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The Recession's Impact on Health Care



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Is Medicine Recession-Proof?



Paul M. Steen, MD

One longstanding belief about medicine is that it is recession-proof because of the insulation provided by an economic model where the consumer is not the payer. But the complexity that is today's medicine puts that simplistic model to the test. For example, the turmoil in the financial markets makes it harder for hospitals to raise money, in turn making it harder to buy capital equipment and putting vendors at risk. At some hospitals, compensation changes are now taking place. Because of these observations, the Editorial Board of Worcester Medicine felt it was time to re-examine this concept.

In the lead article, Chancellor Collins of UMass addresses many of the business issues facing hospitals in general and specifically the impact on teaching hospitals with their unique obligations. Katherine Tromp's look at pharmacy and the recession concludes, "The changing economic trends in pharmacy practice and pharmacist employment indicate that the field may not be as 'recession proof' as previously suggested."

Sometimes we can be very academic or business-oriented about the recession's role in healthcare. Chris McPartland's article gives us the patients' very personal view of losing a job and its subsequent impact on medical availability and health treatment decisions. This leads us nicely to the next set of articles as job loss leads to a search for health care outside the HMO or fee-for-service options. These three articles examine the impact of the recession from the viewpoints of a free medical program (Saint Anne), a community health center (Great Brook Valley), and an emergency department (Saint Vincent Hospital). All are impacted by a rising demand on their services, decreased funding from state and local government, and fewer charitable contributions.

On the whole, healthcare generally weathers poor economic times fairly well, but it's not recession proof. The articles in this month's issue of Worcester Medicine will demonstrate just how much recession impacts all these different healthcare delivery options and how each has responded with positive actions that benefit patients.

Paul M. Steen, MD

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medicine

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The Recession's Impact on Health Care

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Making Bold Moves in a Down Economy

Michael F. Collins, MD



Michael F. Collins, MD

The University of Massachusetts Medical School has faced important choices on how to address the recent economic downturn. External factors such as investment losses, access to capital markets, endowment declines and reductions in state support, to name a few, threatened to impinge upon the implementation of our strategic plan, and, ultimately, our success.

We believe that our commitments ~ to create the health care delivery system of the future, to educate the workforce of tomorrow, to establish an ideal learning environment, to focus on translational research endeavors, to be an efficient and effective academic health sciences center and to make a global impact ~ are essential to the vitality of our university, our Commonwealth, and our world. As such, they cannot be stalled or abandoned solely because of external economic conditions.

It is within this context that our institution is investing in strategic areas that we believe will have far-reaching and long-lasting impacts.

How are we able to forge ahead with our plans in such a volatile economic environment?

Over the years, in response to significant declines in our state appropriation, which currently accounts for less than five percent of annual revenues, our medical school has developed diverse business lines to support and advance institutional growth. Two of those are a \$325 million school operations enterprise and a \$240 million research enterprise, not uncommon at most peer institutions. But what distinguishes us from virtually every other American medical school is two other business lines: a \$450 million consulting division called Commonwealth Medicine and a \$90 million vaccine production business called Massachusetts Biologic Laboratories, the only non-profit, FDA approved manufacturer of vaccines and biologics in the nation.

Taken together, these four distinct business lines insulate our medical school from declining state support and market fluctuations. When coupled with the reality that our medical school depends little on endowment income to support operations and capital projects, the surpluses generated from our business lines not only insulate our school, but also give us the financial stability and flexibility to undertake strategic investments.

Clearly, without a diversified business model we could not have proceeded with the \$405 million Albert Sherman Center Project, which has as its centerpiece an approximate 500,000 square foot educational and research facility slated to open in 2012.

Moving ahead aggressively on the Sherman Center Project may run counter to conventional wisdom, a fact which might dictate that we limit support to our existing programs and leave new initiatives on the shelf, to be dusted off during better times. But because doing so enables us to advance many of the commitments highlighted above, we have decided to make bold moves. Why?

First, the discoveries that will occur within this new facility could change the face of medicine and conquer diseases that have been unresponsive to conventional therapies.

Second, as the state's public medical school, we have a responsibility to expertly train the next generation of health care providers who will, in part, help to meet the growing demand for patient services as a result of health care reform.

Third, as this is the life sciences moment in Massachusetts, we have pledged to do all that we can to take advantage of this moment, and through the Sherman Center Project and a \$90 million state investment in support of it, we are partnering with the Commonwealth to strengthen the state's global leadership position in the life sciences.

Fourth, this facility will have an enormous economic impact on the region and the state. Construction spending on the project is expected to support almost 6,000 total jobs, thereby contributing to over \$760 million in total statewide economic impact during building. When fully operational, the Sherman Center is projected

to support approximately 1,600 total jobs and \$264 million in total statewide economic impact. Together, the construction and operation of the facility will generate over \$1 billion in economic activity in our state, and it will solidify Worcester as a hub for life sciences research and industry.

Never mind the effect of the economy on medicine; these figures underscore the effect of medical investment on the economy.

Fifth, interest rates are at historic lows, making campus borrowing for the Sherman Center feasible within our long-range financial plan. These advantageous rates, when tied to declining or stagnant construction-related prices, contribute to an environment ripe for undertaking large-scale capital projects.

We have made the determination that this economic downturn provides us with an opportunity to enhance our medical school's and the region's position as a national leader in medical education and research. By thinking strategically, acting boldly and managing prudently, we are seizing the moment.

We believe that the health and wealth of our Commonwealth may depend upon these important initiatives.

Michael F. Collins, MD is the Senior Vice President for the Health Sciences at the University of Massachusetts and Chancellor of the University of Massachusetts Medical School.

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Pharmacy *Is it Recession-Proof?*

Katherine M. Tromp, PharmD and Edward T. Kelly, PhD

Reports in the news are beginning to suggest that the nation's recession is ending; however, an increase in the rate of unemployment continues. The rate of unemployment in Massachusetts was reported at 9.3% as of September 2009.¹ From September 2008 to September 2009, the state of Massachusetts lost 110,200 jobs; 9,200 jobs were lost from August 2009 to September 2009 alone. Worcester-CT Metropolitan NECTA region lost 4,100 jobs over the past year with a loss of 100 in the past month.² The impact of these economic trends on healthcare practices and patient care must be considered. The financing of care and healthcare coverage is tied to employment. Traditionally, the employment of health professionals, specifically pharmacists, has been considered "recession proof." Does this statement hold true in light of the current economic climate?

The answer to this question involves examining the complex interplay of the demand for various types of health care services and the financing of care. The profession of pharmacy has not been immune to these factors. Pharmacy and pharmacists are caught between the economics of care and a changing practice environment. Pharmacists have found themselves in a paradoxical dilemma caused by the pressures of the economy and the movement to expanded models of cognitive services. Three important aspects of the pressures on pharmacy are the manpower issues, the state of coverage for services, and patient needs and behaviors. These issues are exacerbated in a slumping economy.

