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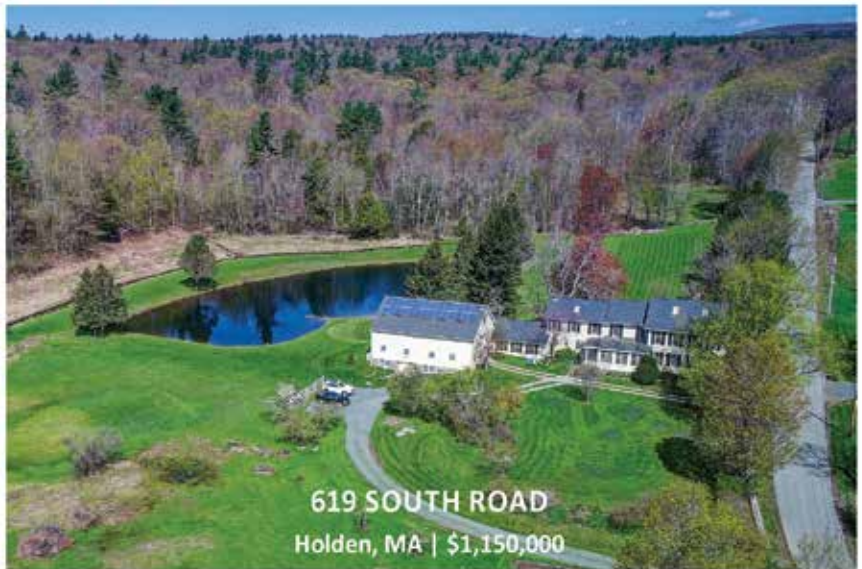
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Editorial

Jane Lochrie, MD



Jane Lochrie, MD

Since our last issue of *Worcester Medicine*, two police officers have been shot answering routine calls. Both shooters' families allege that the shooter had mental illness that was not being treated. It is time to examine why a state that has some of the best health care facilities is not providing patients with mental illness with the help that they require. A common theme in all the articles in this issue, Mental Health Part 2, is the stigma that often accompanies the diagnosis of mental illness and the necessity to change this.

Our first article is a "must read." Paul Richard, the executive director of The SHINE Initiative, describes the initiative's mission, "to combat discrimination and to destigmatize mental health conditions in children, adolescents and young adults." They engage directly with the young people and the adults who care for them. In addition, the staff works with the schools to disseminate evidence-based information. They emphasize the importance of asking for help and that asking for help is not a weakness but a strength. Student Wellness Advisory Teams (SWAT) empower students to become mental health and wellness advocates.

This issue also includes the Berlin Award-winning article by Laurel O'Connor, MD, a third-year resident in Emergency Medicine at the University of Massachusetts Medical School. She describes the chaos and demands of a busy day in the Emergency Room when a young male accident victim is brought in with life-threatening trauma. As a testament to her concentration on her patient, she does not realize that she lost the bracelet that was given to her from her sisters on her wedding day until much later in her shift.

Jennifer Dante, LICSW, explains her role as a psychiatric social worker in the Program for Assertive Community Treatment (PACT) at Community Healthlink. The program delivers intensive care post discharge from a psychiatric hospital. Patients are referred to as "the people we are privileged to serve." Patients are asked about their individual goals, and treatment is built around their objectives.

The exciting new program at the University of Massachusetts School of Graduate Nursing that addresses the ongoing shortage of mental health professionals in Central Massachusetts is described by Karen Dick, Ph.D., GNP-BC, FAANP, and Mechelle Plasse, Ph.D., PMHCNS-BC, PMHNP-BC. The school is now offering a post-graduate certificate program in psychiatric mental health to nurse practitioners who want to increase their scope of practice to the mental health community. The

program will offer a nurse practitioner the knowledge and competency to provide comprehensive mental health and substance abuse treatment in a variety of settings.

The role of the Massachusetts Association for the Blind and Visually Impaired (MABVI) is described by Sassy Outwater-Wright. The association supports people undergoing vision loss and helps them to adjust to or cope with blindness with one-to-one counseling sessions and peer support. She opines that physicians are on the frontline of destigmatizing blindness. Blindness is a "visible disability" and directly impacts the person's social identity. Major depression, feelings of loneliness and other mental illnesses have all been linked to vision loss, especially in the elderly. She advocates for integrative treatment protocols, involving mental health, rehabilitation and socialization, led by informed and involved physicians.

A frequent contributor to *Worcester Medicine*, Dr. Gary Blanchard advocates for the caregivers of patients with Alzheimer's disease. He states if there was a job description for this, no one would apply for the job – long hours without breaks and no job training or manual to help guide the applicant, despite requiring high cognitive, emotional and physical skills. This often results in depression, burnout and financial hardship for the caregiver who is undervalued and underappreciated.

The Student Perspective is provided by Brent Schell, a fourth-year medical student at the University of Massachusetts Medical School. He describes an alternative treatment for schizophrenia called Open Dialogue. Rather than looking at delusions and hallucinations as symptoms, some propose that these are things that are the mind's attempt to control a very painful experience. The main idea behind Open Dialogue is if you help the person to understand the experience, to put into words their suffering, then the real healing can take place.

Anna Morin, PharmD, dean at the Massachusetts College of Pharmacy and Health Sciences, explains the role of the psychiatric pharmacist. This requires at least two years of additional training after acquiring a PharmD degree to become a board-certified psychiatric pharmacist. Psychiatric pharmacy involves the application of evidence-based pharmacotherapy and the knowledge of physiological, psychosocial, administrative, regulatory and clinical sciences to care for patients with psychological and/or neurological problems.

As always, don't close this issue of *Worcester Medicine* without reading Legal Consult, As I See It and Society Snippets.

Finally, I would like to recognize our managing editor, Joyce Cariglia, for her 30-plus years of dedicated and enthusiastic support and commitment to *Worcester Medicine*. Joyce will be retiring at the end of the year after a distinguished career as the executive director of the Worcester District Medical Society. She will be sorely missed.

Mental Health is a 'Good and Natural Thing'

Paul Richard



Paul Richard

Three years ago, The SHINE Initiative addressed the faculty of a Central Massachusetts high school during its professional development day. The session began with a direct question: “Please raise your hand if you have mental health?”

Of the estimated 125 educators assembled in that school’s auditorium, a half dozen raised a hand. A few others raised a hand slowly, seemingly without conviction, and only after receiving a gentle nudge from a colleague.

I then assured everyone that we all inherit mental health by virtue of being born with a brain.

That exercise became a “teaching moment,” and it’s been incorporated into nearly every presentation, training, forum and group conversation conducted since by The SHINE Initiative.

It also affirmed my belief that when the words “mental health” are uttered, people too often think “mental illness,” and ensuing awkwardness, reticence to discuss and stereotypes emerge.

It comes as no surprise that mental health and mental illness are often conflated, and that stigma has long been a powerful force in society. Stigma is defined as a mark of shame or disgrace based upon “an unfair or unfounded set of beliefs.”

The SHINE Initiative mission is to “*combat discrimination and to destigmatize mental health conditions in children, adolescents and young adults*,” and our approach has been to engage directly with young people and the adults who care for them.

Among the dozens of classroom dialogues our staff has had with young people is one that occurred last winter. After sharing evidence-based information with high school students and answering their questions, the classroom emptied. However, one young lady lagged behind to express her gratitude. She disclosed that she was being treated for depression. I suggested that was a “good thing,” and she agreed, but she quickly became tearful. When I asked what was wrong, she replied: “My parents told me they wanted me to see a therapist so I could be ‘normal.’ Do you know what it feels like to be considered ‘abnormal’ by your parents?”

Similar refrains are being expressed by many other young people whom we encounter in schools – public and private – throughout Central Massachusetts.

Juxtapose these anecdotes with the knowledge that half of lifetime cases of mental illness begin by age 14 and three-quarters by age 24. The National Institute of Mental Health estimates that one in five young people ages 13 to 18 have lived with a serious mental health condition at some point in their young lives.

A Youth Risk Behavior Survey conducted in 2015 of more than 3,500 high school students in Massachusetts revealed that 27.4 percent expressed feelings of “*sadness or hopelessness*” that lingered for two weeks or more – a strong indicator of a possible mental disorder.

