health information exchange through the Health Information Security and Privacy Collaboration (HISPC). The collaboration is funded by the Agency for Healthcare Research and Quality (AHRQ) and the Office of the National Coordinator for Health Information Technology (ONCHIT).

The HISPC project involves exploring barriers and best practices surrounding current health information exchange in a variety of healthcare settings. Members of the HISPC project will be meeting with the Physicians Advisory Panel at the September 14th meeting to discuss these issues.

The State Review Committee and Community Reviewers continue to work diligently towards selecting the vendor who will build the Health Information Exchange System. The announcement of the vendor is anticipated in late September/early October.

The many community committees have been very active. The Consumer Engagement Committee continues to develop the focus group guide, and based on the initial feedback of the focus groups, is identifying future topic areas for additional focus consumer groups. The Administrative Data Exchange Committee, charged with bringing insurance information on patients to the HIE has convened the full committee representing providers, vendors and insurers and they are currently assessing and developing community standards for specific data formats. The Policy and Legal Committee continues to work through specific consent and authorization issues.

E-prescribing in Rhode Island Update:

Dr. David Gifford, Director of Health, and Jeff Newell COO of Quality Partners of Rhode Island, acting as Co-chairs of the Rhode Island Quality Institute E-prescribing work group, have been moving forward with identifying barriers for both prescribers and pharmacies to adopt and utilize e-prescribing for all their prescription transactions.

They will be convening 2 work groups. The first work group will work with the remaining few Pharmacies in the state that have not been certified to accept electronic prescriptions. The group will work on solutions to overcome the barriers that have been identified. The second work group will bring together the three managed care organizations in the state and the top three EHR vendors to discuss how they can work together to make patient eligibility and formulary files available for physicians at the time they prescribe. The availability of this information at the time of prescribing will reduce phone calls by the patient, pharmacy and physician and help speed adoption of both EMR's and e-prescribing.

In addition the committee is working with SureScripts to identify the various areas where prescription data resides, which will help guide the development of complete medication histories.

For more information about e-prescribing in Rhode Island, please visit www.GetRxConnected.com/RI or call 1-866-RxReady (1-866-797-3239).

Institute of Medicine (IOM): All prescriptions should be electronic by 2010:

A report by the Institute of Medicine says more than 1.5 million Americans are harmed by drug errors in medical settings each year and calls for all prescriptions to be written electronically by 2010. The report said, on average, a hospitalized patient is subject to at least one medication error per day, despite recent initiatives to improve the administration of medicines. To read the article visit: www.nytimes.com/aponline/us/AP-Drug-Errors.html

Physician Voluntary Reporting Program (PVRP)

Dr. Mark McClellan testified about Pay For Performance (P4P) to the House Committee on Energy & Commerce. It was the Subcommittee on Health's hearing on "Measuring the Quality of Physicians' Services." In the testimony he discusses the Physician Payment Update, quality measures, PVRP, and CMS demonstration. According to Dr. McClellan's statements, 6400 physicians nationwide have indicated a willingness to participate in PVRP.

To access testimony: http://energycommerce.house.gov/108/Hearings/07272006hearing1994/McClellan3126.htm

CCHIT Announces Certification for Certified Ambulatory EHR products:

The Certification Commission for Healthcare Information Technology has named 18 vendors to receive certification for their ambulatory electronic health record products. Products that comply with 100 percent of the functionality and security criteria tested during the inspection will bear the CCHIT CertifiedSM seal. (http://www.healthcareitnews.com/story.cms?id=5244)

The CCHIT Certified mark —a "seal of approval"—provides the first consensus-based, consistent benchmark for am-

bulatory EHR products. By looking to products with the CCHIT Certified seal, physicians can reduce their risk when investing in this technology. The certification criteria have been designed to ensure that products provide a broad foundation of functionality, will evolve to be interoperable with other systems, and include security features that protect the privacy of personal health information. To be certified, a product must comply with 100 percent of the CCHIT criteria. http://www.cchit.org/vendors/apply/certseals/

Visit here to see the complete list of certified vendors: http://www.cchit.org/certified/2006/CCHIT+Certified+Products+by+Company.htm

CDC Report: More Physicians Using EHRs:

About 24% of physicians in the U.S. said they used full or partial electronic health records in 2005, compared with 21% in 2004. Most experts agree that EHRs can reduce medical errors and costs. However, there still is disagreement over who should pay for EHRs and some experts are concerned about patient privacy.