The U.S. Department of Labor predicted that pharmacist employment would rise 22% from 2006-2016.³ This "much faster than the average" increase in employment was based upon a number of factors including the aging population, scientific advances, and increasing coverage from health insurance plans. It is true that the population is aging and the use of prescription drugs continues to climb, albeit at a slower rate. However, these projections will have to be revisited in light of manpower shifts. Pharmacists are delaying projected retirement dates as a result

of declining rates of return on retirement investments. These activities are common across medicine, dentistry and other professions. Furthermore, in certain geographical areas of the country, including New England, the number of pharmacy schools is expanding, and a number of the current programs are graduating larger classes. Pharmacy chains are slowing their expansion plans, resulting in fewer new job opportunities than originally projected. All of these factors are causing a shift in the supply and demand of pharmacists.

Manpower and staffing of pharmacies is acutely tied to the economics and demand for prescriptions. The latter is driven by physician prescribing patterns and the consumers' choice of how they will spend their disposable income. The payment for prescriptions has long been considered to exhibit price insensitivity. This was the result of increased prescription coverage by insurance. The economic slowdown and increase in job loss has caused loss of much of this coverage. The consumer must in many cases decide how he or she will allocate scarce dollars across daily needs. The result of these circumstances has caused a slower increase in prescription sales, resulting in a decrease in overall profitability. Pharmacies have experienced a significant increase in the switch from brand name to generic prescription drug products. Patients have utilized other coping mechanisms by extending the time before seeking to have prescriptions refilled or not having maintenance prescriptions refilled. Pharmacies are receiving more requests for partial filling of prescriptions. Pharmacists are being urged by patients to contact the patients' physician to request therapeutic changes to less expensive alternatives that are covered by insurance at lower copayments. In addition to these actions, patients are foregoing physician office visits and are relying more on self-care and self-medication.

The impact of these actions is reflected in pharmacies by the reliance on "front store" inventory for supporting profitability. The traditional prescription area inventory has increased in

cost and importance for pharmacist managers. This has become particularly true as pharmacy experiences a rise in the availability of biotechnology- derived therapeutic products. In order to control this area, pharmacists are reducing their inventory and have become more conscious of cost control. Pharmacists have, in some cases, forewarned patients to phone a number of days ahead of time to order a refill. This gives the pharmacist time to order and stock the necessary entity. This “just in time” inventory method is replacing the traditional method of holding inventory and maintaining backup of all prescription items.

The change in inventory maintenance is not the only transformation pharmacists are facing. Pharmacists have long been considered the most accessible health professional; however, the public did not always utilize their skills and knowledge. Both primary care physicians and patients are relying more on the knowledge of pharmacists to make therapeutic recommendations. Pharmacists also are becoming more utilized by the public for immunizations and blood pressure and blood glucose monitoring (or determinations). Consumers are aware of the fact that having these services done at the pharmacy often is less expensive than the copayments associated with a visit to their primary care physician. Additionally, an increasing number of pharmacists are practicing medication therapy management. This service, which is covered by Medicare and some insurance programs, is aimed at lowering the cost of health care and improving the effectiveness of drug therapy. Among the positive outcomes of this service for the consumer is the identification of duplication of therapy, adherence issues, drug-drug interactions, and other concerns for care. The effect of these changes on consumers is clear. Consumers are experiencing longer wait times as pharmacies have reduced the number of pharmacists and technicians that work at any one time. The decrease in on-hand inventory is causing patients to wait one or two days for the

drug to be shipped to the pharmacy. Consumers also are being inconvenienced as pharmacies shorten their hours of operation. Additionally, locations that had been determined as suitable for supporting the opening of additional pharmacies may not see that pharmacy come as quickly as corporate decision makers originally planned.

While pharmacists may be faring better in this economic climate than some other professions, the fact that negative implications are occurring cannot be ignored. The economic climate for health care and pharmacy in particular suffers from a common malady, consumer value choices. This economic situation has affected consumer preferences. The value placed on health care impacts the manner in which the consumer expends scarce resources ~ which in this case means money. The shift in how consumers allocate their money is affecting pharmacy. The changing economic trends in pharmacy practice and pharmacist employment indicate that the field may not be as “recession proof” as previously suggested.


(Footnotes)

- 1 The Commonwealth of Massachusetts Executive Office of Labor and Workforce Development. Department of Workforce Development, Division of Unemployment Assistance, Press Release 10/15/09
- 2 The Executive Office of Labor and Workforce Development (EOLWD) Website, Massachusetts Quick Facts
he Executive Office of Labor and Workforce Development (EOLWD), Massachusetts Quick Facts.
The Executive Office of Labor and Workforce Development (EOLWD), Massachusetts Quick Facts.
- 3 Occupational Outlook Handbook, 2008-09 Edition, Bureau of Labor Statistics, United States Department of Labor, updated December 18, 2007.

(Endnotes)

- 1 Dr. Tromp, Resident and Dr. Kelly, Professor of Pharmacy Administration, at Massachusetts College of Pharmacy and Health Sciences-Worcester

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A Patient's Perspective Seeking Health Care in the Great Recession

Chris McPartland

Walking into my office on a late January morning alongside my boss, I asked a simple question that had been looming heavily on my mind. "Sales have been down, and I'm worried about layoffs in this economy. What's your take on things?" He confidently replied that I need not worry. About 3 weeks later I was in my office checking emails and was called in to see my boss, who was on the phone with our human resources department. My heart was pounding. I knew what was happening. I was laid off. Position eliminated, I drove home thinking that my severance package would tide me over until I found a new role, and I wasn't worried about my lack of health coverage since I hardly ever needed a doctor's visit.

As the days turned into weeks and then months, my anxiety, which I always thought was normal, worsened, and I found myself having constant panic attacks. These panic attacks were crippling, and I found myself thinking about how I have had panic attacks my entire life and just never realized what they were because they had never been this severe.

Unemployed and anxious, I turned to my family for suggestions and ideas because we have a history of mental illness and my mother is a former RN. Shortly after discussing my options, I decided to go see a therapist whom I knew and trusted, but without health coverage, I was forced to pay him cash for my visit. I spent nearly two hundred dollars on a 1½ hour visit. My therapist recommended I go to see my primary care physician and discuss getting on an SSRI.

Again I was worried about doctor visits and how to pay for them, and on top of that, I now needed a prescription. I could hardly afford to keep my car payment current along with my rent, credit cards, gas, oil, and other expenses, and I live in a state that requires that I have health insurance. With my severance gone and only unemployment to get by, I could not afford any other expense, especially something as expensive as insurance.