As The SHINE Initiative examined each of these elements, its staff and board of advisors determined that our most positive impact could be realized by promoting mental wellness through a pedestrian approach devoted to educating young people, and the adults who serve as their caregivers, about the causes, signs, symptoms and treatments for mental illness. We also acquaint them with positive coping mechanisms as tools to help manage an illness or to prevent it from becoming a chronic condition. Additionally, we highlight the role anyone can play as a supportive caregiver and the importance of being non-judgmental and a good listener. And, as we were so adroitly reminded by a student at Montachusett Regional Vocational Technical School, we emphasize the importance of asking for help, that asking for help is not an admission of weakness, but an act of strength.

Our strategy has drawn increased and widespread interest from school administrators, teachers and students alike.

In the past five years, we have engaged directly with 31,000 (and counting) young people, and the parents, teachers and other adults who care for them, through a series of 200 (and counting) classroom presentations, teacher/staff trainings and parent and community forums and conferences.

During The SHINE Initiative’s earliest encounters with students, many self-disclosed a personal disorder or that of a family member. They then asked what they could do to promote a better understanding by their peers and caregivers of the nature of mental health and brain illnesses and what it feels like to live with a mental disorder. What emerged was SWAT – Student Wellness Advisory Teams – developed by The SHINE Initiative as a vehicle for empowering students to become mental health and wellness advocates. In addition to in-school messaging campaigns to promote mental health and wellness, several SWATs have organized “ReFresh Days,” whereby students and faculty alike engage in yoga, meditation, music, dance, interactions with puppies and other seemingly benign activities to simply “decompress.” One student organizer said “ReFresh Day” has brightened her school’s culture and has helped students “enjoy being young.” Another student said it demonstrated that administrators and teachers “care about our mental health and not just our grades.”

What began in 2015 as a handful of SWATs in local high schools has grown rapidly to a presence in more than 30 high schools and middle schools in Central Massachusetts. Recently, SWAT has drawn the attention of the news media across the Commonwealth, including WBZ-TV’s “Eye on Education,” NECN’s “The Take,” and feature articles in the *Worcester Telegram & Gazette*, *MetroWest Daily News*, *Lowell Sun* and several weekly and community newspapers. In turn, school administrators from communities well beyond Central Massachusetts have reached out, acknowledging the need to incorporate mental health education and promotion in their school’s culture and curriculum.

We see only benefits to viewing mental health through a positive lens, and it begins by educating ourselves by sharing information that is factual and evidence-based.

The young people who are themselves the very focus of our mission have become an inspiration and force in shaping how we think about, talk about and relate to mental health.

It’s a behavior that adults and society might emulate.

Paul Richard is the executive director of The SHINE Initiative.

The Bracelet

Laurel O'Connor, MD, PGY3

The Gerald F. Berlin Creative Writing Award at the University of Massachusetts Medical School honors the poetry, fiction and essays of medical students, physicians in training (interns, residents, fellows), graduate students and nursing students from the medical school. The award was established to encourage creative writing and reflection by health professionals in training and to honor the father of Richard M. Berlin, MD, a UMass faculty member who practices psychiatry in western Massachusetts, is a poet and also sponsors the award.

Laurel O'Connor, MD, has been a consistent contributor and consistent winner, as a medical student and as a resident in Emergency Medicine at UMass. This is her final winning entry, as she finished her residency in June 2018.

It was a testament to her distraction that it took her so long to notice that the bracelet was missing. The familiar cool weight on her right wrist, usually tucked just under her sleeve, was gone. She stared at the naked limb for a moment but peculiarly felt none of the usual frustration and regret that accompanied losing a loved possession. Instead, she felt oddly peaceful, accelerated forward into the acceptance stage of grief. It must have fallen off and was probably long-buried inside a ripped glove at the bottom of a biohazard bag. It was nobody's fault, and it was gone. Half-heartedly she wanders back to the now pristine trauma bay, eyes roving over the now shining, damp floor and empty trash bins. A crisp sheet covers the stretcher, and the room smells faintly of bleach. She thinks that the missing bracelet is an exercise in perspective.

One hour ago, she was standing in the exact same spot, setting up her table. It's almost a meditation, she's done it so many times. She taps out a rhythm in her head. Open the airway cart. Endotracheal tube out, stylet loaded, check the balloon with a syringe. Mac 4 blade, test the handle light. Video scope loaded up behind and to the left, just in case. Oxygen on. Suction ready.

The room buzzes with sordid anticipation as the staff gathers. People waver between speculating on the nature of the trauma and casual work chat, the weather and an upcoming trip to the Caribbean, a vent being turned on, someone's kid is failing math. Chest tube and cordis kits loaded onto metal stands, the Belmont transfusion machine whirring to life, the weather again. What should they order for dinner? She thinks: In five minutes flat, lives will be altered or ended. As they leave the room, they'll finish their conversation about Aruba. Then take a deep breath, wipe their foreheads and move on to the next room.

The medics turn the corner, and a disciplined silence falls. It's a wretched package that they move over to the stretcher wrapped in straps and immobilizers, the fabric of jeans, a shirt, a jacket half cut off and hanging over the edge. The green bag over a man's face, giving jerky breaths between report.

"Male, unknown age, hit by pickup truck at high speed. Thrown twenty feet. GCS 4 on scene. Unable to intubate. Hypotensive, tachycardic. Unstable pelvis. Large volume of blood. Obvious open right femur." She picks over the words she hears as she pulls her mask on and grabs hold of the spattered backboard.

The medic finishes, and it's like someone wrenches up the volume on a speaker.

*Airway is not secure; let's get an airway.
Seventy-two over thirty.
Get him on the monitor.*

*Open the cordis kit.
I need a blood runner.*

As her hands do what they've done a hundred times, muscle memory kicking in, she thinks I could have been an accountant, an art historian, one of those nebulous consultants, but here I am. Absurdly she wants to laugh.

"Etomidate and Rocuronium are in, let's have a look," she says instead. Blood splashes the top of her face shield as she pries open his mouth, and she nudges the mask with her elbow so the smudge isn't obstructing her view. Teeth, tongue, posterior oropharynx, then just pink. Too far in, she pulls back, and the epiglottis swings down.

"O2 Sat 95, 94," someone yells accusingly. She pushes up and away, and a bloody mess awaits her.

"Suction."

"91 percent." She maneuvers the yankuar in and out and is rewarded with a glimpse of white vocal cords.

"Tube." Someone shoves the tube into her hand, and she slides it down past the mac blade.

"Tube is in." The respiratory therapist pulls the stylet. The end-titile CO2 monitor turns gold with the first ventilation.

"Tube is good." She looks up, the spell of concentration broken and the sound of the room ratchets up again. To her left, a chest tube is being loaded onto a Kelly clamp; the resident's fingers are already snaking their way into the man's chest. On the right, the cordis is being slammed into the groin, and two nurses are hanging blood on the Belmont. Someone pages orthopedics for the femur fracture, and they've called back over the speakerphone, shouting over the chaos. The monitor beeps so furiously that it seems like it might implode. The heart rate is too high, the blood pressure too low.

Her bracelet slides up her wrist. It's just a light chain with a single silver charm, a gift to her from her sisters on her wedding day. She lifts her arm so it slides back beneath her sleeve.

She looks down at the patient and wipes some of the blood from his mutilated face. He couldn't be more than thirty, if that, she surmises from the few unscathed patches of smooth skin and dark hair. Gently she pries back his eyelids and shines a penlight down over them. Blown pupils, nonreactive. She has a sneaking suspicion she knows how this story is going to end.

I need another blood runner.

Call the OR.

Get me the 6-inch plaster.

The urge to laugh is back. She isn't a particularly excitable person, at least by her own standards. In fact, the usual frowning of her forehead and half-lidded look to her eyes that some might mistake for disinterest or apprehension is actually her thinking, working expression, running through algorithms, techniques and memories. She doesn't get agitated or loud, only quieter and more precise. When she's truly thrown off her guard, out in the deep end, ready to flee, she laughs. She stifles a giggle and wonders if this is what it feels like to glance up during combat, everything slowing and blurring, the observer not quite believing each event as it happens, yet seeing the aftermath of violence as though

under a microscope.

