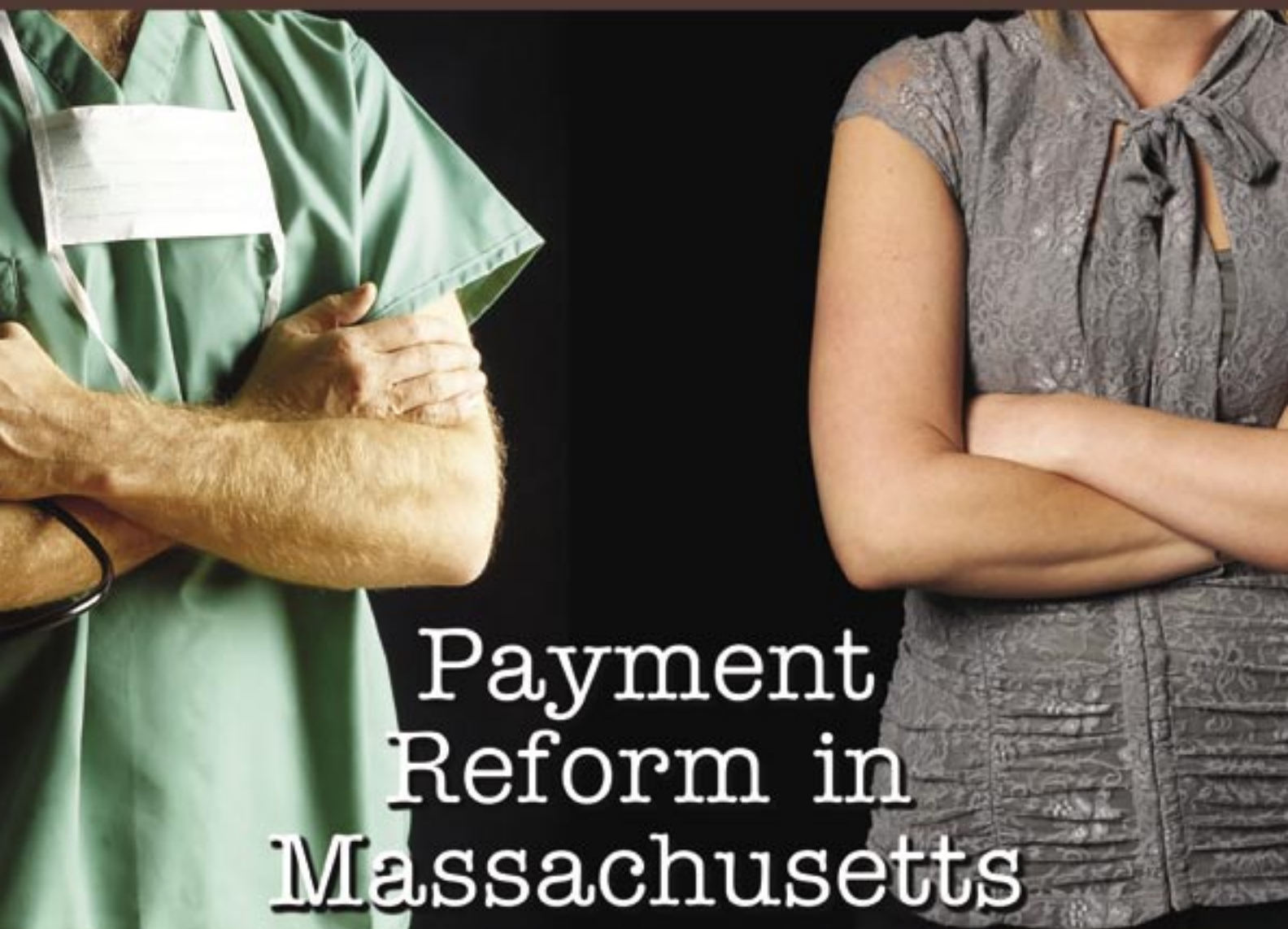


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## Payment Reform in Massachusetts

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# Payment Reform in Massachusetts



**Paul M. Steen, MD**

In the forthcoming year, as we reach the fifth anniversary of the legislation, healthcare reform will dominate the headlines. Driven by budget issues, is it actually working on what needs to change. *Worcester Medicine's* Editorial Board decided we should take another look at the issue with experts from different constituencies within the state to see as many viewpoints as we can.

We started with the Secretary of Health and Human Services, JudyAnn Bigby, discussing the problems we face with health care in Massachusetts. Rightfully proud of the 98% coverage of state residents and even better coverage of children, she then goes on to list the remaining issues facing the state, along with possible solutions. Next is the Massachusetts Association of Health Plans' (MAHP) view presented by Lora Pellegrini; they hope that it won't become "one-size-fits-all," and offer nine steps that could prevent this from happening. Lynn Nicholas from the Massachusetts Hospital Association (MHA) talks about the leadership role MHA hopes to take in the debate. This article is a very thorough discussion of the history, issue-by-issue, over the course of the legislation. As she says, "Healthcare payment reform is a complicated issue and we all must contribute to making the end result successful." This article deserves a detailed reading. Georgia Maheras' article personalizes this issue by looking at diabetes and a specific patient's struggle with the disease. She describes how the Massachusetts Campaign for Better Care hopes to keep the discussion on patient-centered care as debate rages this year so that budget talk doesn't drown it out.

The final article, by Worcester's own Lynda Young, President Elect of the Massachusetts Medical Society, discusses health care reform from the physician's perspective. As she says, "There is no going back to status quo. The rising cost of care, the decline in state revenues and the variation in pricing in institutions delivering this care are the key drivers which need to be contained. It is not feasible to do this reform on the backs of providers only."

What a year lies ahead of us. Let the fun begin.

**Paul M. Steen, MD**  
Editor

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# medicine

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# MASSACHUSETTS HEALTH AND HUMAN SERVICES FOR THE COMMONWEALTH OF MASSACHUSETTS

## The Problem with Health Care in Massachusetts: The Way We Pay for It

Secretary JudyAnn Bigby, MD



**Secretary JudyAnn  
Bigby, MD**

In the four years since I assumed the role of Health and Human Services Secretary of Massachusetts, residents of the Commonwealth have witnessed significant changes in the health care landscape. We have successfully implemented health care reform to achieve 98% coverage of all state residents, the Affordable Care Act was signed into law by President Obama on March 23, 2010, and the state has accomplished near universal coverage of all children

~ an estimated 99.8%, including 20,000 more children enrolled in MassHealth during the past year alone.

Still, significant challenges persist that are fundamental to the health care delivery system in Massachusetts ~ namely, that it operates in a high-cost, fee-for-service environment rather than as a model that encourages coordinated, patient-centered and cost-effective care. A leading priority of the Patrick-Murray Administration during its second term is to address systemic health care costs in Massachusetts. To achieve meaningful change in this arena, the enduring elements of health care costs must be tackled in a comprehensive way. Integral to achieving this goal is putting the right tools in place so that the state can ensure success of this key agenda item.

Last August, the state's Legislature enacted ~ and the Governor signed ~ what is commonly referred to as the small business health care cost bill, or Chapter 288, which further empowers the state's Division of Insurance to regulate insurance rates. This law does even more than regulate rates, however, and will facilitate the state's ability to contain health care costs for small businesses, which in turn will lower costs for individuals and families in the years to come. While regulating rates is essential to achieving lower costs,

the long-term solution is to shift the health care payment and delivery system from one that rewards the volume of care to a system that rewards the value of the care provided.

The Patrick-Murray Administration supports the formation of accountable care organizations (ACOs) that will gradually accept more and more responsibility for the overall care of their patients. By forming ACOs, providers are held accountable for a patient's care ~ primary care physicians and specialists alike work in an integrated and coordinated environment rather than in isolation and by charging a fee for each individual visit. This is important because today we know much more about preventing diseases like diabetes and heart attack. We know how to prevent complications after surgeries such as joint replacements. Providers achieve the best outcomes for their patients when they communicate with each other, share important information, and engage the patient. This is the type of care we want to support.

Bundled payments, paying a group of doctors within an integrated practice for services and costs related to the treatment of a particular condition, rather than paying each provider piecemeal, show promise in holding down costs while improving coordination. With a bundled payment, physicians can also assume the responsibility of treating a chronic condition such as asthma or diabetes, and therefore provide whatever care is most appropriate for the patient. This model encourages more coordinated care in the interest of treating a condition that requires patient education, adherence to medicines, and regular monitoring of clinical tests.

A more integrated system ~ in Massachusetts or any state ~ can only be accomplished if there is close coordination with the federal government, which provides payment for about 50% of the population. The newly-formed Center for Medicare and Medicaid Innovation (CMMI) is designed to authorize the participation of Medicare

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*continued from page 6*

and Medicaid in a more coordinated model and to support states' implementation of new payment methods and information technology that supports coordinated care.