http://www.ihealthbeat.org/index.cfm?Action=dspItem&itemID=123461

HHS unveils exceptions, safe harbors for IT sharing:

HHS announced new federal regulations that will allow hospitals and some other organizations to donate e-prescribing and electronic health records technology and support services to physicians. The regulations create broader exceptions and safe harbors to federal fraud-and-abuse laws, in terms of qualified donors and recipients, than initially proposed last October.

http://www.modernhealthcare.com/news.cms?newsId=5434&potId=FS

President Bush To Sign Executive Order Establishing Health IT Standards, Requiring Quality Measurement Systems for Federally Funded Care Providers

HHS Secretary Mike Leavitt told the nation's governors that the Bush administration will soon require all health care providers who receive federal funds to adopt quality-measurement tools and uniform information technology standards, the Washington Post reports:

http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=38972

House passes health IT bill

The House approved the Health Information Technology Promotion Act of 2006 on July 27, which codifies the Office of the National Coordinator of Health Information Technology and sets up a committee to make recommendations on national standards for medical data storage. The bill also develops a permanent structure for national interoperability standards.

http://www.healthcareitnews.com/story.cms?id=5273

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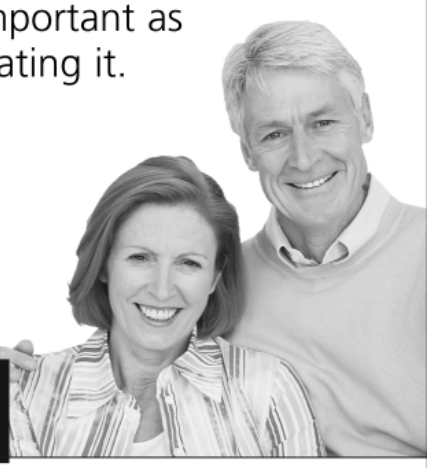

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Information for Contributors

Medicine & Health/Rhode Island

Medicine & Health/Rhode Island is a peer-reviewed publication, listed in the *Index Medicus*. We welcome submissions in the following categories.

Contributions

Contributions report on an issue of interest to clinicians in Rhode Island: new research, treatment options, collaborative interventions, review of controversies. Maximum length: 2500 words. Maximum number of references: 15. Tables, charts and figures should be camera-ready. Photographs should be black and white. Slides are not accepted.

Creative Clinician

Clinicians are invited to describe cases that defy textbook analysis. Maximum length: 1200 words. Maximum number of references: 6. Photographs, charts and figures may accompany the case.

Point of View

Readers share their perspective on any issue facing clinicians (e.g., ethics, health care policy, relationships with patients). Maximum length: 1200 words.

Advances in Pharmacology

Authors discuss new treatments. Maximum length: 1200 words.

Advances in Laboratory Medicine

Authors discuss a new laboratory technique. Maximum length: 1200 words.

Medical Myths

Authors present an iconoclastic, research-based analysis of long-held tenets. Maximum length: 1200 words.

For the above articles: Please submit 4 hard copies and an electronic version (Microsoft Word or Text) with the author's name, mailing address, phone, fax, e-mail address, and clinical and/or academic positions to the managing editor, Joan Retsinas, PhD, 344 Taber Avenue, Providence, RI 02906. phone: (401) 272-0422; fax: (401) 272-4946; e-mail: retsinas@verizon.net

Images in Medicine

We encourage submissions from all medical disciplines. Image(s) should capture the essence of how a diagnosis is established, and include a brief discussion of the disease process. Maximum length: 250 words. The submission should include one reference. Please submit the manuscript and one or two cropped black and white 5 by 7 inch prints with the author's name, degree, institution and e-mail address to: John Pezzullo, MD, Department of Radiology, Rhode Island Hospital, 593 Eddy St., Providence, RI 02903. Please send an electronic version of the text and image to: JPezzullo@lifespan.org.