She notices a broken fingernail on his left pinky, which is flopping carelessly over the side of the stretcher. A shred of blue fabric tucked under his shoulder is a remnant of the T-shirt he was wearing. Little did he know when he pulled it on this morning that it would soon be cut to pieces by strangers. She wonders if he had liked that shirt.

*I lost my pulse.
No carotid pulse.
Start Compressions.
Epinephrine.
Get me a thoracotomy tray.
Get that blood in now.*

He has a tattoo on his chest, on the right side, a gnarled bare tree, its branches twisting up around his clavicle towards his shoulder. Does it represent a memory or a symbol that meant something only to him or maybe a drunken lark? The branches dance as though windswept as they push up and down on his chest. She lays a hand on his neck and concentrates on feeling.

Rhythm check.

Gently fluttering under her fingers, a light quivering beat. "I have a carotid pulse," she yells out, twice because the first time her voice is too quiet to be heard. She hadn't adjusted to the noise of the room.

*OR is ready.
Is that leg stabilized?
CT surgery is on their way.
Family in the waiting room.*

She lays her hand on his neck, stabilizing it with her other, half afraid if she moves it will be gone. She imagines a butterfly under her fingers, flitting out to perch on the barren tree below it. She imagines a thousand things he hasn't seen or done. She wonders if he's dreaming right now.

"What's my neuro exam?"

She looks up.

"Pupils six millimeters bilaterally, not reactive."

There's a momentary lull in the noise level; everyone in the room knows this portends badly. The social worker's shoulders square up as she prepares herself for the conversations ahead. The trauma chief wonders crudely if they're fighting a futile battle.

Not yet, she thinks. The butterfly is still under her fingers, trying valiantly to escape. Her bracelet slides back down her wrist.

She remembers her wedding day, then thinks of all the days she remembers. Who is going to remember today? A wife? A child? Parents? Will she? How many days like this can she bear to remember?

"Pulse is gone."

*Get those sharps out of the way.
Start CPR.
I have a carotid pulse!*

She imagines a green and yellow butterfly on a bleak winter tree.

It happens again and again, a skipping record. More blood, more adrenaline for patient and providers both. Every time, the flickering pulse is fainter. She wants to feel it so ardently she worries she'll imagine its presence.

*How many units are in?
Pelvic immobilizer.
Continue CPR.*

And then it's over.

Time of death, 16:41. Thank you everyone.

Around her, people pull off masks and gowns, gingerly throw away scalpels and needles, tuck tubes and lines underneath a clean white sheet, which seems out of place in the room strewn with debris. There is iodine and blood splattered across every surface. She thinks about how it was probably a normal day for this man. There would be calls, and so many more normal days would begin to end.

They walk out of the bay. The trauma intern slams an open palm against the wall. Outside the light is fading, even though it is only mid-afternoon. For a moment she thinks about slipping outside into the bitter cold air, just to breathe.

Before she can flee, two nurses are upon her.

"Five wants more pain medicine."
"The family in three wants an update."

She takes a breath. The drunk in the hallway is waking up and harassing the tech watching him. A slew of resulted labs and unseen patients no doubt wait on her computer screen. A young man in his twenties lies in a stretcher waiting for her to stitch up his wrist, which fell victim to a box cutter at work. His mother catches her sleeve.

"Miss, when are you going to take care of this?"

She eyes the cut and thinks about the broken face, one that would have taken hours to repair, but the chore now rendered tragically unnecessary.

"As soon as I can."
"We've waited almost an hour."
"I'm sorry, I'll get to it as soon as –"
"And that will be –"

Irritation and decorum battle in her head.

A colleague walking the other way clasps her on the shoulder and turns her around.

"Excuse me," he says. "I need her for a second." He drags her away.
"What's up?"
"Just rescuing you. Are you OK?"

She nods.

Breathe, next room. Perspective.

A blonde nurse stands in front of her, eyes pleading.

"Room three, now, please. The family is driving me crazy."
"Okay, room three, I'm going!"

Three middle-aged women converge on her as she enters the room, jumping up from their vigil around the family patriarch.

"No one's been in here for hours. What's going on?"
"Well, so far, all of the tests have been reassuring."
"Well, he's not leaving until he gets a diagnosis."

She gives the room a wane smile. "Well, sometimes in the emergency department we don't get a diagnosis, but we rule out the life-threatening things and –"

She watches their hard eyes and knows her usual strategy isn't making headway. At the back of her mind, she's still counting compressions and frantically searching for that elusive winged heartbeat. Her words die in her throat. "We are waiting for few more tests to result. I'll be back as soon as they're available. Please excuse me." She turns on her heel before they can demand specifics.

Out in the hallway, she shrugs her shoulders, then notices the absence of cool metal sliding down her wrist. She pulls back her sleeve. The bracelet is gone.

Laurel O'Connor, MD, is a PGY3 in the Department of Emergency Medicine at University of Massachusetts Medical School.

Psychiatric Social Work and Assertive Community Treatment for Persons with Severe Mental Illness

Jennifer Dante, LICSW



Jennifer Dante, LICSW

I'm delighted to have the opportunity to tell you a bit about psychiatric social work and how we work with people with more severe and persistent mental health problems in a program called Program for Assertive Community Treatment (PACT) at Community Healthlink (CHL). PACT programs directly provide individuals with a full range of community-based services that are available 24 hours a day, 7 days a week. We provide a multidisciplinary treatment

team, including therapy, case management, psychiatric care, nursing services and peer support. We don't arrange the care – we are the care team, along with the client. The team meets daily to review everyone's care, and a staff member is available at all times. CHL currently has three PACT teams in Worcester County serving up to 80 clients each, and patients are referred by the Department of Mental Health that contracts the services.

Assertive Community Treatment programs began in Wisconsin in 1972, when three clinical researchers – Arnold Marx, MD, Leonard Stein, MD, and Mary Ann Test, Ph.D. – working at Mendota State Hospital noted that most of the gains that patients achieved in the hospital were quickly lost once the patients were discharged. The researchers speculated that more intense care delivered in the community post-discharge could help with this problem. They tested this hypothesis by moving hospital staff to community-based care and evaluating the program's capacity to alleviate symptoms, improve patients' quality of life and reduce overall costs. Multiple randomized, controlled trials over four decades have continued to demonstrate the effectiveness of ACT programs, particularly for patients who have required multiple hospitalizations and intense care.

The core of what we do at PACT is engage people who have been often marginalized by society as a whole and help them with the goals they want to achieve. It is a beautiful process to establish these relationships and witness what follows. Years ago, when I was first introduced to ACT programs in California, my mentors eschewed the terms "patients" or "clients" and simply called the people we were trying to help as "the

people we are privileged to serve." I believe that this frame of reference helps remind us that no one has to share with us their private concerns or their delusions or their history of trauma. When we inquire with deference and respect, we often find hope and opportunity where other efforts have failed. We begin our conversation with the individual's goals and build the scaffolding to support these goals over time. Over time, we earn the right to discuss sensitive issues with the people we serve. I also feel that it is important to remember that as a practitioner, we do need to earn the right to have these conversations, as long as there is not a safety risk. If we lead with these, without developing rapport, it could inadvertently close the door to treatment. Delivering person-centered and strength-based care is not simply a slogan in PACT – it is the heart of what we do. It is also at the heart of what we do at CHL. I chose to join CHL after reading the mission and values of the agency. I was looking for a position at a PACT team, but finding an agency reflective of my personal and professional values was key for me. I found my values reflected back to me in CHL's defined values. I most strongly resonated with the goal of "Empowerment of the individuals we serve and continued efforts to eradicate stigma associated with mental illnesses and addictions." This is something that I try to embody in my work with the people I am privileged to serve, as well as with the employees and the program I am privileged to serve.

My own path towards psychiatric social work began with an undergraduate interest in psychology, but I veered toward social work and an MSW degree based on my exposure to partial hospital programs and the influential role models I met there. I have found that the profession allows for a wide range of opportunities to work with clients, and I enjoy the latitude to move from therapy to offering more concrete assistance with life's challenges. The ACT model incorporates the idea of in vivo treatment – a trip to the grocery store involves working on interpersonal skills and symptom management, as well as buying ingredients for dinner. When I returned to the East Coast, I worked as a therapist in an office-based practice. I enjoyed this, but missed the kind of engagement and rewards I find in working with our community members that need help most. I initially joined CHL as a PACT clinician and have more recently been involved as a program director. This has allowed me to promote the model, along with the mission and values of Community Healthlink, and help staff and the individuals we serve reap the benefits of the collaborative relationships at the core of PACT.