While it is apparent that many providers are beginning to organize themselves into integrated care organizations and payers are rapidly beginning to move toward alternatives to fee-for-service payments, it is important that the state play an active role in helping to ensure that this evolution develops in a way that truly lowers costs while improving the quality of care. To do this, we must empower physicians and patients to be the stewards of the health care system. The Patrick-Murray Administration will propose legislation in the coming weeks that will serve to carefully guide the development of payment reform but will leave providers and payers free to use their own creativity to create new models of integration and payment reforms that best serve their patients and customers.

The federal health care reform law, the Affordable Care Act (ACA), contains many provisions that will help all states reform the payment and delivery system.

Massachusetts has a distinct advantage in achieving health care payment reform ~ the Commonwealth is already well poised to apply the state's existing medical home model to support primary care as a strong base for accountable care organizations. Current medical practices that are organized as "medical homes" ~ where the patient is at the center of coordinated care ~ will gradually phase in the use of bundled payments for certain conditions. Physicians have shown their willingness to participate in reforms and we are currently developing plans to solicit the health care community's vision for the shape and structure of ACOs. Similarly, with the implementation of global payment pilot programs, providers and payers have demonstrated that they are ready to accept the challenges to improve care while curbing the growth of health care costs and will be able to pioneer the efforts needed to reform the health care delivery system.

*Dr. JudyAnn Bigby is Secretary of Health and Human Services for the Commonwealth of Massachusetts.*



# MASSACHUSETTS ASSOCIATION OF HEALTH PLANS (MAHP)

## MAHP's Perspective on Payment Reform in Massachusetts

Lora M. Pellegrini, Esq



**Lora M. Pellegrini, Esq**

We face a critical moment in health care. The continued increase in the cost of health care is unsustainable and is placing enormous strain on Massachusetts employers and residents and state and municipal budgets. Action is necessary to reform how we pay for care and to lower costs for Massachusetts businesses, consumers, and cities and towns.

Through the Committee on the Status of Payment Reform, MAHP has been an active participant in the discussions on reforming the payment system. Like many participants in this discussion, we agree that the predominantly fee-for-service (FFS) payment model rewards volume and often promotes more fragmented and uncoordinated care, and that we should transition towards a system that rewards quality and efficiency while reducing costs and significantly slowing future health care growth. It also is critical to address the variations in rates paid to providers to ensure that payment reform does not unintentionally memorialize current market distortions.

Recent reports by Massachusetts Attorney General Martha Coakley<sup>1</sup> and the state's Division of Health Care Finance and Policy<sup>2</sup> found that increases to health care premiums have been driven by increases in the prices paid to providers for medical services and that the most expensive providers do not necessarily provide the highest quality care. The Attorney General's report went on to highlight that there is not a direct correlation between the rates paid to providers and the type of payment model used. In fact, some of the highest paid providers are paid using a global payment model and some of the lower costing providers are paid using fee-for-service. According to the Attorney General's report, "Price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other

hospitals or provider groups...Price variations are not correlated to quality of care, the sickness or complexity of the population served, the extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid, or whether a provider is an academic teaching or research facility." Essentially, the higher prices charged by certain providers have no correlation to the quality of care they provide, the acuity of their patients or the type of institution where the care is provided. Instead, those prices are a result of the market clout those providers have. Achieving the long term cost control goals associated with reforming the payment system and reducing the cost of health care requires effectively dealing with the market clout issues raised by the Attorney General to ensure that payment reform does not lead to further consolidation (and higher costs) in the marketplace.

Massachusetts health plans and providers have already made significant progress in transitioning the market to one that rewards high value and coordinated care. For example, some plans are implementing global payment-like models and expanding contracts to supply support to providers in the form of assistance with budgeting, population-based analytics, risk adjustment, and care coordination. We should learn from those initiatives, capitalizing on the existing infrastructure and expertise in the marketplace to encourage future innovations that will produce the goals of payment reform.

Rather than a prescribed "one-size-fits-all" approach, the best way to achieve this is through a voluntary, market-based approach with clearly defined goals aimed at improving care and lowering costs. At a minimum, payment reform must:

- Ensure that the health care system continues to meet the needs of the residents of the Commonwealth
- Reduce the rate of increase in per capita health care spending to stabilize or reduce health care cost trends and provide demonstrated savings to employers
- Ensure that providers have the tools they need to effec-

tively manage care through timely data on cost, utilization and outcomes

- Include participation of all payers, public and private, and address cost shifting from public to private payments due to inadequate public reimbursement
- Increase access to primary and preventative services delivered in an integrated manner and deliver care in an appropriate setting
- Create incentives that reward high value, low cost providers
- Measurably improve quality standards and patient outcomes through aggressive quality reporting and corrective action planning
- Decrease remaining waste, fraud, and complexity within the system
- Ensure that payment reform does not result in market consolidation that does not benefit employers and consumers and increases costs.

It will be important for state government to have a role in establishing guardrails that help guide the transition to payment reform.

This should include the creation of a new Payment Reform Advisory Council to help facilitate the transition with clearly defined responsibilities including setting cost and quality goals and measuring progress in meeting the goals, as recommended by the Special Commission on Payment Reform.

As in 2006, we have a unique opportunity to put Massachusetts at the forefront of health reform and lay the appropriate foundation for an effective payment reform system to thrive. It will require the same level of commitment as it did nearly five years ago from hospitals, physicians, health plans, employer organizations, consumer groups, and policymakers; this time, however, the focus must be on controlling costs. Ultimately, how we address the dynamics and distortions of the current marketplace will determine how we achieve payment reform's goals of better integration of care, better alignment of incentives, and lower costs.

*Lora Pellegrini is the President and CEO of MAHP, a non-profit organization committed to promoting high-quality, affordable health care in Massachusetts. MAHP represents 13 member health plans, which provide health care coverage to more than 2.3 million residents.*

*Feedback on this article can be sent to [info@mahp.com](mailto:info@mahp.com).*

*(Footnotes)*

*1 Office of the Attorney General, Examination of Health Care Cost Trends and Cost Drivers, Pursuant to G.L. c. 118G, § 61(2)(b), Report for Annual Public Hearing, March 16, 2010. [www.mass.gov/Cago/docs/healthcare/final\\_report\\_w\\_cover\\_appendices\\_glossary.pdf](http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf)*

*2 Division of Health Care Finance and Policy, Massachusetts Health Care Cost Trends, 2010 Final Report, April 2010. [www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Researcher&L2=Physical+Health+and+Treatment&L3=Health+Care+Delivery+System&L4=Health+Care+Cost+Trends&sid=Eeohhs2&b=terminalcontent&f=dhcfp\\_researcher\\_cost\\_trends\\_cost\\_trends\\_final\\_report&csid=Eeohhs2](http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Researcher&L2=Physical+Health+and+Treatment&L3=Health+Care+Delivery+System&L4=Health+Care+Cost+Trends&sid=Eeohhs2&b=terminalcontent&f=dhcfp_researcher_cost_trends_cost_trends_final_report&csid=Eeohhs2)*



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# MASSACHUSETTS HOSPITAL ASSOCIATION

## Hospitals' Leadership Role in Massachusetts Healthcare Reform: Moving from Volume to Value

Lynn Nicholas



**Lynn Nicholas**

While national healthcare reform has captivated, enthralled or enraged much of the US population, here in Massachusetts it is state healthcare reform that is garnering the most attention. The federal law is modeled largely on what Massachusetts has been doing since the Bay State passed healthcare reform legislation in 2006, and Massachusetts has a real advantage on this front because we are the early adopters when it comes to healthcare reform.

For the last few years, Massachusetts has been on a “volume to value journey” in healthcare. First came Chapter 58 of the Acts of 2006, which required all residents over the age of 18 to obtain health insurance coverage and provided free or subsidized health insurance on an income-based sliding scale. Then Chapter 305 of the Acts of 2008 (also called the Cost Containment Law) began examining specific healthcare cost issues and also established a Special Commission on the Health Care Payment System. And just last July, the legislature passed Chapter 288 ~ the “small business relief bill” ~ in an effort to tackle escalating insurance premiums faced by the Commonwealth's employers. Both Chapters 305 and 288 will continue to have significant impact on all healthcare stakeholders, particularly hospitals, into the foreseeable future.

In terms of providing healthcare coverage, Massachusetts is far and away the best state in the nation. More than 98 percent of our residents are insured, and more than 400,000 people who were uninsured in 2006 now have coverage. In addition, a significant percentage of those newly insured individuals are contributing to their health insurance payments.

