

# WORCESTER medicine

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# medicine

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# Editorial

Jane Lochrie, MD



**Jane Lochrie, MD**

Military personnel and their families can face health concerns that vary from those of civilians. These may include, but are not limited to, exposure to unusual agents and infectious diseases, as well as severe physical, neurological and emotional injuries.

The media has focused public attention on the inadequacies of care at the Veterans Health

Administration (VHA). But the important role that community physicians play in providing health care for veterans and their families has largely escaped scrutiny. Veterans don't usually offer information about their military service unless they are asked.

Most medical schools do not include veterans cultural awareness in their curriculum or graduate medical education programs. Physicians and other providers have a professional obligation to identify veterans and to achieve at least a general understanding of why and how to ask questions pertinent to their medical and psychological well-being. This issue of *Worcester Medicine* examines what is being done in Central Massachusetts to address these concerns.

In the first article, Dr. Michael Collins, senior vice president of Health Sciences, University of Massachusetts and chancellor of University of Massachusetts Medical School, explains the collaboration of the medical school with the VHA. They have a common goal – to enhance the quality of and access to health care for veterans in Central Massachusetts and beyond. This includes a 13,000-square-foot specialty care annex located on Plantation Street that offers podiatry and audiology services, and the VHA now occupies 15,000 square feet in the Ambulatory Care Center on the UMass campus, providing much needed

mental health and cardiology expertise.

Dr. Daniel Lesley, a neurologist at the Central Western Massachusetts VHA, describes how the job of a deployed physician is very different from that of a standard hospital or outpatient clinic. Physicians live with their patients and often act as mentors, leaders and life coaches. They must monitor and enforce public health codes, anticipate hazards and maintain readiness for mass casualties.

Linda Cragin, MS; Janet Fraser Hale, Ph.D., RN, FNP; and Tina Runyan Ph.D., ABPP, informs us of what is being done at UMass Medical School and the UMass Graduate School of Nursing to teach clinicians how to ask the important question “Have you or a loved one ever served in the military?” Veterans constitute 9 percent of Central Massachusetts’ population and most have never been asked this question. They point out that all who serve in the military do not qualify as veterans or qualify for veterans’ benefits.

Amanda Morrill, Pharm.D., RPh, BCPS, explains that 40 percent of pharmacists at the VHA have a Scope of Practice. This allows them to manage a spectrum of disease states as independent practitioners with prescribing privileges. The VHA is on the forefront of the team-based, patient-centered care model and allows the pharmacists to utilize their doctoral education. The pharmacy students from the Massachusetts College of Pharmacy and Health Sciences also participate in this unique patient care experience.

During undergraduate education, our student author, Ensign Yevin Roh, wanted to serve globally, but more so, he wanted to work with underserved and vulnerable populations most affected by health care disparities. He relates how he merged his dreams by joining the Navy, where he can simultaneously serve the vulnerable community worldwide and serve his country.

Please don't close this issue without reading our Legal Consult, the President's Message and Society Snippets.

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# President's Message

James B. Broadhurst, MD, MHA



James B. Broadhurst, MD, MHA

I was humbled as I introduced Dr. Terence Flotte to present the 221st oration to the Worcester District Medical Society. It is an honor and a privilege to serve as your president – to lead an organization which has endured – indeed, thrived – for more than two centuries. Our mission of advancing medical knowledge, promoting the highest professional and ethical standards and working to improve the health and well-being of Central

Massachusetts residents is evident every day, thanks to you, our members, who support this organization. We are the third largest medical society in the state and the third oldest in the country. Our society is strong, thanks to students, residents, physicians and the great work and efforts of the Alliance.

We are very proud of the fact that our district comprises members and leadership from the medical school, the various hospitals, community health centers, group practices, solo practices and all specialties. We are the only district to feature a bimonthly magazine and a weekly television show. Although we may have diverse interests and different backgrounds, few organizations can boast the privilege of welcoming and uniting such a diverse group of gifted, dedicated and inspired individuals with a shared passion and commitment for making our health care environment and our community the best it can be.

This year, I have made a particular effort to include two broad topics for discussion, reflection and greater understanding within our society. This past fall, our annual Louis A. Cottle Lecture featured an insightful presentation by Dr. Diane W. Shannon titled “Physician Burnout: An Under-recognized Problem.” Our society and our Central Massachusetts health care institutions are recognizing the reality of physician burnout and the promise of a variety of strategies to help prevent and ameliorate such burnout. These approaches are part of the overall term “wellness,” and wellness programs are now part of undergraduate and graduate medical training, as well as part

of professional society and health care institutional initiatives.

In December, members gathered for a holiday reception and the WDMS newest tradition: A Night at the Movies. We watched *Something the Lord Made* – a dramatization of the life of Vivien Thomas, an African American man who joined the lab of Alfred Blalock at Vanderbilt University in the 1930s and who learned to be an outstanding laboratory surgical assistant and teacher. Ultimately, he was recognized with an honorary degree from the Johns Hopkins Medical School. Our discussion after the film focused on the depiction of institutional racism and the enduring issues of unconscious bias, disparities in medicine, the value of diversity in our profession and the complications of privilege.

We joined together for several additional events during the past year. Our fall meeting again celebrated the medical students identified by our Scholarship Committee for support in their medical education. The Women in Medicine Committee celebrated 25 years of great work with a breakfast and spirited discussion of current legislative issues led by Alex Calcagno, director of Advocacy, Government and Community Relations for the Massachusetts Medical Society. In February, we gathered to honor our members who volunteer their time serving on our committees and enjoyed a Music Worcester concert by the Venice Baroque Orchestra and its performance of Vivaldi’s Four Seasons.