Jennifer Dante, LICSW, is the program director for the Program for Assertive Community Treatment (PACT) I at Community Healthlink.

A Post Graduate Psychiatric Mental Health Nurse Practitioner Program in Central Mass

Karen Dick, Ph.D., GNP-BC, FAANP and Mechelle Plasse, Ph.D., PMHCNS-BC, PMHNP-BC



Karen Dick, Ph.D., GNP-BC, FAANP

The lack of adequate funding and treatment options for the mentally ill is typically a silent battle waged only by those who are advocates for this population, such as current clients, recovering consumers and their family members or loved ones. The mental health crisis and the silence surrounding it has been linked to ongoing stigma for those in need of mental health treatment and the closing of several mental health facilities across the country. But whatever the cause or causes, this crisis is brought into the media spotlight when tragedy strikes. The failing mental health system is suddenly thrown front and center in response to senseless acts of violence such as mass shootings.

This sudden and intense attention gives hope to those advocating for mental health services; however, this hope is fleeting, as the media soon shifts to the next sensationalized topic. This intense scrutiny of the broken system is too brief to shift public attention or to effect any change.

In Massachusetts, as well as across the U.S., we have seen a loss of funding for preventative and active treatment for those with mental health concerns. However, with the uptick in mass violence, the decline in civil discourse, the ongoing challenges related to homelessness and the epidemic of opiate addiction, the time for a sustained assessment of mental health services in this country is now. According to the Substance Abuse and Mental Health Services Association's (SAMHSA) 2014 national survey, 3.71 percent of Massachusetts adults have been diagnosed with a severe and persistent mental illness, such as schizophrenia, with just over 17 percent of Massachusetts adults diagnosed with any mental illness. Of those adults with mental illness in this state, approximately 46 percent do not receive any mental health treatment.

In addition to the well-known depressive risk for the older adult, we have seen an increase in depressive suicidal behavior in adolescence in Massachusetts, as well as across the U.S. SAMHSA reported a rate of 11 percent for adolescents with symptoms suggestive of Major Depression (2015). The Center for Disease Control and Prevention reported on data accumulated over a 24-year period and found Massachusetts high school students had a depressive rate of 27 percent, with 15 percent thinking of suicide and 7 percent attempting suicide (2016).

Despite the growing need for mental health treatment, there are spreading shortages in the mental health workforce which remain an ongoing concern in Central Massachusetts and an even greater concern in the rural areas of the Midwest and southern states (Lieberman, Goldman, Olsson, Pincus & Sederer, 2017). UMass Medical School Graduate School of Nursing (GSN) looks to address this gap in service by now offering a post-graduate certificate program in Psychiatric Mental Health. The Psychiatric Mental Health Nurse Practitioner (PMHNP) program offers the already practicing nurse practitioner (NP) the knowledge and competency to provide integrated and comprehensive mental health and substance abuse treatment to patients in a variety of settings across the lifespan. Our students will enjoy a

curriculum reflective of the numerous advances in behavioral research and evidence-based treatments for mental illness and substance abuse. Our graduates will be prepared to diagnose and treat patients' acute or chronic mental health conditions, provide psychotherapy to those coping with psychosocial stressors and/or offer management strategies for those with addiction issues.

Graduates of this certificate program will have gained additional knowledge and competency in the assessment and diagnosis of psychiatric mental health disorders, psychosocial adjustment concerns and be able to provide psychotherapy and prescribe medications for patients of all age groups. Our certificate program graduates will be eligible to take the American Nurses Credentialing Center Psychiatric-Mental Health Nurse Practitioner board certification examination. Upon graduation and certification, our graduates will find themselves in high demand with their new expertise. PMHNP graduates, certified across the lifespan, will provide services in a variety of settings and to some of the more underserved patients in both mental health and primary care. We know from our current experience with GSN graduates from our three other NP tracks (Family, Adult Gerontological Primary Care and Adult Gerontological Acute Care) that they tend to stay in the area after graduation to take positions locally. Our graduates also are often hired in the clinical settings where they had completed student clinical rotations.

This new program is currently enrolling students for fall 2018 matriculation. The curriculum consists of 22 credits of course work and 630 direct clinical hours in various settings and across all age groups. Courses will be delivered in an online/hybrid format. Prospective students may take up to three courses as a non-matriculated student before applying. The program will initially only accept practicing NPs who are looking to expand their scope of practice. The current plan is to develop a separate track in our nurse practitioner program which will be open to students who are not already a NP.

The PMHNP Program at UMass Medical School GSN will join UMass Amherst as the second Post-Graduate Psychiatric Mental Health NP Certificate Program in the UMass system.

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Physicians Are a Critical Link in Preventing Adjustment Disorder for Patients with Age-Related Eye Diseases Causing Vision Loss

Sassy Outwater-Wright



Sassy Outwater-Wright

There is no one right way to be blind or visually impaired. This is the governing principle of the Massachusetts Association for the Blind and Visually Impaired (MABVI). It guides our decisions and health care practices, because we serve people, not medical conditions or disability types. We serve people with varying degrees of adjustment to vision loss. Many of our clients have additional comorbidities, disabilities or life circumstances that may affect how they adjust to vision loss. We offer a robust mental health adjustment counseling program within a peer support-driven model. Through our support groups across Massachusetts, our

one-to-one counseling sessions and working with MABVI staff who act as peer supports, we assist the person undergoing vision loss to adjust to or cope with blindness. By using assistive technology acquisition and instruction, learning practical daily living skills and through use of adjustment counseling, clients can adjust to vision loss on their terms. Each client is a human being who is undergoing a traumatic shift in identity and life circumstance and who deserves absolute respect, autonomy and opportunity.

Society's perceptions of blindness provide some of the biggest barriers patients face. Misperceptions of how tasks are managed contribute to the stigmas that still restrain patients from pursuing rehabilitation therapy or adjustment counseling. Doctors are at the frontline of destigmatizing blindness. The medical field must closely examine its connection to the medical model of disability, versus social or justice models of disability, and begin to incorporate mental health awareness into treatment of eye diseases using integrative health care solutions. In medical care, we teach that the body is broken, and clinicians must strive to cure, fix or treat the body, not the malady. This can allow stigma to flourish surrounding the intersections of body and mind and how society perceives chronic illness, mental illness and disability. Blindness is one of the "visible disabilities" – it directly impacts a person's social identity – how the person is perceived in family relationships and within society. You can't put away glasses, a guide dog, white cane or magnifier. Blindness, for many, starts as a trauma, becomes an identity and, somewhere in between, becomes a grieving process, with fear and rage. Eventually, it becomes opportunity, intriguing possibility and acceptance. At any time, it is possible to shift back and forth along the spectrum of acceptance.

Society fears blindness. We define it as darkness, lack of understanding, ignorance or stupidity in the face of reason. Sometimes we mean a person who is blind. More often, we mean the "act" of being blind to something. This stigma follows a patient into the exam room when receiving a diagnosis of an eye disease. This stigma can also follow physicians into the exam room, causing them to limit the scope of what they perceive their patient capable of doing after diagnosis. Some

patients can be caught in the fear of identifying as blind with a white cane or heavy glasses. A patient who must get close to print in public, can't read well, cannot walk a straight line or must tilt their head to see text face the additional barriers of behavior, which can cause society to stigmatize them. These stigmas and suppositions, or fear of such, can result in episodic depression, isolation, reduction in social activities or other mental illnesses. Such stigmatic views need to be examined and changed as the aging population is set to double in a silver tsunami that will overwhelm our current optometry and ophthalmology system if we are not prudent in managing our knowledge of blindness and mental health adjustment.

Episodic or major depression, feelings of loneliness, isolation and other mental illnesses have all been linked to vision loss diagnosis, especially in the aging population. Vision-decreasing diseases such as age-related macular degeneration contribute to elevated rates of depression for an estimated 1.6 million Americans, according to the Centers of Disease Control. In a study conducted by Johns Hopkins School of Medicine, elderly patients at risk of depression showed a significant decrease in symptoms of adjustment disorder when offered in-home, low-vision occupational therapy. At the root of occupational therapy is the idea that the person is a whole person, not just a disease or set of symptoms to manage.