However, after an initial significant increase in employer coverage, the recent economic downturn has affected employer-based insurance quite negatively. After increasing by 141,000 from June 2006 to December 2008, the number of people getting insurance through their employers fell 115,000 in just the one year from December 2008 to December 2009. On a related note, enrollment in the state's public programs and individual insurance products are up significantly in this same time period.

In addition, although the cost of care to low-income uninsured patients fell initially, it has recently increased due to a combination of increased demand, Medicaid benefit cuts, an enrollment freeze in the Commonwealth Care Bridge program, and healthcare cost inflation. Government support for poor, uninsured residents has not increased significantly, leaving the Massachusetts Health Safety Net (HSN) seriously underfunded. The HSN is a state-, hospital-, and payer-supported fund designed to help hospitals and health centers cover at least some of the costs they incur for caring for poor, uninsured patients. In fiscal year 2010, hospitals faced an estimated \$69 million shortfall in the fund, with a \$130 million shortfall projected this fiscal year. That extraordinary shortfall falls to hospitals alone, with no end in sight.

There has also been a big bump in the road with Medicaid payments. Healthcare reform included a commitment from state government to bring Medicaid payments to hospitals and other providers substantially closer to the actual costs of care. In 2006, the payment-to-cost ratio was around 80%, which means that for every dollar of care, hospitals got reimbursed 80 cents. You don't need to be a business major to know that those kinds of losses are unsustainable.

After initial progress, reductions in Medicaid reimbursement for hospitals and physicians began again in fiscal year 2009 and continue due to the state budget shortfalls. Today hospitals are down to being paid about 72 cents on the dollar.



The Special Commission on the Health Care Payment System took on some of these “big picture” cost issues in its recommendations issued in July of 2009. The recommendations included a move toward “global” or bundled payments as the predominant form of payment to providers in Massachusetts. Under global payments, hospitals and other providers would receive a yearly budget for all their patients rather than getting paid for every office visit, test and procedure. The Commission also recommended the development of Accountable Care Organizations (ACOs) to manage patients’ care across the continuum and accept global payments and allocate those payments based on outcomes and quality performance measures.

Massachusetts hospitals are committed to healthcare payment and delivery reform and believe that global or bundled payments for care result in more coordinated and integrated care, which could help bring down premiums.

Meanwhile, hospitals are already stepping up to the plate to address rising healthcare costs ~ and recent data shows that our hospitals are actually succeeding in bending the cost curve. All told, hospitals reduced expenses by some \$3.1 billion in fiscal years 2009 and 2010 compared to the cost trends of the previous four years.

These savings were accomplished in a number of ways, including the elimination of clinical and administrative positions, programs and services, cuts in compensation and benefits, changes in purchasing strategies, implementation of quality and process engineering techniques, and reduced non-essential spending. While some reductions were one-time in nature, many others are fundamental and permanent.

Massachusetts hospitals have clearly and definitively responded to the call for cost reduction by government, employers, and consumers. Yet during this same time period, while hospitals were bending the cost curve, payments to hospitals for services in those two years have been over \$2.4 billion lower than they would have been had the fy 2004 – fy 2008 trend continued.

The Bay State’s hospitals support payment and delivery reform, but they still need fair and adequate compensation to cover the cost of providing care, as well as access to capital to purchase health information technology and to modernize outdated facilities in order to provide the best care. Just as hospitals are not solely ~ or even primarily ~ responsible for cost increases, additional significant savings cannot be achieved solely through steps taken by those who provide care. Everyone involved ~ caregivers, insurers, legislators, government, business and consumers ~ must share in the solution.

Cumbersome and restrictive rate regulation is clearly not the answer, especially when innovation and rapid change are required to succeed. A number of well thought-out recommendations for healthcare payment reform ~ including the Payment Reform Special

Commission’s final report ~ all discarded calls for more bureaucracy or rate regulation.

Many hospitals are already moving ahead with payment reform efforts voluntarily. For example, Massachusetts hospitals support Chapter 288’s requirements for transparency and administrative simplification of the healthcare system, including efforts to support uniform credentialing of providers and uniform processing of provider claims. And selective networks, if done thoughtfully with patients in mind and not simply as a way to slash payments to providers, can also lead to more coordinated and integrated care while contributing to lower premiums.

Massachusetts state government also needs to keep its word to close the gap between Medicaid reimbursements and the actual costs of providing care. Over the last year and a half, an increasing numbers of hospitals have tried to close the underpayment gap through layoffs. In the last 18 months, Massachusetts hospitals have cut more than 2,260 positions. That means more than lost jobs and a drag on the economy; it means more limited access to healthcare, and that isn’t good for anyone.

The Massachusetts Hospital Association (MHA) looks forward to continuing its leading role in the state’s payment reform and cost containment efforts. In addition to participating in the Special Commission on the Healthcare Payment System and other panels and commissions dealing with healthcare reform, the association has issued a series of reports outlining key areas of concern that must be addressed as we implement reform.

The MHA reports cover Accountable Care Organization (ACO) formation, benefit design, oversight requirements, and how a new payment system will affect societal needs such as medical education, 24/7 emergency care, the important needs to support behavioral health, and the care provided by specialty acute hospitals. They also include ideas for how all healthcare stakeholders ~ insurers, providers, government, employers and patients ~ can move the reform effort forward.

Healthcare payment and delivery reform is a complicated issue, and we all must contribute to making the end result successful. In the coming months, the newly established Special Commission on Provider Price Reform will begin working to navigate some of the complexities of the healthcare payment system. With solid contributions from all healthcare stakeholders ~ insurers, government, employers and patients ~ hospitals can continue to work collaboratively to achieve more efficient, coordinated and cost-effective care in our Commonwealth. Hospitals are eager to do their part.

*Lynn Nicholas is President & CEO of the Massachusetts Hospital Association.*

# HEALTH CARE FOR ALL

## Working Together Toward Better Care

Georgia Maheras, JD MA



**Georgia Maheras,  
JD MA**

Diabetes is the one of the most common chronic diseases in Massachusetts. Over 370,000 Massachusetts residents have diabetes. And this number is growing.

These numbers are startling. Upon reading these daunting statistics, one might even feel a solution is beyond our grasp. But there are people behind these statistics ~ people who struggle each day with diabetes and make the disease impossible to ignore. Diabetes affects

our children, our parents, our grandparents. Our neighbors and friends check their blood multiple times a day and are constantly monitoring their diet and exercise.

Managing a disease like diabetes requires more than just taking a pill every day. It is testing blood multiple times a day. It is learning how to buy and cook unfamiliar foods that might not be to your liking. It is exercising several times a week while juggling work, children and your home.

Stephen is a 66 year-old with type 2 diabetes. He developed diabetes late in life and struggled to work with his clinicians to manage his condition. He struggled until he began participating in a Diabetes Management Initiative at Codman Square Community Health Center.

The Initiative gives Stephen the support he needs to manage his diabetes. There is a care team that provides Stephen with education and motivation, empowering him to take control of his condition. Instead of telling Stephen "No" and "You can't do that," the care team works with Stephen to find solutions.

For Stephen, a critical member of the care team is his community

health worker. She not only records his glucose levels and other medical tests, but also takes him to the grocery store and teaches him how to read and evaluate nutrition labels. Stephen loves to cook, but cooks the way he was taught ~ six decades ago. Stephen's care team has taught him to cook differently while allowing him to eat some of his favorite foods. Foods that were previously on the "never eat this" list are now back on his dinner table. His care team helped Stephen find the best way to control a disease that was ravaging his body.

The Initiative provides patients like Stephen with the care they need. As Stephen says, "The program is structured to help people." Right now, not everyone does has access to this kind of care; the hope is that one day they will. Luckily, there is work being done to expand access to chronic disease management programs and to create a health care system where doctors are paid to keep patients well, not just to patch them up when they are sick.

The Massachusetts Campaign for Better Care is leading the effort to ensure the needs of patients are front and center in the delivery of health care. The Campaign for Better Care believes now is the time to work on controlling costs and improving quality of care for all patients in Massachusetts.

We, the Campaign for Better Care, are specifically concerned with the most vulnerable among us: seniors, those with chronic conditions, the homeless, low and moderate income people, children, and new Americans. We all should get the comprehensive, coordinated, and patient- and family-centered health care we want and deserve.

The Massachusetts Campaign for Better Care will go beyond the statistics about chronic illness to put a human face on the issues to mobilize and engage patients and families to fight for the care they want and need, and to bring the voice and experience of the consumer to policy debates about health care payment reform and how best to implement any new legislation.

Right now, Massachusetts' policymakers are identifying solutions to improve health care quality and lower health care costs. As the conversation continues, the Campaign will be there, sharing consumer stories with policymakers, making a difference and making sure that people like Stephen experience the highest quality patient- centered care possible.