The work of our society is accomplished thorough our committees. I commend to you the reports in this document which chronicle their initiatives and accomplishments.

A special thank you goes to Joyce Cariglia, our executive director, and Melissa Boucher, our administrative assistant. Their tireless efforts, energy and enthusiasm make it possible for the WDMS to offer so much to members. I want to thank all of you for your support, engagement and for all the great things you do in serving the society and this community. Please stay engaged and inspired. It is a joy and a privilege to serve as your president. Together we are truly stronger. Your ideas, friendship and energy are what define the society. Thank you so very much.

*Reprinted from the Worcester District Medical Society 2016-2017 Annual Reports.*



# **VOLUNTEER PHYSICIANS NEEDED FOR ST. ANNE'S FREE MEDICAL PROGRAM**

Jane Lochrie, MD, FACP

I will be assuming the role of medical director of St. Anne's Free Medical Program in June. As many of you know, this program was started by Dr. Harvey (Jerry) Clermont more than 20 years ago.

Our mission is to provide high-quality, respectful and free medical care for the underserved population of Worcester County. The staff is all volunteers and is comprised of dedicated professionals and support staff, many of whom have been volunteering since the program started, and medical students and residents.

The program sees, on average, 50 patients per evening; many are pediatric patients who come to the clinic for physicals, vaccinations and minor health issues. We could really use the help of pediatricians and family medicine physicians, as we are losing our two family medicine physicians and we do not have a pediatrician.

**The program runs every Tuesday night from 6-8 p.m. at  
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# The VA Relationship with the Medical School

Michael F. Collins, MD



Michael F. Collins, MD

It has long been a foundational component of medical education in the United States that students commit to spending a portion of their time caring for veterans, allowing emerging clinicians to begin to understand the special challenges faced by this population of patients. My own medical training included a rotation at the VA's Jamaica Plain campus in Boston. This first-hand experience and connection to those in the local VA health system was quite personal; just a few years earlier, they had provided excellent and compassionate care to my

own father – care that extended his life by a year. For this gift of time, my family and I are profoundly grateful.

More recently, as I have served as chancellor of the University of Massachusetts Medical School, our academic health sciences community has taken great care to explore the many ways in which we might partner with the VA in each of our core mission areas – education, research, patient care and public service. We have been proud to establish a number of collaborations that are varied, rich and mutually beneficial. Some are well-established while others continue to grow and evolve; all of them share the common goal of enhancing the quality of and access to health care for veterans in Central Massachusetts and beyond.

UMass Medical School's most visible efforts to date have centered on working with the VA Central Western Massachusetts Healthcare System to increase veterans' access, particularly their ability to make appointments with medical specialists in a timely manner. In January 2016, we were privileged to stand alongside the nation's then-VA Secretary Robert McDonald, Congressman Jim McGovern and regional dignitaries to cut the ribbon on a new 13, 000-square-foot specialty care annex, located within the medical school's biotech park on Plantation Street. This new patient care center has allowed the VA to provide audiology services to Worcester-area patients for the very first time. Podiatry and optometry services, also offered at the Plantation Street annex, have grown significantly, too, meaning that veterans are now able to receive specialty care closer to where they live, thus avoiding costly (both in time and financial expense) trips to VA facilities in Boston.

More recently, the VA and UMass Medical School have expanded access to much-needed mental health and cardiology services through a collaborative agreement for the VA to occupy 15,000 square feet of space in the Ambulatory Care Center on the UMass Medical School campus. The care is streamlined and provided in a new, state-of-the-art facility that is easy to access and, again, closer to home. At its community-based outpatient clinic, the VA has recently added services to help determine if veterans are eligible for care and compensation. VA Central

Western Massachusetts Healthcare System Director John P. Collins (no relation) reports that veterans, their families and advocates report being "highly satisfied" with the expanded services that are now available to them in Worcester.

Indeed, the stakes are high. Each year the VA provides 350,000 appointments for more than 26,000 veterans throughout Massachusetts' five westernmost counties at its six care sites and through partnerships with private-sector providers in the community. The VA is committed to increasing the utilization rate among local veterans while continuously improving the services provided in Central and Western Massachusetts. The good news is that it seems reasonable to hope that additional resources may be available to do so in the foreseeable future.

President Donald Trump's preliminary spending blueprint that was announced in March signals that his administration will satisfy a campaign promise and increase the VA's \$180 billion budget by 6 percent. At the time of this writing, a detailed plan has yet to be announced. However, according to a report in *Military Times*, the additional funding would support a continuation of the Veterans Choice Program, which increases VA/private partnerships to allow veterans to access the care they need within 30 days and 40 miles of their home, allows for technology investments to improve the effectiveness and efficiency of services and prioritizes programs aimed at ending homelessness among veterans.

All of these are worthy goals. I am proud to share that the University of Massachusetts Medical School's mission of service to veterans is imbued into the daily efforts of many faculty members who keenly understand that working on behalf of service men and women results in direct benefits to veterans while fostering advances that benefit patients everywhere. Such faculty members include David Smelson, Psy.D., a national leader on the issues of veterans homelessness and substance abuse; Kristen Mattocks, Ph.D., a health researcher who launched the first-ever VA study of maternal health care issues and needs; Melissa Clark, Ph.D., who is collaborating with the Rhode Island VA to assess the needs of and improve the quality of life for veterans with upper limb amputations; and Janet Hale, Ph.D. and Linda Cragin, MS, who were honored for their work to train nurse practitioners to better understand veterans' unique concerns and the best ways for non-VA primary care providers to address those needs.