At MABVI, we offer a cycle of services to meet each person's needs. We use in-home, low-vision occupational therapy and mental health adjustment counseling with a social worker, therapist or in a peer support group. We also provide assistive technology instruction, one-to-one volunteer matching for community activities such as grocery shopping and going to the gym or concerts – we treat the whole person. This integrative approach, with a wide variety of clinical care and social supports available, addresses the physical adjustment learning process faced by someone losing their vision, as well as the psychosocial effects of blindness. Learning that you can be blind and still get out and enjoy your favorite activities or take care of your household, work, shop, travel and read – that knowledge is liberating, and all it takes is support, knowing that there are a variety of ways and resources to learn to adjust.

We must treat vision loss as a chronic condition. An integrative treatment protocol involving mental health, rehabilitation and socialization, led by the informed and involved physician, is crucial. Mental health support, when coupled with practical tools for learning to manage daily living tasks, results in patients who feel supported, connected, aware and empowered to adjust to chronic disease management, even as their vision declines. It all starts with a physician and support staff being informed, aware and mindful of integrative low-vision support. A physician who diagnoses vision loss and is aware of the resources and supports in their community can help patients adjust and thrive in their chosen activities if they work closely with organizations to help the person transition to supported, integrative care. When this works, it can reduce depression, falls, hospitalization, institutionalization and allow a patient the choice to receive services they need to live a fuller and independent life.

Sassy Outwater-Wright is the director of the Massachusetts Association for the Blind and Visually Impaired. She specializes in assistive technology training for persons with multiple disabilities, digital accessibility user experience and health care advocacy and access rights for disabled women. She also serves on the board of directors for World Eye Cancer Hope USA. Sassy lost her sight in both eyes in early childhood due to retinoblastoma. She is totally blind and has additional disabilities from brain tumors in early adulthood.

Caring For Those Who Care For Alzheimer's

Gary Blanchard, MD

"You have to do *something*, anything. Please, you can't let this continue. I just can't do this anymore."

It is a desperate entreaty that, sadly, I have heard more times than I can remember now. It is a plea I was never prepared to even consider during medical school, and, later, during residency, one that I did not have to meaningfully address for a patient and his or her caregiver in a way that I had to longitudinally own. But it is real, human and, at times, seemingly omnipresent amongst those wonderful people who care for a loved one with Alzheimer dementia.

In my job as a geriatrician, I have seen soldiers with military combat experience sobbing uncontrollably, ridden by guilt, unable to fulfill the ongoing, relentless requirements of their caregiving role. I have seen many practicing physicians assume this job and suffer identical nervous breakdowns, ravaged by insomnia, depression and isolation. I have seen attorneys, engineers and teachers all similarly struggle – as this often 24/7/365 role does not spare the well-educated, the financially secure, the physically strong or the emotionally resilient. It is, I have found, without help, a plea that is almost *normal* to make at some point.

If being a caregiver was written up as a job posting, one would not rationally apply: long hours without the guarantee of regular breaks; no formal on-the-job training offered nor any manual provided, despite requiring high cognitive, emotional and physical skills; and an ever-lurking feeling of being undervalued and underappreciated by even, at times, your own family and friends.

And, yet, here they are: elderly spouses, sometimes frail, with medical problems of their own; adult children in their prime working years, saving for retirement, with jobs that do not look favorably on unanticipated family medical problems; grandchildren – millennials – forestalling their own education to help support their grandparent and parents. We cannot do what we do without their daily support.

Of course, this "job" is usually not considered by society to be formal employment, even for those who readily acknowledge they have solely assumed the role of a de facto nursing home (only without any team support or shift work). By and large, it is done out of love, devotion and selflessness – and yet, the end result is that the care provided by these people often results in their own depression and financial hardship. These are the people who often suffer in silence.

Nearly 1 in 3 U.S. adults have been conscripted into the role of caregivers – 43.5 million of whom provide care to those in midlife or older adults (*National Caregiving Alliance*, 2017). As a result, for every person in a nursing home in America, there is another frail older adult with functional deficits who is *not* in a nursing home, due primarily to the efforts of their caregiver in helping with basic ADL support and organizing/administering medications.

Alzheimer's is a public health crisis – a progressive, incurable disease that, in its later stages, is frequently characterized by behavioral symptoms that are uncharacteristic, unsettling and unrelenting. The risk of caregiver burnout is particularly high for those caring for these older adults with dementia and behaviors/

neuropsychiatric symptoms.

Physicians often assume the lay public knows how to effectively communicate with patients with Alzheimer dementia and/or treat behaviors in Alzheimer's patients. But, truly, until you have been in the position of dealing with an older adult who is pacing, frantic, concerned, agitated and restless at 3 a.m., knowing that you have to go to work the next day, knowing that tomorrow will unfold the same scenario ... none of us can truly know how we would try to "de-escalate" that situation.

So, how do we as physicians do better? How can we help those caregivers for patients with Alzheimer dementia at risk of burnout, and, in so doing, possibly even prevent episodes of elder abuse committed by simply overtaxed, overwhelmed caregivers? It is endlessly tricky – as the caregivers are not necessarily our own patients, but, nonetheless, it is often obvious that the most helpful thing we can do during a visit – the item with the lowest number needed to treat – is to offer empathy, a listening ear and/or respite to an overwhelmed caregiver.

My personal humble advice to which I strive but do not always achieve:

- Encourage the caregiver to function as a member of the care team in your office as much as possible.
- Encourage caregivers to improve their self-care and maintain their health, emphasizing that the primary predictor of whether an older adult can stay at home is their own emotional health.
- Provide education about dementia and refer to local agencies for support, particularly Elder Services of Worcester Area, which has information on and access to various programs related to caregiver education, support groups, resource utilization (e.g., home health aides, homemakers) and respite services in the community (including adult day programs).

We as physicians cannot do all this alone. I often feel that it is impossible for me, within the context of a time-limited visit, to be able to sufficiently address, just to name a few: advance directives, deprescribing medications, reviewing the rationale for and against other medications, mediate family disagreements, etc. And, oh, by the way, explain the expected trajectory of Alzheimer dementia and review non-pharmacologic strategies for de-escalation. An ideal primary care environment would be one with ready access to social work and case management to help with resource utilization and more collaborative, humanistic care.

When I see an overwhelmed, overburdened caregiver of a patient of mine, I feel as if – at least on some level – I have let them down. If my primary responsibility as a geriatrician is to maximize the ability of an older adult to remain independent for as long as possible, there are oftentimes no higher-yield intervention than allying with a devoted caregiver and fortifying our team to honor the wishes of an older adult. We all need to do our best to hear the pleas, often unspoken, of these loving caregivers.

Dr. Blanchard, a geriatrician, is the Geriatrics medical director and the Palliative Care medical director at Saint Vincent Hospital (SVH). He is the leader of SVH's Nurses Improving the Care of Health System Elders (NICHE) team, which is devoted to improving the care of vulnerable older adults utilizing interdisciplinary team approaches.

Psychiatric Pharmacy

Anna Morin, PharmD



Anna Morin, PharmD

Faculty in the Department of Pharmacy Practice at Massachusetts College of Pharmacy and Health Sciences (MCPHS) University School of Pharmacy-Worcester/Manchester work as part of an interprofessional team at various clinical sites in Massachusetts and New Hampshire to provide comprehensive, patient-centered medication management to optimize drug therapy, improve therapeutic outcomes for patients and reduce overall health care costs. Faculty also serve as preceptors to pharmacy students, residents, fellows and students in other health professions.

During my 16-plus years as Pharmacy Practice faculty, I have had the unique experience of serving as a preceptor and working with a multidisciplinary team to care for patients at two inpatient psychiatric facilities. Please do not misunderstand; I am not unique – there are thousands of “psychiatric pharmacists” in the U.S. – however, the response to my clinical practice site is often unique. When people hear that I am a psychiatric pharmacist, they often ask, “Aren’t you afraid to work with those patients?” or “Why bother? They’ll never get better.”

