

# WORCESTER medicine

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## Homelessness

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## president's message



**Jane Lochrie, MD**

It has been my privilege to serve as the president of the Worcester District Medical Society (WDMS) for the past year. We remain a vibrant, crucial and progressive grass roots organization. It has been a pleasure working with all of the committee members and with their help we have had a very productive year.

First of all I would like to thank Joyce Cariglia, the Executive Director, for her creativity, resourcefulness and inspiration. Without her, there would be no WDMS. I have never worked with anyone so organized, methodical and congenial. Melissa Boucher has been a wonderful addition to the organization. She has brought a wonderful skill-set with her, especially her expertise with the computer. Please watch our website for upcoming events. You can now watch Health Matters on the web and they have recorded over one hundred programs!

We now have 1,836 members; this number reflects an increase from 1,382 in 2006. This improvement in membership allows us to improve our advocacy at the local, state and national level.

Under the capable guidance of Paul Steen, MD, *Worcester Medicine* is flourishing. The Editorial Board has upgraded the quality of paper for the publication and this has made a spectacular difference in the appearance of the six issues on timely topics that were produced over the year.

Jay Broadhurst, MD continues to chair the very active Public Health Committee. This year Goods for Guns, under the leadership of Michael Hirsh, MD, removed 241 guns from the streets of Worcester, including an AK-47. WDMS served as a resource providing volunteers for Community Immunity and other influenza clinics to the Worcester Division of Public Health, who in conjunction with community partners, held influenza clinics throughout the City of Worcester during the 2009-2010 Influenza Season. As of February 28, 2010, 144 clinics were held, 14,607 H1N1 doses were administered, and 2,584 Seasonal doses were administered.

Dennis Dmitri, MD and the Legislative Committee sponsored another very successful Legislative Breakfast at which many important issues and bills were discussed. In addition, Dr. Dmitri represented WDMS at the AMA National Advocacy Conference in Washington, DC, March 1-3, 2010.

The Medical Education Committee had another very active and effective year. Most importantly George Abraham, MD and his team successfully completed the re-accreditation process to award Continuing Medical Education Credits. We are currently the only district society in Massachusetts to have the distinction.

The committee recently sponsored the Fourth Annual Louis A. Cottle Medical Education Conference focusing on the ARRA (The American Recovery and Reinvestment Act of 2009) Health Information Technology Incentives.

The Alliance has a very important presence on many of our committees. In addition, they have been working with the Elm Park Community School for the past several years on promoting healthy eating and exercise and now play an essential role in Mass in Motion. Through their volunteer work, they are making a positive impact on our community.

WDMS brought together the five health care leaders (CMIPA, Fallon Clinic, Fallon Community Health Plan, UMass/Memorial Health Care and Saint Vincent Hospital) to create the Worcester E-Mail Collaborative. Soon all physicians in Worcester will be on a list serve that will allow the members to share important patient information on a secure electronic system. We are also collaborating with University of Massachusetts Medical School to establish a vaccine registry that will allow all health care professionals access to Massachusetts residents' immunization records.

Other activities at UMass include, Career Night, a networking dinner with the medical students that promotes career development. Joyce Cariglia and Peter Schneider, MD continue to serve on the Humanities in Medicine Committee of the Lamar Soutter Library. Tracy Kidder, author of *Mountains Beyond Mountains* and *Strength in What Remains*, will be the guest speaker at the next Meet the Author Series on May 19<sup>th</sup>.

It has been an honor working with all of you and I am looking forward to another productive year.

**Jane Lochrie, MD**

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**WORCESTER**

# medicine

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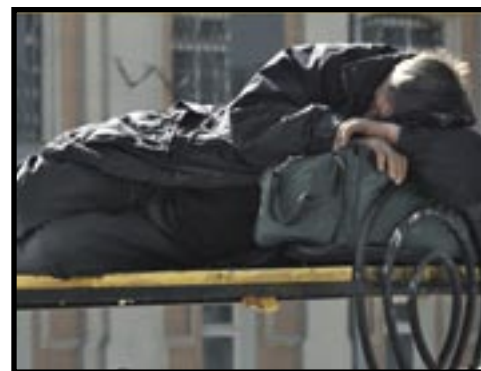
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# Homelessness

Thoru Pederson, PhD



Thoru Pederson, PhD

“Bum,” wino,” “drug fiend,” “psycho” -- these are only some of the labels that are often applied to the homeless. Others sound less harsh -- “vagabond,” “freeloader,” “misfit” -- but are essentially as cruel. All of these terms have one thing in common: each conveys a complete miscomprehension of this profound malady.

Many of the homeless have fallen into this abyss rather precipitously

-- sometimes from a surprisingly stable-looking previous perch. Linda had a low paying job, no joint income from a spouse or partner, and has no surviving family or substantial assets. But she was getting by. Then -- the job is lost, a couple of rent payments are missed and, in what might seem an instant, she finds herself doing something she had never imagined -- living out of her car -- that is, until it is repossessed. To be sure, others among the homeless have come to this dire situation from a progression of addiction problems or mental illness, sometimes both. But they too are often victims of circumstances including the push over the past decades to deinstitutionalize the mentally ill in the hope of tractable community support. I know of one former patient who lived in the woods for more than a year, surviving an unusually cold New England winter in an unheated shack, after both inpatient and outpatient care had failed. So we must bear in mind that there are some cases of homelessness intersecting with other conditions that can be very obdurate; this too is a medical as well as social challenge.

In the belief that the definition of health embraces not only the

somatic but also the emotional and even social context of a person's life, we are devoting this issue of *Worcester Medicine* to the topic of homelessness. This decision sprang from a conference on homelessness convened this past January by the Health Foundation of Central Massachusetts and attended by members of the editorial board and the Worcester District Medical Society. It served to activate many of us already familiar with the issue and for others revealed, perhaps for the first time, the problem of homelessness as a genuine health issue. The hope of further promoting awareness and stimulating ongoing dialogue on the many facets of homelessness underlies this issue of *Worcester Medicine*.

Three of the thematic articles arose from the conference. Nan Roman, President of the National Alliance to End Homelessness, was the keynote speaker and in her article conveys the complexities

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have one thing in common: each  
conveys a complete miscomprehension  
of this profound malady.*

of the problem from her experienced perspective. Former Massachusetts Lt. Governor Thomas P. O'Neill shares with us in his article, as he did at the conference, the very personal and moving account of his own family's experience. Jan Yost, President and CEO of the Health Foundation of Central Massachusetts, and the organizer of the conference, describes the Foundation's research and grant making in the area of homelessness, including its successful Home Again program.

Three other articles expand the theme to include other vantage points of experience and insight. James O'Connell, President of the Boston Health Care for the Homeless Program, tells us of a disturbing case that illuminates the profound healthcare challenges that can loom. Erik Garcia, Medical Director of the Homeless Outreach and Advocacy Project in Worcester, describes how his organization has been successfully reaching the homeless and delivering needed care. Clara Savage of Common Pathways, with the assistance of Linda Weinreb of UMass Medical School, presents