Our students – some of whom are themselves veterans – are instilled with a noble desire to continue this commitment, a fact that gives me great hope for the future. They, along with our faculty and leadership, understand that our medical school's goals are symbiotic with those of the VA as it explores new models of collaboration to meet the complex and changing needs of new generations of veterans. The University of Massachusetts Medical School is poised to do all we can to assist the VA in achieving its goals and would urge other organizations in a position to help to consider doing so.

*Michael F. Collins, MD, is the senior vice president of Health Sciences at the University of Massachusetts and the chancellor of University of Massachusetts Medical School.*

# Medicine in the Military and After

Daniel Lesley, MD

My medical alma mater was a military school, the Uniformed Services University. A fundamental lesson I learned there is that military medicine is not just medicine practiced in military situations, but a unique discipline with its own medical and organizational principles.

The classes taught at USU included not only the usual medical courses, but also more esoteric studies like undersea medicine, the treatment of nuclear/biological/chemical weapon exposure and the reduction and mitigation of the wounds of the spirit that are involved in battle fatigue and PTSD. Lessons and field exercises on setting up makeshift hospitals, responding to mass casualties and leading corpsmen or medics under our command were integrated into our training. Over the course of my career so far – in the combat zones of Iraq and the Persian Gulf, in the cramped quarters of life at sea, in military, civilian and Veterans Health Administration hospitals and clinics – many of those lessons have proved all too useful.

In a combat zone or a deployed environment such as a ship, the job of a physician may be very different than it would be in a hospital or standard outpatient clinic. As part of a deployed unit, we physicians have many roles to play in addition to our medical duties. As officers, we function as command staff, department heads and training supervisors for the entire crew. We are responsible for the construction or repair of our medical spaces, have control of a budget of tens of thousands of dollars for supplies and equipment and have direct input to the commander of our ship or unit over the medical hazards of the environment or mission. We have to monitor and enforce public health codes, anticipate medical hazards that may change daily as our unit moves and maintain readiness for mass casualties, all while scrounging for medical supplies in foreign lands.

The relationship with our patients is also very different. Whether on a ship or in the desert, we live with the people we take care of. We depend on them for safety, food, shelter and getting us our electricity and supplies. We have to know the jobs of each of the people we treat, the unique dangers and exposures they face and the effect on the people around them of their absence or limited function. If someone in our unit is injured or becomes ill and we don't evacuate them, we may find ourselves in a medical situation that exceeds our medical resources/capabilities. However, if we send them home, we degrade the capabilities of the unit performing the mission and may put even more people at risk, or cause a critical mission to fail, at the cost of even more lives.

During the “down time” between sick calls, military duties and emergencies, we may function as a combination leader,

mentor and life coach to the enlisted medical personnel under our command. I've tutored corpsmen taking college courses in Greek art, economics, English and biology while deployed. I've helped them to put their finances in order, taught them how to invest their money wisely and helped them apply for college. My Sailors, Marines, Soldiers, Airmen and Coasties are like family away from home. So life deployed can be extremely rewarding, as well as very challenging, since we're not just doing a job, we're living within and for a family of service members.

Even away from deployment, in a hospital or clinic setting, military physicians may face unusual pressures. One of the differences between a military hospital and a civilian one is that the staffing of a military hospital may meet the needs of its patient population under normal conditions; however, when an emergency or war breaks out, up to a quarter of the military hospital's critical medical and support staffing may suddenly be called away to a deployment, leaving the rest to take over for their deployed co-workers in providing the usual medical care. The responsibilities of any individual may be more diverse as a result, but so are the opportunities to participate in medical care outside one's usual scope of experience.

My current post-military practice, as a neurologist in the Veterans Health Administration, is actually a continuation of military medicine by other means. Working at the VA means learning how to deal with the aftermath of a century's worth of different war wounds – the old physical injuries from bombs and bullets, the nerve damage from toxic exposures to harsh environments and chemicals and the psychic scars of having to see, endure and sometimes do the unimaginable. Those scars have to be distinguished from each other, but they all have to be dealt with together if the patient – the former service member who might not have served alongside you but certainly served for your sake – is to get the care he or she deserves.

Thankfully, the VA as I've seen it has a wide variety of resources, well-integrated with each other, to untangle those interwoven problems, with social, psychiatric, financial and administrative support to supplement the medical care. And the ability to get patients what they need in any of those realms of care, without having to worry about insurance coverage or pressure to up-order tests, is a blessing that lets me focus my time on being present and focused on my patient, not my business practice. Because working for the VA is not taking care of business. For me, as a veteran myself, it's taking care of family.

*Daniel Lesley, MD, is a neurologist at the Central Western Massachusetts VA.*



# Have you or a loved one ever served in the military?

Linda Cragin, MS, Janet Fraser Hale, Ph.D., RN, FNP and Tina Runyan, Ph.D., ABPP

This may seem like a simple question to include in a patient's history. But is it routinely included, and is it a simple question?