I am certain that my faculty colleagues who support cardiovascular, infectious disease, oncology or other health disciplines at their clinical sites are not asked these types of questions. In addition, students have been reluctant to participate in a clinical rotation at a psychiatric facility, assuming that individuals with psychiatric diagnoses are dangerous, cognitively impaired and simply untreatable. Working as part of an interprofessional team to better understand and optimize the pharmacotherapy associated with treating psychiatric illnesses is the focus of my work with students. However, it is also important to dispel the stigmas often associated with a psychiatric diagnosis and help students to understand that patients with mental illnesses come from all types of ethnic and socioeconomic backgrounds, rarely present a danger to themselves or others and can be effectively treated through pharmacotherapy and psychotherapy. As part of clinical activities, students are able to directly interact with patients and come to find them to be intelligent and deserving of respect and care.

Psychiatric pharmacy, similar to any other type of pharmacy specialty, involves the application of evidence-based pharmacotherapy and the knowledge of physiological, psychosocial, administrative, regulatory and clinical sciences to care for and about patients with psychiatric

and/or neurological disorders. Psychiatric pharmacists also play a role in the design and testing of new medications, working with pharmaceutical manufacturers or independent research laboratories on drug development or clinical trials. Collaboration and education are a hallmark of pharmacy practice, and psychiatric pharmacists have opportunities to interact with patients, family members and caregivers, as well as local and national organizations.

Psychiatric pharmacists must also have a comprehensive understanding of the many diagnoses covered in the Diagnostic Statistical Manual of Mental Disorders, fifth edition (DSM-5).¹ The Board of Pharmaceutical Specialties (BPS) recognized psychiatric pharmacy as a specialty beginning in 1992 (www.bpsweb.org). Psychiatric pharmacists begin their careers the same way as other pharmacists, completing a doctorate in pharmacy (PharmD) and becoming a licensed pharmacist. Most pharmacists interested in specializing in psychiatric pharmacy complete at least two additional years in specialized residencies or fellowships and pursue becoming a board-certified psychiatric pharmacist (BCPP). Qualified candidates must pass a rigorous examination administered by the BPS and maintain certification through continuing education.

The College of Psychiatric and Neurologic Pharmacists (CPNP; www.cnp.org) was founded in March of 1988 to advance a vision where all individuals with a psychiatric or neurological illness receive safe, appropriate and effective treatment provided by a psychiatric pharmacist as part of the health care team. The more than 2,100 members of CPNP work directly with patients and caregivers to apply specialized clinical knowledge and skills, educate and train health care professionals and develop new knowledge in order to improve health outcomes for those with psychiatric, substance use and neurologic disorders. In addition, CPNP works closely with the National Alliance of Mental Illness (www.nami.org) to provide medication education for patients, their family members and the public. Studies show including a psychiatric pharmacist as a member of an interprofessional health care team is cost-effective, improves medication effectiveness and adherence, and decreases the incidence of medication adverse effects.² A “Psychiatric Pharmacy Manifesto” published in 2011 provides additional information on CPNP and the role of the psychiatric pharmacist.³

Anna Morin, PharmD, is a professor and dean of the Department of Pharmacy Practice at Massachusetts College of Pharmacy and Health Sciences.

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Dialogue with a Psychotic Patient and How It Shaped My Approach to Caring for Those with Mental Illness

Brent Schell, MS4



Brent Schell, MS4

“So, what brought you into the unit this admission?” I asked Mr. P., who was the first psychotic person I had interviewed by myself as a medical student. “The ambulance,” he said, with a befuddled look on his face. I then clarified that I was asking about the incident that led to his admission, to which he replied, “I was sitting in my chair, and then someone who drove the ambulance picked me up and brought me here.” At that point, I lost track of where to go next with the interview, as I had not previously encountered an individual who was as concrete as Mr. P.

I then began asking any question that came to mind, whether or not it fit within the context of the previous one. I somehow justified that if he was giving nonsensical answers to my questions, then I was free to be nonsensical in the order in which I asked them. Clearly, this interview was not going as planned. Then, something interesting happened when I asked him if he ever went to college. For the first time in the conversation, he clearly replied that he did not want to talk about it. I, of course, was agreeable, as I had given up on the notion that my interview would be fruitful. He seemed content that I did not push the issue and began to give me more expansive answers to the questions that followed. He seemed to persevere about getting back home so that he could get back to his work, and he revealed all sorts of delusional thoughts about why he was brought to unit in the first place. As I just listened, he continued to tell me that he did not want to take his antipsychotic medication because it made him feel stupid, and that this was what was keeping him from going back to school or work. Then, to my surprise, he started telling me about his previous experience in college and how he ultimately had to withdraw because of his illness. At that time, I missed the significance of the fact that he was now opening up to me, and I proceeded to close the interview.

Afterwards, I learned that Mr. P. had refused to converse much with anyone prior to my interview, and the staff was surprised that our conversation lasted as long as it did. Was it possible that my scattered interview actually helped Mr. P. in some way? I assumed that it did not, but then I started to wonder if there was any value in paying close attention to dialogical patterns when speaking with psychotic patients. If someone was to speak to enough psychotic patients, would it be possible to find a common language, pattern or sequence, which could allow psychiatrists to interpret what a psychotic person is really trying to say? I was really intrigued by that thought, and when I later heard about an alternative form of treatment for schizophrenia called Open Dialogue, I jumped at the chance to learn more about it for an upcoming assignment.

I learned from my research into Open Dialogue that some people have a profoundly different way of looking at psychosis. Rather than looking at delusions, perseveration and hallucinations as simply symptoms, some propose that these things are the mind’s attempt to control a very painful experience – a logical reaction to an illogical problem. One of the most interesting views of psychosis that I came across was the idea that psychosis is an utterance of metaphors of things that have actually happened in a person’s life, but of which the individual has not found the language to express. The main idea behind Open Dialogue is that if you help a psychotic person to understand their experience, to put words to their pain and suffering, then real healing can take place.

Continuing my investigation, I was fortunate to find several conversations that have been transcribed from Open Dialogue meetings. It was clear that the psychotic dialogue of these individuals transitioned from essentially delusional, disorganized speech to poignant expressions of circumstances and feelings that preceded their psychotic break. Using these expressions as a starting point, the therapist and other participants in the Open Dialogue meeting can then help the patient to reconstruct his or her understanding of his or her own situation by providing external reference points within the group conversation. In a sense, the psychotic person, who has lost the ability to test and interpret reality, can now temporarily rely on the group participants to do this for him or her. And the shocking part is that once the sane individuals say something that resonates with what the psychotic person is feeling, the psychotic person seems to gain more insight into his or her own experience. One of the founders of Open Dialogue, Jaakko Seikkula, explains that this is possible because one component of our own self-perception is based on what other people think about us. “I borrow your eyes to see myself.”

The haunting part about considering this new approach to psychosis, if indeed it is true, is that the standard approach to managing psychosis is likely to make the problem worse for the individual. By focusing on the symptoms of psychosis, labeling whole discourses of expression as delusional and disorganized, we might make the psychotic person further lose trust in his or her own feelings. In my interview with Mr. P., I did not even attempt to write his delusions down on paper, as I assumed his answers did not make any sense. But when he told me about his school, and I let him control the discussion as he saw fit, it seemed to impact the rest of our conversation.

In the end, what I learned from Mr. P. and from my research on Open Dialogue is the importance of having genuine dialogue with my future patients. In complex circumstances, where psychological stress is obscuring the clinical picture, the most important thing that I can offer patients might just be to make them feel heard. Jaakko Seikkula comments that there are two prerequisites to life: “to breathe and to be in dialogue.” Thus, by extension, if we can help others by validating their experience or feelings, we might be able to restore a part of their lives that has been neglected for quite some time.

Brent Schell, MS4, is a fourth-year medical student at the University of Massachusetts Medical School.

Why the Doctor Can't See You Now and How We Can Fix the System

Fred Baker, MD, FAAFP



Fred Baker, MD, FAAFP

EHR systems reduced billing costs related to physician services,” with estimates of billing costs running about \$100,000 per primary care provider annually.

Ninety-two percent of physicians state the prior authorization process delays patient access to necessary care. The biennial Physicians Foundation Sept 2016 Physician Survey of more than 17,000 physicians found 73.8 percent of physicians cite the patient relationship as the most satisfying aspect of their jobs, followed by “intellectual stimulation” at 58.7 percent. Yet 80 percent of physicians reported being overextended or at capacity, with no time to see additional patients. Citing these challenges, 48 percent of surveyed physicians plan to cut back on hours, retire, take a non-clinical job, switch to “concierge” medicine or take other steps that will further limit patient access. With estimates this could reduce the physician workforce by tens of thousands of full-time equivalents (FTEs). I am hearing similar sentiments from many more of my colleagues.