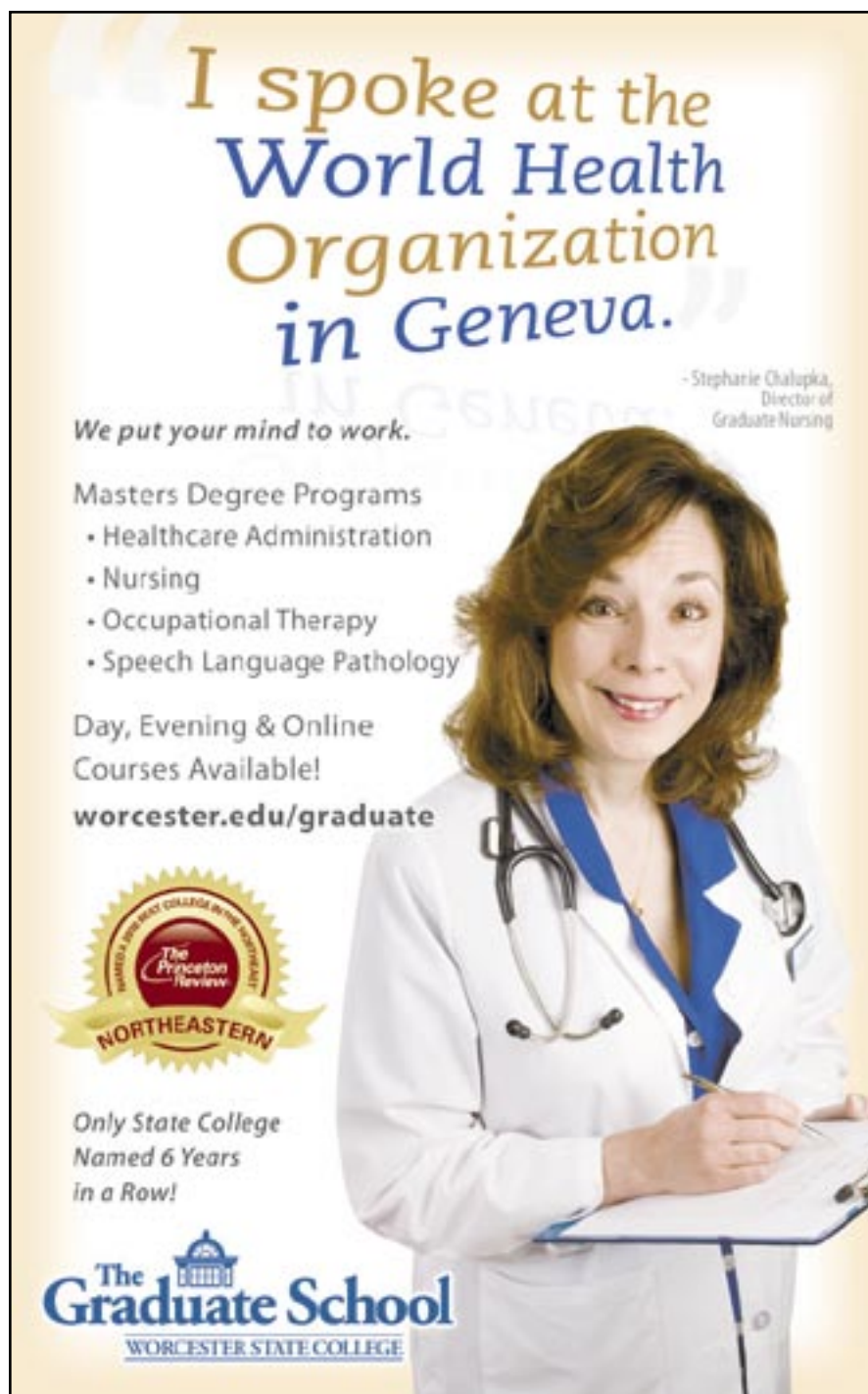


a comprehensive account of the many community resources that have evolved in our empathic locale and are such a vital dimension of the overall landscape.

We are grateful to the authors for sharing their wealth of experiences and perspectives. We hope readers will learn from these thoughtful articles, reflect on their messages, and recognize the numerous ways in which homelessness and healthcare intersect. My grandmother used to say: "If you have health, you have everything." But what if a home is a key part of having or acquiring health? Then the saying might become: "A home is everything." And so, our obligation to the homeless could not be clearer. We must bring them home, by bringing them homes.

The guest editor typically confines these remarks to the issue's content related to the theme at hand. But one very important item in this issue warrants an exception. I refer to the article by Guenter Spanknebel, based on the 214<sup>th</sup> Annual Oration he delivered to the Worcester District Medical Society this past February. Known to his peers as a remarkably talented physician, a superbly skilled teacher and an outstanding human being, Dr. Spanknebel conveyed in his heartfelt oration yet other dimensions of his life that were unknown to many in the audience, and which reflect with such poignancy on his fine character. We are proud to bring some of his memorable oration to you in this issue and in so doing offer him our enduring admiration.

*Thoru Pederson, PhD, a member of the WDMS Editorial Board, is a Professor of Biochemistry and Molecular Pharmacology at the University of Massachusetts Medical School.*



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# Housing First

Nan Roman



Nan Roman

It may be a surprise that this edition of *Worcester Medicine* is focused on homelessness – clearly a social issue but not as clearly a medical one. But in fact, homelessness is a problem with very significant health implications. Having a safe and stable home may be the most important factor in determining the health of a homeless individual.

Who are homeless people? Homelessness is a shockingly

common experience among poor people in the United States today:

10 percent of people living in poverty and one percent of all the people in the country experience homelessness every year. Although there is a pervasive stereotype that the typical homeless person is someone disheveled, disabled, and living on the streets, in fact homelessness affects families, children, and youth as well as single adults and disabled people.

The majority of people who become homeless – families and single adults – are homeless for largely economic reasons. They have a medical or other problem, they miss work, lose their job, and get evicted. Since it takes first and last month's rent and often a security deposit – thousands of dollars – to get back into an apartment, they turn to shelters where they stay until they can find a new place to live. About 80% of people are able to do this in a relatively short period of time, and they exit the shelter system, never to return.

This portion of the homeless population does not look appreciably different from individuals and families who live in poverty but are housed. It does not have a higher rate of disability, more children,

or lower education levels. No set of characteristics sets them apart from poor people who have stable housing and employment. Fundamentally, they are low-income people who have lost their housing for economic reasons, and because our country lacks an adequate supply of affordable housing, they experience a period of homelessness while they find themselves a new place to live.

If we focused on re-housing this group of people as quickly as possible, we could eliminate this most common type of homelessness. In fact, quite often it would cost less to provide such individuals and families with the financial assistance they need to quickly move into a new home than it does to keep them in the homeless system. Rapidly returning them to housing would also help them avoid the negative consequences of shelter stays, including severe stress, depression, and illness.

*Housing is often among the most cost-effective health interventions. In Massachusetts and around the country, the homelessness system is shifting its focus from shelter to housing in both policy and practice. A focus on housing can successfully end homelessness and help people achieve well-being and health.*

A minority of homeless people face much more substantial hurdles to returning to housing and stability. These are people with chronic disabilities: mental illness, addiction, and physical disabilities, among a host of other challenges. They really cannot get out of the shelter system on their own. As a result, they languish in it, often for years.

Perhaps surprisingly, the solution for this group of people is also housing. But in this case, it is permanent supportive housing: permanent, subsidized housing with services attached. There is a strong and growing body of literature that demonstrates the cost-effectiveness of permanent supportive housing for people with disabilities, particularly with respect to health costs.

A landmark study in New York City, looking at 4,000 mentally ill homeless individuals, found that the public cost of housing these individuals in permanent supportive housing units was virtually the same as leaving them homeless. Essentially, it cost the public \$40,000



– to leave them homeless or to house them. Permanent supportive housing resulted in particularly large savings for Medicaid.

A recent study published in the Journal of the American Medical Association showed even more dramatic cost implications. 1811 Eastlake, a permanent supportive housing development operated by Downtown Emergency Service Center (DESC), houses chronic street inebriates, many of whom have been homeless for decades. The majority of the tenants are severely disabled from years of serious alcohol abuse and often also from traumatic brain injuries caused by repeated violence and falls. While homeless, these medically fragile and disabled individuals are frequent users of ambulances, emergency rooms and hospitals, not to mention jails and prisons. However, once housed and stabilized, their use of publically funded, acute care systems diminishes. According to the study, ending their homelessness saves the public \$2,500 per month per tenant.

From research such as this and from improving practice in cities, towns, and rural areas across the country, advocates and service providers have proven that housing is the most effective tool for ending homelessness.

Housing works for people who are homeless for economic reasons; a stable home is the platform we all require to educate our children, acquire gainful employment, comply with treatment, and improve our well-being. The faster people get back into housing and get linked to services, the more quickly they are able to stabilize and find independence.

Housing also works for people with disabilities. Long stays in shelter or even transitional programs are costly and can have very poor outcomes. Shelters are designed to help in a crisis – they are not places to live. These poor outcomes, coupled with the potential cost savings demonstrated by research, offer a compelling argument for permanent supportive housing for homeless people with disabilities.

Housing is often among the most cost-effective health interventions. In Massachusetts and around the country, the

homelessness system is shifting its focus from shelter to housing in both policy and practice. A focus on housing can successfully end homelessness and help people achieve well-being and health.

Communities across the country now have the proven solutions they need to solve the problem of homelessness and improve the lives and livelihoods – and the health – of their residents. All of us have a stake in accomplishing the goal of ending homelessness.

*Nan Roman, President of the National Alliance to End Homelessness, is a leading national voice on the issues of homelessness and housing. She holds degrees from the University of Illinois.*





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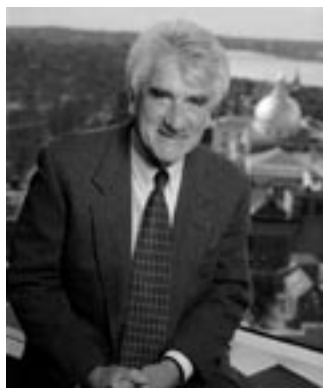
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# Lessons Learned from the O'Neill Family Story

Thomas P. O'Neill III



**Thomas P. O'Neill III**

I grew up in a fortunate household. It was not only that my father was a well-respected political leader who would eventually gain fame internationally through his status of the Speaker of the U.S. House of Representatives. It wasn't just that my brothers, sisters, and I were able to access resources – like education and opportunity – that others who were less fortunate but no less deserving did not have.

Our fortune was primarily tied to

the fact that we were raised by two loving parents who worked hard to give us those advantages and who provided guidance as well as affection.

And still, like so many families, we were touched by homelessness. The story has become a familiar one to so many. My brother Michael, as smart and as capable as anyone there was, at some point succumbed to an addiction and mental illness. Slowly but surely, that addiction took away his success and his ability to cope, and ultimately left him on the streets. As many families do, we struggled with finding effective ways to help him. We had all the resources available to the family of the Speaker of the U.S. House, yet we could not solve this problem for Michael.