Images In Medicine

Traumatic Pneumatocele

Robert S. Crausman MD, MMS

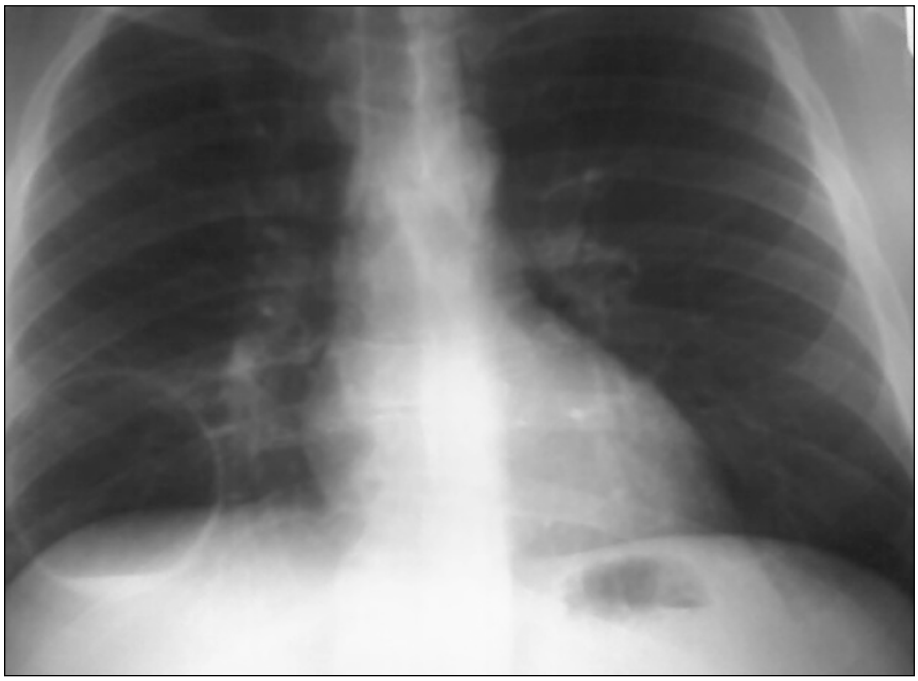

Figure 1.

Figure 2.

PA and Lateral Chest radiograph taken several days after this 38 year-old man suffered a significant trauma to his right lateral and posterior chest. The patient, who worked with industrial machinery, was next to a piece of hydrolic equipment that malfunctioned and exploded, throwing him and a co-worker against a steel railing.

The chest radiographs demonstrate a 7 cm diameter, thin-walled cyst. A so-called traumatic pneumatocele can result when there is sudden compressive trauma of the lung and chest-wall rupturing small airways.

The air-fluid level apparent in both projections likely represents a small volume collection of blood. Radiographically traumatic pneumatoceles are indistinguishable from those caused by acute infectious pulmonary processes (e.g. Staphlococcal pneumonia)

The natural history of a traumatic pneumatocele is to slowly resolve over weeks to months. They may become superinfected as evidenced by an increasing air-fluid level within the cavity. They may, less commonly, persist for years. Subsequent rupture may also occur.

Robert S, Crausman, MD, MMS, is Chief Administrative Officer, RI Board of Medical Licensure and Discipline, and Associate Professor of Medicine, Brown Medical School.

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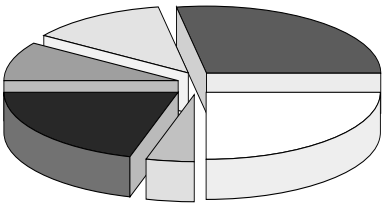

Health Insurance Update

Rhode Island Institutes a New Statewide Uniform Physician Application Process

Patricia E. Huschle, MS

The Office of the Health Insurance Commissioner last year established "The Professional Provider-Health Plan Work Group" to implement a number of initiatives aimed at alleviating the administrative burdens experienced by physicians and their staffs.[1] One of the Work Group's objectives was to develop a statewide uniform credentialing process for the purpose of verifying the professional qualifications of health care providers who want to participate in a health plan's provider network. This new application process, which will take effect in 2007, is designed to reduce the paperwork and confusion associated with both the initial credentialing and the re-credentialing (occurring every three years) processes. Since physicians generally participate in several health plans, and because renewals are often on different cycles, the credentialing process has become a source of frustration and lost time. This initiative is aimed at reducing the frustration and administrative burdens experienced by physicians and their staffs.