It is nearly impossible to find free health care options for the average person. Insurance costs, doctor visits, and prescriptions cost a lot of money, and I felt very hopeless until I found the (free) clinic.

Finally the phone rang with some good news. My mother had discussed my situation with her primary care physician and asked him if he would see me, and she was willing to pay for my visits so that I could get started on my new prescription. To her surprise, he let her know that he volunteers on Tuesdays at a free clinic in Shrewsbury

where medication is available, and that he would be able to help me at no cost if I could come down. Having never needed a free clinic, I knew nothing about what to expect upon my arrival. I filled out some forms and was seen within an hour. That night, I walked out with a prescription for Lexapro, and I had paid nothing.

Free clinics cannot really afford to advertise, but they are out there for those of us in need. Without the clinic and the doctors, nurses, and interns who volunteer their time, I would have continued to suffer from panic attacks; I have no idea how much longer it would have made my already difficult job search. Every thirty days, I returned to the clinic for a quick check-in and refill of my prescription, and each time I left thankful, with the same amount of money in my pocket as when I had arrived.

I cannot imagine what I would have done without the clinic and the help of Dr. Joel Popkin. During the long months that I was unemployed, I received very little good news, so stumbling upon the clinic was the best thing that happened to me, other than finding a suitable new job. If not for the help of my family, I would have continued to worry about paying for doctor visits, prescriptions, or insurance, and certainly ~ if those expenses had to come from out of pocket ~ I could have lost my car or duplex, or defaulted on my credit cards.

It is nearly impossible to find free health care options for the average person. Insurance costs, doctor visits, and prescriptions cost a lot of money, and I felt very hopeless until I found the clinic. I would encourage those who are out of work and cannot afford to purchase insurance to consult their former primary care physicians and personal networks to find help in a troubled economy. In MA, the implementation of universal coverage and the additional requirement to carry insurance has increased the number of insured residents. However, it has also caused a serious delay in obtaining treatment. So, even if you are fortunate enough to be able to afford your own coverage, finding a doctor who will see you and be able to spend an adequate amount of time with you is difficult. Many physicians have had to close their doors to new patients or delay appointments through no fault of their own. Our state created a plan that, in my opinion, backfired. Simply because one has insurance does not mean he or she can even be seen by a doctor in a timely manner.

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Voluntary Free Medical Programs and the Massachusetts Economy

Harvey G. Clermont, MD, FACS and Jane A. Lochrie, MD, FACP

Momentous increases in health care expenditure and in health insurance premiums are affecting Americans personally and profoundly and have become a major national economic problem. Massachusetts health care reform is failing miserably. Fifty-nine percent of Massachusetts hospitals are reporting a decline in elective surgeries, and 24 percent report that they have, or will, cut services. Sixty-four percent of our hospitals are reporting staffing cuts.

Facing a massive budget shortfall, lawmakers tried to cut roughly 30 thousand legal, taxpaying immigrants out of the state-subsidized Commonwealth Care program, including those who are on active treatment for cancer. They are now being reinstated in a staggered fashion but they will no longer be covered for dental, hospice or skilled nursing care under the scaled-back plan.

Boston Medical Center has filed a lawsuit against the state claiming it is being shortchanged by a whopping \$181 million annually. The hospital claims the state is not adequately covering the costs of Medicaid, Commonwealth Care and the uninsured, saying reimbursement rates have dropped to just 64 cents on the dollar.

I can only shake my head in disbelief when I read the deliberately misleading figures estimated by the Massachusetts Division of Healthcare Finance & Policy and the simple regurgitation of the numbers by the media that only 2.7% of Massachusetts residents remain uninsured due to the 2006 law mandating the near-universal coverage and imposing a financial penalty for failure to insure.

At our Saint Anne's Free Medical Program, we have experienced a 30% increase in the number of patient visits as a direct result of this law. We went from an average of 60 patient visits in an evening to approximately 80 visits. How can this be and who comprises this additional 30%?

The numbers are clear. Twenty percent or two-thirds are new visitors/immigrants/refugees/unemployed residing in Central Massachusetts and 10% are underinsured (despite being insured they are spending over 10% of their gross income on healthcare). This latter group is

predominantly in the 19-30 age group. Most of them are working and earn at least 300% of the federal poverty level (defined as 100% = \$10,220 per year). Others have insurance, but cannot find a primary care physician.

What is ignored is the simple word "eligible" when estimating the percent covered in Massachusetts. We continue to encourage immigrants and refugees to seek our freedoms here in the United States, have numerous short term visitors to our expanding biotech and medical industry in Massachusetts, and are increasing the unemployment numbers in skilled professions with unrealistic COBRA charges. Where do these people go when an urgent healthcare problem arises? They can go to an emergency room and wait to get expensive care paid out of pocket or they can try to go to an urgent care at one of the regional healthcare facilities where ~ again ~ long lines are present. To avoid this, they come to Saint Anne's, where we offer numerous services including medical, pediatric, women's health, immunizations, medications, mental health, minor surgical, durable medical equipment, and social service.

More importantly, however, we offer three rapidly disappearing, nearly anachronistic elements that presently exist in patient care. These are face to face instead of face to monitor dialogue, respect for the individual, and no third party interposition between the physician and patient. Economically, unemployment numbers are also very conservative and deliberately misleading. Many of the "unemployed" have families who have also lost their health benefits even though the unemployed person may be receiving unemployment checks. We at Saint Anne's can corroborate the studies that have proven that the uninsured are living sicker, dying younger, and waiting too late for treatment, resulting in more expensive and intense care with the cost being spread across the system (i.e. we pay).

Additionally, the laying off of several Worcester Department of Public Health nurses due to budgetary constraints has resulted in the closure of the city tuberculosis testing program and immunization clinic. These functions have added an additional 20% in patient

visits at Saint Anne's as well. We now see over 90 patient visits per Tuesday evening.

When alterations are made to one element in our complex healthcare system, a knowledge of the entire system and its interrelations is essential to avoid strains on the other elements. For example, the relative paucity of primary healthcare providers should have been known to our legislators before political gain and insurance greed pushed the bill through in its present form.

Many other elements of our system are similarly being ignored presently on a federal level: malpractice reform, avoidance of federal pharmaceutical contracts, narrowing of the specialty-primary care reimbursement gap, capping of the total healthcare budget, et cetera.

May I leave you with a final thought? Why are voluntary free medical programs and alternative medicine thriving despite the poor economy? Traditional and organized medicine certainly need to analyze this question and when they look in the mirror, stop asking the simple question, "Who is the fairest of them all?"

Harvey G. Clermont, MD, FACS is the Medical Director of three all-volunteer Free Medical Programs in the Central Massachusetts area.

Jane A. Lochrie, MD, FACP is the Program Director at St. Vincent Hospital and a volunteer at St. Anne's Free Medical Program.