The economic strength and security of any society or nation is often evident in the value it places on the health care of its citizens. The collective efforts of both public and private sector stakeholders are necessary to procure better outcomes in a system of shared values, responsibilities and burdens. What's most disturbing in our “free-market health care system” is how third parties can arbitrarily impose reduced reimbursement (even retroactively) for appropriately rendered professional services. Yet, at the same time, third parties are not subject to the same restraints to control costs, as others must unmercifully assume substantial losses or cuts in services, pay or benefits, if not outright bankruptcy, to subsidize them. Furthermore, despite clinicians' best efforts to persuade patients to embrace healthy lifestyles, they are often penalized for variables for which they have no influence or control. These scenarios include patients: who by choice or by significant socioeconomic disadvantage have poorly controlled chronic conditions; who actively choose to decline cost-effective preventive care; or who may require very expensive, but appropriate, care and resources, such as imaging, biologics, medical devices, home care services, etc., for which there are no alternatives. What business model would find it acceptable or sustainable to demand that auto mechanics pay for drivers' car damages or car maintenance costs? Health care professionals are held

to a different and unrealistic standard.

How sad that the complexity of taking a thoughtful history and processing complex details to derive a meaningful treatment plan for a patient must be rivaled or surpassed by the complexity of billing, attestation, documentation and regulations. Almost daily, physicians are barraged by emails to pay for the “privilege” of attending a webinar or seminar or reading documents to better understand the complexities of billing and documentation or the nuances of new regulations at the expense of more meaningful pursuits. There is an obscene fascination with data collection and reporting, as opposed to focusing on the true priority: exemplary patient-centered care. Dr. Don Berwick, a former Centers for Medicare & Medicaid Services (CMS) administrator, correctly notes that we should stop excessive measurement and abandon complex incentives.

Some authors wisely note that we should invoke a moratorium or time out to reassess and revise performance measures given the costs, invoked inefficiencies, burden and preponderant lack of evidence that they positively influence patient outcomes. Andy Slavitt, another former acting administrator for CMS, was noted as having heard physicians express how quality “measures become more about compliance, not quality improvement; technology often distracts instead of supports patient care; and that many small impositions from afar add up to a feeling that CMS just doesn't get what physicians are facing.” Various articles are commending the Centers for Medicare & Medicaid Services (CMS) for a newly released proposal of the Physician Fee Schedule for 2019 that intends to afford physicians more time to focus on patient care by reducing computer time, simplifying coding and streamlining regulatory and documentation requirements.

The addition of reimbursable codes for virtual or remote visits appears to be a welcome change and departure from the implicit notion that there is no value in non-face-to-face visits. However, as health care expert Shawn Martin notes, “The most intriguing – and controversial – portion of the proposed rule would collapse the number of codes for office visits by new patients (99201-99205) and existing patients (99211-99215) from five levels in each category to just two per category.”

Thus, one of the major concerns is that in the process of simplifying the coding as it currently stands, there is the undesirable effect of devaluing the complexity of care. *Medical Economics* cites Brian Outland, director of regulatory affairs for ACP, who expresses the sentiment the Physician Fee Schedule could disadvantage physicians taking care of complex and frail patients and that, “A doctor could have a patient come in that has a cold or some less-sensitive problem and get paid the same as a physician taking care of someone with four or five chronic conditions that require attention and care and much more time.” Another expert, representing oncologists, retorts, “And their scheme to pay a physician the same amount for evaluating a case of sniffles and a complex brain cancer simply defies all logic. It is the antithesis of value-based health care and cheapens the medical care seniors are entitled to under Medicare.” A wire from the AMA notes that a letter from the AMA and about 170 other organizations representing physicians was sent to CMS Administrator Seema Verma supporting the immediate enactment of a three-component initiative to reduce “note bloat” redundancy, while opposing a proposal to collapse payment rates for physician office visit services over concern about unintended consequences.

In closing, we need to resist the insatiable appetite by some to micromanage care into a one-size-fits-all mode of care. We need to reject the clunky and disruptive “outsourcing” demands of third-party data collection and reporting imposed on busy clinicians and their staffs, and we should indeed demand a moratorium on quality measures, insisting upon evidence, tangible value and minimal disruption. The focus must always be on the patient. We need the time to foster a therapeutic patient relationship if we are to improve access and outcomes. Third parties should fully and unequivocally support those efforts.

Frederic Baker, M.D., FAAFP, is a full-time practicing family medicine physician, serving 24 years with an outpatient practice in Holden with UMass Memorial Community Group Physicians. He is a past president of the Worcester District Medical Society, past president of the Massachusetts Academy of Family Physicians and a fellow of the American Academy of Family Physicians.

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The Duty of Care and the Quest for Payment

Peter J. Martin, Esq.



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Does a pharmacy have a legal duty to a patient to notify that patient's physician about the need for prior authorization for a prescription medication? In a recent wrongful death action involving a patient who died due to an inability to afford medication for a life-threatening seizure disorder, the Massachusetts Supreme Judicial Court answered this question in the affirmative. The decision expands the scope of pharmacists' duties beyond conducting prospective drug reviews and offering to counsel patients to include communicating vital insurance coverage information to prescribers. The rationale for this expansion of legal duties appears to be that the pharmacist is best placed to perform the new function of acting as intermediary between

the third-party payer and the prescriber. Can the same rationale be used to increase the legal duties of other caregivers as they navigate between patients, payers and other providers?

Yarushka Rivera, a MassHealth beneficiary, had a seizure disorder for which she was prescribed Topamax by her neurologist, Dr. Schoeck. When her family tried to renew the prescription, a Walgreens pharmacist informed them that MassHealth required a prior authorization form to be filled out and signed by the prescribing physician before the medication would be covered by MassHealth. Under MassHealth rules, it does not notify physicians of the need for prior authorization, but only the prescribing physician could submit the prior authorization form, not the pharmacist or patient.

In this case, there was no evidence that a Walgreens pharmacist notified Dr. Schoeck's office of the need for a prior authorization form for Rivera's medication, though there was testimony that a Walgreens pharmacist told Rivera's mother that Walgreens would do so. Testimony at trial indicated that Rivera's family contacted Schoeck's office seven times over the course of four months, ending in October of 2009, about the need for the prior authorization form and tried unsuccessfully four times to fill the prescription at Walgreens. The family could not afford the approximate \$400 out-of-pocket cost of the medication. Rivera's mother testified that at an appointment with Dr. Schoeck in the middle of October 2009, Rivera told her physician that she had not been able to take the medication since August because Schoeck's office had not processed the required paperwork. At the end of October, Rivera suffered a seizure and died.

The case went to the Supreme Judicial Court on an appeal from the trial court's grant of Walgreens's motion for summary judgment on the ground that it owed no legal duty to Rivera. In its decision, the SJC held: "In light of the evolving nature of the pharmacist-patient relationship, Walgreens's specific knowledge regarding the need for prior authorization, the industry-wide customs and practices of pharmacies handling prior authorization requests, and the foreseeability of the harm to Rivera, we conclude that Walgreens owed a limited duty to take reasonable steps to notify both Rivera and Schoeck of the need for prior authorization each time Rivera tried to fill her prescription." It is worth unpacking each element of this holding.

First, the evolving pharmacist-patient relationship. The court acknowledged that pharmacists are not required by statute or regulation to facilitate prior authorization processes for patients, but in light of other patient-service functions served by pharmacists, they are "well situated to assist patients with certain issues regarding their medications." This is an argument based on the placement of a caregiver in the complex relationships among the patient, the insurer and other caregivers. In principle, it could be used in a variety of

contexts to add to providers' legal duties owed to their patients.