Overview

The Work Group approached the credentialing and the re-credentialing by first agreeing that:

- the application and the verification processes were distinct and needed to be handled separately.
- collection of the physicians' data for credentialing and re-credentialing purposes was the primary concern for the physicians' offices.
- the duplication of effort associated with the verification process (i.e., health plans, hospitals, medical groups all reaching out to the same entities to confirm application data) should be eliminated.
- the verification portion of the application process should be transparent to the physician's office; and
- identification of a common credentialing verification organization (CVO) will be addressed at a later point.

The Work Group then identified the **Council on Affordable Quality Healthcare's (CAQH)**[2] electronic "data collection tool" as a common application form that has an established local, regional and national presence. The Work Group agreed that it would adopt the CAQH form as standard rather than establishing a statewide application as Massachusetts and other states have done.

The Credentialing Application

The CAQH application form is comprehensive; it takes into consideration data required by all the national health plans. Physicians are responsible for completing the form once online and then either attesting to the validity of the existing information, or updating the information, every 120 days. The availability of data at a continually updated status will eliminate the need for the health plans to interact with a physician's office. The physician will be given the option to select which participating plans may access his/her online data. In addition, this process will entail no direct costs to physicians. The health plans cover the costs through access fees paid to CAQH.

Currently, **UnitedHealthcare (UHC)** requires the use of the online CAQH application, as do other national carriers and some of the health plans located in Massachusetts and Connecticut. Thus, Rhode Island physicians who have already completed the CAQH online application will be able to use the same form for both **Blue Cross and Blue Shield of Rhode Island (BCBSRI)** and **Neighborhood Health Plan of Rhode Island (NHPRI).** Effective January 1, 2007, however, BCBSRI will be able to access the CAQH data online. Until then, BCBSRI will accept a print version of the online form. NHPRI will also accept a print version of the form. No date has been set for NHPRI to go online with the CAQH credentialing form process.

The Hospital Association of Rhode Island is currently reviewing the efficiencies of working with the CAQH form. The Lifespan hospitals began accepting the CAQH form in lieu of their own medical staff application as of June 2006.

Effective Date of the Statewide Uniform Application Process

The official date of the statewide uniform application process is January 1, 2007. BCBSRI will begin to alert its providers to begin to complete the online application in the fall. Detailed mailings and informational sessions will be scheduled to prepare the provider community for this transition. The success of this endeavor will require that the providers complete the application in a timely way and be diligent about keeping their online data up to date.

The OHIC is very pleased at the effort and cooperation that the Work Group put forth to make the statewide uniform application process a reality. Any questions regarding this initiative may be addressed to the health plans directly or to the Office of the Health Insurance Commissioner.

For more information about current efforts of the OHIC to ensure the fair treatment of the state's health care providers, please visit www.dbr.state.ri.us/health_insurance.html.

Notes

1. The membership of the Work Group varies based on the subject of its current initiative. For this initiative the Work Group included Christopher Dooley (W&I PHO), Dan Egan/Craig Syata (HARI), Lorraine Roberts (Lighthouse MD), Paul Carey (RI Urological Specialties), Joel Kaufman M.D./ Charlene Denton (Lifespan/Physicians PSO), Lois Booth (RIH Medical Staff Office), Steve Detoy (RI Medical Society), Fernanda da Costa/Donna Valletta (RI Department of Health), Robert Cambio/Holly Vota- (BCBSRI), Jason Martiesian/ Mary Bennett (UHC) and Maureen Brousseau (NHPRI).
2. CAQH is a not-for-profit alliance of health plans, networks and trade associations that was created to promote collaboration among health plans on initiatives that promote administrative simplification.

Patricia E. Huschle, MS, is Provider Liaison, Office of the Health Insurance Commissioner.

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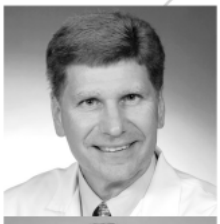

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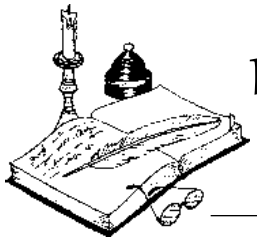

Physician's Lexicon

The Eyes Have It

The human eyeball, some 26 millimeters in lateral diameter, is an astonishing repository of complex anatomic structures each endowed with an equally complex etymologic—and sometimes mythologic—substrate.