Please join us and the work of the Campaign for Better Care. We need your support and your story so that the improvements we make to our health care delivery system will truly make it more patient-centered.

Georgia Maheras, JD MA is the Campaign Manager for the Massachusetts Campaign for Better Care & a Private Market Policy Manager at Health Care For All. She can be reached at [gmaheras@hcfama.org](mailto:gmaheras@hcfama.org).



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# MASSACHUSETTS MEDICAL SOCIETY

## Play It Again ~ Payment Reform for the Practicing Physician

Lynda Young, MD



**Lynda Young, MD**

In 2006, Massachusetts passed the first of several pieces of legislation concerning health care reform. The initial goal was to get coverage for as many citizens as possible. Here we are in 2011 with that goal accomplished ~ we have more than ninety-seven percent of our citizens in the Commonwealth now covered with some form of health insurance.

Next up ~ how to pay for this

“revolution” in health care. Governor Patrick convened the Special Task Force on Payment Reform which submitted its report to him in July of 2009. Since then, the Health Care Quality and Cost Council, part of the Governor’s Executive Office of Health and Human Services, has been mulling over ways to reduce costs, or at least slow down rising costs, and improve quality in health care delivery. The focus is now on payment reform. As Accountable Care Organizations (ACOs) begin to develop, or continue to develop, different payment systems will come into play. These ACOs will receive payment from both public and private insurers for services provided by the members of the organization. Members must include primary care physicians who will coordinate care of their patients with other service providers. These other providers could be hospitals, specialists, behavioral health services, long term care facilities, etc., depending on the need of the ACO.

A variety of payment methods have been proposed ~ the one we hear the most about is “global payments.” This methodology uses fixed dollar payments for care that patients receive in a given time period. To many of us, it sounds a lot like capitation, which we weathered in the 1990s. We are told that the major difference between the two is that global payments are risk adjusted with “stop-gap” measures should some patients develop significant problems and need costly care. But still, global payments place us, the providers, at financial risk for both occurrence and management of medical conditions. This risk is something most of us know little about and we are fearful of the consequences. We also hear about “bundled payments.” In the federal legislation, bundled payments are pretty much the same as global payments. In Massachusetts, bundled payments are based on the expected costs for a clinically defined episode of care. This payment methodology has been in use in a variety of “episodes”

*In the federal legislation, bundled payments are pretty much the same as global payments. In Massachusetts, bundled payments are based on the expected costs for a clinically defined episode of care.*

such as CABG and joint replacement procedures. In theory, it does not penalize providers for caring for sicker patients, but not every illness falls neatly into bundles.

It is clear that good ol’ fee for service will go away for the majority of us. There are, however, instances of certain special-

ties where fee for service will be necessary. For instance, a pathologist reviewing a biopsy slide doesn’t fit into this method to receive reimbursement for his or her services. The structure of an ACO will need a lot of work and ~ we hope ~ pilot programs to see what does and doesn’t work. We need to move slowly and carefully, making adjustments along the way as necessary to keep the goal of better quality and cost control in sight.

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For practicing physicians, participation in an ACO and some sort of payment model should be voluntary, not mandatory. Our state has a diverse geographic distribution of physicians. "One size does not fit all." The practices in the Boston area may have little trouble fitting into one of these models, while practices in the western part of the state may never be able to participate. In the creation of ACOs, there must be diversity in design and flexibility in implementation. They should be physician led, not hospital led, and should foster and promote innovation with multiple organizational models and multiple payment methodologies. Physicians will need financial help in setting up the technology necessary to coordinate care and interact with their colleagues.

There are other factors to consider, too. These issues will be very important as we move forward in making our system better for everyone. Some of the concerns which must be addressed are: quality measures must be scientifically valid, there must be some kind of professional liability reform and consideration of the cost of defensive medicine, anti-trust rules and their enforcement must be adjusted to fit the needs of transparency of costs and care given, and there should be one oversight entity which includes a majority of providers as members.

In summary, our "revolution" in this state in health care reform has become a basis for the federal health care law (PPACA) of March 2010. There is no going back to status quo. The rising cost of care, the decline in state revenues, and the variation in pricing in institutions delivering this care are the key drivers which need to be contained. It is not feasible to do this reform on the backs of providers only. We need to be ready to change ~ from the fee for service model many of us are most familiar with to other payment methodologies. Quality and access are a must, but better coordination of this care is an admirable and attainable goal. We need to move more slowly and carefully so these changes can be evaluated and changed as necessary for this monumental project to be successful. We providers in our medical community are crucial in the success of this project. We must be willing to change for the sake of our patients and the viability of our practices.

*Lynda Young, MD, is President Elect of the Massachusetts Medical Society and is a practicing pediatrician at Chandler Pediatrics, Worcester.*

# THOMAS PARTNERS

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## INVESTMENT MANAGEMENT

### Lose less to make more.

#### Lost confidence...

The S&P 500 has delivered two good years in a row; still, equity mutual funds have suffered net outflows and portfolio allocations to equities have generally declined.

Could it be that reluctant equity investors fear that common stocks will never again deliver attractive gains, over time? Or, have recent losses undermined their confidence? They know it is easy to make money in the market's good years, but fear they will just give it back in the bad ones.

#### Low frequency, high impact...

Periodic market declines are an integral part of the common stock experience. Over the last 40 years, the S&P 500 has suffered calendar-year losses 22.5% of time and the average calendar-year losses were a minus 15.2%.

It took, therefore, more than one good year to get back to even after a loss-year and it took more than two good years to get back to the market's 40-year average annual returns of 10.1% per year.

In other words, loss-years have had more influence on investors' over-time returns than their low frequency would suggest. No wonder investors fear them.

#### Tolerate and protect...

Investors have always hoped to control loss-years by avoiding them altogether. So far, however, there is no way to enjoy all the market's gains and none of its losses. The better strategy has been to tolerate periodic declines in prices and do whatever necessary to make sure they have the opportunity to recover eventually.

One way to avoid converting temporary price declines into perma-

nent impairments has been to avoid too-high priced stocks; they do well in rising markets, but typically very poorly when markets fall. Too often, they never fully recover at all. A simple technique is to avoid stocks with relatively high P/E ratios.

Another way avoid converting temporary price declines into permanent impairments is to resist selling stocks at depressed prices; quite simply, stocks sold at depressed prices never have a chance to recover. Dividends can fund distributions without forcing sales at low prices.

#### Recent market declines...

"Fewer high-P/E stocks and more that pay dividends" should have done well during the market's recent meltdown...and they did.

The S&P 500 Index (with dividends reinvested) was down 11.4% from 9/30/2007 through 12/31/2010, but a portfolio consisting of all the dividend-paying stocks in the S&P 500, minus any that had a P/E in the top 25%, was actually up 2.7%.

But, when viewed over longer periods ~ particularly those with many more good years than bad ~ did the loss-prevention strategy do less well than the general markets?

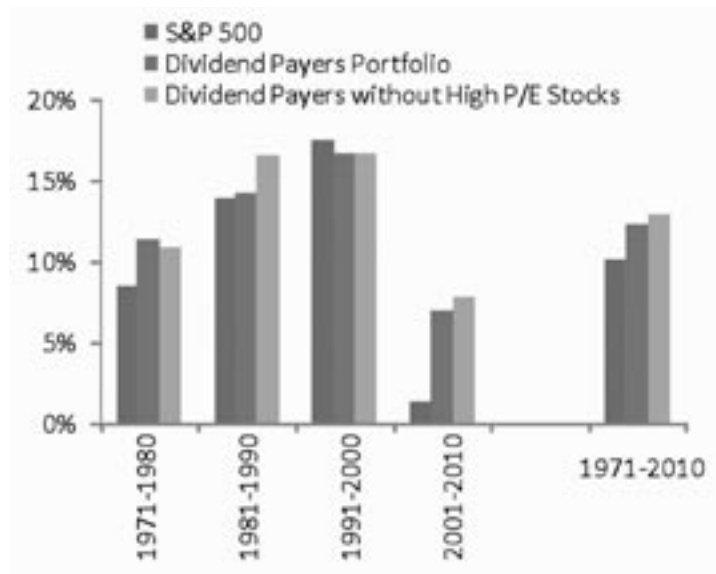
#### Rising-tide performance...

The following compares the average annual returns of: (1) the S&P 500 Index (w/ dividends reinvested) with (2) only the dividend-payers in the Index and (3) dividend-payers minus high-P/E stocks. The upper chart assumes no withdrawals. The lower chart assumes that 4% of initial values was withdrawn the first year, with subsequent annual withdrawals grown by the rate of inflation.