Homelessness remains one of the great shames of our society and this Great Recession has only made it more visible. The public perception of homelessness is usually linked to those who are chronically homeless and living on the streets. Most do not realize that in Massachusetts today, the average age of a homeless person is nine years old and that the nine year old is either living in a shelter or in a motel. And that while addiction and mental illness often contribute to chronic homelessness, the single most important factor in predicting if a person or family will become homeless is

income. Those who are poor are far more likely to end up without a place to stay than those who are not. This is true regardless of whether or not they are employed – a high percentage of people who become homeless have jobs. Most who end up homeless are not chronically so – they spend some time in shelter but eventually become housed. But still, they are often without the resources they need to prosper.

The recession has only added to this crisis. We will not know really how many people have become homeless due to the economic crisis until this summer when the U.S. Department of Housing and Urban Development releases the results of its biennial homeless census counts which were conducted at the end of January. But we can look at the situation here in Massachusetts to see that the number of people without permanent housing has increased. The Commonwealth's homeless shelters, which provide shelter housing for 2,000 families and 2,900 individuals, have been filled to capacity since 2008, and the state has been forced to place many homeless individuals and families in motels.

Thankfully, there are also many organizations, individuals, and an increasing number of resources – and innovative thinking – available to help homeless residents of Massachusetts. Organizations like the Massachusetts Coalition for the Homeless, Homes for Families, and the Massachusetts Housing and Shelter Alliance are advocating for effective and cost-effective public policies to ease homelessness, like promoting Housing First models and expanding the number of rental vouchers available to homeless families. These solutions have proved successful in other states and are becoming progressively more popular here. Additionally, Governor Deval Patrick and Lieutenant Governor Tim Murray (who spent time as a housing advocate while a student at Fordham University) have put real political capital and resources behind the idea of ending homelessness in Massachusetts.

Additionally, social service agencies that work directly with the homeless population are thinking creatively to find solutions to end homelessness. For instance, the Cambridge-based non-profit Heading Home, Inc., which runs several shelters throughout Greater Boston, has recently launched its Partnership to End Family Homelessness. This unique effort brings together funds from private and public sources to provide homeless families with not only housing but also the kind of services they need to stay out of poverty. These services include job training classes to move them out of dead end jobs, life-skills mentoring, and asset management development. The organization recently received a grant from the City of Boston to expand its model, which builds on lessons learned from Housing First efforts elsewhere.

Furthermore, Massachusetts has also become a leader in understanding and dealing with the health care challenges presented by those who are homeless or extremely poor. In 2008, Boston Health Care for the Homeless Program (BHCHP) opened Jean Yawkey Place, the first-of-its-kind facility dedicated to meeting the medical needs of the region's homeless population. In addition, BHCHP continues to provide medical care to thousands of homeless men, women, and children who live in shelter and are on the streets. Perhaps one of the most important functions of Jean Yawkey Place is that it will make it easier for the doctors and medical professionals treating the physical needs of their homeless patients to also address the mental health and addiction issues that are a factor in causing chronic homelessness.

In a period where so many are struggling to pay their bills and live healthy lives, it is difficult to find hope when it comes to an issue as intractable as homelessness. But there are reasons to be hopeful. More and more families – like mine – are coming to understand the issues that lead to chronic homelessness and are finding ways to help their loved ones. And more and more organizations and government entities are providing the kind of resources and services families and individuals need to see their way out of homelessness to a self-sustaining life. Most importantly, more and more people are beginning to recognize that homelessness is a problem we can all solve if we work together to do so.

*Thomas P. O'Neill III is the former Lieutenant Governor of Massachusetts and CEO of O'Neill and Associates.*

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# The Health Foundation of Central Massachusetts, Inc.

Janice B. Yost, EdD



**Janice B. Yost, EdD**

*Author's Note: The Foundation was created in 1999 with the proceeds resulting from the sale of Central Massachusetts Health Care, Inc. a physician-initiated, not-for-profit HMO.*

While homelessness is a complex social issue, its solution is relatively simple. The “housing first” approach, where homeless people are housed and provided with case management and support

services necessary for them to function at their highest capacity and remain housed, has been proven effective in communities across the country, including Worcester.

Homelessness most often results from a lack of affordable housing. A job loss, divorce, illness, or other significant change in personal circumstances can be the tipping point that leads to homelessness, especially with this region's high cost of living and expensive rental market. Some people have ended up homeless because of the devolution of social services, including closing institutions that once served those with mental illness or diminished cognitive capacity. The disease of addiction to alcohol and other substances has played a leading or contributing role for many who are homeless.

In recent decades, communities have essentially responded by providing homeless people with emergency shelter, like the People In Peril Shelter in Worcester, or transitional shelter. Shelters do not directly address the causes of homelessness. Rather than crisis housing, shelters have become more rehabilitative, serving homeless people for longer periods of time and at a greater cost. Consequently, the expanding shelter system has not reduced the prevalence of homelessness and has led to increasing lengths of time people spend in the system. Indeed, studies indicate that those who

are chronically homeless accounted for 50% of the total shelter days in New York City and Philadelphia (Culhane & Metraux, 2008).

Homelessness can be both a cause and a consequence of poor health. The premature mortality rate among homeless adults is estimated to be three to six times that of the general population. Homeless individuals are at a substantially greater risk for a range of health problems, including high blood pressure, asthma, diabetes, arthritis, HIV/AIDS, substance abuse and mental health disorders. Some homeless people are exposed to new health risks such as frostbite, leg ulcers, upper respiratory infections, and trauma resulting from assaults that are the result of living on the street (National Coalition for the Homeless, 2010).

Facing these facts in 2000, Congress began the paradigm shift from a system of sheltering to housing homeless people by requiring the US Department of Housing and Urban Development (HUD) to set aside 30% of its allocation for permanent housing programs. Cities across the country introduced the “housing first” approach and documented its efficacy, which has informed the plans to end homelessness in Massachusetts and in Worcester, as well as in hundreds of other communities.

Worcester's homeless service providers came together in 2006, intent on ending adult chronic homelessness through Home Again, a “housing first” project. Community Healthlink serves as the lead agency for Home Again, and other partnering organizations include: Central Mass Housing Alliance, Dismas House, Henry Lee Willis Community Center, Jeremiah's Inn, and SMOC/People in Peril Shelter.

The Health Foundation of Central Massachusetts has thus far granted \$1.6 million for Home Again, including funding for the project to be evaluated using a randomized controlled trial. Early results are in. The Home Again 21-month outcome evaluation, conducted by researchers from the Boston University School of Public

Health, using reliable assessment measures, compared the progress of 29 Home Again participants to that of a randomly assigned group of 30 control subjects who received the standard care. Key findings (Rothman & Baughman, 2009) were:

- Home Again participants were 2.5 times as likely to achieve and maintain housing over six months (97% vs. 38%).
- Home Again participants' use of hospital emergency room services decreased by an average of 1.46 visits per three months. By contrast, the control group reported an increase of 0.62 visits per three months.
- Home Again participants were nearly twice as likely as participants receiving standard care to have good social support (34% vs. 19%).

Using electronic surveillance and medical records, other researchers have studied the effect of "housing first" on chronically ill homeless adults' emergency department visits and hospitalizations. The magnitude of benefit was large: conservative analyses suggest a 29% reduction in hospital days and a 24% reduction in emergency department visits. This translates into substantial health care impact. For every 100 chronically ill homeless adults provided with the "housing first" approach, the expected benefits over the next year would be 49 fewer hospitalizations, 270 fewer hospital days, and 116 fewer emergency department visits (Sadowski, Kee, VanderWeele & Buchanan, 2009).

Planning for Home Again involved identifying the 120 adults who were chronically homeless in Worcester. Here, as in other parts of the country, that segment of the homeless population has remained relatively finite. In recent months, Home Again has brought the total number of individuals housed to 50, most of whom formerly frequented the People In Peril Shelter.

Another "housing first" pilot project in Massachusetts found that annual costs for Medicaid, shelter and incarceration per person

*Homelessness can be both a cause and a consequence of poor health. The premature mortality rate among homeless adults is estimated to be three to six times that of the general population. Homeless individuals are at a substantially greater risk for a range of health problems, including high blood pressure, asthma, diabetes, arthritis, HIV/AIDS, substance abuse and mental health disorders.*

decreased from \$33,327 before housing to \$24,066 for housing, in-homes services and program operation associated with the housing placement, resulting in an annual savings to the Commonwealth of \$9,261 per person. Once housed, Medicaid expenses on average dropped by 67% per person (Massachusetts Housing and Shelter Alliance, 2009).

Federal, state and local resources have shifted from a system of sheltering to one of housing, because it is effective, it costs

less, and moreover, it is the humane response to homelessness. The vision of ending homelessness is within sight.