While not a representative sample, the majority of veterans involved in teaching about veterans' health and military service at UMass Medical School (during a Veterans' Health clerkship for second-year medical and advanced practice nursing students) have not been asked this question by their health care providers. Until three years ago, this question was also not a part of the medical school's curriculum.

A common misconception is that we don't need to ask about military service in the civilian health care system because veterans go to the Veterans Health Administration (VA). In fact, fewer than 25 percent of all Massachusetts veterans seek health care through the VA.

In the U.S., veterans constitute 7 percent of the total population (U.S. Department of Veterans Affairs); in Massachusetts, veterans are 7 percent of the population and 9 percent in Central Massachusetts (Massachusetts Department of Veterans Services). This makes Massachusetts home to slightly less than 400,000 veterans. The youngest veterans are more likely to be Reserve and National Guard soldiers who return to civilian life when not on active duty.

The question is not a simple one. We teach the students to ask the question in this way for specific reasons.

Not all who serve in the military qualify as a veteran or qualify for veterans' benefits. A veteran is defined as "a person who served in the active military, naval or air service and who was discharged or released under conditions other than dishonorable" (Title 38 CFR).

There are different types of military service. Active duty is full-time service, with the exception of leave (vacation) and pass (authorized time off). While active, members fall under the jurisdiction of the U.S. Department of Defense and serve in the Army, Air Force, Navy, Marine Corps or Coast Guard. Members of the Reserves and National Guard are considered part-time (one weekend/month, two weeks/year) unless called to active duty; and most have been called, one or more times, since Sept. 11, 2001.

The objective of the Reserves is to support active duty forces, and each branch has a reserve component. Reservists attend basic training and military job schooling full-time, but this does not count toward the service requirement for benefits, nor does the weekend inactive duty training (IDT) or the two-week active duty training (ADT) each year. When called by the president and secretary of defense to active duty to support military operations, the time is considered active duty and contributes

toward veterans' benefits. As noted above, Reservists resume civilian life in between times in training or on active duty.

Members of the Army and Air National Guards also attend basic and military job training and complete IDT and ADT requirements. Like Reservists, this time does not count toward benefits. The Guard reports to the governor in its home state. The governor can call the Guard to active duty – if a state of emergency exists – for relief and protection beyond local law enforcement. This time does not count toward veterans' benefits. Like the Reserves, the Guard can be called to active duty by the president and secretary of defense, and this counts toward benefits. Since the first Gulf War (1991), the Guard and Reserves have been called more often to active duty.

Generally, in order for a former service member to receive certain VA benefits, the person must have active service for a minimum time, generally 24 months. For people who enlisted prior to Sept. 8, 1980, there is no minimum service requirement. There are exceptions – for example, service-connected disability compensation benefits are exempt from the length of service requirement.

There are further qualifications to get VA health benefits. A veteran must first enroll, and eligibility will then be determined. In addition to active duty status, some veterans may be afforded enhanced eligibility status: Prisoners of war, Medal of Honor or Purple Heart recipients, etc. Veterans are assigned to one of eight priority groups (Priority Group 1 is veterans with a 50 percent or greater service-related disability; Group 8 is for veterans with a gross household income above VA levels and who meet four of six subpriorities). Accessing VA health services depends on the assigned priority group and availability.

Some veterans feel they don't deserve veteran status. They may not have been deployed overseas, been injured or may have only served during peacetime. The ethos of military service – integrity, trust, self-sacrifice and the commitment to something larger than oneself – can contribute to the feelings of being less worthy than others of veteran status.

Given the widening divide between civilians and military service, some veterans hide their military service. It is only recently that our country has learned to recognize and honor those who serve, even if the politics of war are not supported.

Military service may also have a significant impact on individuals who were dishonorably discharged, which may not be disclosed if asked about veteran status. The Massachusetts Department of Veterans Services Statewide Advocacy for Veterans' Empowerment (SAVE) program recognizes this and serves all those who have served. They may also be able to help reverse a dishonorable discharge. The Department of

Defense is now recognizing that some of the earlier “other than honorable discharges” may be due to service connected post-traumatic stress or traumatic brain injury, and some cases are being reviewed.

The students are taught to ask “if you or a loved one have ever served,” as family members are also affected by military service. In a recent Pew Research Center study, 77 percent of adults older than 50 have an immediate family member who served. For those 30-49 years old, more than half (57 percent) have an immediate family member, and among those 18-29, only one-third (33 percent) have an immediate family member. With the closing of major military bases in Massachusetts, family members of those who serve, including guardsmen and reservists, may be the only ones in their neighborhood, or the only child in a school system, whose spouse/parent is deployed.

And finally, the question is not limited to U.S. military service. With the significant number of immigrants and refugees in Central Massachusetts, participation in military service in other countries may have a significant impact on the individual’s health.

If the answer is “yes” – now what? First, celebrate. This critical piece of information may help you better understand the patient in context, his or her symptoms, and the way he or she interacts with the health care system. In addition to the possibility of VA services and potential compensation for health issues, knowing a patient’s military service history and years/eras served may help to focus on possible diagnoses.

You also potentially have additional resources to care for this patient, and you do not have to navigate the systems alone. There are representatives who can be of assistance and numerous online resources (see below).

Please ask this question. There are many reasons why someone has not or might not want to access services at the VA. Ask, listen, try to understand the barriers from their perspective, and over time, they may agree to services. Or they may already be getting services from the VA, and you will want to coordinate care. At a minimum, you can thank them for sharing, as it can help you care for them

and for other veterans.