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Emergency Department Utilization Surge during the Economic Recession *Not Your Typical Commodity*

Michael J. Burns, MD

The United States has been in an economic recession since December 2007 and is now burdened with a double-digit unemployment rate of 10.2%.^{1,2} Massachusetts has an unemployment rate of 9.3%, which is its highest level in 33 years.^{3,4} Although Massachusetts has a Medical Security Trust fund that largely subsidizes a laid-off worker's health insurance premium for as long as he or she collects unemployment, loss of job eventually leads to loss of health insurance. On first glance, insufficient health insurance coverage coupled with financial hardship from job loss and rising copayments should provide strong disincentives for patients voluntarily going to the Emergency Department (ED) for medical care. On closer analysis, however, loss of health insurance coverage is often associated with loss of primary care and specialty physician assignment and with the need to use the ED for all aspects of healthcare. The Emergency Medical Treatment and Active Labor Act (EMTALA) passed in 1985 renders the ED the only place in the U.S. health care system that is required to provide health care to an individual regardless of ability to pay or insurance status.

Whereas the recession has undoubtedly led to a loss of health insurance over the past two years for some privately insured patients in Massachusetts, health care coverage has simultaneously been added for some previously uninsured patients as part of the Massachusetts Universal Health Care Plan. At 4.1%, Massachusetts has been credited with having the lowest rates of uninsured people of all 50 states.⁵ Unfortunately, access to health insurance is not equivalent to access to care. There are shortages in nearly every field of medicine, with shortages of PCPs being the most pronounced.⁶ Furthermore, many providers are not bound by EMTALA law and may refuse to see uninsured patients or those covered by a certain payors due to their inability to collect adequate payment for the care provided.

People outside health care might wrongly presume that health care would mirror other commodity-driven industries and slow in an economic recession. Patients, however, get sick as they always have and continue to have healthcare needs. As front-line, 24/7 providers of health care that are largely devoid of barriers to prevent access,

EDs serve as barometers for the health care crisis. Currently two years into the recession, ED visits have steadily increased in both Boston and Worcester area hospitals, with an increase that ranges from 3 to 10%. In one recent study, overall ED visits from six hospitals (3 tertiary, 3 community) in the Boston area increased almost 10% between 2006 and 2008.⁷ More specifically, in the Central Worcester area, overall ED visits at Saint Vincent Hospital have increased steadily each of the past 4 years, with a 5.5% increase over the past 12 months. Similarly, ED visits at the UMass Memorial Medical Center (both University and Memorial campuses) have increased by 8% over the past year.⁸

Is the recession responsible for the recent surge in regional ED visits? That is not clear, as several other factors simultaneously influence ED volumes. First, the population census continues to increase annually in Central Massachusetts ~ more patients leads to more visits to the same number of EDs. Second, longer life expectancy has led to an aging population that needs emergency care more often. Third, Massachusetts, like the nation, is suffering from a primary care physician (PCP) shortage, thus resulting in patients continuing to utilize the ED for their primary care. Fourth, even patients who have a PCP are often more likely to visit the ED for care due to its convenience and, ironically, more timely access to care. For instance, while the Massachusetts Universal Health Care Plan initiative increased the numbers of patients who are insured in the state, it did not simultaneously create a system that facilitates patient access to the existent PCP pool. Fifth, despite copayment increases that are meant to discourage inappropriate use of the ED, most patients who seek emergency care do not have to pay prior to or at the time of emergency care (as mandated by the EMTALA law). While appropriate, the financial disincentive is temporally separated from the visit. In addition, many patients have subsidized insurance and are not subject to ED copays. Sixth, ED volumes have surged twice this year due to outbreaks resulting from novel influenza A (H1N1) infection. Currently, the ED volume at Saint Vincent Hospital has increased by 10% due to a marked increase in influenza-like illness presumed to be largely due to H1N1 infection.

How has the recession affected the types of patients treated in regional EDs? Thus far, the change, if any, is small. While the overall ED volume at Saint Vincent Hospital has increased since December 2007, patient acuity, admit rates, and payor mix (self pay, subsidized and privately insured patients) percentages have not changed significantly. Interestingly, a recent study aimed at determining the impact of health care reform in Massachusetts on Emergency Department use demonstrated that the overall number of ED visits increased at similar rates in those patients with publicly subsidized insurance (including Commonwealth Care patients) and those with largely private insurance.⁷ Ironically, the number of ED visits decreased for uninsured patient during the study period.

Despite a recession that has already lasted two years, the negative reimbursement effects (e.g., bad debt increases) have not yet been experienced by many health care organizations. Health insurance loss often lags well behind job loss due to health care subsidies provided for those collecting unemployment. As unemployment checks dry up for many in the coming months, so will their health care subsidies. Thus far, increases in bad debt can be attributed to increased copays and deductibles from scaled-down benefit plans ~ patients are incurring the cost burden and are less able or apt to pay. As unemployment-associated health care subsidies end, however, self-pay and bad debt percentages are likely to rise sharply.

Since enactment of the prudent layperson legislation for Emergency Care in Massachusetts in 2000, patients appropriately determine what symptoms constitute an emergency and thus largely dictate their visit to an ED for care. EMTALA law affords patients unrestricted access to emergency care regardless of their ability to pay. Some patients are frustrated by the inability to reach their physician, even if the turnaround time for a placed call is just a few hours. Even worse, the wait to physically see many PCPs and specialists may be days to months, respectively. Some patients are unable to secure care due to insurance restrictions or unaffordable out-of-pocket expenses. For others, the inability to secure follow-up is due to cultural, language, knowledge gap, financial, or transportation barriers. All of these factors render the ED an understandable place to seek medical care. Waiting in an ED for several hours for care is less aggravating than waiting for several days to see your PCP. While it is

naïve to think that the recession does not play a role in the surge of ED volume in Massachusetts, the reasons are multifaceted and not likely to go away without sweeping reform coupled with assistance provided to an overburdened primary care system.

Michael J. Burns, MD, FACEP, FACMT is Chief of Emergency Medicine at Saint Vincent Hospital in Worcester and Assistant Professor of Medicine at Harvard Medical School.

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The Recession's Impact on Health Care

The View from Great Brook Valley Health Center

Antonia G. McGuire, RN MPH

On the national front, the effects of this stressed economy have far reaching consequences on our public health. The Bureau of Labor Statistics states, "The national rate of unemployment has doubled over two years, triggering a ripple effect in the health care landscape." And according to the U.S. Census Bureau, "...the numbers of uninsured and people living in poverty are also on the rise." So then, how does this affect a community health center in Massachusetts where we have been on the cusp of health care reform? Massachusetts remains committed to health care reform implementation, while realizing there may be challenges ahead as the economy struggles to recover.