Second, the court turned to the question of "specific knowledge"; in this case, that of the pharmacy regarding danger to a particular customer. Normally, under the "learned intermediary" doctrine as understood in Massachusetts, the legal duty of a drug manufacturer or a pharmacy to warn of such dangers runs only to the physician, who has the ultimate duty to warn his or her patient. One reason for this rule is that imposing a duty on pharmacists to, for example, warn a patient about a medication's general side effects would interfere with the patient-physician relationship. However, as in cases where a pharmacist is aware of contraindications related to other prescriptions a particular customer may be taking, conveying that information to the patient or to her physician facilitates that relationship. Here, that exception to the learned intermediary doctrine is applied not in the case of patient-specific clinical information, but regarding the requirements of that patient's insurance coverage.

The court then turned to industry practices to determine if a standard of care had been established among pharmacies to notify physicians and not patients of the need for prior authorization. Expert testimony at trial established that Walgreens pharmacists routinely notify prescribers' offices directly of the need for prior authorization and that this practice is typical in the pharmacy industry. Thus, the court concluded, "The skill and knowledge of pharmacists today involve more than the dispensing of pills. A pharmacist exercising the skill and knowledge normally possessed by members of the professional community ordinarily would notify a patient and the prescribing physician that prior authorization is needed."

Next, the court considered the foreseeability of the harm to Rivera. Under general principles of tort law, in order for there to be a duty to exercise reasonable care to avoid harm to others, the foreseeability of that harm must be reasonable. Presumably, the court felt that the fact that Rivera's prescription would ordinarily be paid for by MassHealth indicated that without MassHealth coverage, it would be reasonably foreseeable that Rivera would be unable to pay for the prescription. The court went further than establishing a pharmacist's duty to warn the patient of the need for prior authorization, so that the patient can then convey that requirement to her prescribing physician. That duty requires the pharmacist to notify the prescribing physician directly, since it is the pharmacist, not the patient, who has the relevant information and required forms.

The court took pains to establish that this duty is not unlimited. The pharmacist is not required to ensure that the physician received the request for authorization and will act on that request. Also, the pharmacist is able to choose whatever means of notification she or he deems reasonable. Moreover, the duty only applies where insurance coverage is denied specifically because a prior authorization form is required.

A dissent written by Justice Lowy in this case raises some broader issues. He describes the cause of Rivera's tragic death as a "systemic flaw" in the interactions among not just pharmacists, but also patients, physicians and health insurers. Justice Lowy was concerned that pharmacists, as opposed to health insurers, may not have the best means to control or avoid the risks in the prior authorization system. He asked whether the court's opinion might enable physicians and health insurers to delegate a portion of their responsibilities in that system to others.

We may ask similar questions about how expansive the duty of care might prove to be for providers acting within complex systems of care involving case management obligations and the integration of many types of caregivers. As the physician-patient relationship evolves within these complex structures, what specific knowledge regarding the prerequisites of insurance reimbursement, in the context of customs and practices developed within integrated systems of managed care, might the physician be required to understand and communicate in order to avoid liability?

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

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Worcester District Medical Society

Calendar of Events

2018

September 14
Friday
7:30 a.m.
Beechwood Hotel

27TH ANNUAL WOMEN IN MEDICINE BREAKFAST

Speakers: The Honorable Harriette L. Chandler, Massachusetts State Senator for the 1st Worcester District

Cosponsored by Physicians Insurance Agency of Massachusetts (PIAM)

October 11
Thursday
5:30 p.m.
Beechwood Hotel

13TH ANNUAL LOUIS A. COTTE LECTURE

Topics: TBD

A generous bequest from the Louis A. Cottle Trust was received allowing WDMS to establish an annual lecture series in memory of Dr. Cottle, a dedicated Worcester physician.

November 14
Wednesday
5:30 p.m.
Beechwood Hotel

FALL DISTRICT MEETING AND AWARDS CEREMONY

The dinner meeting includes the Dr. A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and Scholarship Award Presentations.

November–December 30 & 1
Friday and Saturday
9:00 a.m.
MMS Headquarters and the Westin Hotel, Waltham, MA

2018 INTERIM MEETING AND MEETING OF THE MMS HOUSE OF DELEGATES

All WDMS members are invited to attend as guests and may submit a resolution to the Massachusetts Medical Society.

December 13
Thursday
5:30 p.m.
Washburn Hall, Mechanics Hall

HOLIDAY RECEPTION AND A NIGHT AT THE MOVIES

Join us for a holiday buffet and movie with a group discussion to follow.



For more information about WDMS
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2019

February 13
Wednesday
5:30 p.m.
Beechwood Hotel

223RD ANNUAL ORATION

Hope for Haiti: Healing One Patient at a Time

Orator: Jane Lochrie, MD

Dr. Lochrie is the medical director of the St. Anne's Free Medical Program, editor of *Worcester Medicine*, past-president of the WDMS, and current chair of the Personnel Committee. She recently traveled to Haiti for a medical mission.

March 1
Friday
7:00 p.m. reception;
8:00 p.m. program,
Mechanics Hall

CZECH NATIONAL SYMPHONY

100 Years of Leonard Bernstein, *Candide Overture*, *West Side Story* Dances, Selections from *Trouble in Tahiti* and *Songfest*, and *Mass Meditations*

March 13
Wednesday
5:30 p.m.
Beechwood Hotel

WOMEN IN MEDICINE LEADERSHIP FORUM

Program to be determined

March 30
Event to be announced
March 30 is National Doctors' Day when patients, friends, family and colleagues honor physicians and express their gratitude for physicians' continuing commitment to patients and exceptional medical care.
The event will be sponsored by the Worcester District Medical Society Alliance.

April 10
Wednesday
5:30 p.m.
Beechwood Hotel

ANNUAL BUSINESS MEETING

Meeting includes presentation of the 2019 Community Clinician of the Year Award.

May 2 & 4
Thursday and Saturday
9:00 a.m.
the Seaport Hotel and World Trade Center, Boston

2019 MMS ANNUAL MEETING AND HOUSE OF DELEGATES

All WDMS members are invited to attend as a guest and may submit a resolution to the Massachusetts Medical Society.

May 16
Thursday
5:30 p.m.
University of Massachusetts Medical School

MEET THE AUTHOR SERIES

"Attending"

Author: Ronald Epstein, MD, professor of Family Medicine, Psychiatry, Oncology and Medicine (Palliative Care), University of Rochester School of Medicine and Dentistry

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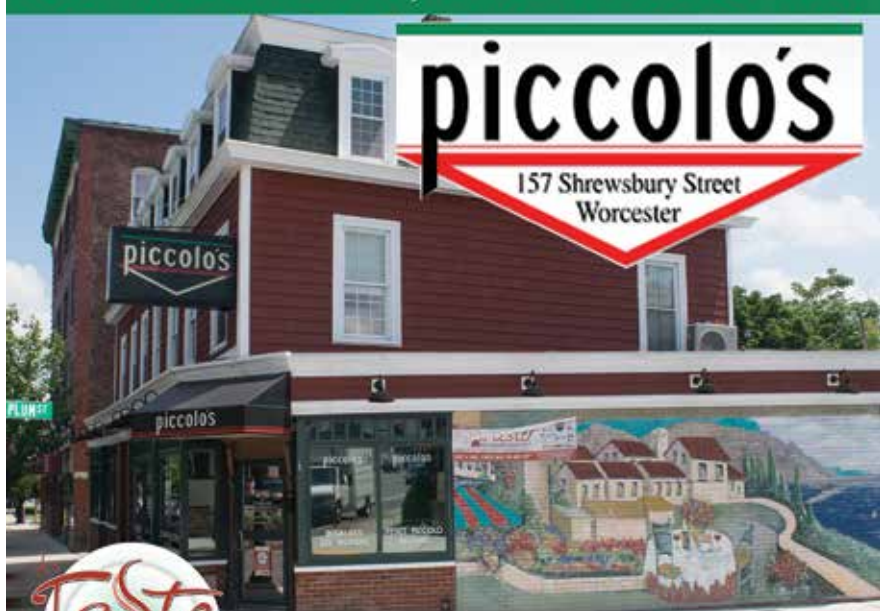
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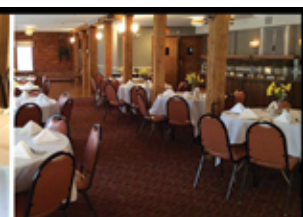
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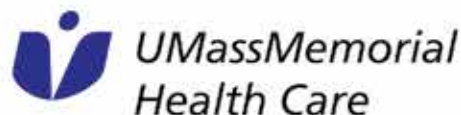
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