*Linda Cragin, MS, is the director of the MassAHEC Network, a workforce development program at UMass Medical School. Janet Fraser Hale, Ph.D., RN, FNP, is a professor and associate dean for Interprofessional and Community Partnerships at the UMass Graduate School of Nursing. She is also a retired colonel in the U.S. Army Reserves. Tina Runyan, Ph.D., ABPP, is clinical associate professor and director of the Post-doc Fellowship in Clinical Health Psychology in Primary Care at UMass Medical School. She served six years active duty in the U.S. Air Force/Biomed Science Corps.*

#### Resources:

1. Those with connections to military services are fortunate as Massachusetts is recognized nationally for the services provided through the state Department of Veterans Services: <http://www.mass.gov/veterans/>. Each city and town has a veterans’ services officer: <http://www.mass.gov/veterans/utility/local-veterans-service-officers-3.html>.
2. SAVE: <http://www.mass.gov/veterans/health-and-well-being/counseling/suicide-prevention-only/save.html>.
3. The Office of the Attorney General’s resource guide is an excellent summary: <http://www.mass.gov/ago/docs/civilrights/vets-guide.pdf>.
4. Blue Book: <https://northwesternda.org/sites/default/files/Veterans.pdf>.
5. The US Department of Veterans Affairs has service sites across the state: <https://www.va.gov/directory/Guide/state.asp?STATE=MA&dnum=ALL>.
6. There are outreach staff in the Central Western Massachusetts region: <http://www.centralwesternmass.va.gov/>. To find their local events, <https://www.facebook.com/VACWMASS/>.

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# Pharmacy Practice in the VA Setting

Amanda M. Morrill, Pharm.D., RPh, BCPS

*Please note that my views are my own and are not reflective of the Veterans Health Administration.*

Of the more than 297,000 pharmacists in the United States, approximately 7,000 practice at the Veterans Health Administration (VHA).<sup>1,2</sup> This practice type is unique in a variety of ways, from the population treated to the scope of clinical responsibilities and care delivery setting. Pharmacists who practice outside the VHA are typically limited in their ability to provide independent, direct patient care, in part due to the lack of national recognition by health plans as patient care providers.<sup>3,4</sup> Approximately 40 percent of VHA pharmacists have Scope of Practices, determined by education and training, that allow them to manage a spectrum of disease states as independent practitioners with prescribing privileges. In this way, the VHA is (and has been since the mid 1990s) on the forefront of the team-based, patient-centered care model and allows pharmacists to utilize their doctoral education. This also increases veterans' access to care and affords more time for physicians to see patients for complicated issues.

As a clinical pharmacy specialist at the Veterans Affairs Medical Center (VAMC), I have the opportunity to care for veterans in the Tobacco Cessation and Primary Care clinics. In each clinic, the veterans are given 30 minutes of dedicated time with the pharmacist to focus on medication management, self-monitoring and lifestyle changes. This permits frequent follow-up to monitor and make changes, as well as a dedicated clinic to answer veteran questions between appointments. The Tobacco Cessation Clinic, an interdisciplinary clinic, follows best practices for tobacco cessation, utilizing both behavioral interventions and medication management during 30-minute appointments with a pharmacist and psychologist with personalized follow-up. Due to time, as well as other constraints, this model is not widely available in many practice settings.

Another unique aspect of pharmacy at the VAMC is the “backwards” way of filling prescriptions. In the community, most retail pharmacy prescription pick-ups follow a similar pattern: patient states name, is handed medication and asked if they have any questions for the pharmacist; the answer is often no, marking the end of the interaction. At the VAMC, the prescription pick-up process turns the tables, opening the lines of communication and collaboration with patients, as its name – Without Walls (WOW) – implies. At WOW, veterans first sit down for a face-to-face meeting with the pharmacists, facilitating a discussion and changing the perceived dynamic from customer service provider to patient health care provider.

Then, the patient picks up the medication. Doctor of Pharmacy students, who I precept on clinical practice rotations, frequently remark positively about this process. Most recently, one noted it was not only efficient but also a much safer way to dispense medications.

In addition to utilizing clinical skills beyond the typical pharmacy practice, it is the patient population that makes the VHA such a special place. I am often reminded of their resourcefulness and how much they have given for our country. One afternoon, while caring for patients for diabetes management in the Primary Care Clinic, my patient was a middle-aged veteran who had been seen in the clinic before, however, not by me. After reviewing his home blood glucose log, we started to discuss the relationship between his diet, activity and the glucose

readings. Throughout this review, the patient was continuously looking at and typing on his phone. As I'm sure many of you have experienced in your practice or talking to teenagers, this can be a frustrating situation. Of course, I grinned and continued with the appointment. As I was discussing what changes would be made to his insulin dosing, he looked up at me and said, “Sorry I keep looking down. I have a TBI and the only way I can remember everything is to put it into my phone.” A TBI is a traumatic brain injury. The whole time, the patient had been typing our discussion points into his phone and paying close attention. It is better than a notebook or journal for him because he has it with him all the time! Any frustration was immediately replaced with inspiration that he had found a way to adapt. It was a good reminder to adapt my approach to make it easier for him, such as spell out drug names and double check to make sure the changes are typed correctly.