From Cape Cod to Boston, Worcester to Holyoke, health centers already provide primary and preventive care to one out of every nine residents in the Commonwealth of Massachusetts. The recession has resulted in an even greater spike in demand particularly among middle income residents, many of whom have lost either their jobs or their health benefits. This places community health centers in an interesting community position; our demand for services grows, which stresses our capacity to offer access to all of those in need.

The rising patient demand means we need to open our doors of access to more patients and to provide more visits. The rising patient demand means that more service locations are needed. The rising patient demands means that we need more clinicians. The rising patient demand means that many of the patients walking through our doors for the first time are unemployed and no longer have medical insurance coverage, and we have to assist them in navigating the system to locate affordable health care plan options. The rising patient demand means that patients walking through our doors for the first time present with more pressing needs due to having delayed care or avoided preventive care simply because of access or affordability.

The recession has resulted in an even greater spike in demand particularly among middle income residents, many of whom have lost either their jobs or their health benefits.

Our community goals are two-fold. We provide patients with much needed primary care and we also provide jobs. Health centers in Massachusetts employ nearly 10,000 individuals. Great Brook Valley Health Center employs 320 staff members. We provide critical entry level jobs and training and career building opportunities. We employ professionals like doctors, nurses, dentists, dental hygienists, mental health professionals, pharmacists, social service professionals,

health educators, and medical interpreters, among others. Such opportunities help the community prepare for an improved economy and can make a difference in restoring consumer confidence and belief in the future of our economy. This benefit of public investment in community health centers as economic engines cannot be underestimated. Because

health centers serve as large employers for some of the state's most vulnerable and blue-collar neighborhoods, they are a hub of activity and a beacon of hope for communities determined to avoid an even greater economic depression.

But there is another more challenging side to the workforce, that of healthcare professional shortages, particularly that of primary care physicians. There is not enough of a supply of physicians wanting to work in Community Health Centers to meet the ever-increasing demand from patients needing primary care services. How do we shore up the public's primary health care needs during this time of primary care physician shortage? The American Recovery and Reinvestment Act (ARRA), also known as federal stimulus funds, has been pivotal in providing the kind of temporary lifeline health centers need to weather this economic crisis. While the stimulus funds do not cover the cost of care itself, Great Brook Valley Health Center did receive funds to hire additional workforce that would allow us to "grow our patient access and visits" but we had to get inventive about creating more space in a building that is already at its capacity for treating patients.

So, we moved administration, finance, billing, development and human resources out of our building at 19 Tacoma Street in Worcester and moved into a nearby vacated space that was for lease at a non-profit partner, the American Red Cross. This creative partnership will shore up both non-profits and our continuing relationship will serve us both well. With this move, we will be able to create a more patient- centered space for mental health and an additional eight clinical exam rooms in our medical department. ARRA funds will pay for most of the build-out and will also pay for the clinical staff for the first year of hire to increase access to care for patients. Great Brook Valley Health Center is not alone ~ across the state, stimulus funds have allowed nearly 40 health centers to hire new doctors, begin long-planned and much needed renovation projects, extend their hours of care, and create and retain jobs for community residents who are struggling to stay afloat in this sinking economy. Our construction at 19 Tacoma Street will happen in phases so as not to disrupt patient care and it will allow us to open our doors to over 2,000 additional patients. It has been less than six months since the first round of federal stimulus funds became available for distribution to cities and communities in an attempt to cushion the worst effects of the recession, and this money has already made a

vital difference to the people served by our organization in Central Massachusetts and in Metro West at our Framingham site.

Stimulus funding was the right prescription for the health center in 2009, a one time investment to create more jobs and to create greater patient access. But, it will be a challenge to weather the state budget crisis that has resulted in funding cuts of over \$700,000 to Great Brook Valley Health Center alone. As we look to the future, we must continue to stabilize coverage for those who have lost either coverage or financial resources, continue to shore up the health safety net, and focus on prevention, self care, healthy eating and active living as the best possible prescription for the health of our community.

Antonia G. McGuire, RN MPH, is President and Chief Executive Officer of Great Brook Valley Health Center.

navicare

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Investment Management

Does Warren Buffett Watch “Mad Money”?

Greg Thomas, Chairman/CEO, ThomasPartners, Inc.

Stick with Cramer...

Former hedge fund manager Jim Cramer has a popular television program called “Mad Money.” With rapid-fire advice to “buy, buy, buy” or “sell, sell, sell,” he reinforces the perception that profits are made by exploiting short-term price volatility.

The program has all the drama of a country preacher’s tent-show. Jim chastises investors for failing to take profits; he confesses when his recommendations go wrong. Investors feel saved; past mistakes are erased and a future of unending gains seems all but guaranteed.

Playwrights and authors exaggerate distinctive features or traits to help the audience get the point. Jim Cramer is the stock market’s exaggeration of its short-term orientation; he is a hyper-active representation of the fact that short-term price swings are mostly theatre, not science.

The “Oracle of Omaha”...

In contrast, Warren Buffett believes that even if stock prices are irrationally volatile in the short run, eventually they catch up (or down) to the fundamentals. Accordingly, Buffett focuses on characteristics like cash flows, earnings stability and growth, and dividends. He coolly buys when others are panic-selling, never losing sight of the underlying intrinsic values.

Unlike Cramer, Buffett tends to hold stocks for long periods of time. Like the skilled bridge player that he is, he plays the cards (a.k.a. the “markets”) he is dealt, sometimes calling for aggressive bidding, other times calling for defense. He expects to win over time, but not every hand, and as an investor, certainly not every year.

Buffett is also a larger-than-life exaggeration; in his case, it’s of the market’s fundamentals-driven rationality over the longer term. His performance over many decades is unrivaled and he is as arrogant about his ability to ignore the market’s short-term mood swings as Cramer is arrogant about his ability to exploit them.

Investor schizophrenia...

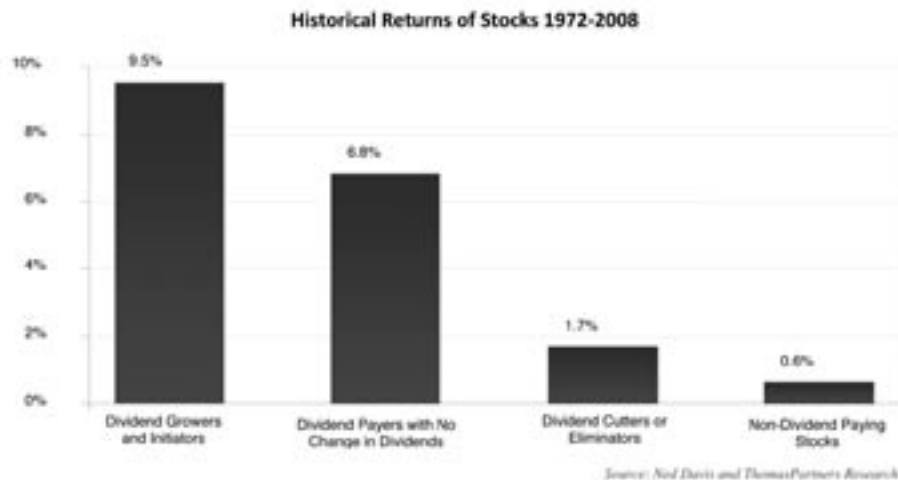
Curiously, both Cramer and Buffett can be right ~ though not generally at the same time ~ as long as each plays his own game, not the other’s.