"Fewer high-priced stocks, more dividend-payers"



## No Withdrawal



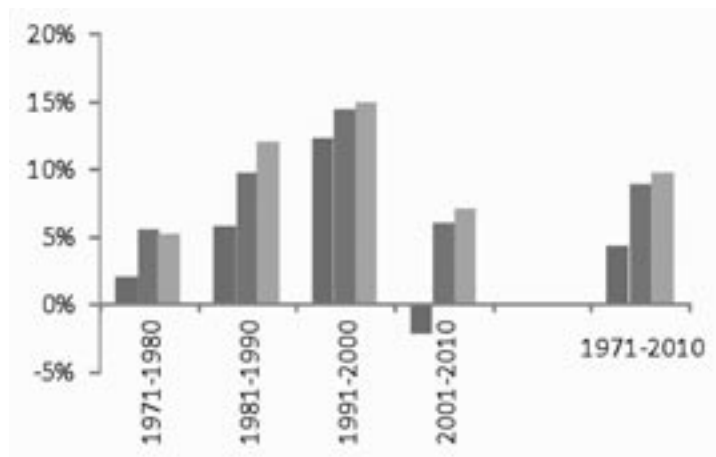
## Looking ahead...

Investors have ample reason to expect another good year ~ the third in a row ~ in 2011. The economy is showing better growth than expected. The Fed's recent dedication to economic recovery reduces the risk of owning equities. 2011 is the third year of a Presidential cycle; since WWII, the third year delivered positive returns 95% of the time.

But investors also have reason to assume that eventually stocks prices will generally turn down. Why? Because rising markets over multiple years eventually breed too-high prices, at least among speculative stocks and asset classes.

Investors who are prepared today will likely survive the correction tomorrow, and eventually prosper. They may not enjoy attractive returns all of the time, but they are much more likely to enjoy attractive returns over time.

## With Withdrawals



Source: ThomasPartners Research\*

During the 1990s ~ when markets were rising and there were few loss-years ~ little benefit was gained by protecting portfolios from loss-years. But, in the 2000s ~ when markets were generally falling and there were a lot of loss-years ~ that protection reaped substantial rewards.

Less expected, however, was the impact of loss-year protection on 40-year returns; it delivered better-than-market performance. In other words, over the last 40 years, if investors had always protected their portfolios from loss-years, they would actually have enjoyed better total returns as a consequence.

*\* The results of the back tests shown do not represent the results of actual trading using client assets but were achieved by means of the retroactive application of a model that was designed with the benefit of hindsight. Observations is a proprietary publication and the property of ThomasPartners, Inc. Any reproduction or other unauthorized use is strictly prohibited. All information contained in Observations was obtained from sources deemed qualified and reliable; however, ThomasPartners, Inc. makes no representation or warranty as to the accuracy of the information contained herein. Past performance is no guarantee of future results; investments may lose money.*

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# “The Patient as Writer ~ The Physician as Writer”

Harvey Fenigsohn



**Harvey Fenigsohn**

On September 22, two speakers ~ Margaret J. Cutter, PhD, a UConn literary scholar and Suzana K. Makowski, MD, a UMass palliative care specialist, spoke at a Humanities in Medicine program sponsored by the Lamar Soutter Library at the UMass Medical School. Both speakers presented compelling evidence for the restorative value of a human side of medicine ~ the healing benefits of thorough communication between

patient and doctor.

Professor Cutter's presentation on Charlotte Perkins Gilman, an influential turn-of-the-last-century writer and feminist, complemented the National Library of Medicine's travelling exhibit "The Literature of Prescription" on display at the Library this fall. The display showcased Gilman's challenge to the medical profession through the therapeutic power of writing the novella *The Yellow Wallpaper*. Dr. Makowski based her presentation on seven years of experience as a palliative care physician, emphasizing the same therapeutic advantages of better patient-doctor communication, both written and oral.

Professor Cutter, the author of *Unruly Tongue: Identity and Voice in American Women's Writing, 1850-1930*, a study of how female writers found ways to sound an authoritative voice in a male-dominated world, concentrated on *The Yellow Wallpaper* (1892). Gilman's classic, fictional tale of a treatment for mental illness gone terrifyingly awry closely resembles the story of Gilman's own struggle with post-partum depression. Highly creative, Gilman chafed against the Victorian restrictions of married life and motherhood, longing for greater intellectual and artistic fulfillment.

When the author became despondent after the birth of daughter, Gilman's husband advocated the treatment of Dr. S. Weir Mitchell, a nervous disease specialist whose "rest cure" for neurasthenia was originally developed for soldiers recovering from Civil War-induced

traumas. One of many debating "the woman question," Mitchell claimed that the then apparent epidemic of neurasthenia, or nervous exhaustion, among women resulted from their attempts to exceed their limits. Weir believed women would most benefit from a "rest cure," refraining from reading, writing, and talking to others

In *The Yellow Wallpaper*, the narrator finds herself confined to her bedroom, formerly a children's nursery with bars on the window. The narrator takes comfort in a secret diary, but gradually loses her sanity, the result of mandatory isolation and the prohibition against any intellectual or creative pursuits. She becomes obsessed with fantasies about a woman trapped behind the garish wallpaper, one she labors in her delusions to free by peeling off the paper. As Cutter explains in *Unruly Tongue*, the "cure" prescribed for the narrator of *The Yellow Wall Paper* "...actually destroys her (114)."

Like the protagonist of her Gothic novella, Gilman followed Weir's prescription, nearly undergoing a similar mental breakdown. However, unlike her literary alter ego, the author ended her treatment and her marriage, ultimately writing *The Yellow Wallpaper* to expose the negative effects of Dr. Weir's treatment. According to Gilman, "I wrote the story, not to drive people crazy, but to save people from being driven crazy, and it worked." (1) Regardless of whether we interpret the story as a condemnation of patriarchal hegemony or as a critique of a particular mental health practice, we can agree the story helped heal its author, proving far more curative than the medical treatment she repudiated.

In considering the medical implications of Gilman's novella and her short story, Dr. Clair's Place (1913), Professor Cutter noted the author's emphasis on the importance of the physician and patient truly understanding each other through speaking and writing. She explained how Gilman stressed the need for physicians to attend to their patients, actively listening and responding to their stated needs rather than simply defining patients by their illnesses.

In Dr. Clair's Place, an innovative female physician rejuvenates her patients with stimulating treatments, the reverse of Dr. S. Weir Mitchell's regimen of passive idleness and forced isolation. Cutter quoted Gilman's doctor urging her patient to "...make notes, setting

it all down on a sort of chart” and for the physician to ask “...careful questions, not as a physician to a patient, but as an inquiring scientific searcher for valuable truths.” She concluded that Gilman’s ideas might well serve as a model for medical treatment today.

Following Professor Cutter’s presentation, Dr. Makowski advocated the same benefit of paying full attention to her patients’ expressed concerns, recording the patients’ personal stories in addition to charting their diagnoses and treatment. She suggested that a doctor should talk less and listen more, becoming more patient with her patients. According to Makowski, “...a physician must be just as concerned as to what sort of patient has a disease as she is about what sort of disease the patient has.”

Like Gilman’s fictional Dr. Clair, the UMass physician emphasized the importance of carefully noting her patients’ questions and providing clear, honest answers. Despite the impressive technical advances made in medicine since Gilman’s time, Makowski noted that she must contend with the bureaucratic impediments imposed by today’s managed care ~ excessive paperwork, high costs, and, especially problematic for a palliative care physician, limited time for patient treatment and collegial exchanges.