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# Do Not Go Quietly

James J. O'Connell, MD



**James J. O'Connell, MD**

Despite his youthful 43 years, Ned ranks among the most difficult, contrary, cantankerous, frightening, and outrageous individuals I have encountered in my 25 years of caring for homeless persons. A proud denizen of Boston's streets, his nightly badgering of all of us working on Pine Street Inn's overnight van included an expletive-laden recitation of the litany of shelters and soup kitchens from which he had been barred.

And the stories behind each bar would make your hair stand on end. A loner from a town north of Boston, Ned couldn't sit still in grammar school and couldn't calm a rage that consumed him. He fought constantly, stood up to everyone, as often pummeled as victorious. He was on the streets by age 17, quelled his inner storm with a host of substances, found trouble brewing in most alleys and doorways, and began a longstanding joust with the courts and prisons. When I first met him in 1985, he mentioned that the only time he felt in control was in a prison cell – and he proudly preferred solitary confinement given his issues with authority.

In the early 1990s, he bought a bus ticket to the West Coast but bailed out in Las Vegas. Gambling, the desert, and a city that never sleeps captivated him. He suffered a devastating leg injury while hitchhiking, with multiple fractures necessitating several surgical procedures in the ensuing years. He scrambled back to Boston and arrived with an infection deep in the bones. Despite exasperating efforts, this osteomyelitis never truly healed. In early 2000, we faced a difficult decision together: either amputate the leg above the knee, or place in a rod that would fuse the leg and prevent him from ever bending his knee, leaving him (as Ned would yell to whomever could hear) “a damn peg leg.” He chose the latter and came to McInnis House, our medical respite program, for post-operative care. He lasted a few weeks, but his rage won out and he smashed a phone and frightened the staff. I had never known him to leave any place voluntarily; he needed to be expelled, deflecting the responsibility away from himself. It was a mistake for me to point that out to him.

On the streets, his leg never healed and the infection persisted, giving him intense pain that he treated with a smorgasbord of substances. During one of his self-named “hissy fits” near Downtown Crossing in the winter of 2002, the police picked him up for protective custody. He had some outstanding warrants and ended up with two years to serve in jail. One of the warrants was issued after he had refused to go to court to face a charge of urinating in public. “You try and find a public toilet in downtown Boston. I refuse to be seen as a criminal for peeing in an alley, and now they are charging me with ‘exposure’.” Give me a break! I’m not a criminal and I’m definitely not a pervert or a sexual offender. I just don’t have a home and the judge can kiss my behind.”

He was as offensive and irritating as he could possibly be to the prison guards, hoping to be placed in solitary confinement where he could manage his anger. A known drug-seeker, his constant complaints of intense back pain fell on skeptical ears. He wrote long letters from his isolation cell that began to hint at the fragile boy beneath the fury, although always peppered by his outrage at the prison clinic for not taking care of his “terrible” pain. I understood the dilemma of the staff attempting to care for this classic “difficult patient.” The letters kept coming with requests for John Grisham books and a subscription to the Boston Herald; they were coupled with escalating pleas for help with his pain. He couldn't sleep, complained that prolonged sitting or standing caused severe pain in his lower back that radiated down the length of his right leg. I realized with some guilt that all of this was new. His innumerable surgeries and chronic pain had been in the left leg, never the right.

I negotiated the bureaucracy and visited him on Halloween. His skin was blanched and diaphoretic, the loss of weight dramatic, and his months of agony horrifyingly apparent. The lung cancer, subtle and missed on his admission chest x-ray to jail, had metastasized and literally crushed many of the bones in his spine. We spoke with the attentive physician at the jail's clinic, and an expedited MRI revealed a large mass in his right lung and several compression fractures in his thoracic and lumbar vertebrae, but the results had not been communicated to the clinic staff at the jail. Ned adamantly, but perhaps wisely, refused chemotherapy but accepted palliative radiation therapy for the compression fractures over the next six weeks.



Ned had only a few months to live at best. We pushed hard for parole, which was granted in early January. But the bureaucracy stalled; parole requires both internal and external review. He also was required to have a place to go in the community that was not a shelter, and we promised the judge that we would provide end-of-life care for him at our McInnis House. Interestingly, inmates who complete or “wrap” their sentences can be released and go to a shelter or the streets. He became dyspneic and was admitted to the hospital with an aspiration pneumonia. The cancer in his lung had grown large enough to block his esophagus, and he was unable to swallow food. Stubborn, angry, and resilient, he improved enough to return to prison and continued to eat whatever he wanted.

I was on the van when the ICU physician called me on Wednesday of the first week in February, 2002. Ned had been struggling for air in his jail cell, admitted to the hospital, and death seemed imminent. He refused intubation because we couldn’t guarantee he would get better, and he was transferred to a room on a medical floor where comfort measures were instituted. Still a prisoner, he was chained to his bed and accompanied by two armed guards.

Ned defied the odds and fought death doggedly and bitterly. His brother journeyed to be with him, and our team joined in the sad but moving vigil. Our nurses massaged his feet, bathed and turned him, and kept lavender near his bed and his favorite songs on the radio. I had the opportunity to spend much of the weekend with him as well, cherishing those last conversations with a man who so captivated and baffled me. His single request was to not let him die in chains. After much cajoling, the parole board released him on Friday evening as long as we guaranteed McInnis House as his post-release address. The shackles were removed, the guards departed, and Ned finally was ready to give up his struggle. He died early Sunday morning. His death tendered a fleeting glimpse into the lifelong rage of a man dealt an unplayable hand, born into abject poverty with dreams dashed and

opportunities limited by a chemistry that bathed him in pain and anger. Yet from beneath his angry veneer a stunning courage and raw honesty emerged. To the end he remained his own person.

*James J. O’Connell, MD, is President of the Boston Health Care for the Homeless Program.*

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# Who Is Homeless in Worcester: What resources are available?

Clara P. Savage, EdD



**Clara P. Savage, EdD**

Traditionally, low income, mentally ill, physically disabled, alcohol- and drugs-addicted, and jobless individuals are considered the most likely homeless population. However, today's homeless are also working poor, recent college graduates unsuccessful in job hunting, teenage mothers and their children, unemployed/ recently laid off middle-aged,

victims of the foreclosure crisis, and others. More than one-third of the homeless population is now comprised of families and children. As we all know, many people live from paycheck to paycheck with a limited "safety net" of personal savings or extended family for support, and it takes just a few missing paychecks to end up homeless.

In January 2010, the Central Mass Housing Alliance (CMHA) Annual Homeless Point in Time Survey found that the total number of homeless persons in the City had decreased slightly. The number of homeless individuals saw a 12% reduction and the number of chronically homeless individuals declined by 38% in 2010 over the number in 2009. These numbers are attributed to a new system and enhanced resources from the Department of Housing and Urban Development and the Central Mass Health Foundation's commitment to housing the chronically homeless rather than warehousing them in shelters.

The number of homeless families remained steady from 2009 to 2010. In 2009, the number of homeless families had increased by 38% over 2008 and so, given the current economic crisis, it is a significant success that the number of homeless families did not increase in the last year.

The Worcester Teen Housing Task Force in August 2009 surveyed 513 youth: 142 were homeless, 91 of the 142 were living in a shelter and 51 said they were either temporarily living with friends, in a car, in the park, or on the streets. Many of them did not know of the services available to them.

What are we doing as a community to prevent homelessness and serve current homeless?

In 2007, the Worcester City Manager assembled a Task Force on Homelessness charged with identifying new strategies to coordinate resources for the homeless. This Task Force presented a "Three Year Plan to End Homelessness in Worcester" with recommendations including focusing on "Home First," decreasing the number of homeless in shelters, and eliminating the PIP shelter in downtown Worcester following the research suggestion and the best practice of providing housing first before introducing any other services. There are current efforts to provide neighborhood stabilization. The Community Development Corporations and Homeownership Center are reaching out to current and potential victims of foreclosure by providing homeowners with small loans and increasing affordable housing units in the region. They are joining efforts with businesses and nonprofit such as UMass Memorial Health Care to provide financial incentives for their employees in becoming first time homeowners. The Worcester Community Housing Resources, in partnership with local and state housing agencies, are a national example with their "receivership" initiative that rehabilitates foreclosure properties and brings them back into the market as affordable rental units.

Worcester homeless shelters and service providers have joined with community stakeholders to implement a significant change to past approaches in addressing homelessness for families and individuals in our community. The approach is a shift from crisis management to a "housing first" strategy. Through up-front assessment, coordination of resources, and building collaborations with property owners,

Worcester has led the way in Massachusetts to work to reduce the reliance on emergency sheltering and shift to a focus on housing. Over time, this will allow the region to shift funds currently draining the homelessness state budget through long-term shelter stays into providing short- and long-term subsidies for permanent, affordable housing for the (potentially) homeless.