Ordinary investors, however, tend to be attracted to both styles, at the same time: they profess a commitment to long-term fundamentals but secretly covet a desire to win every quarter. The unfortunate consequence is a tendency to “buy” on fundamentals and “sell” on emotions, an inconsistent mix of styles that usually fails to capture the potential benefits of either.

A solution might be found on the psychologist’s couch ~ perhaps, a discovery of some magical emotion-control technique. An easier solution might be found in the right approach to market volatility. If investors accept the likelihood of volatility, rather than fight it, and fashion ways to tolerate it, there will be less angst when volatility does inevitably arrive.

The “Eighth Wonder”...

Dividends paid on common stocks are always positive and cannot be recaptured when markets turn down. As such, dividends can be used to buy new shares every year, in both good years and in bad. The consequence is a constantly growing number of shares



owned. It is a form of compounding that Einstein once called the “eighth wonder of the world.”

One curiosity of dividend reinvestment is that its impact is enhanced when markets are in decline; the dollars of dividend income do not decrease, but the prices of the new shares to be bought do.

Wharton professor Jeremy Siegel calls dividend reinvestment a “bear market protector and bull market accelerator.” He even goes so far as to suggest that investors who regularly reinvest dividends should hope for frequent and severe market downturns; they will enhance long-term total returns.

The Bonus...

Dividends do more than just inspire patience when markets are in decline and more than just buy more shares; dividends have historically provided added compensation without inhibiting price appreciation.

Observe the following data covering the period from 1972 through 2008; it assumes that in each year, all publicly-traded stocks were placed in one of four portfolios, based on the dividend characteristics exhibited in the prior year.

Historical Returns of Stocks

*12/31/1972-12/31/2008

Source: Ned Davis and ThomasPartners Research

These facts say it all: over the last 36 years, stocks that have maintained and/or grown their dividends have delivered better total returns. These facts give investors reason to avoid over-reacting to short-term volatility; investors who move in and out all the time will never collect the dividends or buy the new shares so important to long-term performance.

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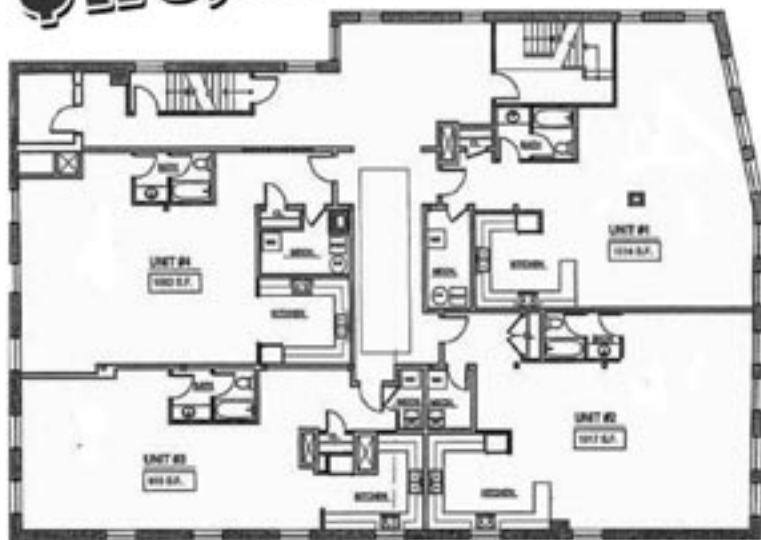
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The Language of Life

(Francis Collins, *Harper Collins Publisher*)

Reviewed by Terence R. Flotte, MD

Dean, Provost and Executive Deputy Chancellor, UMass School of Medicine

All scientists hope that their work will have a lasting impact on humanity. The cryptographers who decoded the human genome are no exception. A leading figure among these individuals, Francis Collins, describes the current and potential impact of genomics on the frontlines of clinical medicine in *The Language of Life*. In doing so, Collins demonstrates his considerable skill as a teacher and storyteller, illuminating key concepts of “personalized medicine” throughout this work in a series of real-life vignettes, touching upon issues ranging from the genetics of race to the use of genetic markers to individualize cancer treatment.

The book begins with a very personal account of how the specter of heritable cancer risk haunted members of Dr. Collins’ own family. Another personal account is used to demonstrate the current utility, limitations, risks, benefits and costs of the commercially-available, consumer-accessible whole genome scans. From these very personal illustrations of the importance of understanding genetic predisposition, Collins goes on to systematically describe the basics of genetics and the differences between DNA diagnosis of single gene disorders (such as cystic fibrosis) and the use of genetic risk markers in polygenic conditions (such as type 2 diabetes). He introduces the “RBI” mnemonic (for “risk, burden, intervention”) to make the latter, more subtle, concept accessible to both physicians and the lay audience. Only such a gifted teacher could communicate so effectively with both groups, neither talking down to clinicians nor talking over the heads of the general public.

After laying a solid foundation of basic concepts, Collins tackles the specific medical conditions on which genetic testing is having an effect now, including both germline and somatic mutations in cancer, age-related conditions, neuropsychiatric disorders, and the pharmacogenomics of warfarin dosing. Carefully avoiding fanciful speculation, the author bases each of these chapters on currently available technology. Specific examples of the utility of available genetic tests in each domain are provided. This section is further enriched throughout by historic accounts of which Collins was a part, such as the first clinical application of the BRCA1 gene discovery to a family at very high risk for breast and uterine cancer.

The author also approaches the highly charged issue of the genetics of race. This section is presented in a remarkably straightforward, impartial manner, illustrating the profound limitations of the classifications imposed by our social definitions of race. Not stopping there, Dr. Collins gives a basic framework for the crucial area of health disparities research, which strives to understand both genetic and environmental predispositions of diseases that are more common in some groups than in others.

In the final section, the author makes a few predictions about the future impact of personalized medicine in the clinical arena, very astutely pointing out the coming clashes between the uniformity of care delivery implied in “comparative effectiveness” research and the individualization of therapy based on an individual’s genetic profile. He makes fascinating predictions about the future of gene therapy and stem cell therapy. Finally, he reinforces a theme of personal empowerment by possession of one’s own genetic information, turning on its head the concept of genetic fatalism. Only in this last item do we see a glimpse of the philosophical facet of Dr. Collins’ thinking that shone very brightly in *The Language of God*.