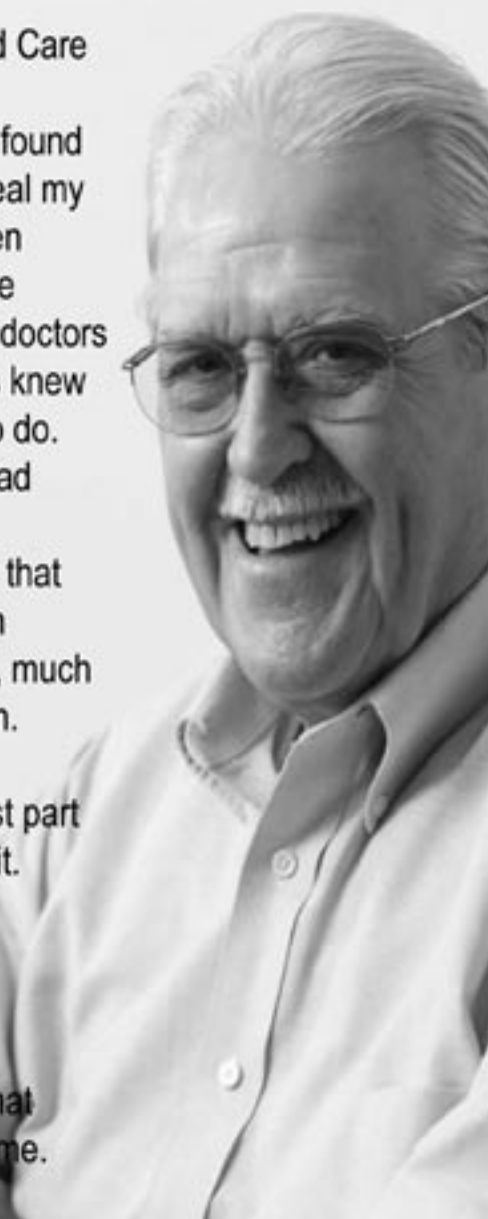
To overcome these limitations, Dr. Makowski founded the “Lois Green Learning Community,” an interdisciplinary community for medical professionals in palliative care working in Central Massachusetts. Through regular meetings and an interactive website, [www.loisgreenlearningcommunity.org](http://www.loisgreenlearningcommunity.org), Dr. Makowski strives to bring together palliative health care workers ~ students, staff, residents and physicians ~ to interact with colleagues and share their patients’ wants and concerns

In her talk, Dr. Makowski also spoke of the value of the humanities in medicine and medical education, noting the power of great literature to help caregivers understand their patients, relieving “burnout” and “compassion fatigue” when sympathy for the patients’ pain becomes overwhelming. Dr. Makowski was honored with The Leonard Tow Humanism Award in 2010 for her efforts to exemplify what was also Charlotte Perkins Gilman’s ideal doctor ~ a compassionate, sympathetic physician committed to communicating with her patients.

(1) *Charlotte Perkins Gilman, “Why I Wrote the Yellow Wallpaper,” 1913. This article originally appeared in the October 1913 issue of The Forerunner magazine.*

*Harvey Fenigsohn writes book review for the Humanities in Medicine website at the University of Massachusetts Medical School library. His latest review of Lois Green’s The Last Chapter is available at [http://library.umassmed.edu/humanities-med/book\\_reviews.cfm](http://library.umassmed.edu/humanities-med/book_reviews.cfm). He can be reached at [harvey.fenigsohn@umassmed.edu](mailto:harvey.fenigsohn@umassmed.edu).*

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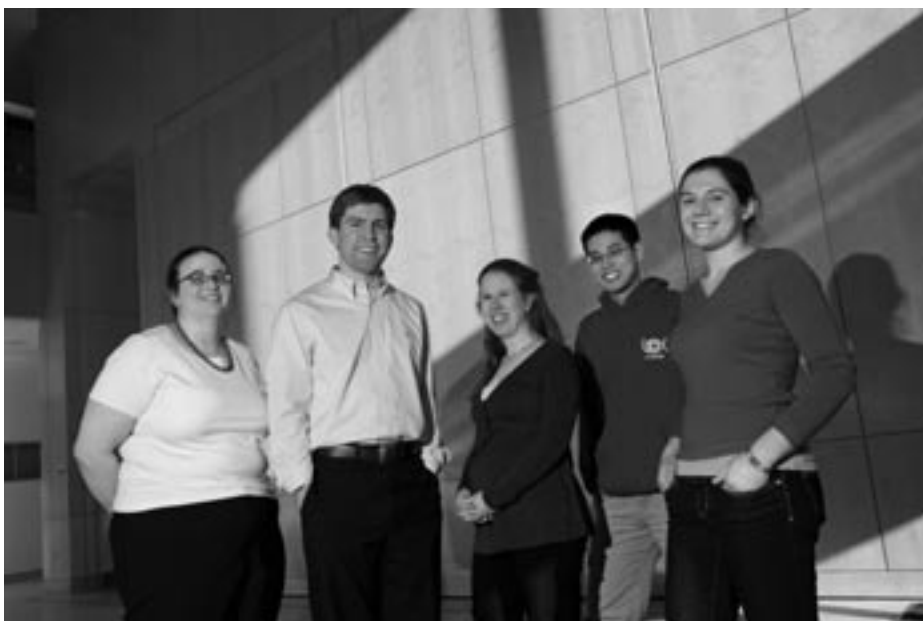


# MD/PHD Program at UMMS Provides Unique Opportunity for Clinical Research

Carole Upshur, EdD

The University of Massachusetts Medical School (UMMS) MD/PhD program was started in 1986 and currently has 57 students enrolled. The goal of the MD/PHD program is to provide highly motivated students opportunities to develop skills and experience in both biomedical investigation and the practice of medicine. It is a rigorous and challenging program that takes about eight years to complete, and the student is awarded both the PhD in Biomedical Sciences and the MD degree. Like other MD/PhD programs nationally, the UMMS students in the past primarily pursued their thesis research in basic biomedical lab sciences. This was true at UMMS until the development of the UMMS/ Graduate School of Biomedical Sciences (GSBS) PhD track in Clinical and Population Health Research (CPHR). UMMS MD/PhD students now have the opportunity to pursue epidemiology, clinical trials, and health services research as their doctoral work. The UMMS/CPHR doctoral program remains unique among MD/PHD programs nationally, which continue to emphasize training in basic biomedical sciences.

The CPHR doctoral program was launched six years ago within the UMMS GSBS to meet the urgent call to improve the speed at which research discovery leads to changes in patient care. At the time, both the Association of American Medical Colleges ("Clinical Research: A National Call to Action," AAMC, 1999) and the National Institutes of Health (Zerhouni, NEJM, 2005) were calling for a change in the way biomedical research was funded, structured and supported, including the provision of training programs. The CPHR core curriculum focuses on de-



**UMMS MD/PHD students in Clinical and Population Health Research. From left to right the students are: Lisa Nobel, Dan Frendl, Shira Fischer, Joshua Chang, and Suzanne Czerniak.**

veloping advanced skills in epidemiology, biostatistics, and clinical research methods and ethics, and provides hands-on rotation experiences and research mentoring in all areas of NIH-defined clinical research: from initial translation of laboratory knowledge to clinical trials, and from there to practice implementation, health services, and population health research. Interest quickly was identified among MD/PhD applicants who saw clinical research as a more direct way to meld their aspirations as physician-scientists.

Currently there are five MD/PhD students in the CPHR track. A common theme among these students is an interest in a closer loop between their practice as a physician and improving health care through their research. MS1 Lisa Nobel, sought out UMMS



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for the availability of the clinical research track. She had completed an MS in Epidemiology at McGill University in Montreal. Lisa notes, "A physician scientist in clinical research is able to direct research to emphasize clinical relevance and to therefore enlarge the impact on the health of individuals and entire populations...."

Dan Frendl, MS2 echoes this view but with a focus on health care system research: "There is a strong need for well-trained physician scientists with an interest in healthcare systems and healthcare delivery...I not only want to be a physician who cares for my patients ...I also want to treat broader challenges we encounter in healthcare that impact patient care." Mr. Frendl has completed a summer rotation with Dr. John Ware, PhD, an internationally known health outcomes expert in the UMMS Department of Quantitative Health Sciences and is planning thesis research on patient outcomes and health-related quality of life.

Shira Fischer will be the first CPHR MD/PhD graduate when she completes her doctoral work this year. Ms. Fischer worked at the Institute of Medicine before beginning medical school and developed a strong interest in "implementation and systems issues that prevent the medical knowledge we do have from being applied effectively." Her thesis research focuses on using electronic records to track laboratory monitoring of ambulatory patients on high-risk medications (such as digoxin). This work builds on her published qualifying paper (J Am Med Inform Assoc. 2010 Nov 1;17(6):631-6) that found inconsistent evidence that electronic systems improve laboratory test monitoring in the ambulatory setting. This is a critical health care improvement issue because poor monitoring can result in delayed or missed patient diagnoses and adverse drug events.

As increasing numbers of the MD/PhD class see the opportunities in the Clinical and Population Health Research Doctoral track, UMMS expects to be in the forefront of developing the next generation of physician-scientist leaders in clinical research and health care systems improvement.

*Carole Upshur, EdD, is a Professor of Family Medicine and Community Health & Quantitative Health Sciences and Associate Dean and Program Director, Doctoral Program in Clinical and Population Health Research.*

# Don't Ask, Don't Live

Michael Hirsh, MD



**Michael Hirsh, MD**

The Florida State Medical Society faces similar issues to physician organizations in other states: shrinking reimbursements, insurance company tiering schemes, increasing bureaucracy in the reams of paperwork needed to care for patients, shrinking memberships because of time constraints on the overworked physicians. But they are also facing a challenge in the Florida State Legislature that is as of yet unheard of in the other

states. Proposals in both legislative houses in Florida are being advanced to make it a felony for a Florida physician to ask a patient or the parent of a patient about the status of gun ownership/possession/storage in the home of the patient. The sponsors of the bill claim that these questions are a violation of the 2nd Amendment rights of the patients and of their privacy rights as well.