The *Telegram & Gazette* article of January 23<sup>rd</sup>, 2010 reported on the meeting of more than a 100 public and private sector leaders in Central Mass at the Beachwood Hotel for a health policy and homelessness panel and discussion hosted by the Health Foundation of Central Mass. Speakers included Nan Roman, President of the National Alliance to End Homelessness. She emphasized the need for analyzing the consequences of living on the street, both to the homeless and the taxpayer. The concept of “Housing First” was highlighted. Ms. Roman provided the example of “David,” a Washington, D.C. man who, after spending decades in prison, became a free man but found himself lost. Often, he considered re-offending so he could return to jail; at least there he would have secured a meal and a roof over his head. “It took \$44,400 in public funds to keep David homeless,” Ms. Roman said, tallying up the psychological services, court and shelter costs that the man built up in less than a year on the streets. Renting a one bedroom apartment in Worcester for David would cost about \$9,600 plus the rehabilitation services.

This approach will make a difference in someone’s life. It is critical to think and act outside the box, keeping in mind that one approach is not able to solve all cases. The Health Foundation of Central Mass has ending homelessness as a top priority. Since 2007, the Foundation has contributed \$1.6 million to projects that address homelessness, and is committing an additional \$500,000 to the cause over the next two years.

CMHA is one of the leading agencies in Worcester working with all shelter providers and in close partnership with the State Department of Housing and Community Development in an innovative new approach regarding homeless families. The focus on housing, diversion from shelter through homelessness prevention, and using state resources to house families rather than send them through a very costly shelter system have been extremely successful. In January, 2009, all family shelters in Worcester were full and an additional 80 families were sheltered in hotels. The number of families in hotels one year later was reduced to only three. Additionally, from July 2009 through March 2010, 59 families who would otherwise have entered emergency shelter were placed in safe, affordable housing at a cost savings of approximately \$14,000 per family based on an average six-month length of stay for those who enter shelter.

Regarding services available for current homeless individuals and families, there is a one-stop main source: [WorcesterResources.org](http://WorcesterResources.org) under Homeless Programs in Worcester with auto-translation in Spanish and Portuguese. Among other resources for the homeless, this site lists “Worcester Area Homelessness Agencies,” including:

- Abby’s House, for women and children victims of domestic violence
- Friendly House, with multi-services for homeless prevention, emergency shelter, and transitional housing
- Catholic Charities, which provides financial assistance and housing counseling for individuals and families at risk of homelessness
- YWCA in Worcester, with short-term and transitional housing for women at risk of homelessness
- Central Mass Housing Alliance provides housing counseling assistance, elder home repair and maintenance, and support programs
- StandUp For Kids-Worcester, a volunteer organization, is starting a number of new programs with high schools.

For state-wide resources, visit [www.mahomeless.org](http://www.mahomeless.org). In addition, Common Pathways is committed to updating our community indicators to monitor the status of housing as a critical element of the health and quality of life in our city and region. We encourage all health care providers to update their information about resources available for the homeless in Worcester and encourage their patients and their families to visit [WorcesterResources.org](http://WorcesterResources.org) for information and tips and/or to dial 2-1-1 for non-emergency and referral services.

*Clara P. Savage, EdD is Director of Common Pathways and CHNA 8, the healthy communities coalition for Worcester and nine towns around Worcester. She is also a community organizer and leader in working with neighborhoods about social determinants of health.*



# Healthcare and Housing of Worcester's Homeless

Erik Garcia, MD

Millions of Americans will suffer through at least one episode of homelessness in the next year, but it's difficult to understand the health impact of homelessness without recognizing that this term refers to a broad spectrum of living situations; poverty, instability, isolation and shame are often common factors. There's the homeless mother residing in a congregate shelter with three other families, the homeless Vet suffering from PTSD and alcoholism who lived year round under tarps behind the McDonalds, the heroin-addicted teen "couch surfing" from place to place as each welcome runs out. Each suffers unique health risks as a direct result of his or her homelessness and each face barriers, both personal and systemic, to obtaining adequate healthcare. At the Homeless Outreach and Advocacy Project (HOAP) division of Community Healthlink, we try to assess and address each individual's needs with a group approach to care. By offering case management, mental health, medical and substance abuse services, we provide the opportunity for positive change, whether it's a night off the streets, an appointment with a psychiatrist, or the keys to an apartment.

I've been the Medical Director of HOAP since completing my residency at UMass in 1994 and I still remember how scared and out of place I felt during my first visit to the Public Inebriate Project (PIP) shelter on Main South in Worcester. It was a mid-winter night during a two-week rotation with then Homeless Outreach Medical Director Steve Rappaport, and the place was crowded and loud and chaotic. It seemed dangerous. Many residents were clearly under the influence of drugs or alcohol, and many displayed obvious signs of mental illness. Amidst all this were Steve and the HOAP outreach team, providing care and counseling while teaching me the most valuable lesson of my career in homeless services:



**(L to R) Nechy Corriveau (case mgr), Tammy Robertson (substance abuse case mgr), Patricia May (medical case mgr), Erik Garcia and Joyce Landers (nurse practitioner). Photo by Phil O'Brien**

that showing concern for the well-being of another person immediately gives you something in common. Seems simple, but many homeless patients have never experienced the trust implicit in a relationship with a primary care provider. Earning that trust, and the appreciation that comes with it, has been one of the most gratifying parts of my job. It's been years since that first visit to the shelter and I am still struck by how traumatizing and dehumanizing homelessness can be. I've never left the shelter without a sense of relief and a

little shame that I was going home to a warm and safe place of my own.

The most recent development in healthcare for the homeless, the Housing First initiative, is an effort to provide warm and safe places for Worcester's most vulnerable chronically homeless shelter and street dwellers. For years, our approach to housing involved a stepwise and structured approach which sought to gradually progress a person towards his/her greatest potential for independent living. For many however, the rules and stipulations found in traditional congregate shelters created barriers. Housing First initiatives seek to remove barriers to independent housing while providing enough support and guidance to keep people housed safely. We've already seen the impact this has had at the PIP shelter, with many patients I've seen there for years finally having a place of their own. What remains to be seen is whether this will have a significant impact on the number of Worcester's homeless and on the health and well-being of people who are now housed in relative isolation.

*Erik Garcia, MD, is the Medical Director of the Homeless Outreach and Advocacy Project (HOAP).*

# “You Have Saved Our Lives”

The 214th Annual Oration was delivered to WDMS physician members and guests on February 3, 2010.

Guenter L. Spanknebel, MD



**Guenter L. Spanknebel, MD**

I had heard these words for the first time in my life when I was about 9 years old. Who would ever express such awesome thoughts to a little 9-year-old? What were the circumstances?

Doing a few calculations around my birthday you will promptly get to the middle of the 2<sup>nd</sup> World War. Regensburg/Danube, the Bavarian town I grew up in, was

famous for its Messerschmidt factories, its strategic railroad center and the enormous army camp facilities ~ all worthwhile bombing targets. But there were also historical, religious, and architectural treasures over 2000 years old ~ absolutely tabu-untouchable and, I suspect, under the protective umbrella of the Pope ~ that even the vicious elements of that terrible war had to respect. My family lived in a house located between railroad center and army camps.

Every so often, usually in the middle of the night, the wailing sounds of sirens would send us into the steel-and-concrete-enforced cellar because “unfriendly” bomber squadrons had been detected flying in a pattern that would bring them close to or over our town.

After the usual noise and cursing with the rush into the protective cellar, it became very quiet. Soon one could hear the rumbling sound of the large propeller-driven airplanes. If the sound stayed the same before fading away we knew the planes would unload their deadly cargo on a target away from Regensburg. But all too often we would hear a soft hissing sound added to the rumbling. This hissing would turn into a swooshing noise of the type a leaky pneumatic tube system can make. But, have no fear, the swoosh would end with an explosion at least a mile away from you.

But then ~ once ~ a loud, horrific swooshing sound surprised us without warning. It turned into a shrill, ear piercing whistle for the fraction of a second before ending with a strike of thunder that shook the floor and cellar walls, filled the air with dust, sand

particles, smoke, the smell of old wood, bomb explosive powder... death. Quiet and peace followed. And into this peace rang the voice of Mrs. Endres: “Guenter, you have saved our lives!”

It took a while before I mustered the courage to ask her, “Why?” She explained that I had loudly screamed in fear and that, at the height of the swooshing noise, I had yelled, “Almighty God, spare my life and I will become your priest!”

The bomb was pushed away from our 2-story house to hit a 6-story apartment building across the street, 100 feet away, destroying it and its cellar but not killing anyone ~ all its occupants had moved away.

For a long time, I forgot about my promise ~ or, subconsciously, tried to suppress its consequences.

After all, my father was a 5<sup>th</sup> generation musician and music academy trained conductor and my mother was an accomplished pianist. Why would they have me go to piano lessons? Why did I have to learn to play violin and cello? Obviously, they had me earmarked to become a 6<sup>th</sup> generation musician!