The pharmacy students gain this insight while observing and participating in patient care. Much of their learning is not only from the pharmacists but from the veterans themselves. During orientation, I draw their attention to the small details, such as the televisions in the waiting rooms often playing soap operas, rather than the news, in order to avoid triggering a flashback in veterans with PTSD, or the pictures on the wall and service details of VHA employees who are veterans. The orientation ends with a stop at the Wall of Valor, a memorial for the veterans of New Hampshire who gave the ultimate sacrifice in Operation Enduring Freedom, Iraqi Freedom or New Dawn. Even if the students do not go on to work in the VHA, this experience will carry into their practice, where they may care for the 75 percent of veterans who seek care outside the VHA.<sup>4</sup>

Pharmacy practice at the VHA is professionally and personally rewarding on multiple levels. From a professional practice standpoint of providing independent, direct patient care in a patient-centered, team-based model to the daily opportunity to learn from the veterans and hear their pride when discussing their service, the VHA pharmacy services are a practice model for health care systems, and it is an honor to work toward fulfilling the VHA mission to “serve those who have served.”

*Amanda M. Morrill, Pharm.D., RPh, BCPS, is an assistant professor of Pharmacy Practice at the School of Pharmacy-Worcester/Manchester at MCPHS University in Manchester, N.H., and has a practice site at VA Medical Center in Manchester as a clinical pharmacy specialist.*

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# In service to the vulnerable at home and abroad

Ensign Yevin Roh, BS



Ensign Yevin Roh, BS

*Opinions expressed in this article are solely the author's own and do not reflect those of any affiliations.*

All four years as a pre-medical and public health student at UMass Amherst, I hung the same poster over my bed: a map highlighting areas where Doctors Without Borders provided care across the globe. I dreamed of traveling the world and treating the underserved and building relationships with communities in need. I had the privilege of engaging in two service-learning projects in Kenya and Cambodia as an undergraduate, which

affirmed my dream to work globally and also forced me to think critically about health care within my home country. Both of these projects connected with immigrant populations in the U.S., and it became clear to me that borders are minor obstacles for illnesses. This became more obvious in my public health courses, where I learned of health disparities within the U.S., of how infant mortality rates in under-resourced U.S. communities are comparable to countries with less access and infrastructure.

After much self-reflection, I concluded that I wanted to serve globally, but more so, I wanted to work with underserved and vulnerable populations most affected by health disparities, whether they are in the U.S. or abroad. Unfortunately, I did not know how to merge my dreams of service to the vulnerable on a local and global scale. I feared my dreams were mutually exclusive and would remain unfulfilled.

I remember the exact moment I felt like I could reconcile my dreams of global and local service, and it was the same moment I decided to pursue a career in Navy medicine. It was 2010 at the East Coast Asian American Student Union conference at UPenn during a session titled "Officer & Medical Doctor: Traveling the World & Saving Lives while Serving in the U.S. Navy." The workshop included a video highlighting the Navy's humanitarian response to the earthquake crisis in Haiti. One story stood out: a pregnant woman whose pelvis had been crushed by rubble. Both her life and the life of her child were saved by an emergency C-section aboard Comfort, a U.S. Navy hospital ship.

I was moved; I felt a call to service. My two dreams had materialized into one: I could serve the vulnerable worldwide and serve my country simultaneously through the Navy. Across the globe, there are disasters to respond to, remote areas where health care is inaccessible, and gaps to fill where infrastructure is lacking. And in service to my country, the ranks of the armed forces are filled by many brave people from vulnerable backgrounds – immigrants hoping to earn citizenship, working-class youth looking for stability and/or a college education, people escaping home and countless more. When the moment came to apply to medical school, I applied concurrently to the Navy's Health Professions Scholarship Program, so I could begin my career right away.

Now, as I approach my graduation in 2018, I'm compelled to reflect on what has kept me passionate about the underserved and my future with the Navy. I've had the opportunity to work with some of Massachusetts's most vulnerable populations – the homeless, the incarcerated, the mentally ill, veterans, transgender youth, patients who are in the grips of addiction and on the road to recovery, refugees, immigrants, the impoverished and more. It is a privilege to hear their stories and to be included in their journey to better health. Taking part in their health care has never been easy, but it has always been rewarding. Small strides can make a big impact, and the simple courtesy of a thorough and hopeful medical interview can dramatically change their follow-up care.

Having dipped my toes into our country's health care system, I've come to believe with all the optimism (and naïveté) of a medical student that the greatness of a physician, a commonwealth and a nation is measured by how it treats its most vulnerable communities and individuals. The attending physicians I've admired the most are the ones who treat their stigmatized patients with the utmost respect and do not use disparaging language to describe them. The aspects of Massachusetts's health care and public health system that I've come to admire the most are the programs that target children, improving sexual health education for students and coverage for low-income patients, as well as a complicated network of community health resources that tackle issues such as addiction, domestic violence, after-school programs and the arts.

Our nation, though imperfect, still strives for greatness in the way it allocates resources for the vulnerable – through programs such as WIC, SNAP, Medicare and Medicaid. Above and beyond the care our nation provides for vulnerable people within our own borders, the Navy takes another step toward the vulnerable across the globe by providing humanitarian medical care as part of the Pacific Partnership, educating physicians of nations in need and answering the call for medical aid when natural disasters strike. This, to me, epitomizes our efforts to be great – an ability to care, a willingness to serve the neglected and a mission to actively seek out the sick.

I am reminded of a quote by President Kennedy, "I can imagine no more rewarding a career. And any man who may be asked in this century what he did to make his life worthwhile, I think, can respond with a good deal of pride and satisfaction: 'I served in the United States Navy.'"