Even more tantalizing to many readers will be the insights provided here as to the approaches that Dr. Collins may emphasize as he embarks on his tenure as the Director of the National Institutes of Health (NIH). In that role, he will direct \$40 billion per year of biomedical research funding and will head the leading federal policy-making body in the field. Thus, it is distinctly possible that some of his predictions about the future of personalized medicine may be more than random speculation. Could further regulation of direct-to-consumer genetic testing be on the horizon? Will there be further investment by NIH in novel therapeutics such as gene therapy and stem cell therapy? How will competing needs of comparative effectiveness research, health disparities research, and genomics research be balanced? While this book does not provide all the answers, it certainly does give us some insight into the guiding principles and perspectives of one of our time’s most influential scientific thinkers.

WDMS Remembers Its Colleagues

John G. Koomey, MD 1925-2009

Always available in what today is called 24/7, John Koomey was truly an ideal anesthesiologist for both the patient and the surgeon. He was knowledgeable and up to date, friendly and compassionate with folks he dealt with, and thorough in his planning and in his performance. John was very careful in positioning the patient on the operation table (an important detail) and he was a master of the difficult lateral approach with a spinal needle.

Over and above, he was a nice person and a good conversationalist, well versed in politics, in sports, and in Armenian history, which was his heritage.

Dr. Koomey served with distinction in the army, and then he gave the same devotion to Saint Vincent Hospital, where in thirty clinical years he also trained a superb group of certified anesthesia nurses, both men and women.

When the hospital decided to change from a private practice mode (as was John's anesthesia group) and convert to a hospital employee basis, John was replaced and thus continued his career at the then Holden District Hospital.

We all met John's love, his wife Peg, at the numerous staff social functions which years ago were de rigueur, and we knew what proud parents they were of their seven children, and their geometric family expansion.

There really were good ol' days, and we were there with John. He was greatly appreciated and will be very much missed.

Stuart R. Jaffee, MD

John P. DiCicco, MD 1945 - 2009

Dr. John P. DiCicco of Shrewsbury, a well-respected Worcester Ear, Nose and Throat Physician, passed away Tuesday, October 6, 2009, surrounded by his beloved family. He was 64 years old.

John was born in Providence R.I., the son of the late Dr. John P. DiCicco, Sr. and Gabriell Dionne DiCicco. He earned his bachelor's degree in Pre Med from Georgetown University in Washington DC, and his Medical degree from the University of Rome, in Italy.

John completed his residency at the Pittsburgh Ear, Nose and Throat Hospital. He maintained a private practice and was on the staff of St. Vincent's Hospital for more than 30 years. John is survived by his wife of 39 years, Lucia (Fascianelli) DiCicco, his children, John, Vanessa M. DiCicco, and Rosa L. Abraham, and his grandson Mateo DiCicco.

John's life was shaped by his love of and devotion to his family and friends and his dedication to his practice and his patients. John loved to travel, was an avid photographer, and also enjoyed fishing, especially at Cape Cod. He liked watching the Red Sox or Patriots with friends. He especially treasured the times spent with Father D'Orio. John was content driving his Jag and sharing a cup of espresso with his friends.

After John's diagnosis and surgical treatment for his renal cancer, he knew his prognosis was grim, with an average expected survival of about 1 1/2 years. Throughout that time, he never complained or sought sympathy. He remained courageous with a positive attitude and a smile. He always asked how you were doing before you could ask him the same.

Once asked what he thought about dying, he said his faith was not only about believing in an afterlife and being with those who had passed on before him, but also about doing good and helping others. He said, "I believe when everything is considered, I've done good and will be rewarded in heaven. Although I wish I had more time on earth, I have no fear of death."

John truly led by example. He was kind hearted, strong, and dedicated. John treated everyone with respect, and enjoyed life to its fullest. John was always willing to help others, never asking for anything in return. He touched those fortunate enough to have known him in a special way, and his faith in God put him at peace.

We'll miss our conversations and his wisdom, understanding and kindness. Our lives have been enriched by John. He will be greatly missed.

Peter Tomaiolo, MD

Wilfred T. Small, MD
(1920-2009)

Wilfred T. Small, MD was born in Milton, MA. His size was oxymoronic to his name; he was 6' 4," handsome and athletic. He graduated from Bowdoin College in 1938 and Tufts Medical School in 1946. Sports figured largely in Will's life, with baseball and track and field topping the list. He played minor league baseball and was recruited for the US Team at the Pan Am games. He served in the US Navy on a destroyer in Guantanamo Bay during WW II, returning safely to Boston for his surgical training at Children's Hospital and the Peter Bent Brigham Hospital. His Chief was the late Dr. Francis Moore. Dr. Small was said to have the "eye of an eagle" and the "hands of a woman" in the operating room.

Married and the father of two sons, Will moved the Small family to Worcester in 1953 and joined the Worcester Memorial Hospital surgical staff under the very able leadership of the venerable Dr. George Dunlop, beginning a career partnership with Dr. Jack Chandler. Dr. Small served many Worcester service organizations including the Boys' Club, of which he was a Director, and the Economics Club, of which he was an officer. In 1970 Will served on the Project Hope ship in North Africa.

Dr. Small became Chief of Surgery at the Memorial Hospital and Professor of Surgery at the University of Massachusetts Medical School. In 1980, he recruited me with "Robert, my boy, you need to come to Worcester." Will's booming "my boy" was legendary and often I repeat it unfortunately and unintentionally to some of our women surgical residents! Over the next eight years, I came to know Will Small as a disciplined surgeon with excellent surgical judgment both within the operating room and ~ more importantly ~ outside of it. He was enthusiastic for his balanced life, his family (dear wife "Moody" who predeceased him, four sons and eleven grandchildren), his vocation, academics, and for the privilege of teaching the next generation. In 1988, at his retirement grand rounds, Will was honored by presence of the late Dr. Francis Moore, his first Chief of Surgery.

Will Small served Central Massachusetts most ably as a surgeon, citizen and role model. Among his aforementioned accomplishments, it must be recorded that he indeed experienced a hole-in- one playing golf! I had dinner with him at Little Compton, RI about six years ago. While we sipped a martini he spoke of his father, who sipped a daily martini only to die in his sleep at age 104 AND 6 months! If only.....

Robert M. Quinlan, MD

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**Robert A. Schreiner, MD
(1953-2008)**

It is difficult to believe that nearly two years have passed since the unexpected death of Robert A. Schreiner on April 24, 2008. Beloved by his family, patients and friends, Robert was a primary care physician at the Fallon Clinic, having previously been in private practice in Worcester.