The end of the war came closer. With it fears of a final battle and bombing of our town grew. From far away, my father ordered a sergeant to drive us with our most precious belongings away from town into the country about 15 miles away. After passing destroyed, still-flaming buildings and burning trains, we ended in a small village at the farmhouse of the village mayor. “Find living quarters for this wife of an officer and her 3 small children,” the sergeant demanded. “There is no free space here or in the village,” was the reply. After all, it was the middle of the night! Coolly, the sergeant drew his gun, held it into the face of the “Burgermeister,” and said he would start shooting if the family were not accommodated in 20 minutes! This gesture found us prompt entry into a whitewashed, empty pigsty with fresh straw and blankets. It was actually quite comfortable there. Unfortunately, we had to sit much of the time in a hand dug earthen bunker to survive a fierce battle between a crazy SS-Major in command of 3 fixed-turret tanks and the allied forces.

One day, I followed 2 soldiers in black uniforms who crawled behind a garden wall where they rested their guns. One said, “Viszler 800,” pointing at a small figure with a white flag moving towards the American line. So the other aimed his gun at the person who was about ½ mile away. “You can’t do this,” I said. “Please, don’t shoot him!” “You will never become a German soldier, you are not worth it.” He turned around, I looked directly into the opening of his gun! His angry eyes must have seen something in my face that stopped him from pulling the trigger.

One morning, four G.I.s in a Jeep drove into the yard and announced the end of the war. They wanted to speak to the “Burgermeister,” but only his obese, unkempt wife was around. When she saw the soldiers she remembered the need to show something white to indicate surrender. Frantically she looked around for the color of peace but found nothing. Suddenly she remembered! She grabbed for something inside her sweater and with a mighty heave she tore out – her bra – and held it up for all to see. It really was no longer snow white – but it obviously did the trick! Nobody shot at her!

After the sounds of war had ceased, it did not take long to befriend 3 boys from a neighboring farm. Among the four of us, we shared one bicycle. It was my turn to drive it to the end of the village and back, 10 or 15 minutes. When I returned, I found them peacefully sleeping together. No one would get up to take over the bike. I noticed black little holes in the skin of their upper bodies. Adults rushed to the scene, one pushed me back into the arms of my mother so I would not see that my buddies were all dead, killed instantly by the explosion of a hand grenade they had found and played around with. Was I spared because I had a promise to keep?

The return to regular high school activities took a while. I remained with the language section rather than going into mathematics.

Soon I found myself busy with Latin, English, French, Italian and – of course – German, but other subjects had to be studied as well. Although my teachers knew that I was the “Musikmeister’s” son, likely to go into music myself, they had their individual personal ideas about what would be good for me. Here began my honest struggles amongst the temptations of success caused by the As in the finals, my teachers’ wishes, and my promise of long ago. Luckily, a friend of my family, Dr. Schmid, came upon my dilemma. His immediate answer was, “I’ll make a doctor out of you! Not only will you be able to help patients with their bodily ills, but you certainly will have priestly access to their souls when needed.” And I was accepted into med school.

My life as a medical student was full of adventures. During my 1<sup>st</sup> summer vacation, I became a mason’s apprentice, carrying bricks and cement bags to help with the rebuilding of homes destroyed by bombs. I earned money I needed for text books. At the same time, I came to know the plights of people who might ask me for help in the future. 18 years old, in top physical shape, I thought I could carry more cement bags at once than anyone else, 110 lbs/bag, 440 lbs total, to a storage place 90 feet away. One case of beer was the bet. But then came a 50 year old bundle of muscle and bones who schlepped 5 bags across the finish line!

The next day, I paid my dues and invited each one of my co-workers to pick up a bottle. To my utmost surprise, there was palpable hesitation. No one had ever experienced a lost bet being paid. Distrusting the unbelievable generosity, one finally shouted, “You probably p’d in it!” No sweat! I opened a bottle, drank from it, and everybody followed suit. Now I was one of them, not just a medical student. A few days later, one of the workers wanted to see my hands. When he discovered the callused, coarse skin, the mini cuts and bruises, he showed his concern and advised me, “You should not do this heavy lifting of bricks and iron rods, doc, look at your hands, how

will you ever be able to do delicate surgery?” Everlasting lesson learned: concern and trust come from the heart and don’t need money, academic title, or social status.

As I begin to tell you about another adventure I had in the building industry, I can’t help but feel shudders going down my back. We had a “construction elevator” that was used to haul up on a little platform bricks cement, sand, water, and whatever was needed to build a 6-story building. The elevator shaft consisted of a 60+ foot long rigid tree trunk with a slippery-smooth surface and a diameter of 3 feet. When one segment of the building was finished, we would carefully let the trunk come down to lie on the ground parallel to the house wall. It took at least 15 men to lift this monster onto their shoulders and transport it to where it was needed next. One day I was ordered to the very front. I hung on to the trunk with all my strength. The man at the end guided us with his loud voice: “All to the left.” I quickly ducked and loaded my portion onto my right shoulder: “On three – one, two, thr...” I did not hear the last number because I was catapulted forward by a vigorous kick into my lower back that took my head, in fact my whole body, out of the trajectory of crushing doom. Of course, I thanked my co-worker loudly, profusely, for having watched over me but in my heart I said what my surroundings could not hear: “Thank you for helping me to keep my promise!”

Fortunately, there were many other jobs open for me during weekends and semester vacations – 12 to be exact – before I received my MD degree. Streetcar conductor was one of them. My trailer car was kept clean at all times. One day, a well-dressed gentleman entered the back platform of my car. I recognized him as one of the doctors in town. He opened a small paper bag with cake or a sandwich in it. He promptly devoured it, then crumpled the paper into a ball and threw it on the floor. Being a third year medical student, I addressed him quietly: “So sorry, my dear colleague, that

your eyesight is so poor, you can't even see the waste paper basket in the corner!" "How dare you to call me dear colleague? Besides, there is no wastepaper basket!" My thundering response? "I am a medical student indeed there is no basket! So why do you throw your garbage on my clean floor?" I believe he never used a street car again...

After receiving my MD degree, I undertook an internship in pathology at the University, then I had the good fortune to be selected by the Ventnor Foundation to come to the United States for postgraduate medical education while learning about democracy. Two and half years later, I returned to Germany to fulfill the requirement for an immigration visa. I continued residency training in internal medicine and soon found out that a higher degree of responsibility and extra work came to rest on my shoulders due to the intense educational and work experience given to me at our Worcester Memorial. E. G., the chief of medicine of a city hospital I worked at asked me whether I would cover his clinical responsibilities while he was on a 2-week vacation. Of course I would! That gave me the chance to start regular meetings with my colleagues on the medical wards to discuss EKG findings and to present difficult patient management. I insisted that pneumonia cases not only had good H&P exams but convincing X-ray findings and appropriate therapy with antibiotics ~ if needed ~ selected after culture result known.

Almost two weeks later, I received a letter from the city mayor: "Dear Doctor, you must stop treating patients with antibiotics the way you do. You have exceeded your medication account by DM 1000.00. Should you decide not to follow this order the money for excessive expenditures will be taken out of your salary [monthly salary about DM 1000.00]! I was tempted to tell the mayor where to go – to med school. Fortunately, the chief returned from vacation a couple of days later...

However, ever since, I have fought systems controlled by penny pinching bureaucrats who disrespect doctors' decisions and are disinterested in good patient care.

During morning rounds with the chief and presentation of difficult cases for his advice, I showed him a very sick lady in heart failure. He agreed with the diagnosis and recommended a small dose of fast acting I.V. digitalis. I begged to differ because she had severe chronic obstructive pulmonary disease with predominant right sided failure and a shot of strophanthin could kill her. No learned discussion followed but instead I received, "You young wipper-snapper! I am many years older than you, you do what I tell you!" My response? "I trained under a great cardiologist, several years older than you. He taught me not to do what you are ordering me to do." Silence followed, dead silence.

The next morning started my weekend off. I later was told the chief, on morning rounds, told the resident to give the lady strophanthin right there and then. The resident probably said, "Yes, Sir," maybe even clicked his heels, and then dutifully gave her the medication – where upon she dutifully died on the spot.

And then there was the story of the 7 year old boy who was admitted to my floor overnight "in shock." The very concerned admitting physician could not get a BP reading despite I.V. saline. The chief noted the presence of microcytic hematuria and suspected strep infection and glomerulitis.

On PE, the boy was afebrile, warm, dry, and a little scared. The BP was 162 – Diastolic that is, 235 systolic. My working diagnosis was pheochromocytoma and this was confirmed by the few tests available at the time. Exact tumor localization by means of vena cava catheterization and measurement of plasma catecholamines was not indicated, according to the chief. Transfer to the University Hospital was felt to be too embarrassing for a case of glomerulitis. On

morning rounds a few days later, I found the little boy cold in his bed, dead. On limited autopsy, I found a well-encapsulated, round, 30 gm pheochromocytoma at the upper end of the left kidney. Deep mixed emotions – grief, sadness, guilt, anger, fury – made me run into the chief's office – "Here is your glomerulitis!"