The American Academy of Pediatrics Section of Violence, Poisoning and Injury Prevention has previously released a position paper indicating that asking a parent if there are guns in the home or in the home of places where the children play is one of the single best ways of preventing firearm injuries in the pediatric population. The Florida proposed law would not only make this questioning impossible, it would make it punishable by imprisonment and/or a fine.

The CDC data has clearly shown that the gun in the home is much more likely to be the source of suicide, domestic violence, and gun

injury/homicide for the homeowners than for any intruders. This information has served as part of the recommendation that favors inquiring about gun storage status in encounters with well patients in the primary care setting.

Regardless of one's position on the right to bear arms, our society's respect and belief in the sanctity of the doctor-patient relationship is one that has helped advance medical care in our civilized world. This legislative intrusion into that relationship is just as much an assault on human rights as is the infringements it seeks to prevent. A "gag" order on physicians will only serve to harm the public health and add to the already tragic burden this country bears for the unchecked and irresponsible presence of weapons where we work, live and play.

I urge you to support the Florida State Medical Society in organizing opposition to this dangerous and imprudent interference

into the health of the Commonwealth of Florida. The Worcester District Medical Society is proposing a resolution to be adopted by the Massachusetts Medical Society at their annual House of Delegates meeting to show such support. At the time of publication of this piece, we do not yet know whether the measure will be adopted in Massachusetts. Let's hope

physicians in our Commonwealth will be as courageous as our colleagues in Florida.

*Let's hope physicians in our Commonwealth will be as courageous as our colleagues in Florida.*

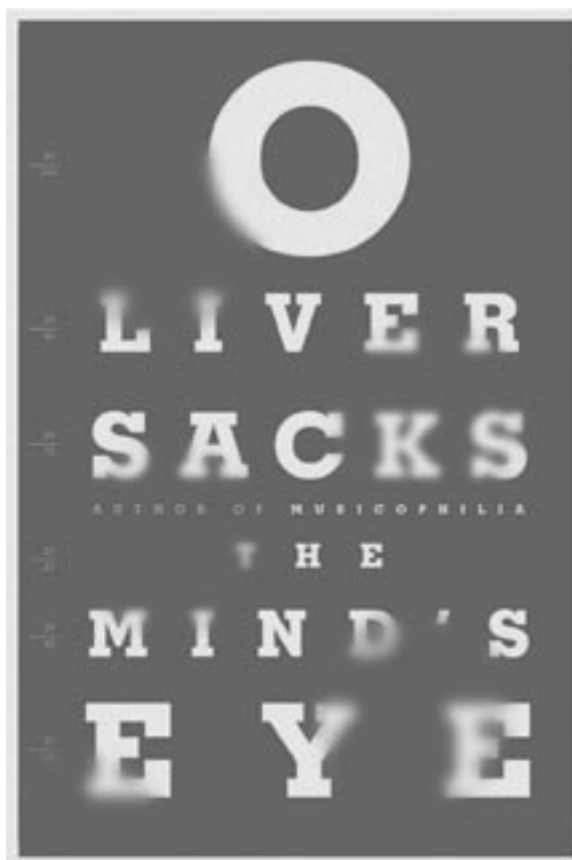
*Michael P. Hirsh, MD, FACS, FAAP, is Vice President of the Worcester District Medical Society and a Delegate of the Massachusetts Medical Society.*

# Oliver Sacks' The Mind's Eye

William J. Schwartz, MD

Oliver Sacks, neurologist and author, has written a new collection of patient case histories in *The Mind's Eye*. By my count, it represents the ninth installment of this genre, which began with the publication of *Migraine* (1970) and includes *Awakenings* (1973), *The Man Who Mistook His Wife For a Hat* (1985), and *An Anthropologist on Mars* (1995), books that have spawned feature films, stage adaptations, and even a chamber opera. In *The Mind's Eye*, Sacks brings us tales that illuminate examples of disorders of the “visual” brain. There is a 70-year-old mystery writer whose stroke leaves him unable to read, including words that he has just written himself (alexia without agraphia, or pure “word” blindness), a 67-year-old pianist with an alexia for musical notation that is the first symptom of a dementing illness with focal features (posterior cortical atrophy), a neurobiologist who gains binocular, stereoscopic vision many decades after childhood surgery to correct her strabismus, and stories of agnosias for places and faces, hallucinations and other alterations of mental imagery, and even the author's own experiences suffering from ocular melanoma. As we have come to expect from Sacks, each account is chronicled in fine detail with warmth, wit, and wonder.

The book reminded me that there must be other visual brain disorders not yet appreciated, and one not included in this compilation is already becoming known. In addition to the sense of sight, the retina is necessary for entraining daily (circadian) rhythms to day and night. The responsible visual system is anatomically and physiologically distinct from the visual systems for oculomotor function



and image formation. This system includes a specialized mechanism that relies on a novel non-rod, non-cone opsin (melanopsin), a subset of photoreceptive ganglion cells that forms a monosynaptic pathway to the hypothalamic suprachiasmatic nucleus (SCN), the site of an endogenous circadian clock, and a population of SCN neurons that appears to function as “luminance” detectors. We are now realizing that there are individuals with deficits in this system, who can see but not entrain; instead of blindness, they present with sleep-wake disorders or even psychiatric symptoms. Perhaps we will read about them in the next edition.

Ultimately, *The Mind's Eye* is a book about people, not lesions, and a clinician who is focused on the diagnosis and care of individual patients, relying on a nuanced analysis of clues elicited by the clinical method. And what is especially emphasized here is how pa-

tients cope and brains adapt, often with heightened new abilities in compensatory skills. It's a book about hope.

*William J. Schwartz, MD is Professor of Neurology at UMASS Medical School.*

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# WDMS Remembers Its Colleagues

## Bruce Row Brown, MD (1917-2010)

It is with high regard and deep appreciation that we who had the privilege of knowing Dr. Bruce Row Brown recognize his many accomplishments and services as a physician, humanitarian, academician and historian. Bruce Brown was born in Framingham, MA, the city that remained his lifetime residence. His professional address was the Worcester Memorial Hospital, where he served as the first member of its Division of Hematology, undoubtedly recruited by the late Dr. Roger W. Robinson, then Chief of a maturing Dept. of Internal Medicine at this venerable community hospital.

While at Harvard College, Bruce became part of The Study of Adult Development, known as the “Grant Study,” which followed 268 students, including President John F. Kennedy<sup>1</sup>. The study’s goal was to elucidate the variables that contribute to a happy and productive adulthood. In 1948, Bruce and his wife joined 5,207 other Framingham residents participating in a government study known as the Framingham Heart Study; over decades, it revealed that cholesterol, smoking, hypertension, obesity and physical inactivity contributed to the accelerated development of coronary heart disease.

Fewer than 250 of the study’s original participants are still living!

In 1955, during internship, one of us (LDC) cared for Dr. Brown’s young patients with leukemia and other forms of lymphoma. Although therapeutic options were very limited, Bruce discussed diagnosis and prognosis in a forthright yet very compassionate manner. As

revolutionary advances in therapy began to be introduced, Bruce remained committed to stressing “quality of life” options in light of the grave side effects of treatment. He championed frank discussions of “end of life” options in support of the “death with dignity” movement.

In 1967, Dr. Brown and his wife travelled to Kabul, Afghanistan to serve Care Medico, a program founded by the late Drs. Thomas Dooley and Peter Comanduras, who recognized the need for sharing American capabilities and aid in establishing better medical services in newly developing countries (2). Re-reading Dr. Brown’s report is especially illuminating in light of the course of international relations that followed his experiences there.

Following retirement, Bruce served as the President of the Framingham Historical Society. He wrote a series of stories about growing up in Framingham that is available in a single volume.

Bruce is survived by his daughter Ellen and sons Dr. Bruce, a pediatrician in Maine, Dr. David, a medical journalist in Baltimore, and five grandchildren. Doctor Bruce R. Brown will be remembered as a splendid role model and for his most distinguished career.

**Lorenzo D. Campos, MD**  
**Leonard J. Morse, MD**

1. *The Study of Adult Development. The Atlantic*, June 2009.

2. *Afghanistan, Kabul and Care Medico. Brown, B.R. Worcester Medical News*, 32, 8, 10-13, April, 1968.