After graduating from the College of the Holy Cross, he received his MD degree in 1980 from Georgetown University School of Medicine. He then completed his residency in Internal Medicine at St. Vincent Hospital. Upon completion, he entered medical practice in Worcester and, at the time of his death, was a senior primary care internist for the Fallon Clinic.

Robert was full of energy and ideas; he was a planner and had a unique gift with words. He enjoyed his work and took great pride in delivering the finest care. The stunned reaction of his patients at the time of his death was testimony to his devotion. He had a great number of interests outside of medicine. He was a devoted husband and father of two daughters. They enjoyed time at Cape Cod. He was an accomplished golfer from an early age and a sought-after playing partner. He enjoyed his Harley, was a skilled woodworker and spent hours at local streams indulging his passion for fly-fishing.

Robert's death left a gaping hole in the lives of his family, friends, co-workers and patients. I often relied on his advice in times of need and am honored to have shared so much time with him.

Indeed, the world is a better place for Robert's presence.

John Platt, MD

**Gerald J. Carroll, MD
(1930-2009)**

Along the course of life's journey, he was born into a medical ambiance well established by his physician father. The molding and maturation of Gerald John Carroll continued while he was in Jesuit High School and was reinforced at Fordham University where he was embraced and influenced by the strict code and discipline of Jesuit mentors. His formal medical training began at University College Cork in Ireland and continued at St. Vincent Hospitals in New York and in Worcester. He completed his thoracic surgery training at Boston City Hospital.

Dr. Carroll realized some of his most satisfying and productive years when he joined his friend and mentor, the iconic Dr. Paul F. Ware. Both were of keen intellect, were voracious readers with a myriad of interests and, while utilizing refined skills as thoracic surgeons, fulfilled their innate desire to aid their fellow man. They served legions of grateful and loving patients. The premature and untimely death of Dr. Ware forced a painful accommodation following which Dr. Carroll continued his practice of thoracic surgery for the remainder of his career.

His wife June was his beloved companion. She was the matriarch of a predominately male family (four sons). She taught them the true meaning of grit, courage and determination, especially during her final days.

Friendship occupied the highest pedestal in his value system. To Dr. Carroll, friendship was no superficial, intangible, inert association, but a deep-rooted, tangible and well-defined dynamic, sustained and nurtured by

frequent communion, commitment and unswerving loyalty. Among his most enduring disciplines was reading, which guided him throughout his life. He appreciated that reading and learning could be joys; his prodigious appetite for reading was legendary, as no amount of it could satiate his appetite, nor satisfy his unquenchable thirst for knowledge. Laughter was Dr. Carroll's fuel. He loved sharing anecdotes and humorous tales. When he came into possession of a new offering, his irrepressible exuberance telegraphed his mission. The trademark grin and chuckle accompanied by the spasmodic undulation of his midriff guaranteed imminence of delivery. He loved laughter as he loved those who laughed with him.

Dr. Carroll's life ended in May 2009. While we struggle to fill that painful void created by his passing, we, as fellow physicians, must appreciate that we are the beneficiaries of Dr. Carroll's life accomplishments. His life's work exemplifies the noble Hippocratic tradition while enhancing the venerable and hallowed image of The Physician.

He was a kind, gentle man who touched our souls while leaving his indelible footprints on our hearts. Requiescat in pace!

Stanley L. Kocot, MD

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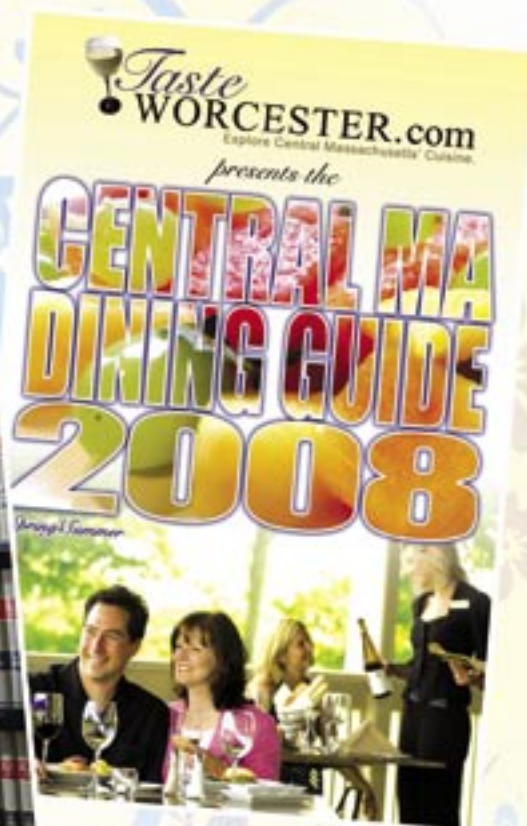
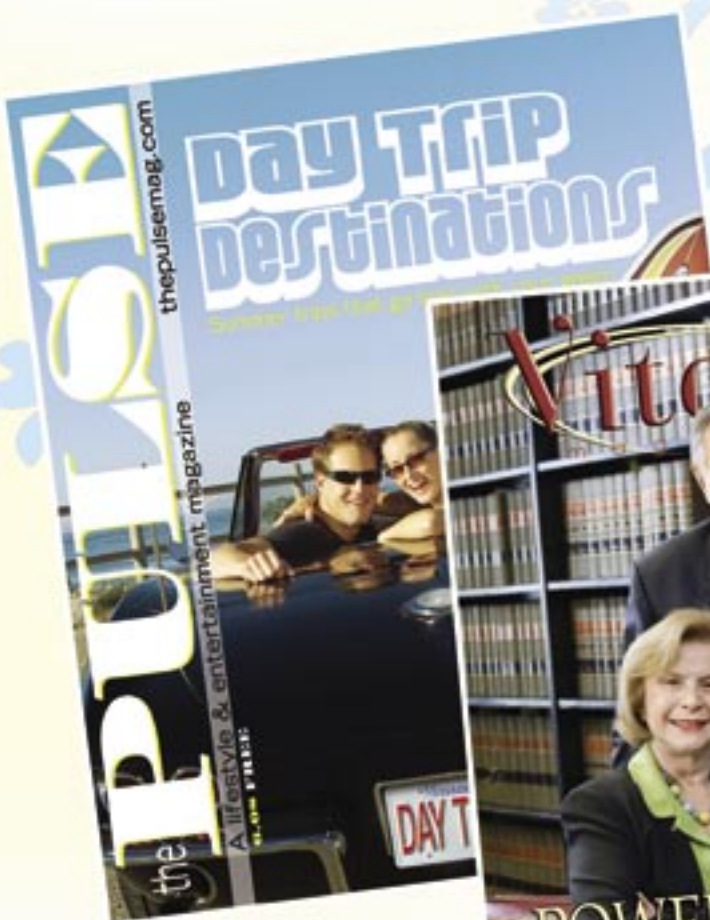
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