The conjunctiva, the mucous membrane which envelops much of the anterior eye, is derived from the Latin, *conjunctivus*, meaning serving to connect, as in comparable words such as conjugation and disjunction. The unrelated word, conjecture, however, stems from the Latin, *conjectus*, meaning to hurl or throw together and is taken from a yet earlier word, *jacere,* meaning to throw, as in the word, ejaculate. The Latin, *jaculum*, meaning that which is thrown, has evolved into the English word, javelin.

The retina is from the Latin, *rete*, meaning network which in turn is derived from the Hebrew, *reseth*, also meaning network. The anatomic term, retina, was coined by the physician Gerard of Cremona [1114? – 1187]. The same root gives rise to cognate words such as reticulum and reticule. The English word, retinue, however, is from the French, *retinir*, meaning to hold back or retain.

The iris is named after Iris, the messenger of the gods in Greek mythology. She is remembered as the maiden with an iridescent gown beset with jewels hastening through the firmament upon her colorful path—called the rainbow by mortals—as she bore her confidential messages. Derivative words include iridectomy, iridescent and iridium.

Vitreous is derived from the Latin, *vitreus*, meaning a resemblance to glass and is the progenitor of such English words as vitreous, vitrescent and Vitrina, a genus of snails with glasslike, transparent, spiral shells. Sulfuric acid was formerly called oil of vitriol because of its glassy appearance. This has given rise to the adjective vitriolic meaning scathing or extremely caustic.

Cornea [more accurately, cornea tunica] means, in Latin, a horny layer. And choroid, as in choroid plexus, is from, a Greek word meaning membranous or leatherlike, and defines the vascular plexus between the retina and the sclera [which is from a Greek word meaning hard or dried up as in words such as scleroderma and sclerosis.]

The ocular uvea, viewed by the ancient anatomists as dark purple in color resembling ripe grapes, is from the Latin, *uva*, meaning grapelike. The small, dangling projection from the soft palate, the uvula, is derived from the same metaphor.

– 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			
	October 2005	12 Months Ending with October 2005		
	Number (a)	Number (a)	Rates (b)	YPLL (c)
Diseases of the Heart	196	2,966	277.3	4,715.0
Malignant Neoplasms	174	2,376	222.1	6,684.5**
Cerebrovascular Diseases	41	506	47.3	815.0
Injuries (Accidents/Suicide/Homicde)	27	404	37.8	6,139.5
COPD	27	550	51.4	500.0

Vital Events	Reporting Period		
	April 2006	12 Months Ending with April 2006	
	Number	Number	Rates
Live Births	1,079	13,258	12.4*
Deaths	908	9,772	9.1*
Infant Deaths	(8)	(101)	7.6#
Neonatal Deaths	(6)	(85)	6.4#
Marriages	416	7,358	6.9*
Divorces	246	3,170	3.0*
Induced Terminations	402	4,840	365.1#
Spontaneous Fetal Deaths	96	1,084	81.8#
Under 20 weeks gestation	(92)	(1,018)	76.8#
20+ weeks gestation	(4)	(66)	5.0#

(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

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MEDICAL MALPRACTICE TOPICS

INFORMATION FOR RHODE ISLAND PHYSICIANS FROM BABCOCK & HELLIWELL

Avoiding Risk

Improving Early Detection of Breast Cancer

John Tickner, CPCU, President, Babcock & Helliwell

The medical malpractice insurance industry does more than defend doctors and pay claims. It continually reviews past data to detect emerging risks, and then researches ways to reduce these risks. Here's just one example of where the industry's efforts have reduced risk. It's a timely example, given that October is Breast Cancer Awareness Month.

For many years, women have been encouraged to perform self-exams of their breasts for lumps, and to get mammograms regularly. By the late 1990s, 60 percent of U.S. women were receiving mammograms, a four-fold increase in ten years. The tests were finding tumors in their earliest stages, when about 90 percent of cases can be cured. However, while survival rates were improving, the medical malpractice insurance industry was seeing a disturbing trend. Failure to diagnose breast cancer lawsuits had increased, becoming one of the leading reasons doctors were sued.

Beginning in the 1990s, the Massachusetts medical malpractice insurance industry began analyzing its past lawsuits. The goal was to identify factors associated with the successful defense of malpractice cases that involved the failure to diagnose breast cancer. The ProMutual Group team was headed by Dr. Samuel Zylstra of the University of Massachusetts Medical School and included medical personnel and company risk managers. The team analyzed 132 breast cancer cases closed by ProMutual Group between January 1999 and December 2004. These cases closed with an aggregate indemnity payment of over $47 million, including 12 cases with payments of $1 million or more.