Had I been a better teacher, could I have convinced the medical establishment to do the right thing? As you know, I returned to Worcester just about at the moment when my visa requirements were fulfilled and I had picked up all the paperwork – 1 hour before all our consulates in the world were closed due to the murder of our President, Jack Kennedy.

I finished my training, established my practice in gastroenterology, and dedicated myself to medical education. Needs assessment through objective quality assurance and practice experience was my guiding light in program development.

Decades later, again under the auspices of the Ventnor Foundation, I was sent to Berlin to give a lecture to German professors on American quality assurance. My visit there coincided with the time "the wall came down" in November of 1989.

Looking back, re-visiting much improved German medicine, today I believe more than the brick-and-mortar wall came down then.

I have come to the end of my oration and want to thank you for listening. I have to admit to you that I am still working on my promise of long ago – and that I am happy that I ever made it.



# Medical Orders for Life-Sustaining Treatment:

## Helping Patients to Make Their End-of-Life Treatment Preferences Known

Christine McCluskey



**Christine McCluskey**

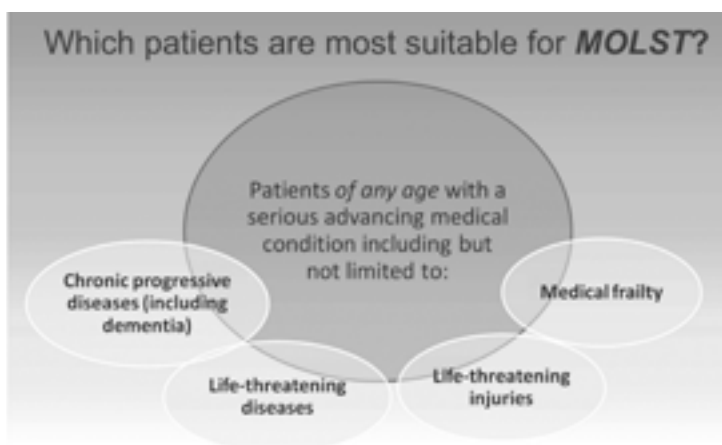
As of April 1, a new initiative is underway in the Worcester area: Medical Orders for Life-Sustaining Treatment (MOLST), a program to improve communication regarding patient preferences about end of life treatments across health care settings. Enacted by the Massachusetts Legislature in Chapter 305, Section 43 of the Acts of 2008 requires the establishment of a pilot program in Massachusetts to help persons

communicate their wishes for medical care as they approach end of life, since such preferences for treatment are often not known or discussed. The demonstration program is being implemented in select health care facilities located in the Worcester area, and coordinated and managed by the UMass Medical School – Commonwealth Medicine Center for Health Policy and Research, Dissemination and Implementation Unit. Soliciting input from a wide array of organizations and individuals, both local and state-wide, has made the process a highly inclusive one and will help to ensure the consideration of many relevant issues for this complex topic.

MOLST is intended for patients nearing the end of life with serious advancing illness, such as life-threatening disease or life-threatening injury, chronic progressive disease, or medical frailty. Not only a form but also a process, MOLST is intended to be signed as medical orders only after discussions have occurred between the clinician and the patient and family regarding a patient's medical condition, prognosis, goals for treatment and benefits and burdens of treatment. When completed and signed by the clinician (physician, nurse practitioner, or physician assistant) and the patient (or the health care agent or a guardian, as permitted by MA law), the MOLST form is considered valid and constitutes an actionable medical order that can be honored across treatment settings. The form is bright pink, and is designed to be easily identified by health care providers. It is particularly useful for EMS personnel in the event of an emergency.

The MOLST form is similar in principle to the current Massachusetts Comfort Care/Do Not Resuscitate Verification Form, but provides

more options for different treatments and includes the ability to either accept or refuse a treatment. MOLST is different from a health care proxy since it allows a person to specify treatment preferences and becomes effective immediately, while the health care proxy allows an individual to appoint a person to make health care decisions in the future, if a loss of decision-making capacity occurs.



The MOLST Steering Committee and its various work groups have been busily preparing the Worcester community for implementation of the program, providing training for MOLST signatories and other health care professionals at the implementation sites, and education and outreach for other stakeholders in the community, including consumers and potential patients and their families. A comprehensive process evaluation will be conducted throughout the implementation period in order to make recommendations for statewide expansion of MOLST when the demonstration period ends at the end of December, 2010. Complete information about MOLST, including training tools, consumer information, a sample of the MOLST form, an informational video as well as other materials are available on the MOLST website, at [www.MOLST-MA.org](http://www.MOLST-MA.org). Or the MOLST demonstration program may be reached by calling 508-856-5890.

*Christine McCluskey is Community Outreach Director at the Dissemination and Implementation Unit of the Center for Health Policy and Research at Commonwealth Medicine, UMass Medical School.*

# Refugee Immigration

A message from the Commissioner of Public Health, Worcester, MA

Leonard Morse, MD



Leonard Morse, MD

The recent tragedy in Haiti has summoned compassion from not only the medical profession, but also from the entire world.

Currently, the City of Worcester welcomes and facilitates the resettlement of approximately 600 new emergency refugees annually. Medical clearance and continuing care is largely provided by Catholic Charities, the Lutheran Social Services, the Family Health Center

of Worcester, Great Brook Valley Health Center, Worcester's free clinics and the City's three very dedicated public health nurses.

The Haitian earthquake, followed by the earthquake in Chile, prompted the suggestion that Worcester's regional community resettlement preparedness needs to expand. If there are members of the Worcester District Medical Society who would volunteer free medical service to an Emergency Immigrant family during and beyond the resettlement period, it would certainly exemplify shared humanitarian responsibility and broaden personal experiences.

The goodness of each physician sharing the commitment lightens the burden for everyone.

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# Charity in Law and Practice

Peter Martin, Esq.



**Peter Martin, Esq.**

Many health care provider organizations in Massachusetts are tax-exempt entities. They provide services to insured, uninsured, and under-insured patients as well as a variety of community benefits, and may receive reimbursement for their services from public and private payers that do not cover the costs of the services rendered. They enjoy relief from income and property taxes despite the fact that they charge sometimes substantial

fees for their services. It has been widely recognized under both federal and Massachusetts law that receipt of reimbursement for health care services does not deprive the provider of these tax benefits.

However, a recent Illinois Supreme Court decision upends what has appeared to be well-established law in this area and supports a highly stringent standard for granting property tax exemption to health care providers. While it should be noted that the decision was not signed by a majority of the justices and therefore is not binding precedent even in Illinois, the decision logically derives significant conclusions from the premise that offering health care services in and of itself is not sufficiently “charitable” to support a property tax exemption. In an era in which municipalities and other taxing authorities are strapped for tax revenues, it is instructive to review the recent Illinois decision and envision what arguments might be made in Massachusetts for denying property tax exemption to providers, and what providers may need to do to rebut such arguments.

The aforementioned case involves Provena Covenant Medical Center, an acute-care hospital in Urbana, Illinois, and part of the six-hospital Provena Hospitals system. The hospital operates a 24-hour emergency department, a full range of inpatient and outpatient services, as well as free health screening programs and clinics. In 2002, the hospital earned over \$117 million in net patient service revenue and received \$6,938 in charitable contributions. It had a

charity care policy based on federal poverty guidelines that used a sliding scale of discounts from the hospital’s usual billed charges. The hospital’s application to the county for a property tax exemption for 2002 was denied on the grounds that the property was not owned or used consistently with the Illinois property tax exemption law, and that denial was appealed up to the Illinois Supreme Court.

That law grants a charitable property tax exemption only to property owned by an institution of public charity and exclusively used for charitable purposes and not otherwise used with a view to profit. The Court noted that federal tax-exempt status is not sufficient for property tax exemption under Illinois law. Citing an earlier Illinois case, the Court stated that a charitable institution is one that, among other things, “earns no profits or dividends but rather derives its funds mainly from private and public charity.” Charity in turn is defined as a gift or other voluntary transfer given without consideration: “When patients are treated for a fee, consideration is passed. The treatment therefore would not qualify as a gift. If it were not a gift, it could not be charitable.” Given the above-noted disparity between the hospital’s net patient service revenues and charitable donations, the Court concluded the hospital did not derive its funds mainly from private and public charity.

The Court cited a Massachusetts case defining “charity” as a gift to an indefinite number of persons that benefits them by either “relieving their bodies from disease, suffering or constraint, .... by erecting public buildings or works, or otherwise lessening the burthens of government.” The Court’s unusually heavy focus on the importance of the “lessening of the burthens of government” prong of that definition seems to make that prong a necessary part of any charitable activity, rather than one type of charitable activity. Thus, in Illinois, it would appear that in order to obtain property tax exemption, a charitable organization’s activities must lessen the burdens of government, whereas in Massachusetts, lessening the burdens of government is a justification for granting tax exemption but not necessarily part of a test of eligibility for that grant.