## M. Elizabeth Fletcher, MD 1916-2010

The passage into glory of Dr. Elizabeth Fletcher in late October marked the end of a saga in Worcester medicine. Dr. Fletcher ~ “Betty” ~ was the last of the four physicians ~ Dr. Fletcher, Dr. James Brosnan, Dr. John Manning and Dr. John Meyers ~ who, following the death of Dr. John Fallon, assumed ownership and management of the Fallon Clinic.

Until those events in the early nineteen fifties, the Clinic had functioned primarily as a surgical referral center. The new team of physicians began the transformation of the Clinic into a center for comprehensive care, providing primary care, surgical and subspecialty services, and supportive radiology and laboratory ancillaries. In the early seventies, in response to changes in the financing of medical care, the Clinic pioneered the development of the Fallon Clinic Health Plan. During all these endeavors, Dr. Fletcher was a quietly steadfast supporter.

Born in and the recipient of secondary and collegiate education in Syracuse, Dr. Fletcher enrolled in the then Syracuse University College of Medicine at the time when, with rare exceptions, Medicine was a male-dominated profession. Those who knew her were not surprised that this dignified, lady-like woman more than held her own in the face of her male colleagues’[ occasional snide re-

marks.

After a residency in Pathology, Dr. Fletcher completed training in Radiology at the Mayo Clinic. Recruited by Dr. John Fallon, she and her husband William Fletcher moved to Worcester in 1947. Until her retirement, she served as Chief of Radiology at the Clinic.

Rarely, if ever, can an obituary define the fullness of a person's life. So it is with these words. Betty Fletcher was a remarkable woman. Her knowledge of Medicine was broad. Not just a skilled radiologist, she read widely in professional journals and could quote accurately often obscure references. Her works of charity were numerous but unheralded. She was a well-known deep sea fisherman. Childless as she was, she became a substitute grandmother to a family of young people.

On November eighth at Immaculate Conception Church, Dr. Elizabeth's friends and colleagues bid her farewell with words of praise and admiration.

**John A. Duggan, MD**

**Albert Richard Jones Jr., MD  
1923 - 2010**

Dr. Albert Richard Jones, Jr. passed away quietly in his sleep on Saturday, October 30, 2010. He was born January 9, 1923 in Philadelphia, PA. Dr. Jones was an obstetrician and gynecologist practicing in Worcester since 1953.

He was first married to Jean Harriet Laubenstein of Ashland, PA who died in September, 1986. He married his second wife, Carolyn Mary Dolan Shea, in December, 1990; she passed away in March, 2010.

Dr. Jones leaves a daughter, Patricia J. Whiting, who is married to W. Holt Whiting, formerly of Worcester, MA, and now living in Durham, NC. He also leaves a son, Albert Richard Jones III, married to Valerie A. Zimkus of Holden, MA.

Dr. Jones attended Hamilton College as a member of the class of 1944 and Jefferson Medical College, Philadelphia, PA, class of 1947. He completed his residency in Obstetrics and Gynecology at Baltimore City Hospital and Walter Reed Army Hospital. Dr. Jones served in the U.S. Army Medical Corps from 1949 – 1953 and received his honorable discharge at the rank of Captain.

Al Jones was a powerful force in and contributor to the development of the Neonatal Intensive Care Unit and the High Risk Maternity Unit at The Memorial Hospital. He was clinical professor of Obstetrics and Gynecology at the University of Massachusetts Medical School since 1976 and served as Chairman of the Division of Reproductive Medicine of

The Memorial Hospital from July, 1976 to January, 1988.

He founded the Worcester Ob-Gyn Associates, Inc. in 1969; it was the first large group practice of obstetrics and gynecology in Worcester. In 1983, he became a sole practitioner, first at 25 Oak Avenue, Worcester and then at 67 Belmont Street, Worcester. In 1995, he joined the Medical Group Practice of Memorial Health Care and later Women's Health Care of Central Massachusetts.

Al Jones was one of the first and most impressive leaders in medicine whom I met when I moved to Worcester in 1979. He was remarkable not only in his skill as a clinician, but also for his ability to see how best to organize us and move his fellow physicians into the future. He was direct, fair, and with an appreciation for merit above politics. I have often found myself thinking back to the days when he led our department. I hope that not only his memory but also his spirit will live on.

**B. Dale Magee, MD**

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## Worcester District Medical Society Community Resources Now Available Online

Health care providers are asked to assist patients with many diverse needs that contribute to their overall health. The following links are intended to assist busy health providers and their staff in locating everything from fuel assistance to dental care, from domestic violence resources to food programs. Many links are links to other sites that have the specific information that you and your patients can use.

Add the Worcester District Medical Society Community Resources ([www.wdms.org](http://www.wdms.org)) to your internet “Favorites.” You may also want to provide this link to your nurses and front staff and ask them to do the same.

*Developed by the Public Health Committee of the Worcester District Medical Society*

### **Worcester Resources.org**

[www.worcesterresources.org](http://www.worcesterresources.org)

A free online resource for Worcester-area residents in need of housing, food, health care and other basic services

### **Worcester Community Action Council**

[www.wcac.net](http://www.wcac.net)

Helps with heat assistance, food access, tax preparation, employment searches and other types of assistance

### **Elder Services of Worcester**

[www.eswa.org](http://www.eswa.org)

Serves elders over the age of 60 in fifteen communities in the Greater Worcester area with home care, prescription and elder protection services

### **Mass 211.org**

[www.mass211.org/index.html](http://www.mass211.org/index.html)

Dial 211, an information and referral telephone service that connects callers to information about critical health and human services available in their community

### **Senior Center 2009/2010 Elder Information Guide**

[www.worcesterma.gov/e-services/document-center/elder-affairs](http://www.worcesterma.gov/e-services/document-center/elder-affairs)

Provides advocacy and easy access to information and support in the areas of housing, transportation, health, employment, consumer and benefit issues

### **Parents Helping Parents**

[www.parentshelpingparents.org](http://www.parentshelpingparents.org)

Includes a guide for parents whose children are in The Department of Children and Families (DCF) Foster Care

### **Worcester Homeless Action Committee**

[www.greaterworcesterhomeless.org/resources.html](http://www.greaterworcesterhomeless.org/resources.html)

Dedicated to finding solutions for the homeless people of Worcester

### **MassHealth Dental Providers**

<http://masshealth-dental.net/MemberServices/Default.aspx>

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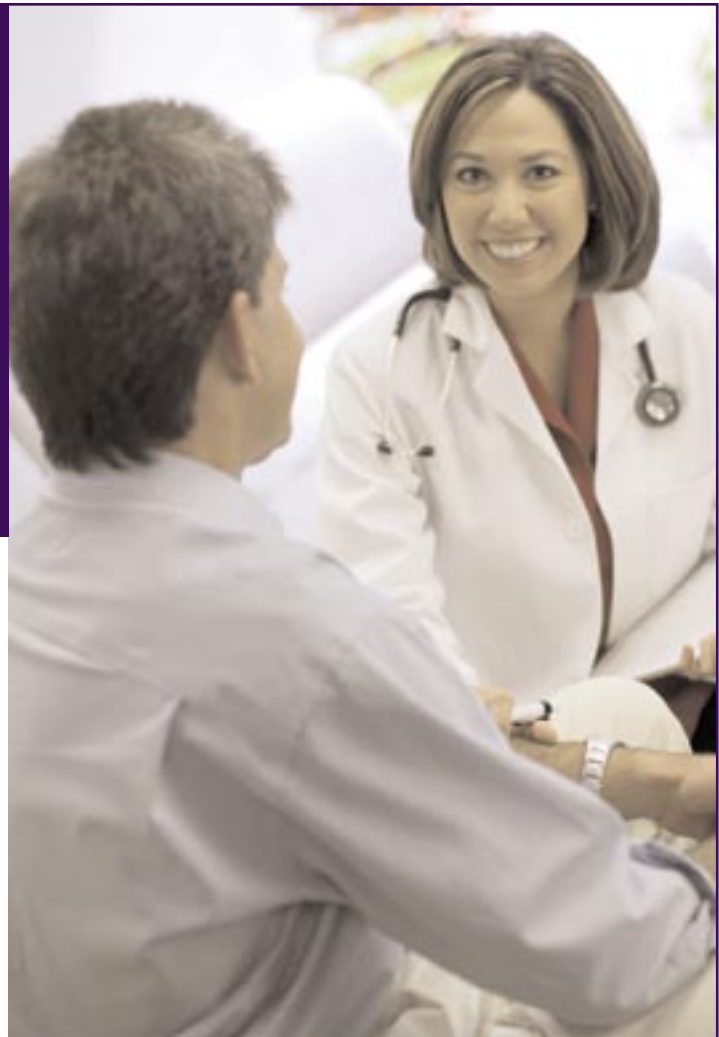
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