Let me share one finding. According to data from the Physician Insurers Association of America, a medical malpractice insurance company trade organization, more than two-thirds of the breast cancer lawsuits filed between 1995 and 2002 involved women 49 and younger. Half involved women under 39.

As many as three-fourths of all post-mammogram biopsy results turn out to be non-cancerous lesions, and the "false positive" rate is 12 times higher among women under 50. Pre-menopausal women are more likely to have dense breast tissue, which makes their mammograms especially difficult to read.

Zylstra's team found that diagnosing breast cancer in its earliest stages is the most effective way to reduce risk of litigation. However, the team also found that when dealing with younger women, physicians relied too much on mammograms, tended to downplay or dismiss potential symptoms, and did not gather enough information about patient risk factors such as family history of breast cancer.

Using such findings, the company developed a multidisciplinary clinical algorithm to guide doctors. The algorithm listed which questions to ask, the risk factors to consider, and the tests to order. The companies' primary care doctors were sent a copy of the algorithm in 2002.

Since the release of the algorithm, the number of breast cancer-related lawsuits in Massachusetts has decreased. According to Maureen Mondor, vice president, Risk Management at ProMutual Group, "The decrease, while involving only a small number of cases, shows us that primary care physicians are now more alert to early signs of breast cancer, monitoring at-risk women more closely, and ordering timely mammogram or ultrasound tests where indicated."

An Offer for Doctors

Although dated, the guidance provided by this algorithm is still useful today. If you would like a copy, call our office or email me. As always, I welcome your suggestions for future topics. E-mail me at jtickner@babcockhelliwell.com or write to me in care of the agency.

***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 Official Organ of the Rhode Island Medical Society
Issued Monthly under the direction of the Publications Committee

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PROVIDENCE, R.I., JANUARY, 1917

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Ninety Years Ago, October 1916

William McDonald, Jr, MD, in "The Light under a Bushel," reminisced about running, as a boy, to fetch Dr. McKaye, whose night-sign and office night bell stood ever-open to patients. "Both the sign and the bell marked "The traditional duty of the family doctor to remain in call so long as strength remained to respond." That tradition has lapsed, as physicians have removed their night lamps, installed small signs, and limited their hours of duty.

An Editorial, "Mosquitoes," bemoaned the summer invasion, "…which might be regarded as a necessary evil in a country town, but is inexcusable in an otherwise progressive city…Oiling the swamps and breeding places will bring temporary relief, but drainage is the rational treatment."

Arthur H. Ruggles, MD, in "Internal Secretions and Mental Disease," cited secretions from the thyroid, adrenal gland, ovaries, and thymus as factors. He reported on 6 cases, including that of a 50 year-old man, admitted for "mental disease" at age 18, and said to have been insane for 3 years. Dr. Ruggles diagnosed a pituitary disorder.

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Fifty Years Ago, October 1956

Leo H. Bartemeier, MD, Medcal Director, The Seton Psychiatric Institute in Baltimore, gave The Arthur Hiller Ruggles Oration: "Common Misconceptions About Mental Health, Mind and Body." The Journal reprinted the talk. He asserted that body and mind are never separate, and that nobody is completely in control of him/herself.

George H. Humphreys II, MD, the Valentine Mott Professor of Surgery, Columbia College of Physicians and Surgeons, contributed "Problems in the Treatment of Adults with Ductus Arteriosus,"

Seebert J. Goldowsky, MD, in "Masters in Medicine – Mr. John Hunter, FRS (1728-1793)," discussed this "colorful personality."

Twenty-Five Years Ago, October 1981

Leonard J. Triedman, MD, in "Surgery for Head and Neck Cancer," wrote: "It is desirable to minimize certain prejudices regarding treatment options." "None of the cancer treatments is considered optimal yet."

Samuel P. Hunt, MD, in "Adolescent Conflict and the Question of Homosexuality: A Guide to the Counseling for Physicians and Sex Educators," cautioned: "….general character and sexual development cannot be overlooked in understanding its unconscious roots."

Bruno Borenstein, MD, and Marion A. Humphrey, RN, contributed: "Current Opinion: Hospice Care in Rhode Island."