Like medical school, I do not anticipate this long journey towards greatness with the Navy to be easy; it may be grueling to serve the sick, but for me, it has also been rewarding. For I anticipate that there will be a time in my life when I will need to honestly ask myself if I did everything in my capacity to better the world and uplift the human spirit. In this regard, the Navy represents to me an opportunity to serve some of the most vulnerable people in our own country and in the world. It represents the greatest part of the American spirit, a spirit I hope to emulate as a physician – an unyielding commitment to the tired, poor and huddled masses yearning to breathe free.

*Ensign Yevin Roh, BS, is a medical student of UMass, a recipient of the United States Navy Health Professions Scholarship Program, and will be serving in the Navy after his graduation.*

# New Mid-level Practitioner Regulations

Peter J. Martin, Esq.



**Peter J. Martin Esq.**

Physician practices participating in MassHealth often have difficulty providing services in an efficient and sustainable manner under MassHealth reimbursement levels. Any development making it easier to provide those services using lower-cost physician extenders would assist practices to continue to provide those services. The Massachusetts Office of Medicaid recently promulgated proposed amended regulations that offer some relief to practices along those lines.

The new proposed regulations would loosen restrictions on the use of “mid-level practitioners,” defined as nurse practitioners (NP), nurse midwives, certified registered nurse anesthetists (CRNA), certified nurse specialists and physician assistants (PA). NPs, nurse midwives, CRNAs, psychiatric clinical nurse specialists and clinical nurse specialists can bill for their own services, or a group practice can bill for their services. The expansion of Medicaid-payable services rendered by these practitioners, as well as some loosened physician supervision obligations, will help medical practices maximize the value of these colleagues.

For example, MassHealth will now accept pre-authorizations for certain non-physician services from these “other practitioners.” Such services include transportation, drugs, durable medical equipment and home health, nursing facility and therapy services. While the phrase “other practitioner” is not defined in this provision, it appears clear that it refers to those mid-level practitioners who have the authority to provide orders, referrals, prescriptions, medical necessity documentation, certifications, plans of care, examinations or take such other actions as may be required by MassHealth as a condition of payment for a particular service.

Specific additional services may be performed by or under the direction not just of a physician but by a specified type of mid-level practitioner. Examples include allergy testing by an NP, clinical nurse specialist or a PA, psychiatric services by a psychiatric clinical nurse specialist, tobacco cessation services by psychiatric clinical nurse specialists and clinical nurse specialists and clinical laboratory services by an NP, nurse midwife, CRNA, clinical nurse specialist and PA.

Although the new regulations retain the obligation for PA supervision by a physician through written guidelines, NPs practicing independently do not need a formal physician “collaborative arrangement,” including written practice guidelines. Presumably this means that an independent NP can write prescriptions without prescriptive practice guidelines agreed to by a physician. Though PAs employed by a group practice must still be under the supervision of a physician, that PA may enroll as a primary care clinician and have MassHealth enrollees assigned to the PA.

The proposed new regulations may be subject to change prior to an effective date of not earlier than Aug. 1, 2017. Physicians and group practices with a significant level of MassHealth participation should keep abreast of these and other new developments as the provider system continues to evolve to delegate more patient care to more types of lower-cost practitioners.

*Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, his practice concentrating on health care and nonprofit law.*

# WISE — Worcester Institute for Senior Education

Mohan Korgaonkar, MD, FACS

Nearly 20 years ago, one of our neighbors, a well-respected attorney in his late 70s who had retired couple of years earlier, came over to our house and buoyantly announced, “Mohan, Ruth and I are going back to school!” He was quite excited about the prospects of being a student again. I was very happy for them. Of course, retirement was distant on my radar then. However, I am glad that I remembered that conversation about three to four years ago and joined WISE.

Worcester Institute for Senior Education is a member-driven organization and gearing up for its 25th Anniversary Celebration in 2018. Founded under the auspices of the Assumption College, it is one of the jewels of Central Massachusetts. In 2015, it received recognition by the *Telegram & Gazette*, receiving the Visions Award for Cultural Enrichment.

The following links will provide detailed information about WISE and the courses it offers (from Movies of the 60s/70s to Socrates, Federalists Papers, U.S. Constitution, etc.). While the courses are stimulating and the teachers distinguished, the best part is the discussion and rich exchange that occurs within the invigorating peer group. WISE also offers other fun things, such as visits to museums, theaters, etc.

The membership consists of individuals from all spheres of the society – attorneys, businessmen and women, academicians, but only a few physicians. No surprise there, and I am not grumbling. After all, as physicians, we not only work long hours but also for a long period of time, tending to our patients. But, like in my own case, when the time of retirement approaches, sometimes it is just a matter of awareness of a richer, healthier alternative. After all, being in the field of medicine, lifelong learning is our DNA.

## How to find WISE:

[www.google.com](http://www.google.com); Then type WISE/ Assumption in the subject line & hit return.

A number of entries will open up. Select the following two for more info:

[cce.assumption.edu/wise/worcester-institutsenior.education](http://cce.assumption.edu/wise/worcester-institutsenior.education)

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# CONGRATULATIONS TO OUR AWARD RECIPIENTS

## ANNUAL BUSINESS MEETING – APRIL 12, 2017

### 2017 COMMUNITY CLINICIAN OF THE YEAR AWARD RECIPIENT



**Sara G. Shields, MD, MS**

Dr. Shields, a Clinical Professor of Family Medicine and Community Health at the University of Massachusetts, Family Health Center of Worcester, received the 2017 Community Clinician of the Year Award.