The Court’s reasoning that the use of property tax-exempt property must lessen the burdens of government seems to be based on the theory that tax revenues lost to the local taxing jurisdiction

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must be paid for by “some compensatory benefit in exchange” for the exemption. This analysis in turn suggests that charitable organizations may be required to deliver some quantum of “charity care” commensurate with the value to them of their tax exemption. Massachusetts has rejected the notion that hospitals must provide a certain percentage of revenues in community benefits, instead only requiring periodic reporting of what those benefits are. It has thus avoided the danger, pointed out in a dissenting opinion in the Provena case, that property tax exemptions would be subject to annual uncertainty, as eligibility for the exemption would depend on shifting economic factors outside the control of the hospital and affecting the amount of charity care provided.

Other elements of the opinion merit review. Although the hospital offered treatment to all without consideration of their ability to pay and had a charity care policy, it did not advertise the policy and the Court claimed it could not distinguish between the hospital’s treatment of bad debt from a for-profit institution’s actions. The hospital’s provision of discounted care to Medicare and Medicaid patients was not recognized as charity, since the Court stated that participation in Medicare and Medicaid was voluntary and provided the hospital with a “reliable stream of revenue.” Many of the hospital’s myriad “community benefits” were irrelevant to the property tax exemption analysis; for example, while free screenings and wellness classes were described as “beneficial to the community,” they were not necessarily charitable, apparently because for-profit organizations offer similar benefits for purposes of generating publicity and goodwill. Expenses of a medical residency program would not count since the hospital was paid for that program. Other community benefits, such as support for shelters and certain training programs, were irrelevant to the analysis because they did not utilize the hospital real estate in question.

The law in Massachusetts shares some similarities to, but also significant differences from, Illinois law. The Massachusetts property tax exemption statute requires that the property be owned by a charitable organization and used by it for its charitable purposes. However, Massachusetts courts do not define “charity” as only encompassing provision of services without any recompense. Here, the courts recognize that so long as fees charged for health care services are reasonable and revenues derived from them are expended for the provider’s operations, then those revenues help advance the organization’s charitable purpose and their receipt does

not preclude a finding that the organization is entitled to a charitable property tax exemption. This is consistent with the general principles of federal tax exemption law, which recognizes both “donative” public charities that derive significant revenues from charitable contributions, and “service provider” public charities that derive at least one-third of their support from revenues from furnishing goods and services related to the charity’s exempt purposes.

*Here, the courts recognize that so long as fees charged for health care services are reasonable and revenues derived from them are expended for the provider’s operations, then those revenues help advance the organization’s charitable purpose and their receipt does not preclude a finding that the organization is entitled to a charitable property tax exemption.*

Perhaps most importantly, the Provena decision stand for the proposition that, for property tax exemption purposes, uncompensated care and bad debt are not “charity” and cannot support either the charitable status of the property owner or the charitable nature of the uses to which the property is put. This has of course been a critical point of dispute with respect to federal tax exemption. If this strict interpretation of what counts as “charity” were to be adopted

in Massachusetts, tax-exempt health care providers dealing with declining and below-cost reimbursements and the fruitless pursuit of patients for their increasing out-of-pocket obligations would not be able to point to the consequent revenue shortfalls as evidence of the charitable nature of their activities. Cash-strapped municipalities would then have an opportunity to revoke property tax exemptions, thereby further burdening, or perhaps ultimately destroying, these providers.

A prudent charitable health care organization in Massachusetts cannot afford to rely on its federal tax-exempt status to justify ongoing property tax exemptions. It may wish to take proactive steps to strengthen its position against future property tax exemption disputes. For example, it may want to advertise and aggressively counsel patients on its charity care policies. It should quantify the actual revenue shortfalls stemming from discounts afforded under those policies. It may want to try to quantify how its services lessen the burden of government at the local and state levels. It may want to ensure the greatest possible use of its property in the rendition of community benefits. While the Provena case rests on its own facts and the peculiarities of Illinois law, there is little doubt that property tax exemptions will continue to be a legitimate source of anxiety for exempt health care providers.

*Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, whose practice concentrates on health care and non-profit law.*

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# What Did Harry Know?

Greg Thomas, ThomasPartners, Inc.

## Modern Portfolio Theory is born...

In the early 1950s, a University of Chicago professor named Harry Roberts observed that stock prices followed no discernible patterns. Stock prices were a “random walk,” akin to the notion that the best place to find a drunk in a park was where you left him; his random wanderings made it impossible to predict where he would go.

This discovery marked the birth of a new age of investment thinking, one where risk could be mathematically measured and managed.

The poster child of this movement was Harry Markowitz, also a Chicago professor. Markowitz argued that portfolio diversification among multiple assets with low price correlations would give investors less risk, but no less reward. This approach became known as Modern Portfolio Theory and won Markowitz a Nobel Prize.

## A pie chart revolution...

Markowitz's ideas seemed magical: less risk at no cost -- who wouldn't want that? Yet no one cared, at least not for a few decades. With markets entering the strongest bull market in history, investors were inspired to pick winning “new economy” stocks, not reduce portfolio risk.

But, the market crash of 2000 undermined investors' and investment advisors' stock-picking confidence. In the aftermath, both wanted safer strategies. The 40 year old Modern Portfolio Theory was tailor-made for the moment.

Within a few years, everyone was doing “it.” Institutions reduced portfolio allocations to bonds, believing that broad diversification would deliver downside protection while higher equity allocations would deliver more reward.

Individuals, whose pie charts commonly reflected drab 50/50 “balance” between domestic stocks and high-grade bond allocations, embraced multi-colored pie charts; their slices invested in more aggressive, but low-correlated, asset classes, styles, and products. No one felt a need for dividends and interest because broad

diversification would mitigate volatility and deliver steady and distributable capital gains.

## The test of decline...

Risk mitigation is unnecessary when markets are rising, necessary only when they are in decline. Markowitz-style diversification did not have to “work” with markets generally rising, though most confused rising asset values with a “working” strategy.

When markets plunged in late 2007, broad diversification did not “work” very well. At precisely the time when low correlations were supposed to provide downside protection, almost all asset classes became highly correlated with each other and virtually all went down together.

Apologists attribute the correlation breakdowns to severe market stress; that argument, however, contradicts the basic notion that diversification offers protection when you most need it.

Critics argue that investors were lured into a “risk trap;” they embraced more risk, thinking that diversification would offset it. When historical correlations failed, investors were left with more risk and less reward, not the other way around.

The ultimate critic, ironically, may be Harry Markowitz. Harry never followed his own Nobel Prize winning advice. “I should have computed the historical co-variances of the asset classes and drawn an efficient frontier [to reduce risk],” Markowitz said when he had the opportunity to allocate his own retirement account. But he didn't; instead, he “split contributions 50/50 between stocks and bonds.”

What did Harry know? Markowitz later explained, “I visualized my grief if the market went way up and I wasn't in it or if it went way down and I was completely in it.” In other words, Harry did not think markets were “efficient” because investors would allow emotions, like he would, to periodically drive prices too high, then too low.

## The moral of the story...

Investors are risk averse, yet optimistic. As such, they easily embrace strategies offering growth and safety. But when the “promise” of safety is broken, especially when markets decline, investors move on to the next thing, usually a new strategy that solves the problems of the last.

It is not surprising, therefore, to see renewed interest in bonds. Investors’ money flow into bond funds has greatly exceeded that into stock funds over the last two years. There also seems to be renewed appreciation for ownership of individual stocks as well, particularly those that might be under-priced in an inefficient marketplace. In effect, the market is shifting to balanced portfolio strategies similar to what Harry Markowitz actually did, not what he said to do.


Were this one of Aesop’s fables, investors might see a moral to the story: “Before following the advice of any financial advisor, Nobel Prize or not, ask what he does with his own money – if it differs from what he recommends for you, it’s time find a new advisor.”

Greg Thomas  
ThomasPartners, Inc.

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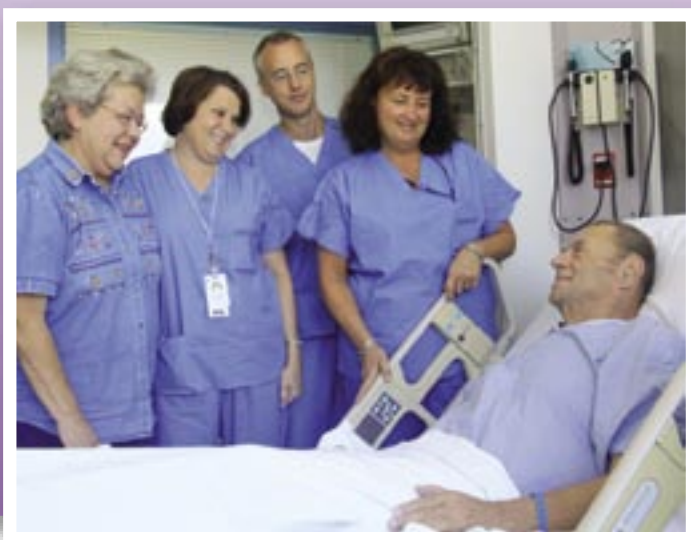
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