Dr. Shields is an accomplished physician, leader, educator, writer and community clinician. Ever since completion of her 1994 Masters Thesis at Brown which was devoted to The Effects of Continuity of Perinatal Care in a Health Center Population, Dr. Shields has ‘walked the walk’ serving as a Family Physician in continuity for over two decades at the Family Health Center of Worcester. She provided full spectrum family health care to the disadvantaged and underserved with an emphasis on women’s health and maternity care (in English and in Spanish), she has served as a mentor and teacher to scores of residents and students.

*The Community Clinician of the Year Award was adopted at the Interim House of Delegates meeting in November 1998. It was established to recognize a practitioner from each district medical society who has made significant contributions to patients and the community. Each district is encouraged to identify one deserving physician each year. It is strongly recommended that recipients be members of the Society, though it is not a prerequisite. Districts are not required to submit a nomination.*

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# WORCESTER DISTRICT MEDICAL SOCIETY 2017 CALL FOR NOMINATIONS

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# Joel M. Seidman, MD, FCCP

May 27, 1938 – February 13, 2017

My dear friend and colleague of 40 years, Joel Seidman, MD, FCCP, died on Feb. 13, 2017, at age 78. After graduating from Harvard College and Medical School, he trained at Brigham Hospital and the VA in West Roxbury. His calling in medicine was as a pulmonologist and intensivist. He served as a lieutenant in the United States Navy. Joel was chief of Pulmonary Medicine at Framingham Union, UMass Medical Center and Memorial (later UMass Memorial) hospitals. He was an associate professor of Medicine and Physiology. Joel was active in the WDMS, Mass Thoracic Society and was president of a national organization.

A yearly medical ethics symposium at Memorial Hospital was initiated by him for the medical residents who came from many different countries and cultures. Although well-versed in the mechanics of medicine, his practice style was humanism. That is what he instilled in his students and all those around him.

Joel was a lifelong learner and led by example. His interests and abilities were widespread: flying, Judaism, the outdoors, woodworking, biking, travel, fundraising, photography, music, computing and so much more.

But what was most important to my friend was his family. He was totally devoted to his wife, Bobbie. They were married for 55 years, and her death, four months before his, devastated him after her long illness. He was most proud of his children, Michael and Marianne; and their spouses, Jody and Rich; and his grandchildren, Max, Carly, Shoshanna and Elianna.

During the last 20-plus years of his life, he endured a terrible disease, primary lateral sclerosis. It attacked and robbed his body, piece by piece. Every day, he faced this nightmare, which took his strength, his ability to walk and his speech. I could only understand a few words over the phone. But he never complained. He would disagree with my calling him courageous, yet he maintained his dignity up to the end.

Farewell, my friend, who was truly a renaissance man and a mensch.

– Michael Baron, MD, FCCP



# Francis X. Dufault II, MD

January 25, 1928 – February 18, 2017

With the recent passing of Francis X. Dufault II, MD, our medical community lost one of our best known and most esteemed colleagues. Frank was a talented physician, an effective and fair administrator, a thoughtful and supportive colleague and a kind friend to so many of us in the Worcester community. His professional accomplishments were substantial: Air Force flight surgeon, fellow of the American College of Physicians, chief of medicine at Hahnemann Hospital, chief medical officer of the Medical Center of Central Massachusetts, president of the Worcester District Medical Society and professor of Medicine at UMass Medical School. However, these accomplishments and titles were not the full measure of Frank. The best way to fully understand and appreciate Frank and his life is to understand what was important to him.

Firstly, Frank was a “family man.” The welfare of his family was his major lifetime focus and commitment. He and his beloved wife, Loraine, raised six children, setting their moral compasses early on. They suffered the painful loss of an adult son. From this wellspring of life experience, Frank was able to give fatherly advice and counsel to his patients without being patronizing or condescending.

Secondly, Frank was a deeply religious man whose faith was the firm foundation on which he lived his life and practiced his profession. He often shared with me that he was an “imperfect vessel” and was well aware of all he could have done better each day. He would say his evening prayers, seeking forgiveness and understanding. He would then start the next day anew, hoping to do better.

Thirdly, he truly loved being a physician and recognized the special gift and responsibility he had been given to lift the burden of suffering from his fellow man. He cared deeply for his patients and used his warm sense of humor, vast medical knowledge and persuasive powers to counsel, help and console thousands of patients over nearly five decades of “working in the vineyard.”

His strong religious beliefs and love of learning were forged in the years he spent at Assumption Prep and, later, Assumption College. He was a proud alum who did much to advance the college’s strengths and reputation while working tirelessly on its behalf. Which brings me to a story Frank told me. It seems that Frank played basketball for Assumption College about the same time the cross-town Holy Cross team were the national champs. The details of the game and whether Frank actually played in the game are now clearly unclear. However, I was left with the distinct – and possibly incorrect – impression that in a pre-season scrimmage, the Greyhounds “took the Crusaders to school,” and that Frank’s two-handed set shot may have had some influence on the game’s outcome. Whether it is true or not is unimportant. It is how I and many of us would like to remember Frank: as one of the best – a great storyteller, a hardworking teammate, a great friend and a good man.

– Michael A. Galica, MD

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